# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Monday, 17 February 2025 – Friday, 14 March 2025**

Virtual Hearing

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| **Name of Registrant:** | **Hugh Anderson Cairns** |
| **NMC PIN:** | 04B0121S |
| **Part(s) of the register:** | Registered Nurse – Adult<br>RNA – 22 February 2007 |
| **Relevant Location:** | East Ayrshire |
| **Type of case:** | Lack of competence/Misconduct |
| **Panel members:** | Bryan Hume (Chair, Lay member)<br>Lisa Holcroft (Registrant member)<br>Kevin Connolly (Lay member) |
| **Legal Assessor:** | Paul Housego |
| **Hearings Coordinator:** | Hamizah Sukiman |
| **Nursing and Midwifery Council:** | Represented by Giedrius Kabasinskas, Case Presenter (17 February 2025 – 11 March 2025)<br><br>Represented by Beverley Da Costa, Case Presenter (12 March 2025 onwards) |
| **Mr Cairns:** | Not present and unrepresented at this hearing |
| **Facts proved:** | Charges 1a, 1b, 2a, 2b, 2c, 3a)i) (in its entirety), 3a)ii), 3a)iii), 3a)iv), 3a)v)1), 3a)v)2), 3a)v)3), 3a)v)4), 3a)v)5)b), 3a)v)6), 3a)v)9), 3a)v)10), 3a)v)11), 3a)v)12) (in its entirety), 3b)i) (in its entirety), 3b)ii) (in its entirety), 3b)iii), 3b)iv), 3b)v)1), 3b)v)2), 3b)vii), 3b)viii), 3b)ix), 3b)x), |

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| | 3b)xi), 3b)xii), 3b)xvii) (in its entirety), 3b)xviii), 3b)xix), 3b)xx) (in its entirety), 3b)xxi) (in its entirety), 3c)i), 3c)ii), 3c)iii), 3c)iv) (in its entirety), 3c)v), 3c)vi) (in its entirety), 3c)vii) (in its entirety), 3d)i), 3d)ii) (in its entirety), 3d)iii) (in its entirety), 3d)v) (in its entirety), 3d)vi), 3d)vii)1), 3d)viii), 3d)x), 3e)i), 3e)ii), 3e)iii) (in its entirety),3e)iv) (in its entirety), 3e)v) (in its entirety), 3f)i), 3f)ii), 3f)iii) (in its entirety), 3f)iv), 3f)v), 3f)vi) (in its entirety), 4, 5, 6a, 6b, 7a, 7b, 7c, 8, 9a, 9b, 10, 11c, 11f, 11g, 12a, 12b, 12c, 12d, 12e, 12f, 12g, 12h, 12i, 12j (in its entirety), 12k, 13b, 16, 17, 18a, 18b, 18c, 18d, 18e, 19, 20, 21, 22, 23 and 24 |
| **Facts not proved:** | Charges 3a)v)5)a), 3a)v)7), 3a)v)8), 3b)v)3), 3b)vi) (in its entirety), 3b)xiii), 3b)xiv), 3b)xv), 3b)xvi), 3d)iv), 3d)vii)2), 3d)ix), 11a, 11b, 11d, 11e, 11h, 13a, 14a, 14b and 15 |
| **Fitness to practise:** | **Impaired** |
| **Sanction:** | **Striking-off order** |
| **Interim order:** | **Interim suspension order (18 months)** |

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Mr Cairns was not in attendance and that the Notice of Hearing letter had been sent to Mr Cairns' registered email address by secure email on 16 January 2025.

Further, the panel noted that the Notice of Hearing was also sent to Mr Cairns' representative at Thompsons Solicitors on 16 January 2025.

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

The panel accepted the advice of the legal assessor.

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

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

**Decision and reasons on application for the Rule 21 application to be held wholly in private**

Mr Kabasinskas then made an application for the proceeding in absence application (Rule 21 application) to be heard entirely in private as [PRIVATE]. This application was made pursuant to Rule 19(3) of the Rules.

The panel accepted the advice of the legal assessor. He reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest. He advised the panel that, whilst this application is made in relation to the NMC's Rule 21 application, the panel may enter into private session at other points in the proceedings [PRIVATE].

Having heard that there will be numerous references to [PRIVATE] in Mr Kabasinskas' Rule 21 application, the panel determined to hold the entirety of the Rule 21 application in private in order to [PRIVATE].

**Proceeding in the absence of Mr Cairns**

Application under Rule 19 was accepted by the panel and the application to proceed in Mr Cairns' absence under Rule 21 was held fully in private.

The panel has decided that it is fair to proceed in the absence of Mr Cairns. The panel will draw no adverse inference from Mr Cairns' absence in making its findings of fact.

**Details of charges (as amended)**

That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:

1) On 18 January 2019 in respect of Patient A failed to inform district nurses:
    a) That they had been discharged from hospital.
    b) That they required catheter care.
2) Between 24 January 2019 and 25 January 2019 in respect of Patient B:
    a) Failed to provide treatment when their blood sugar reading was 3.7.

b) Failed to follow hypoglycaemia protocol.

c) Failed to monitor them.

3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:

a) Administration of medicines, in particular:

i) Between 10 April 2020 and 22 January 2021 on one or more occasions you:

(1) Were unable to classify one or more of the medication/s as set out in Schedule A.

(2) Were unable to explain why one or more of the medication/s set out in Schedule B were prescribed and/or administered.

ii) Were unable to identify one or more of the medication/s as set out in Schedule C.

iii) Were unable to relate medications to conditions or explain the effectiveness of medications.

iv) On or around 2 October 2020 dispensed and administered Ticagrelor without demonstrating you knew what the medication was for and/or why it was being administered.

v) Were unable to complete a medication round satisfactorily in that you:

(1) Between 15 April 2020 and 4 August 2020 on one or more occasions failed to take an unknown patient/s' heart rate/s before administering Digoxin.

(2) Between 10 July 2020 and 17 July 2020 on one or more occasion attempted to administer to an unknown patient the wrong dose of paracetamol.

(3) On or around 25 August 2020 attempted to administer the wrong dose of antibiotics to an unknown patient.

(4) On or around 25 August 2020 failed to administer a teatime dose of insulin to an unknown patient.

(5) On 4 December 2020;

(a) Dispensed an incorrect dosage of haloperidol.

(b) Tried to administer 25mls of haloperidol to an unknown patient.

(6) On an unknown date/s failed to administer to unknown patient/s insulin prior to meal times.

(7) On an unknown date failed to administer pain relief to palliative care patients.

(8) On one or more occasions gave prescribed medication without assessing the unknown patient.

(9) On or around 22 July 2020 attempted to administer the incorrect dose of Buscopan.

(10) On or around 9 August 2020 did not check the packaging strip of unknown medication.

(11) On or around 30 July 2020 failed to provide to two patients their medication.

(12) On or around 27 May 2020 in respect of an unknown patient;

(a) were unable to identify the reason for giving solfidian.

(b) attempted to administer the incorrect dose of solfidian.

b) Patient Care/Organisation, in particular;

i) Between 10 April 2020 and 22 January 2021 on one or more occasion failed to complete and/or incorrectly completed;

(1) Modified Early Warning Scores (“MEWS”) charts.

(2) National Early Warning Scores (“NEWS”) charts.

ii) On or around 21 June 2020 in relation to an unknown patient you:

(1) Failed to escalate to another nurse or medic that their blood pressure was 76/56;

(2) Failed to recheck the reading.

iii) On or around 16 July 2020 failed to carry out nursing observations in relation to an unknown patient.

iv) On or around 9 August 2020 did not check an unknown patient’s pulse manually when reviewing for bradycardia.

v) Between 4 August 2020 and 31 December 2020 on one or more occasion:

(1) Were unable to correctly calculate NEWS scores;

(2) Were unable to explain and/or identify that a high NEWS score in a patient was an issue and/or needed attended to immediately.

(3) Did not calculate a NEWS score for unknown patient/s instead entered a generic score of 16.

vi) In December 2020 in relation to an unknown patient:

(1) Failed to calculate the correct NEWS score of 33;

(2) Entered an incorrect score of 16.

(3) On prompting further failed to calculate NEWS score correctly.

vii) On or around 15 August 2020 were unable to identify and/or observe and/or assess signs of deteriorating patient.

viii) Between June 2020 and 25 August 2020 on one or more occasion failed to provide personal care to patients.

ix) On or around 12 June 2020 required prompting to organise patient care.

x) On or around 22 June 2020 did not give auxiliary staff instructions and/or ask for feedback.

xi) On or around 26 June 2020 were unable manage patient care with other activities.

xii) In June 2020 on one or more occasion required prompting to ask unknown patient/s how their pain levels were.

xiii) Between June 2020 and 22 January 2021 on one or more occasion failed to complete a paperwork contemporaneously.

xiv) In June 2020 on one occasion or more took two hours to complete a medication round.

xv) On or around 12 June 2020 did not administer medication/complete a medication round in a timely fashion.

xvi) On or around 21 June 2020 unnecessarily delayed calculating NEWS scores.

xvii) On or around 12 July 2020 required prompting on managing patient care including;

(1) Patient dressings.

(2) Removing a catheter.

xviii) On or around 15 August 2020 failed to do referrals marked as urgent.

xix) In August 2020 failed to reassess patients in appropriate timescales.

xx) On or around 25 August 2020:

(1) Were unable to identify an unknown patient with a NEWS of 10 was a priority.

(2) Took a whole day to discharge an unknown patient without clinical justification.

(3) Required to be prompted to contact the district nurse.

xxi) On or around 15 July 2020:

(1) Did not carry out fluid balances for patients in beds 4 and 5 despite being asked on more than one occasion to do so.

(2) Did not prioritise completing peripheral venous cannula ("PVC") charts for patients in beds 4 and 5.

c) Documentation and record keeping, in particular:

i) Between 22 May 2020 and 22 January 2021 on one or more occasions were unable to complete fluid and water charts correctly and/or adequately.

ii) On or around 16 July 2020 failed to record a spine x-ray on unknown patient's SBAR and/or nursing notes.

iii) On or around 22 July 2020 failed to record assessment of pain and/or pain management for an unknown palliative patient.

iv) On or around 22 July 2020 in relation to an unknown asthmatic patient failed to record:

(1) medication administered.

(2) whether the medication was beneficial.

v) On or around 15 July 2020 failed to correctly complete a cannula chart.

vi) In December 2020 in relation to Patient C;

(1) Recorded 3 different respiratory rates for the same set of observations.

(2) Incorrectly calculated the NEWS score from the recordings recorded.

vii) Between 1 September 2020 and January 2021 on one or more occasions your written handovers

(1) contained insufficient detail.

(2) did not contain patient plans for the next day.

d) Communication with colleagues, in particular:

i) On or around 27 May 2020 failed to handover an unknown patient was at high risk of stroke.

ii) On or around 12 June 2020 in relation to an unknown patient failed to handover that;

(1) They had low blood pressure.

(2) That Bisoprolol and/or Furosemide had been withheld.

iii) On or around 12 July 2020 in relation to an unknown patient;

(1) Failed to handover that their cannula had tissued.

(2) Failed to document that their cannula had tissued.

iv) On or around 16 July 2020 when giving handover/s in relation to unknown patient/s provided information that was not up to date.

v) Between 1 August 2020 and 30 August 2020:

(1) On one or more occasion gave verbal handover/s;

(a) That were disjointed.

(b) Where information was missed.

vi) Went on a break and did not give colleagues a handover on patients.

vii) On or around 2 October 2020 failed to handover in respect of an unknown patient:

(1) That they had been aggressive and/or violent;

(2) The extent of their aggression.

viii) On 28 July 2020 were unable to explain to an unknown colleague what a Higher Resolution Computed Tomograph ("HRCT") scan was.

ix) On 29 July 2020 incorrectly told Colleague D that an unknown patient was on 24% Oxygen.

x) On or around 30 July 2020 in relation to an unknown patient who was awaiting a blood patch were unable to explain what a blood patch was.

e) Communication with patients and/or patient's relatives, in particular;

i) On or around 15 August 2020 discussed in the presence of one or more patient that [PRIVATE].

ii) On or around 15 August 2020 on one or more occasion unnecessarily repeated questions to patients.

iii) On or around 15 August 2020 in relation to an unknown patient:

(1) Did not notice they were uncomfortable with the content of your conversation.

(2) Were unable to count their respiratory rate.

(3) Were unable to identify if their pulse was regular or irregular.

iv) On or around 15 August 2020 communicated poorly with patients' relatives in that;

(1) You lacked knowledge on patients as individuals;

(2) Your updates were vague;

(3) Your feedback of information to relatives was disjointed and/or did not follow a logical pattern.

v) On or around 25 August 2020;

(1) You did not enter an unknown palliative patient's room your entire shift.

(2) Used informal language when asking two unknown patients about a laxative which they did not understand.

(3) Gave an unknown patient's relative incorrect information about their condition.

f) Infection control, in particular;

i) On or around 22 May 2020 breached health and safety procedures in relation to a patient with MRSA and ESBL.

ii) On or around 27 May 2020 did not challenge a visitor who entered the ward to see a relative without prior consent being given.

iii) Between 17 June 2020 and 25 August 2020 on one or more occasion took a Covid-19 swab from an unknown patient without donning:

(1) Goggles.

(2) A Visor.

(3) An Apron.

iv) In or around July 2020 did not wear Personal Protective Equipment (“PPE”) when you entered an unknown patient’s room when there were infection control precautions in place.

v) On or around 30 July 2020 did not dispose of a used visor in an appropriate receptacle.

vi) On or around 2 October 2020 when carrying out a foot dressing on an unknown patient;

(1) Did not have suitable surface to work on;

(2) Did not have the necessary dressings;

(3) Had to be prompted to change gloves.

4) On or around 28 July 2020 did not move an unknown patient to the discharge lounge for an urgent transfer when requested to do so by a Deputy Charge Nurse

5) On or around 9 August 2020 did not follow your mentor’s instruction to examine patients’ groins before issuing cream.

6) On or around 17 July 2020 in relation to an unknown patient:

a) Failed to place them on oxygen immediately when requested to do so by an Advanced Nurse Practitioner.

b) On one or more occasions had to be prompted to carry out observations.

7) Between 4 December 2020 and 5 December 2020:

a) Did not carry out patient personal care tasks when delegated to do these tasks by your mentor.

b) Did not carry out skin assessment checks personally as requested by your mentor.

c) Refused to help an unknown patient to the toilet.

8) On 22 July 2020 in relation to an unknown patient placed a surgical mask below an oxygen mask.

9) On or around 9 August 2020;

    a) Attempted to connect an extension set to venflon without flushing first.

    b) Failed to check an unknown patient's pulse manually when reviewing for bradycardia.

10) On or around 25 August 2020 were unable to provide basic descriptions of routine investigations frequently used/carried out with respiratory patients.

11) On 10 October 2020 in respect of an unknown patient:

    a) Did not carry out a full set of observations.

    b) Documented a full set of observations when you had not carried out a full set of observations.

    c) Incorrectly recorded their respiratory rate as 18.

    d) Incorrectly documented temperature of 37.8.

    e) Documented the above temperature when there was no thermometer present in their room.

    f) Failed to act on information within the NEWS.

    g) Failed to alert/escalate to medical and/or nursing staff to the deterioration in their condition.

    h) Failed to reassess the patient.

12) In or around December 2020 in relation to discharging an unknown patient:

    a) Failed to complete nursing notes to satisfactory standard.

    b) Delayed attending to personal care.

    c) Sought to inappropriately delegate personal care.

    d) Did not complete the transfer letter.

e) Requested a discharge porter to attend before patient had been showered.

f) Failed to dress them in underwear.

g) Failed use an incontinence pad.

h) Failed to write in the nursing home transfer letter that they were doubly incontinent.

i) Required prompting to remove their cannula.

j) Removed their cannula;

   i) Without wearing gloves.

   ii) Without wearing an apron.

   iii) In the corridor.

k) Failed to enter into the nursing notes that they were going to a nursing home and/or being discharged.

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

That you, a registered nurse,

13) On or around 15 July 2020:

   a) Said to an unknown female staff member in relation to an unknown patient “What has she got chlamydia?” or words to that effect.

   b) Said to an unknown colleague “that as it wasn’t raining out, she wouldn’t win a wet t-shirt competition” or words to that effect.

14) In December 2020;

   a) Stated to Colleague C and Colleague B that you had not recorded 3 respiratory rates for Patient C.

b) Told Colleague A that you admitted that you said you had not, to cover up your mistake or words to that effect.

15) Your actions at charge 14 above were dishonest in that you knew when you denied recording the 3 respiratory rates that you had recorded the 3 respiratory rates and the reason you said you had not was to cover up your mistake.

16) On or around 4/5 December 2020 disobeyed an instruction not to store [PRIVATE] in your tunic pocket when you had been told to keep them in your locker.

17) On or around 4/5 December 2020 having [PRIVATE] on shift refused to go home when requested to do so by your mentor.

18) On 4 December 2020 and/or 5 December 2020 said to an unknown patient:

a) "You're one of them" or words to that effect.

b) That his tattoos were "IRA tattoos" or words to that effect.

c) Spoke to him about being in the army.

d) Stated to him "you lot" or words to that effect.

e) Disobeyed Colleague A's instruction to stop speaking to the patient in that way.

19) Your actions at all or part of charge 18 above were discriminatory.

20) On 4 December 2020 and/or 5 December documented patient skin care when you had not assessed any patients' skin throughout the shift.

21) Your actions at charge 20 above were dishonest as you knew you had not assessed patients' skin and you sought to mislead others to believe that you had assessed patients' skin when you had not.

22) On date/s unknown made entries in unknown patient/s fluid balance charts when you had not measured fluid intake/outtake.

23) Your actions at charge 22 above were dishonest in that you knew you had not measured unknown patients' fluid intake/outtake and you sought to mislead others to believe that you had measured unknown patient/s fluid intake/outtake when you had not.

24) Between 4 August 2020 and 22 January 2021 on one or more occasion in relation to female patient/s refused to undertake personal care.

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

**Schedule A**

Carbamazepine

Spironolactone

Allopurinol

**Schedule B (drug names spellings corrected)-**

Furosemide

Citalopram

Levetiracetam

Solifenacin

Sertraline

Betahistine

Pregabalin

Isosorbide Mononitrate

Carbocysteine

Allopurinol

**Schedule C-**

Citaloparm,

Setraline

Pregabalin

Carbocysteine

Allopurinol

**Schedule D Private**

[PRIVATE].

**Background**

The charges arose whilst Mr Cairns was employed as a Band 5 registered nurse at Crosshouse Hospital ('the Hospital') by NHS Ayrshire and Arran Healthcare Board ('the Board'). He qualified as a registered nurse and began his role at the Hospital in 2007.

The Board alleged that there have been concerns surrounding Mr Cairns' capability since he began his role in 2007, which were noted on his file but never formalised. At this time, Mr Cairns was working on Ward 5D in the Hospital.

In April 2020, Mr Cairns was moved to Ward 3B, a respiratory ward in the Hospital, in a supernumerary capacity and allocated two mentors to assist him in strengthening his practice. He was later placed on a Formal Capability Programme as a result of his lack of competence. However, as there was no progress towards competency, Mr Cairns' capability plan progressed to Stage 2 by September 2020. It is alleged by the Board that, at each formal and informal capability meeting, Mr Cairns showed no improvement in his

competence. The Board further alleged that Mr Cairns was unable to meet the competencies required of a newly-qualified nurse, and that he would be unable to conduct his nursing duties without ongoing supernumerary status and additional supervision. Further, there was concern that Mr Cairns was declining to provide personal care to female patients, and reluctant to undertake personal care for male patients, on the basis that this was work for a health care assistant, and not for a registered nurse.

Mr Cairns expressed to the Board that he felt unsupported by his mentors and that [PRIVATE], and that he was having difficult professional relationships with other staff members at the Hospital.

Following an incident on 10 October 2020, Mr Cairns was suspended, and the capability process was put on hold pending a disciplinary investigation into the incident. In January 2021, Mr Cairns agreed for his contract of employment with the Board to be terminated on the grounds of [PRIVATE] his capability. The Board referred the matters charged to the NMC.

**Decision and reasons on application to admit Witness 7's witness statement as hearsay evidence**

On the fourth day of proceedings, the panel heard two applications from Mr Kabasinskas to allow the written statement of Witness 7 and Ms 1 into evidence, pursuant to Rule 31 of the Rules. Mr Kabasinskas acknowledged that his application in relation to Ms 1 is contingent on his application in relation to Witness 7, so he addressed the panel in turn.

In relation to Witness 7's witness statement, Mr Kabasinskas informed the panel that Witness 7 is a member of NMC staff, and that his evidence relates entirely to the NMC's attempts to engage Ms 1 in these proceedings. He told the panel that Witness 7's witness statement and the three accompanying exhibits have been served on Mr Cairns' representative prior to this hearing.

Mr Kabasinskas referred the panel to Rule 31 and the NMC Guidance on hearsay (DMA-6). He submitted that the panel should have regard to the decisions to, and principles derived from, the cases of *R (on the application of Bonhoeffer) v General Medical Council* [2011] EWHC 1585 (Admin), *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin), *Mansary v Nursing and Midwifery Council* [2023] EWHC 730 (Admin) as well as *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). He reminded the panel that it is dealing solely with the question of admissibility at this stage. He referred the panel to the seven principles for its consideration, pursuant to *Thorneycroft*, which are:

- Whether the statement is the sole and decisive evidence in support of the charges;
- The nature and extent of the challenge to the contents of the statement;
- Whether there was any suggestion that the witness had reason to fabricate their allegation;
- The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;
- Whether there was a good reason for the non-attendance of the witness;

- Whether the regulator had taken reasonable steps to secure the witness's attendance; and
- Whether the registrant did not have prior notice that the witness statement would be read.

Mr Kabasinskas considered the above principles in turn.

On whether Witness 7's witness statement is the sole and decisive evidence, Mr Kabasinskas submitted that his evidence does not speak to any of the charges. He further submitted that Witness 7's evidence is a purely procedural statement evidencing the steps the NMC had undertaken to engage Ms 1 in seeking a further statement from her and attempting to secure her attendance at this hearing.

Mr Kabasinskas submitted that, at this stage, the nature and extent of the challenge to the contents of Witness 7's statement is unknown. He further submitted that there is nothing before the panel to suggest that Witness 7's evidence has been fabricated or that he had reason to fabricate it. Mr Kabasinskas submitted that the consideration of the seriousness of the charges is not applicable, given the nature of Witness 7's evidence, which was procedural.

On whether there is good reason for Witness 7's non-attendance, Mr Kabasinskas informed the panel that he is away from the office and will return on 26 February 2025. He submitted that, if the panel considered it necessary, Witness 7 can be called to give evidence at that time. However, Mr Kabasinskas submitted that this application is made to utilise the allocated hearing time effectively, as Witness 7's evidence is not essential to resolve factual disputes within this case and is instead a procedural statement made in connection with the application to admit Ms 1's evidence as hearsay. He submitted that Witness 7's attendance and live evidence would be of limited value to this panel.

Mr Kabasinskas further submitted that reasonable steps have been taken to secure Witness 7's attendance, and he reiterated that Witness 7 is available to give evidence on 26 February 2025 if the panel considered it necessary.

Mr Kabasinskas conceded that Mr Cairns and his representatives did not have prior notice that Witness 7's witness statement would be read. However, he submitted that there was no lack of fairness to Mr Cairns in allowing Witness 7's written statement into evidence, given all the circumstances of the case, particularly given Witness 7's evidence does not speak to any of the charges.

The panel accepted the advice of the legal assessor. He outlined the decisions in *Bonhoeffer, El Karout* as well as *Thorneycroft*, and *Nursing and Midwifery Council v Ogbonna* [2010] EWCA Civ 1216 he advised the panel to consider fairness to all parties, including Mr Cairns, in its decision. He reminded the panel that it has the opportunity to hear from Witness 7 if it so wished on 26 February 2025, but that Witness 7's evidence did not speak to the charges and instead entirely related to the absence of Ms 1 from these proceedings.

In reaching its decision, the panel considered all the evidence before it, submissions from Kabasinskas and the legal advice. In particular, the panel had regard to the seven principles derived from *Thorneycroft*. The panel considered each of the principles in turn.

The panel determined that Witness 7's evidence is not sole and decisive in these circumstances, as his witness statement and accompanying exhibits relate solely to the NMC's attempts to contact and secure Ms 1's attendance in these proceedings. The panel was satisfied that the evidence is not in relation to any of the charges. On the same limb, the panel determined that the consideration in respect of the seriousness of the charges and the adverse impact on Mr Cairns does not apply in these circumstances.

Further, the panel considered that Witness 7's witness statement has been served on Mr Cairns and his legal representative, and there has been no challenge from either Mr

Cairns or his representative in relation to this evidence. The panel noted that neither Mr Cairns nor his representative is in attendance, but it nonetheless noted that Witness 7's evidence has not been challenged.

The panel accepted Mr Kabasinskas' submission that there is no reason for Witness 7 to fabricate his evidence, and the panel has no information before it suggesting otherwise.

On whether there was a good reason for the non-attendance Witness 7 and whether the NMC had taken reasonable steps to secure his attendance, the panel took into account that Witness 7 is not currently in the office, and it was of the view that his unavailability was for good reason. The panel also considered that reasonable steps have been taken to secure his attendance within the times in which he is available, and the option to call Witness 7 on 26 February 2025 (when Witness 7 returns to the office) is available before the panel.

The panel accepted Mr Kabasinskas' submission on Mr Cairns and his representative not having prior notice that the witness statement would be read.

Taking all of the above into account, the panel considered that Witness 7's evidence details telephone and other communication attempts between the NMC and Ms 1 to secure her attendance in these proceedings. The panel considered that this evidence does not speak to any of the charges, and the adducing of this evidence is necessary for its consideration on Mr Kabasinskas' upcoming Rule 31 application on Ms 1's evidence. The panel noted that neither Mr Cairns nor his representative, who have been sent Witness 7's witness statement, have challenged the evidence. The panel was also of the view that it would not have any questions for Witness 7 in the event that he was called to give live evidence which would assist the panel in its decision-making on facts, and that to admit Witness 7's witness statement would be an efficient use of the available hearing resources.

The panel then considered whether Mr Cairns would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 7 to that of a written statement. The panel determined Mr Cairns and his representative have been provided with a copy of Witness 7's statement and, as the panel had already determined that Mr Cairns had deliberately chosen not to exercise his right to be present or to give adequate instructions to enable lawyers to represent him, neither he nor his representative would be in a position to cross-examine this witness in any case.

Accordingly, the panel concluded that it would be relevant and fair to accept into evidence the written statement of Witness 7.

**Decision and reasons on application to admit Ms 1's witness statement and exhibits as hearsay evidence**

Following the panel's decision on Mr Kabasinskas' Rule 31 application in relation to Witness 7 above, he applied to allow the written statement of Ms 1 into evidence, pursuant to Rule 31 of the Rules. He referred the panel to his submissions on the legal principles underpinning its decision, as above.

Mr Kabasinskas submitted that Ms 1's evidence was relevant only to charge 1 and to charge 2. He submitted that it is not the sole and decisive evidence in support of either charge 1 or charge 2. In relation to charge 1, he submitted that both Witness 4 and Witness 6 were direct witnesses to the incident, and both witnesses are due to give evidence in these proceedings. In relation to charge 2, Mr Kabasinskas submitted that Ms 1 was involved as the investigator, rather than a direct witness, and gave evidence about the steps taken in the investigation which involved Witness 4, whose evidence can be tested by the panel.

Mr Kabasinskas further submitted that Mr Cairns and his representatives have been served with Ms 1's statement and have not challenged its contents. He further submitted that, in any event, all of the exhibits appended as part of Ms 1's statement are either non-

prejudicial to Mr Cairns or appear elsewhere in Witness 4 or Witness 6's witness statements. By way of example, he submitted that Exhibit [PRIVATE]/1 – an email from Ms 2, dated 16 February 2021, detailing Mr Cairns' practice – contained no prejudicial information. The dates of incidents were not prejudicial. He further submitted that Exhibit [PRIVATE]/2 – the local investigation documents regarding the 18 January 2019 incident – involved both Ms 1 and Witness 4, and this information is also exhibited as part of Witness 4's witness statement. In relation to Exhibit [PRIVATE]/3, he submitted that, alongside exhibits which are otherwise part of other witnesses' statements, there are also patient records included, the inclusion of which cannot be argued to be unfair.

Further, Mr Kabasinskas submitted that some of the exhibits appended as part of Ms 1's statement includes Mr Cairns' responses at the time (such as Exhibit [PRIVATE]/4), including responses prepared on his behalf by his union representatives. He submitted that, if this application failed, the panel would not be able to factor in Mr Cairns' contemporaneous response in its decision on facts. Accordingly, it would also be fair to Mr Cairns to admit Ms 1's statement.

In relation to Exhibit [PRIVATE]/5, Mr Kabasinskas submitted that these detailed Mr Cairns' final written warning, and whether or not the incidents occurred is a matter for the panel's professional judgement. He submitted that these are, in any event, not prejudicial to Mr Cairns.

He further submitted that there is nothing before the panel to suggest that Ms 1's evidence has been fabricated or that she had reason to fabricate it. He submitted that there has been no challenge by Mr Cairns, during the Board's internal investigation, that these incidents occurred.

On the consideration of the seriousness of the charges, Mr Kabasinskas submitted that Ms 1's evidence relates to charges 1 and 2, and its accompanying sub-charges. He submitted that these charges relate to Mr Cairns' lack of competence, for which the most severe sanction which could be imposed is a suspension order. He further submitted that

these two charges are not the most serious charges Mr Cairns is facing in these proceedings. Accordingly, the potential outcome of this hearing was not a factor indicating that the statement should not be admitted.

On whether there is good reason for Ms 1's non-attendance and if reasonable steps had been taken by the NMC to secure Ms 1's attendance, Mr Kabasinskas referred the panel to the handwritten letter, dated 18 December 2024, from Ms 1, which stated that [PRIVATE].

The panel also had sight of an email sent by Ms 1 to the NMC, dated 16 January 2025, which stated:

> *"I am really sorry but I will be unable to give evidence.* [PRIVATE]*. Thanks for the offer however I am afraid nil further support would help me in this issue.* [PRIVATE]*…"*

Mr Kabasinskas submitted that [PRIVATE]. He submitted that, by her own admission, Ms 1 would be unable to take her evidence further than what she has already provided in her witness statement, which is dated 20 July 2022.

Mr Kabasinskas further referred the panel to Witness 7's exhibits, and he submitted that the NMC has attempted to engage Ms 1 and offered her additional support to secure her attendance at this hearing. However, the NMC has been unsuccessful in this regard.

Mr Kabasinskas informed the panel that both Mr Cairns and his representatives were served with Ms 1's witness statement prior to these proceedings.

Mr Kabasinskas submitted that there is no question as to the relevance of Ms 1's evidence, and that the question before the panel is one of fairness. He submitted that, given Ms 1's evidence is not sole and decisive to charges 1 and 2 and that the exhibits

contained multiple contemporaneous documents produced by Mr Cairns, it would be fair to both the NMC and to Mr Cairns to admit Ms 1's witness statement.

The panel accepted the advice of the legal assessor, who referred the panel to the advice he provided in the Rule 31 application in relation to Witness 7. He advised the panel that the issue of the weight to be attached to the witness statement was subordinate to the primary decision as to whether it was fair or not to admit the statement. As Ms 1 had no recollection about the matters referred to in her witness statement, she could not assist this panel. There had to be a question over the witness statement itself as it was apparent that Ms 1 did not recall it.

Further, the legal assessor advised that the documents exhibited to Ms 1's witness statement were prepared at the time, and there would not be unfairness to Mr Cairns in those documents being considered. If the panel wished to admit Ms 1's witness statement into evidence in order to ensure that the exhibits were in evidence then, he advised, the contents of the witness statement itself could be given no weight as Ms 1, if attending, would not be able to say that to the best of her knowledge and belief the contents were true, as she now had no recollection of the events covered in the witness statement. All Ms 1 would be able to say was that it was likely that at the time she signed it she thought it was true. He advised that documents submitted by Mr Cairns could be considered by the panel whether or not exhibited to the witness statement: documents provided by registrants were always considered by Fitness to Practise panels.

In reaching its decision, the panel considered all the evidence before it, submissions from Kabasinskas and the legal advice. In particular, the panel had regard to the seven principles derived from *Thorneycroft*. The panel considered each of the principles in turn.

The panel accepted Mr Kabasinskas' submissions that Ms 1's evidence relates only to charges 1 and 2 and the relevant sub-charges. It determined that Ms 1's evidence is not the sole and decisive evidence, as both Witness 4 and Witness 6's witness statements both support the NMC's case in relation to these charges. The panel took into account that

both Witness 4 and Witness 6 are due to give live evidence, and their evidence can be tested.

On the nature and extent of the challenge to the contents of Ms 1's witness statement, the panel considered that Ms 1's exhibits primarily contained documentation involving others in the Board's internal investigation, including Mr Cairns' responses at the time. The panel considered that the witness statement has been served on Mr Cairns and his representative, and there is no information before it of any challenge.

The panel accepted Mr Kabasinskas' submission that there is no reason for Ms 1 to fabricate her evidence, and the panel has no information before it suggesting otherwise.

In relation to the seriousness of the charges, the panel considered that Ms 1's evidence related to two of the 12 charges of lack of competence (and accompanying sub-charges) Mr Cairns is facing in these proceedings, alongside an additional 12 charges (and accompanying sub-charges) of misconduct. The panel determined that, in context of the numerous charges before it, charges 1 and 2 are not the most serious charges.

On whether there was a good reason for Ms 1's non-attendance, the panel considered [PRIVATE] her inability to recollect the relevant incidents. The panel was of the view that this was a good reason for non-attendance, as she would be unable to give effective evidence. Additionally, based on Witness 7's witness statement, the panel determined that the NMC has taken reasonable steps to secure Ms 1's attendance, including offering her additional support.

The panel acknowledged that Mr Cairns and his representative did not have prior notice that Ms 1's witness statement would be read. However, the panel considered that any unfairness caused by this is mitigated by the fact that Mr Cairns and his representative had received Ms 1's statement prior to this hearing.

The panel was satisfied that that Ms 1's evidence is relevant, as it relates to charges 1 and 2.

The panel next considered whether it would be fair to admit Ms 1's witness statement. Taking all of the above into account, the panel considered that Witness 7's evidence details the Board's internal investigation, including the involvement of other witnesses (such as Witness 4 and Witness 6) as well as Mr Cairns' responses at the time. The panel took into account that, in light of [PRIVATE], the panel would not be assisted by her attendance and live evidence in these proceedings in any event. The panel determined that the generalised negative comments made by Ms 1 in relation to Mr Cairns, which do not relate to charges 1 or 2, will be accorded no weight and will be disregarded.

The panel then considered whether Mr Cairns would be disadvantaged by admitting Ms 1's witness statement. The panel determined Mr Cairns and his representative have been provided with a copy of Ms 1's statement and this was not challenged. Further, as the panel had already determined that Mr Cairns had deliberately chosen not to attend this hearing or instruct lawyers to represent him. Given that Ms 1 does not recall the incidents, neither Mr Cairns nor his representative would be in a position to cross-examine Ms 1 in any case.

The panel also considered that some of the exhibits appended to Ms 1's statements were Mr Cairns' contemporaneous response and documentation in the Board's investigation, and it would be fair to Mr Cairns for the panel to consider his responses to the allegations. The panel would not wish there to be any argument as to their admissibility, and admitting the witness statement ensured that there would not be.

Taking all the above into account, the panel concluded that it would be relevant and fair to accept into evidence the written statement of Ms 1. However, the panel determined that it could give the substantive content of the witness statement little or no weight, as the witness had no recollection of the events covered, or of giving the witness statement.

**Decision and reasons on application to amend the charge**

The panel, of its own volition, corrected the spelling of some medication names in Schedules A and B of the charges. It also deleted some duplicate medication names within these charges.

Prior to closing the NMC's case on facts, Mr Kabasinskas made an application to amend the dates in charges 3c)iii) and iv), as well as charge 3d)x). He referred the panel to its powers within Rule 28 of the Rules, and the considerations before it in its decision-making, namely having regard to the merits of the case and the fairness of the proceedings, and that the required amendment can be made without injustice.

Mr Kabasinskas submitted that that the proposed amendments are of a technical nature and are relatively minor as they relate to different dates within the same month. He further submitted that the proposed amendments would not alter the stem and gravity of these charges. Consequently, he submitted that these amendments would not cause prejudice to Mr Cairns, particularly as Mr Cairns and his representative have both received all the documentation relied upon by the NMC.

On the contrary, Mr Kabasinskas submitted that there would be prejudice to the NMC if the panel denied this application. He submitted that these charges would be found not proved on the basis of incorrect dates, as opposed to the NMC's failure to prove the mischief of the charge. He informed the panel that the erroneous dates have been identified through his cross-referencing the charges with the documentation available before this panel as exhibited by witnesses.

The proposed amendments are as follows:

> "That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:

3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:

c) Documentation and record keeping, in particular:

iii) On or around ~~17~~ **22** July 2020 failed to record assessment of pain and/or pain management for an unknown palliative patient.

iv) On or around ~~17~~ **22** July 2020 in relation to an unknown asthmatic patient failed to record:

(1) …

(2) …

[…]

d) Communication with colleagues, in particular:

x) On or around ~~2~~ **30** July 2020 in relation to an unknown patient who was awaiting a blood patch were unable to explain what a blood patch was

And in light of the above, your fitness to practise is impaired by reason of your lack of competence."

The panel accepted the advice of the legal assessor, who advised it of its powers within Rule 28. He advised the panel that its decision must consider fairness, both to the NMC and to Mr Cairns. He further advised the panel that, if it was of the view that amending the dates on the relevant charges is to correct an administrative error which was identified by Mr Kabasinskas' cross-referencing would not be unfair to Mr Cairns, it should accept the application. Conversely, if the panel was of the view that it would be unfair to Mr Cairns for the dates to be amended, then it should refuse the application. He reminded the panel to consider whether the dates would be critical to the findings of these charges from Mr Cairns' perspective in determining fairness.

The panel was of the view that the amendments were administrative in nature. The panel was satisfied that no prejudice or injustice would be caused to either party, including Mr Cairns (who has deliberately chosen not to attend or to instruct solicitors to represent him at these proceedings), by the proposed amendment being allowed. The panel took into account that Mr Cairns and his representative received all the documentation upon which the NMC wished to rely, including the relevant documentation indicating the correct dates for each of these charges. The panel noted that allowing the proposed amendments would not impact Mr Cairns' position on the charges, which he had not admitted. Further, the panel was of the view that this would reflect the evidence before it more accurately.

Taking all of the above into consideration, the panel determined that it was appropriate to allow all of the proposed amendments to correct this administrative error.

**Decision and reasons on facts**

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence before it, alongside the submissions made by Mr Kabasinskas. The panel has drawn no adverse inference from the non-attendance of Mr Cairns.

The panel bore in mind 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: Senior Charge Nurse on Ward 3B at the Hospital

- Witness 2: Staff Nurse on Ward 3B at the Hospital and Mr Cairns' mentor (at the time of some of the incidents)
- Witness 3: Staff Nurse on Ward 3B at the Hospital and Mr Cairns' mentor (at the time of the incidents)
- Witness 4: Senior Charge Nurse at the Hospital and Mr Cairns' manager (at the time of the incidents)
- Witness 5: Deputy Charge Nurse on Ward 3B at the Hospital and Mr Cairns' mentor (at the time of some of the incidents)
- Witness 6: Deputy Charge Nurse on Ward 5D at the Hospital (at the time of the incidents)

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

In reaching its decision, the panel bore in mind the decision in, and principles derived from, the judgment in *Hindle v The Nursing and Midwifery Council* [2025] EWHC 373 (Admin). The panel was mindful of the nature of the charges faced by Mr Cairns in relation to his competence, namely allegations of his general incompetence in several areas of nursing practice. The panel determined that in its decision on some of the sub-charges, it would not adopt a "*silo*" approach towards each sub-charge, as per *Hindle*, and consider the charges as part of a series arising from supervised practice and not as isolated allegations, particularly where the evidence supporting sub-charges is the same.

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

**Charges 1a) and b)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

1) *On 18 January 2019 in respect of Patient A failed to inform district nurses:*
    a) *That they had been discharged from hospital.*
    b) *That they required catheter care."*

**These charges are found proved.**

In reaching this decision, the panel took into account Witness 4's witness statement, which stated:

> *"On the above date [18 January 2019] Mr Cairns discharged the diabetic Patient A who required catheter care, without informing of the discharge the district nursing team who had been providing medical care to Patient A in the community."*

The panel also considered Witness 4's live evidence in relation to Patient A. The panel was satisfied that that Witness 4's account was clear and consistent with her witness statement, and it considered that Witness 4 knew Mr Cairns solely in a professional capacity and would have no reason to fabricate her evidence or be mistaken. The panel was satisfied that her witness statement and live evidence supported this charge and is consistent with Ms 1's hearsay evidence.

The panel also considered Ms 1's witness statement, which stated:

*"Hugh was the nurse responsible for the patient's care on day of discharge. The concern was that he did not contact the district nurses to inform them of the patient's discharge [REDACTED] he hadn't told them the patient had a catheter in and that they required catheter care."*

The panel also considered the interview notes between and Mr Cairns, which stated:

*"[Ms 1]: You didn't phone the DN yourself to advise them of the patient being discharged.*
*HC: No.*
*[Ms 1]: And you didn't feel the need to tell the DN to advise them of the catheter [REDACTED] So this is important/essential information for safe discharge, was there any reason why you did not phone the DN.*
*HC: It is hard to leave a cohort room with 6 patients and you are outside the room."*

The panel noted its conclusions in relation to Ms 1's hearsay evidence. The witness statement of Ms 1 was admitted so that the exhibits could be considered. The panel attached no weight to the contents of the witness statement of Ms 1 for the reasons given above.

However, the panel was satisfied that the documentary evidence attached to the witness statement of Ms 1 is corroborative evidence, as it is the record of interview notes between Mr Cairns and Ms 1. It is a contemporaneous document as part of the Board's formal investigation. The panel noted that this document is neither dated nor signed but noted that Mr Cairns' handwriting appears in this document, indicating that he had read it and not taken any objection to its contents.

As it was a contemporaneous record of a formal internal interview into an enquiry about the matters charged, and Mr Cairns had been supplied with it at the time, the panel decided that it was more likely than not to be accurate, notwithstanding the fact that its author now had no recollection of it.

The panel also had sight of Mr Cairns' handwritten reflection in relation to the incident involving Patient A, as part of the staff statement, which stated:

> *"The demands of caring for my other patients in a cohort room had an impact on the situation, as I could not ignore the demands and care needs of my other patients …*
>
> *The quickness of the discharge lounge collecting the patient also had an effect on the situation as I had none of the patient's documents for information and when afterwards the district nurse phoned the ward I explained this to her and redirected the phone call to the discharge lounge as they would still have the medical and nursing notes.*
>
> *I am aware, on reflection, that I should have referred the patient to the district nurses for catheter care"*

The panel took into account that Mr Cairns accepted that he failed to inform district nurses of Patient A's discharge and cited the "*quickness*" of the discharge lounge and other patients' needs for this omission. Taking all the above into account, with particular regard to Mr Cairns' contemporaneous reflection on the incident at the time, the panel was satisfied that Mr Cairns failed to inform district nurses that Patient A had been discharged from hospital, per charge 1a.

In relation to charge 1b, the panel considered that Mr Cairns' reflection (detailed above) acknowledged that he "*should have referred [Patient A] … for catheter care*", indicating that he failed to do so during discharge.

Accordingly, the panel found both charges 1a and 1b proved on the balance of probabilities.

**Charges 2a), b) and c)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

2) *Between 24 January 2019 and 25 January 2019 in respect of Patient B:*
    a) *Failed to provide treatment when their blood sugar reading was 3.7.*
    b) *Failed to follow hypoglycaemia protocol."*
    c) *Failed to monitor them"*

**These charges are found proved.**

In reaching its decision, the panel had sight of the Advanced Nurse Practitioner ('ANP')'s statement in relation to the incident, dated 22 February 2019, which stated:

> *"Contacted by Staff Nurse Cairns at approximately 0700 hours regarding above patient's blood sugar being low at 3.3.*
>
> ***B-*** *Advised to follow hypoglycaemia protocol as per standard operating procedures. I was unable to attend to the patient at that time due to another patient's acuity at that point.*
>
> *SN Advised there* [sic] *he was told not to treat a hypo and it had been passed over to him the previous night. I asked was the patient palliative care? he advised no. I asked him to look at the medical notes to which he stated we don't normally go by them, we have a handover. Advised once again to refer to medical notes which I was then advised there was nothing documented pertaining to blood sugars- Advised to treat the hypo (Bm 3.3) as per local guidelines.*
>
> ***A*** *- Advised from Hypoglycaemia protocol directly:*

*"Give 15-20 g of quick acting carbohydrate, such as 5-7 Dextrosol® tablets or 4-5 Glucotabs® OR 100mls Original Lucozade® Recheck glucose after 15 minutes. If still less than 4 mmol/L repeat above cycle up to 3 times. If still hypoglycaemic: (a) consider IV 10% Glucose at 100 ml/hour** or 1 mg Glucagon IM (once only)*" …"*

The panel also heard from Witness 4, who told the panel that the Board's policy for treating hypoglycaemia was to give the patient a glucose drink and monitor their blood sugar levels. The panel accepted her evidence and was satisfied that this was consistent with the documentary evidence before it on the Board's policy in relation to treating hypoglycaemia.

The panel also had sight of another staff nurse's internal Board statement on the incident, which was used during the internal investigation, dated 27 February 2019, which stated:

*"On walking past the comfort suite I picked up the patients diabetes management chart and realised that SN Cairns had in fact documented that the patients' blood glucose was 3.7 at 06:30 and no further action had been documented. I went straight in to repeat the patients BM as it was at least 90 minutes after that BM had been recorded, the BM was now 3.1"*

Further, the panel also considered Mr Cairns' reflective account of the incident involving Patient B, which stated:

*"At 6.30hrs 25/01/19 I checked the patients blood sugar which was 3.71 then phoned the ANP as I had done the previous night and stated the patient required bloods to be taken as per the consultants instructions. He asked for more information and what bloods were to be taken, I cannot recall having said to the ANP we don't normally do that. My normal habit before phoning and ANP is to have the medical notes, nursing notes and patients charts in front of me. There seems at this point confusion over what I was saying to the ANP and what he was picking up from me about what was required by the consultant.*

*I was unable to take these bloods myself because*

a) *My cannulation/venepuncture learn pro had lapsed.*

*I had attempted to renew but as the pass mark is 100% and you only get 2 attempts I was waiting for this module to be unlocked so I could revaluate this module.*

*As I had done the previous morning I was instructed by the ANP to treat the patient with 15g/60ml glucose as per hypo protocol. I went back to see and check the patient. The patient was asymptomatic to hypoglycaemia. I gave the patient a piece of chocolate and left a further two pieces sitting on her table. Can I just say that when I gave the patient a piece of chocolate it was not to treat it was a comfort measure in no way was it to treat hypoglycaemia. I explained to the patient what was happening and that her blood sugars were low and that I would be back shortly with glucagon. I left the room to get the glucagon but when I did. I looked into the 6 bedded room and saw that the room was very untidy.*

*This distracted me …"*

In relation to charges 2a and 2b, the panel considered that Mr Cairns, in his own contemporaneous statement, accepted that the ANP instructed him to treat the patient in line with the Board's procedure on hypoglycaemia (namely to give the patient a glucose drink) and he did not do so, choosing instead to give Patient B chocolate "*as a comfort measure*", and not to treat the hypoglycaemia. However, there is no evidence before this panel indicating that Mr Cairns took further steps to treat Patient B's hypoglycaemia or that he gave Patient B a glucose drink. The panel was satisfied that, based on this statement, Mr Cairns was aware that his instructions were to treat Patient B for hypoglycaemia, and to do so in accordance with the Board's policy, and he did not do so. The panel further

determined that this was consistent with the staff nurse's statement that no further actions were recorded by Mr Cairns following a blood sugar reading of 3.7, indicating that Mr Cairns did not monitor or treat Patient B following this reading.

Accordingly, the panel found charges 2a, 2b and 2c proved on the balance of probabilities.

**Charge 3**

Before considering all the sub-charges as outlined within charge 3, the panel took into account that these charges concern Mr Cairns' general competency in administration of medication (sub-charge a), patient care/organisation (sub-charge b), documentation and record keeping (sub-charge c), communication with colleagues (sub-charge d), communication with patients and/or patient's relatives (sub-charge e) and infection control (sub-charge f).

The panel noted that Mr Cairns was mentored by three members of staff (at different times), namely Witness 2, Witness 3 and Witness 5 throughout the relevant time period within this charge. The panel has before it numerous Weekly Review Assessment Documentation as part of Mr Cairns' Formal Capability Programme which were completed by one of the three mentors contemporaneously (largely forming the NMC's case in relation to these charges). The panel also heard live evidence from all three mentors and was satisfied that they all knew Mr Cairns solely in a professional capacity. The panel also considered that the three mentors were not connected in any other way except that they all mentored Mr Cairns, and none of them had pre-conceived notions in relation to Mr Cairns' nursing capability prior to mentoring him. Broadly, the panel was satisfied that none of them had any personal animosity towards Mr Cairns and had instead expressed their professional judgement of Mr Cairns' nursing ability. The panel noted that they appeared invested in supporting Mr Cairns professionally.

Bearing this in mind, the panel determined the following:

**Charges 3a)i)1), 3a)i)2), 3a)ii) and 3a)iii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    a) *Administration of medicines, in particular:*

        i) *Between 10 April 2020 and 22 January 2021 on one or more occasions you:*

            *(1) Were unable to classify one or more of the medication/s as set out in Schedule A.*

            *(2) Were unable to explain why one or more of the medication/s set out in Schedule B were prescribed and/or administered."*

        ii) *Were unable to identify one or more of the medication/s as set out in Schedule C.*

        iii) *Were unable to relate medications to conditions or explain the effectiveness of medications*."

**These charges are found proved.**

In reaching this decision, the panel considered Witness 1's witness statement, which stated:

> *"When Hugh started on the SIP, we very quickly picked up on the fact that he had very little knowledge of what medications were, what they were for or why he was giving them out. In addition, what the risks of certain medications were or what*

*benefits we were looking for … He couldn't appear to relate the medicines to the signs and symptoms manifested by the patients. When spoken to about the concerns, he appeared to have no insight into the seriousness of not being able to do medications. Hugh didn't appear to know the urgency of medicines pain relief. Reporting side effects. None of this was apparent."*

The panel also had sight of Witness 5's witness statement, which stated:

*"When administering medication, you need to know the type of drug you are about to administer and what it's used for. I would ask Hugh questions about drugs whilst we were doing the medication rounds. I would pick well known drugs such as Allopurinol, which is used for gout. When I asked him about Allopurinol, he didn't have any idea what the group or type of medication was. To help Hugh, I explained what Allopurinol was and what it was used for. I then showed him how to look up drugs on the drugs systems, and explained he needs to know what a drug is before dispensing. However, Hugh couldn't retain the information and I would have to do the same process again the following week, for the same drug.*

*After a few weeks there was another patient that required Allopurinol and when I asked Hugh about the drug, he laughed as if it was a joke. He didn't seem to think it was important to know the use of drugs."*

The panel also considered the Weekly Review Assessment Documentation, signed and dated 9 May 2020, which was completed by Witness 5. Under the "*Medication Administration*" header, she stated:

*"This is out* [sic] *third shift with this group of patients, he is not aware of classification of a lot of drugs – some very common. Carbamazepine, Spironolactone, Allopurinol. I have repeatedly explained some of them …"*

The panel noted that the medications referred to by Witness 5 are those listed in Schedule A, pursuant to charge 3a)i)1).

The panel also considered the Formal Stage 1 Capability Meeting notes, dated 4 August 2020, in which Witness 2 remarked:

> *"The main concern is knowledge of drugs, what the drug is for, connecting that to the patient and being able to explain why using it. This is a pattern that has been noted in the weekly meetings even though HC is going to the same patients. We are looking for HC to be able to explain what the drug is used for, the effects on patient, what he should be doing as a nurse to assess the effectiveness of the drug. By the 2nd or 3rd day HC could say what the drug was but not Why he was giving it to the patient."*

The panel also heard live evidence from Witness 5, 3 and 2 in relation to Mr Cairns' medication capability. The panel was satisfied that the live evidence from the three witnesses were clear and consistent with all the other evidence before the panel.

The panel also noted Witness 5's account, within the Weekly Review Assessment Documentation, that Mr Cairns "*is nervous because [she is] watching*". Whilst the panel acknowledged that this may have been the case, it has nonetheless accepted Witness 5's evidence that Mr Cairns was "*not safe to administer on his own*", and that he was unable to classify medication.

In reaching its decision, the panel noted that these charges, in their wording, are broad and non-specific. However, the panel determined that all the evidence before it, particularly the oral evidence from Mr Cairns' mentors supported by the evidence from Witness 1 (a senior nurse), sufficiently indicated that these were basic and wide-ranging medication errors Mr Cairns committed over an extended period. The panel was satisfied that, despite the passage of time, Witnesses 5, 2 and 3 were able to recall their assessment that Mr Cairns was broadly unaware of a wide range of medications and their specific uses. The panel acknowledged that none of the witnesses were able to identify

specific patients, incidents or cases in which this occurred. However, given the wording of this charge, the panel is satisfied that there is sufficient evidence to find these charges proved without specific case, incident or patient information.

Accordingly, the panel found charges 3a)i)1), 3a)i)2),3a)ii) and 3a)iii) proved on the balance of probabilities.

**Charge 3a)iv)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    a) *Administration of medicines, in particular:*

        iv) *On or around 2 October 2020 dispensed and administered Ticagrelor without demonstrating you knew what the medication was for and/or why it was being administered."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 2 October 2020, which stated:

> *"He dispensed + administered Ticagrelor, it was obvious he didn't know what it was + was very hesitant, but didn't look it up"*

The panel was satisfied that this entry made by Witness 5 was contemporaneous and indicated that Mr Cairns both dispensed and administered Ticagrelor without being certain

as to what it was or why it was being administered. The panel found nothing in the witness statements, or the documents provided to it by the NMC and by Mr Cairns which might cast doubt on that evidence.

Accordingly, the panel found this charge proved on the balance if probabilities.

**Charge 3a)v)1)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    a) *Administration of medicines, in particular:*

        v) *Were unable to complete a medication round satisfactorily in that you:*

            *(1) Between 15 April 2020 and 4 August 2020 on one or more occasions failed to take an unknown patient/s' heart rate/s before administering Digoxin."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"Hugh did go away and practice on the main groups of drugs and after he was able to tell me about certain drugs but he couldn't tell me about the effects of the drugs or what we were trying to achieve with the medication. For example, Digoxin. When you give Digoxin it's really important to measure the patient's*

*heart rate prior to giving it. However, I witnessed Hugh trying to give a patient Digoxin without assessing the patient. I stopped Hugh and explained to him that prior to administrating we needed to ensure the patient's heart rate is above 60 bmp so that we can safely administer the medication to ensure the patient doesn't become bradycardic … After a couple of incidents of forgetting this, Hugh did eventually remember that he had to do the heart rate first. I was still always concerned that Hugh was willing to give any drug without knowing about it."*

The panel also considered Witness 3's witness statement, which stated:

*"During the drug rounds, I would ask Hugh about the regular medications we used on the ward and if he knew what they were used for. … He also couldn't remember any of the basic blood pressure drugs. He wouldn't understand the purpose of the drug and the risk factors of it. He would administer Digoxin and then check a patient's pulse, which was the wrong way round. The risk here was if a patient was given Digoxin and their pulse was already below a certain level then it would lower it even further putting them at severe risk of harm."*

The panel also heard live evidence from both Witness 2 and Witness 3. The panel heard from Witness 2 that Mr Cairns failed to take patients' heart rates before administering Digoxin and that this was brought up with Mr Cairns on numerous occasions. The panel was satisfied that the live evidence from both Witness 2 and Witness 3 were clear and consistent with their witness statements.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3a)v)2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

a) *Administration of medicines, in particular:*

v) *Were unable to complete a medication round satisfactorily in that you:*

(2) *Between 10 July 2020 and 17 July 2020 on one or more occasion attempted to administer to an unknown patient the wrong dose of paracetamol."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"With regards to medication administering, these incidents were near misses which were prevented by me. For example, we had a patient who was on 500mg of paracetamol and Hugh tried to give that patient 1g of paracetamol. I had to stop Hugh before he made the wrong administration and explain what he had done wrong. This happened on two occasions with the same patient. On the second occasion I pointed out to Hugh he had already made this mistake the day prior where he tried to give double the amount of paracetamol. This patient was very small and did not need such a high amount of paracetamol."*

The panel also had sight of the Weekly Review Assessment Documentation completed by Witness 5, dated 17 July 2020, which stated:

> *"Hugh misadministered Paracetamol at the incorrect dose. Prevented from giving to patient, mistake identified as potential drug error"*

The panel also had sight of the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header *"16/7/20 working with [Witness 2]*", it stated:

> *"Drug round took 1hr 35 minutes for 7 patients. Drug error prevented as patient was prescribed 500mg of paracetamol but 1000mg dispensed."*

Taking all the above into account, the panel was satisfied that Mr Cairns attempted to administer 1000mg of paracetamol to an unknown patient when only 500mg was prescribed to them. The panel considered that, but for the intervention from Witness 2, Mr Cairns would have administered double the amount of prescribed paracetamol to the patient, which could have had adverse effects on them given their low body weight.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3a)v)3)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*
    a) *Administration of medicines, in particular:*
        v) *Were unable to complete a medication round satisfactorily in that you:*
            *(3) On or around 25 August 2020 attempted to administer the wrong dose of antibiotics to an unknown patient."*

**This charge is found proved.**

In reaching this decision, the panel took into account of the Weekly Review Assessment Documentation completed by Witness 3, dated 25 August 2020, which stated:

*"Poor administration of medication*

- *Attempted to administer wrong dose of an antibiotic."*

The panel was satisfied that this entry made by Witness 3 was contemporaneous and indicated that Mr Cairns had attempted to administer the wrong dose of an antibiotic to an unknown patient. Whilst the panel acknowledged that there appears to be very little detail in relation to this drug error (for example, who the patient was or the extent of error in the dosage of the antibiotic), the panel was satisfied that the mentor's notes were an accurate reflection of the events, it has not had sight of any contradictory information and considered that the evidence was from a competent and conscientious mentor and was reliable.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3a)v)4)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    a) *Administration of medicines, in particular:*

        v) *Were unable to complete a medication round satisfactorily in that you:*

            *(4) On or around 25 August 2020 failed to administer a teatime dose of insulin to an unknown patient."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"…at the end of each drug round a check is carried out by the nurse to check that all patients in case load had been administered all medications due. We do this second check to ensure nothing is missed. I asked Hugh to check the list, he returned to me a short time later stating that no more medications were due to be administered. I had done this in the hope that it would highlight. However, having supervised Hugh doing the drug round I was aware there was an Insulin outstanding. I showed Hugh this on the list…"*

The panel also had sight of the Weekly Review Assessment Documentation completed by Witness 3, dated 25 August 2020, which stated:

> *"Poor administration of medication*
>
> *[…]*
>
> - *Missed a patient out at teatime drug round resulting in palliative patient missing insulin dose."*

The panel was satisfied that this entry made by Witness 3 was contemporaneous and indicated that Mr Cairns failed to administer a prescribed dose of insulin to an unknown palliative patient during the teatime drug round. The panel determined that this was consistent with her witness statement. The panel has not had sight of any contradictory information and considered this evidence reliable.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3a)v)5)a)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    a) *Administration of medicines, in particular:*

        v) *Were unable to complete a medication round satisfactorily in that you:*

            *(5) On 4 December 2020;*

                *(a) Dispensed an incorrect dosage of haloperidol."*

**This charge is found NOT proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"Another big concern I had was an incident that happened one Saturday morning [REDACTED]. A patient required liquid haloperidol and Hugh went to administer it but in an extreme dose that would have killed the patient. I stopped Hugh and I asked if he was sure that it was the correct. Hugh paused and had a think about it and then said yes. I said he can get a calculator out to check it and Hugh insisted it was right."*

The panel also had sight of Witness 3's contemporaneous report of the incident as part of Mr Cairns' Formal Capability Programme, dated 4/5 December 2020, which stated:

*"Patient X with cognitive impairment was prescribed 250 micrograms Haloperidol liquid. Haloperidol 1mg/1ml. After multiple attempts to calculate, I suggested SN Cairns use a calculator if unsure or the drug calculation application on his phone which I had previously shown him. He declined. He advised me as he was opening the bottle that he would administer 25mls. When I questioned if he sure he continued to open the bottle. I had to tell him to stop. … Tried to make out that I had lied but then did state that he had said 25mls. He said if he had of poured it out, he would of realised it was wrong … He showed no understanding of the severity of this drug error. We did a reflection on what had happened later in the day. I asked him what he thought would have happened if I had not stopped the drug administration. He said he did not know. I stated it would have resulted in death, he showed no reaction to this."*

The panel also heard live evidence from Witness 3, who told the panel that she stopped Mr Cairns from dispensing the wrong dosage of Haloperidol as he was about to dispense from the bottle. She confirmed that, at this stage, Mr Cairns had not yet poured out the Haloperidol. The panel was satisfied that her evidence was clear and consistent with her witness statement as well as her contemporaneous report.

Taking all the above into account, the panel determined that, at the exact moment Witness 3 intervened, Mr Cairns had not yet poured the liquid Haloperidol from the bottle, but he was about to do so. The panel considered the wording of this charge – namely that Mr Cairns had dispensed the Haloperidol – and it concluded that the intervention from Witness 3 prevented Mr Cairns from dispensing the medication. The panel was satisfied that Mr Cairns intended to dispense the Haloperidol, but given he had not yet poured the Haloperidol from the bottle, the panel was not satisfied that he had dispensed the medication.

Accordingly, the panel found this charge not proved. The facts found proved are, however, relevant to the next sub-charge even though this sub-charge itself was not proved (which is because of the misuse of the technical word "*dispense*").

**Charge 3a)v)5)b)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*4) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*a) Administration of medicines, in particular:*

*v) Were unable to complete a medication round satisfactorily in that you:*

*(5) On 4 December 2020;*

*(b) Tried to administer 25mls of haloperidol to an unknown patient."*

**This charge is found proved.**

In reaching this decision, the panel took into account Witness 3's witness statement, her live evidence as well as her contemporaneous report, as outlined in charge 3a)v)5)a) above.

The panel considered the wording of this charge and acknowledged that, within a nursing context, the "*administration*" of medication has a specific, technical definition. However, the panel was satisfied that Mr Cairns' insistence that his dosage calculation was correct and his overriding of Witness 3's challenge indicated that he was trying to dispense, and eventually administer, 25mls of Haloperidol. The panel determined that, but for the intervention from Witness 3, Mr Cairns would have done so, and the panel accepted Witness 3's evidence that this would have likely been fatal for the patient.

The panel considered that Mr Cairns told Witness 3 that *"if he had of poured it out, he would [have] realised [the dosage] was wrong*". Given Mr Cairns' absence from these proceedings, the panel was unable to explore this further. However, on the balance of probabilities, the panel was not satisfied that Mr Cairns would have recognised his errors after dispensing the incorrect dosage, given his insistence to Witness 3 that his calculations were correct.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3a)v)6)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    a) *Administration of medicines, in particular:*

        v) *Were unable to complete a medication round satisfactorily in that you:*

            *(6) On an unknown date/s failed to administer to unknown patient/s insulin prior to meal times."*

**This charge is found proved.**

In reaching this decision, the panel considered its findings in relation to charge 3a)v)4) above, in relation to Mr Cairns' failure to administer a teatime dose of insulin to an unknown patient. The panel noted that, given it has already found that charge proved, this

incident would not add to the severity when it considers Mr Cairns' fitness to practise in due course.

In addition to the above incident, the panel also considered the Weekly Review Assessment Documentation completed by Witness 5, dated 14 August 2020, which stated:

> *"Hugh is getting better at prioritising work – however we haven't had any acutely unwell patients this week. Insulin dependent diabetic had finished his lunch and Hugh had made no attempt to give insulin."*

The panel determined that this referred to a different patient as to the one outlined in charge 3a)v)4), as this incident predates it by approximately 10 days. The panel was satisfied that there is sufficient evidence before it to indicate that Mr Cairns failed to administer insulin to patients prior to meal times on at least two occasions.

The panel noted that the evidence before it does not specify individual patients or the exact dates in which these incidents occurred (short of an indication of the week in which they occurred). However, given the broad wording of this charge, the panel was satisfied that Witness 3's contemporaneous observations which were recorded as part of a formal capability process is sufficient and does not undermine the substance of this charge.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3a)v)7)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

a) *Administration of medicines, in particular:*

v) *Were unable to complete a medication round satisfactorily in that you:*

(7) *On an unknown date failed to administer pain relief to palliative care patients."*

**This charge is found NOT proved.**

In reaching this decision, the panel considered the handwritten feedback provided by Witness 3, dated 27 August 2020, which stated:

> *"Due to very sensitive circumstance in the ward and it being 1 of Hugh's patients had to take over the care of an acutely unwell patient/palliative. At this point Hugh is unable to appropriately deal with emergency situations …"*

The panel also considered Witness 1's witness statement, which stated:

> *"Some that caught my attention were the numerous incidences where Hugh would have caused medication errors. Such as there were times he would have failed to give insulin prior to meal times or failed to give palliative care patients their pain relief."*

The panel also heard live evidence from Witness 2, where he commented on Mr Cairns' inability to assess pain for palliative patients, namely failing to ask how the patients were feeling.

Taking all the above into account, the panel determined that none of the evidence specifically refer to his failure to administer pain relief to palliative care patients. The panel was of the view that Witness 3's comment was broad, and only refers to "*taking over*" the care of Mr Cairns' palliative patient, but makes no reference to his failure to administer pain relief to them. The panel determined that Witness 1's statement was insufficiently detailed for it to be satisfied that this charge, as it is worded, is proved given it comments on Mr Cairns' general nursing ability and patient care. The panel was not satisfied that Witness 2 commented on Mr Cairns' failure to administer pain relief in this context.

The panel determined that the NMC has not sufficiently discharged its burden on the balance of probabilities.

Accordingly, the panel found this charge not proved.

**Charge 3a)v)8)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*a) Administration of medicines, in particular:*

*v) Were unable to complete a medication round satisfactorily in that you:*

*(8) On one or more occasions gave prescribed medication without assessing the unknown patient."*

**This charge is found NOT proved.**

In reaching this decision, the panel had sight of the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header *"Wed 29th,* it stated:

> *"Drug round Asked questions after he had administered drugs bearing in mind this was second shift with these patients. There were several drugs he did not know and had administered them twice."*

The same document, under the header "*Thursday, 30th July*", stated:

> *"Again Hugh is dispensing drugs which he does not know. I finished doing the drugs this morning and noticed that Hugh had signed for giving patient an inhaler for 2 days when it was a dif inh [different inhaler] patient had."*

The panel also considered the Weekly Review Assessment Documentation completed by Witness 3 which stated:

> *"No knowledge of drugs their actions or contraindications Got to B5 brought up wrong patient name. He did not identify possible issue despite none of the drugs being in the patient specific drawer."*

The panel further considered the Weekly Review Assessment Documentation completed by Witness 5, dated 7 June 2020, which stated:

> *"I have not worked with Hugh for 2 weeks and see no improvement in his knowledge of drugs. Reading prescription + dispensing is not an issue. But he still does[n't] know what frequently used medication is for …"*

Taking all the above into account, the panel was satisfied that there is evidence for Mr Cairns' poor medicines practice more generally. However, the evidence does not comment on any specific incident whereby Mr Cairns prescribed medication without

assessing the patient. The panel concluded that there is no specific evidence before it that this occurred.

Accordingly, the panel found this charge not proved on the balance of probabilities.

**Charge 3a)v)9)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    a) *Administration of medicines, in particular:*

        v) *Were unable to complete a medication round satisfactorily in that you:*

            *(9) On or around 22 July 2020 attempted to administer the incorrect dose of Buscopan."*

**This charge is found proved.**

In reaching this decision, the panel considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header *"22/7/20 Working with [Witness 2]"*, it stated:

> *"Hugh prevented from giving wrong dose of buscopan, only giving 10mg instead of 20mg."*

The panel also considered the Weekly Review Assessment Documentation completed by Witness 2, dated 22 July 2020, which stated:

*"Hugh stopped from giving wrong dose of Buscopan he'd only deposited ½ dose 10mg instead of 20mg"*

The panel determined that both pieces of evidence were contemporaneous, clear and consistent and reliable. The panel has not had sight of any contradictory evidence.

The panel considered the wording of this charge and acknowledged that, within a nursing context, the "*administration*" of medication has a specific, technical definition. However, the panel determined that, but for the intervention from Witness 2, Mr Cairns would have administered the incorrect dosage of Buscopan to the unknown patient.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3a)v)10)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*a) Administration of medicines, in particular:*

*v) Were unable to complete a medication round satisfactorily in that you:*

*(10) On or around 9 August 2020 did not check the packaging strip of unknown medication."*

**This charge is found proved.**

In reaching its decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 9 August 2020, which stated:

*"Tablet was dispensed that was in wrong box – he did not check strip."*

The panel also considered the Weekly Review Assessment Documentation completed by Witness 5, dated 14 August 2020, which stated:

*"He is administering tablets without checking strip despite last weeks error. He still does not relate medications"*

Taking the information before it, the panel was satisfied that Mr Cairns, on at least two occasions, administered medication without first checking the packaging strip. The panel has not had sight of any contradictory information and considered this evidence reliable.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3a)v)11)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    a) *Administration of medicines, in particular:*

        v) *Were unable to complete a medication round satisfactorily in that you:*

            *(11) On or around 30 July 2020 failed to provide to two patients their medication."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 30 July 2020, which stated:

> *"Hugh feels he is competent to administer medicines unsupervised. I disagree but did step back – 2 pts were missed – meds given at later time."*

The panel noted that this was a contemporaneous record of the incident as witnessed by Witness 5. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 5 was his mentor, and this feedback was provided in context of Mr Cairns' Formal Capability Programme, that this evidence is credible and of sufficient weight, on the balance of probabilities, to find this charge proved.

Accordingly, the panel found this charge proved.

**Charges 3a)v)12)a) and b)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*
    a) *Administration of medicines, in particular:*
        v) *Were unable to complete a medication round satisfactorily in that you:*
            *(12) On or around 27 May 2020 in respect of an unknown patient;*

*(a) were unable to identify the reason for giving solfidian.*

*(b) attempted to administer the incorrect dose of solfidian."*

**These charges are found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 2, dated 27 May 2020, which stated:

> *"Discussed with Hugh that there is a pattern of behaviour ongoing with medication administration … Also unable to identify reason for giving Solfidian which on two occasions would have been given as a 5mg dose when 10mg prescribed. Support was needed to identify this error prior to administration."*

The panel noted that this was a contemporaneous record of Mr Cairns' inability to identify the reason for giving Solfidian as well as at least two incidents whereby Mr Cairns attempted to administer the incorrect dosage, as witnessed by Witness 2. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 2 was his mentor, and this feedback was provided in context of Mr Cairns' Formal Capability Programme, that this evidence is credible and of sufficient weight to find this charge proved.

Accordingly, the panel found charges 3a)v)12)a) and b) proved on the balance of probabilities.

**Charges 3b)i)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

        i) *Between 10 April 2020 and 22 January 2021 on one or more occasion failed to complete and/or incorrectly completed;*

            *(1) Modified Early Warning Scores ("MEWS") charts.*

            *(2) National Early Warning Scores ("NEWS") charts."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"Hugh would frequently complete NEWS charts incorrectly or do the calculations wrong. … There were times when Hugh's recording on a NEWS chart was not full, such he regularly missed including a temperature and it was not recorded. This was concerning as you can't calculate a NEWS score without all the components, such as a temperature but somehow Hugh scored the chart. This was incorrect and identified by me to him and he was asked to correct his charts accordingly."*

The panel also had sight of Witness 3's witness statement, which stated:

> *"Hugh would quite often calculate NEWS scores wrong, almost during ever[y] round of observations."*

The panel also heard live evidence from Witness 3. The panel heard that Mr Cairns was calculating NEWS scores with incomplete information, and that she could not establish how he would reach any particular score as he had not input the complete information required to work it out. She told the panel that, on some occasions, the NEWS scores Mr

Cairns prepared were correctly evidenced and calculated, but many were not. The panel was satisfied that her live evidence was clear and consistent with her witness statement, and the evidence of other witnesses.

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 27 May 2020, which stated:

*"Recent issue with not correctly/accurately recording on a MEWS chart was discussed"*

The panel acknowledged that the source material (such as the MEWS or NEWS charts for individual patients) has not been made available before this panel, as the errors were corrected at the time (thus the correct MEWS/NEWS score would appear on the chart), according to Witness 2's witness statement.

The panel noted that, given the lack of patients' MEWS and NEWS charts, it would be unable to identify specific incidents or dates in relation to this charge (short of the one incident recorded, dated 27 May 2020). However, taking all the evidence before it, particularly the clear recollection from Witnesses 5, 3 and 2 despite the passage of time, the panel was satisfied that this was indicative of a sufficiently memorable concern involving Mr Cairns' nursing practice which spanned a lengthy period of time.

Accordingly, the panel found charges 3b)i)1) and 3b)i)2) proved on the balance of probabilities.

**Charges 3b)ii)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

   b) *Patient Care/Organisation, in particular;*

      ii) *On or around 21 June 2020 in relation to an unknown patient you:*

         *(1) Failed to escalate to another nurse or medic that their blood pressure was 76/56;*

         *(2) Failed to recheck the reading."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 5's witness statement, which stated:

> *"There were incident's when Hugh didn't raise or pass over important information. For example, he had checked the blood pressure of a patient and recorded a very low reading. However, he then went onto a break and didn't tell anyone about it so that we could keep an eye on that patient. I noticed by chance and was able to monitor the patient. Thankfully when I checked the patient's blood pressure again, it was back up. I asked Hugh why he hadn't made anyone aware, and he stated that he thought the machine was wrong."*

The panel also considered the Weekly Review Assessment Documentation completed by Witness 5, dated 21 June 2020, which stated:

> *"Hugh had done a pts NEWS and recorded BP of 76/56. He done nothing about it + went for tea. I happened to find it by chance and rechecked – BP was* [arrow pointing upwards symbol] *98. He said he didn't think machine was working."*

The panel determined that both Witness 5's witness statement and her contemporaneous account of the incident are clear and consistent.

The panel also heard live evidence from Witness 5 in relation to this incident. She told the panel that when a patient's blood pressure is 76/56, action is required because this would be considered a low blood pressure. The panel considered that this was within her area of professional knowledge and accepted her evidence in relation to this point.

The panel considered that Mr Cairns alleged that the blood pressure machine "*was not working*". In his absence from these proceedings, the panel was unable to explore this further.

However, the panel determined that Mr Cairns needed to take further action irrespective of whether the blood pressure machine was working properly. In the event where the blood pressure reading was a concern, Mr Cairns would have needed to escalate to another nurse or medical professional that the patient's blood pressure was too low, in accordance with Witness 5's live evidence to the panel. In the event where the blood pressure machine was not working properly, Mr Cairns needed to obtain a separate reading from another blood pressure machine and escalate at that point. The panel determined that, irrespective of whether the blood pressure machine was properly functioning, Mr Cairns failed to escalate a situation when he should have done so.

The panel noted that this patient's medical charts have not been made available before it. However, taking all of the information above, the panel was satisfied that there is sufficient evidence that Mr Cairns failed to escalate to another nurse or medic that the patient's blood pressure was too low (at 76/56), and he had failed to recheck this reading.

Accordingly, the panel found charges 3b)ii)1) and 3b)ii)2) proved on the balance of probabilities.

**Charge 3b)iii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

        iii) *On or around 16 July 2020 failed to carry out nursing observations in relation to an unknown patient."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"After, I took a step back as I was waiting to see if Hugh would go back and review the patient later to see how they were responding with the oxygen. I waited and I waited but eventually I had to ask Hugh, 'Are you going to do observations on that patient'. Hugh agreed to do the observations but then proceeded to go to the wrong patient and take another patient's observations so I had to tell Hugh he had just assessed the wrong patient."*

The panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header *"16/7/20 working with [Witness 2]*", it stated:

> *"In relation to the patient whose oxygen was restarted yesterday her chart was checked this afternoon and found that nursing observations had not been done. These were done by mentor and Hugh was advised on return from his break."*

The panel noted that in his witness statement, Witness 2's evidence was specific as to what happened, but did not specify a particular patient or a date for this incident. However, taking both of the pieces of evidence before it, the panel was satisfied that, on at least one occasion (16 July 2020), Mr Cairns failed to carry out nursing observations in relation to a patient whose oxygen restarted a day prior.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3b)iv)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

        iv) *On or around 9 August 2020 did not check an unknown patient's pulse manually when reviewing for bradycardia."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 9 August 2020, which stated:

> *"Did not check pulse manually in a pt he wanted reviewed for bradycardia"*

The panel noted that this was a contemporaneous record of the incident as witnessed by Witness 5.

The panel also heard live evidence from Witness 5 in relation to this incident. The panel determined that her live evidence was clear and consistent with her contemporaneous account.

The panel was satisfied that, given Witness 5 was his mentor and this feedback was provided in context of Mr Cairns' Formal Capability Programme, that the contemporaneous account alongside the live evidence is credible and of sufficient weight, on the balance of probabilities, to find this charge proved.

Accordingly, the panel found this charge proved.

**Charges 3b)v)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

        v) *Between 4 August 2020 and 31 December 2020 on one or more occasion:*

            *(1) Were unable to correctly calculate NEWS scores;*

            *(2) Were unable to explain and/or identify that a high NEWS score in a patient was an issue and/or needed attended to immediately."*

**These charges are found proved.**

In reaching this decision, the panel took into account its findings in relation to charge 3b)i) above.

The panel acknowledged the difference in the wording between charge 3b)i) and sub-charge 1) above. However, the panel determined that completing NEWS scores involves calculating individual components within NEWS in order to calculate the overall score. The panel determined that, with the evidence before it as outlined in charge 3b)i), charge 3b)v)i) is found proved.

In relation to sub-charge 2), the panel considered Witness 3's witness statement, which stated:

> *"Hugh's prioritising of workloads was concerning. Hugh was never sure of what to do first and would always pick the minor tasks to do rather than the important ones. For example, he wouldn't prioritise the sick patients care needs. We would sometimes have patients who were medically fit but were waiting on a nursing home and Hugh would go do their observations first rather than a patient who was scoring a high NEWS score….*
>
> *Hugh would quite often calculate NEWS scores wrong, almost during every round of observations. Hugh would find a patient with a high scoring NEWS but he wasn't able to identify that this was an issue and needed attending too* [sic] *immediately."*

The panel considered the Weekly Review Assessment Documentation completed by Witness 3, which stated:

> *"Unable to demonstrate the ability to identify, observe or assess signs of a worsening patient NEWS of 8."*

The panel was satisfied that Witness 3's witness statement was clear and consistent with her contemporaneous account of the incident.

The panel was of the view that the evidence before it showed that a NEWS score of 8 was sufficiently high to warrant further action on the part of Mr Cairns. Taking all the information before it, the panel determined that Mr Cairns was unable to identify that a NEWS score of 8 was high and required attending to immediately.

Accordingly, the panel found charges 3b)v)1) and 3b)v)2) proved on the balance of probabilities.

**Charge 3b)v)3)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*b) Patient Care/Organisation, in particular;*

*v) Between 4 August 2020 and 31 December 2020 on one or more occasion:*

*(3) Did not calculate a NEWS score for unknown patient/s instead entered a generic score of 16."*

**This charge is found NOT proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

*"Often if you would go round after Hugh and check every patient's respiratory rate recording they were all noted as 16 by Hugh. He never seemed to count them and would put a generic 16. On occasions I've went back with Hugh and explained the importance of an accurate respiratory rate, and why we were doing it."*

The panel determined that Witness 3's evidence is clear, in that Mr Cairns would record a respiratory rate of 16 for every patient, rather than the NEWS score.

The panel accepted that respiratory rate scores form a part of any NEWS calculation. However, given the wording of this charge, the panel was not satisfied that the NMC has discharged its burden of proving that, on the balance of probabilities, that Mr Cairns entered a generic NEWS score of 16. The score of 16 entered by Mr Cairns was not a NEWS score but was a generic number entered for patients' respiration rate, entered so that a fictitious component figure was used to calculate the patient's NEWS score. The panel considered that it is incumbent on the NMC to word its charges in accordance with the evidence.

Accordingly, this charge is found not proved.

**Charges 3b)vi)1), 2) and 3)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*b) Patient Care/Organisation, in particular;*

*vi) In December 2020 in relation to an unknown patient:*

*(1) Failed to calculate the correct NEWS score of 33;*

*(2) Entered an incorrect score of 16.*

*(3) On prompting further failed to calculate NEWS score correctly."*

**These charges are found NOT proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"Often if you would go round after Hugh and check every patient's respiratory rate recording they were all noted as 16 by Hugh. He never seemed to count them and would put a generic 16. On occasions I've went back with Hugh and explained the importance of an accurate respiratory rate, and why we were doing it. I identified a patient that had a rate of 33+ which was alarming and the patient actually went up to the high dependency unit. Hugh had failed to identify the patient had a respiratory rate that high. On this occasion, whilst I was standing back I was counting then Hugh put 16. I told Hugh that 16 was wrong and asked if he wanted to count it again to give him the opportunity to correct it but even with prompting he wasn't able to carry out the task."*

The panel also had sight of Mr Cairns' Assessment of Competency, dated December 2020 which was completed by Witness 3. Under the "*Patient Assessment*" header, Witness 3 stated:

> *"Not completed to satisfactory standard. Patient C had 3 different respiratory rates recorded for same set of observations and NEWS calculated did not match any of the recordings. The 4 remaining NEWS scores from the room were added wrongly also. I took SN Cairns round the charts to explain where he had gone wrong and why he could not put 3 respiratory rates for the same patient. He then went on to lie and state*

*he did not do this when I highlighted this to him with Colleague C and [Witness 1]. Only when I left the room to obtain the chart to show him again that he admitted he had lied to cover him mistake."*

The panel considered that both Witness 3's witness statement and the contemporaneous Assessment of Competency were clear and consistent, in that both the reading of 33 (charge 3b)vi)1)) and the generic score of 16 (charge 3b)vi)2)) related to the unknown patient's respiratory rate, rather than their NEWS score. In relation to charge 3b)vi)3) in particular, the panel noted that there was some prompting of Mr Cairns from Witness 3. However, the panel was satisfied that this prompting and subsequent failure on Mr Cairns' part to correctly calculate was in relation to the unknown patient's respiratory rate, rather than their NEWS score.

Considering all the evidence before it, the panel acknowledged that a patient's respiratory rate does form part of a NEWS score, thus the reference to the NEWS score in the Assessment of Competency completed by Witness 3. However, given the wording of the charges, there is no information before the panel in relation to this unknown patient's NEWS score, and all the evidence relates, in its entirety, to the respiratory rate recorded by Mr Cairns for this patient.

Accordingly, the panel found charges 3b)vi)1), 3b)vi)2) and 3b)vi)3) not proved.

**Charge 3b)vii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*b) Patient Care/Organisation, in particular;*

vii) *On or around 15 August 2020 were unable to identify and/or observe and/or assess signs of deteriorating patient."*

**This charge is found proved.**

In reaching this decision, the panel took into account its findings in relation to charge 3b)v)2) above.

The panel considered this charge based on its unspecified wording and was satisfied that there is sufficient evidence before it. However, the panel noted its similarities to charge 3b)v)2) (found proved) and that it appeared to concern the same unidentified patient. On this basis, the panel accepted the evidence in respect of that charge equally applies to this charge.

However, the panel would bear in mind the potential duplication between this charge and charge 3b)v)2) above in determining Mr Cairns' fitness to practise at a later stage in these proceedings. It noted that it should not use duplicated charges to indicate a higher level of lack of competence on Mr Cairns' part.

Accordingly, the panel found this charge proved on the same basis as charge 3b)v)2) above.

**Charge 3b)viii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

viii) *Between June 2020 and 25 August 2020 on one or more occasion failed to provide personal care to patients."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"This is because Hugh was very reluctant to do any personal care with patients. If a patient needed washing, Hugh would never do it. If the nursing assistant was busy and he was free as he was supernumerary, I would ask him to help and give a patient a wash or something but I would come back later and Hugh would say they didn't want a shower, but I know they had told the nursing assistant they did, which is why I asked him to do it. This happened more often or not so I felt he had a reluctance to do any personal care. This is why I don't think he would be suitable to work in a care role."*

The panel also considered Witness 3's witness statement, which stated:

> *"Hugh would refuse to put women on bed pans, take them to commodes or to take them to the bathroom. Hugh said it was because he didn't feel it was right for a male nurse to do personal care for women. I raised this as a concern with Hugh numerous times and we spoke about what's the difference in myself taking a male patient to the toilet and him taking a female patient to the toilet. I highlighted if the female is consenting to him taking her to the toilet then there is no issue apart from his own personal view, knowing that it is a career where you are going to have to carry out these kind of tasks. Hugh wouldn't even check a female patient's skin care. If you were in a 6 bedded female room, Hugh would do nothing because he wouldn't do skin checks, personal care or take them to the toilet. He therefore wouldn't carry out any of their care needs. …*

*If I gave Hugh a job to do that he considered should be done by a nursing assistant he would go and get them to do it instead, even though I specifically asked him to do it. Hugh just didn't want to do these jobs."*

The panel also had sight of the Weekly Review Assessment Documentation, dated 7 June 2020, which stated:

*"I have not witnessed Hugh washing anyone this week."*

The panel also had sight of the Weekly Review Assessment Documentation, dated 25 August 2020, which stated:

*"Hugh did not carry out any personal care during the shift. He was asked by me to assist a patient to the commode. He then asked a Nursing Assistant to do this for him."*

The panel noted that the second observation by Mr Cairns' mentor is approximately two months after the issue was first raised on 7 June 2020.

The panel also heard live evidence from Witness 2 and 3 to Mr Cairns' refusal to conduct personal care for patients. Witnesses 2 and 3 told the panel that Mr Cairns would refuse to conduct personal care for female patients and would delegate the task to nursing assistants. The panel was of the view that both witnesses were clear and consistent with both their own witness statements as well as with all the other contemporaneous documents before it.

The panel also heard live evidence from Witness 5. She did not say that she had witnessed him carrying out personal care for patients, only that she had not observed him refusing or heard that he had refused to do so. The panel noted this possible inconsistency with the evidence of Witnesses 2 and 3. The panel was of the view that, given Witness 5's seniority, Mr Cairns was less likely to refuse her instructions in

comparison to instructions from Witnesses 2 and 3 (who were less senior than Witness 5). Neither Witness 2 nor Witness 3 said that they had reported this refusal to Witness 5.

Taking all the above into account, the panel was satisfied there is sufficient documentary and oral evidence before it from Witness 2 and Witness 3 to find this charge proved on the balance of probabilities. Whilst the panel accepted Witness 5's evidence that this was not an issue she was aware of in relation to Mr Cairns, the panel determined that Witnesses 2 and 3, who were Mr Cairns' mentors and worked more closely with him over a prolonged period of time, were more likely to be able to observe Mr Cairns' refusal to conduct personal care if instructed by a nurse who was less senior than Witness 5.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3b)ix)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

        ix) *On or around 12 June 2020 required prompting to organise patient care."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 12 June 2020, which stated:

*"Hugh is still needing prompting to organise patient care, he is getting better giving aux instruction + asking for feedback…"*

The panel noted that this was a contemporaneous record of the incident as witnessed by Witness 5 on 12 June 2020. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 5 was his mentor and this feedback was provided in context of Mr Cairns' Formal Capability Programme, that this evidence is credible and of sufficient weight to find this charge proved.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3b)x)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*
    b) *Patient Care/Organisation, in particular;*
        x) *On or around 22 June 2020 did not give auxiliary staff instructions and/or ask for feedback."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 21 June 2020, which stated:

*"Hugh still needs to work on time management + prioritising his workload … He is still neglecting to ask for feedback from Naux or give reports*

*[…]*

*What I find concerning tho* [sic] *is the fact he hasn't given aux any instruction or asked for any feedback."*

The panel also had sight of the documentation compiled as part of Mr Cairns' Formal Capability Programme, under the header "*Working with [Witness 5]*", which stated:

> *"Poor communication between staff ie didn't give aux working in room a report or ask for feedback."*

Taking all the above into account, the panel was satisfied that there is sufficient contemporaneous documentation indicating that Mr Cairns was poor with his communication, particularly in respect of not giving auxiliary staff instructions and asking for feedback. The panel was satisfied that 21 June 2020 falls within "*in and around 22 June 2020*", per the wording of the charge.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3b)xi)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

xi) *On or around 26 June 2020 were unable manage patient care with other activities."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 5's witness statement, which stated:

> *"Hugh also couldn't prioritise his workload or patients. For example, he would be doing observations and something more urgent would happen, or someone would ask him something, but he wouldn't stop what he was doing to deal with it, even if it was an urgent or priority matter. Hugh would always want to finish what he was doing first."*

The panel also considered the Weekly Review Assessment Documentation, dated 26 June 2020. Under the "*Identified Areas of Concern and Action Plan*" heading, it stated:

> *"Hugh need* [sic] *to time manage in a shift to participate in personal care, as this seems to be raised every week. Hugh needs to balance personal care with other activities in ward. eg paperwork."*

The panel considered that this was the professional judgement from Witness 5, who had numerous interactions with Mr Cairns as she was his mentor at the time. The panel was satisfied that Witness 5 is clear and consistent in both her witness statement and contemporaneous evidence.

Taking all of the above, the panel was satisfied that, based on the evidence before it, Mr Cairns was unable to manage patient care alongside other activities required of him.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3b)xii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

        xii) *In June 2020 on one or more occasion required prompting to ask unknown patient/s how their pain levels were."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"We had lots of patients who were in a lot of pain and were on strong opioids. I had to keep asking Hugh how their pain levels were and he would just reply that he didn't know. I would say, 'Have you asked them?' and he hadn't. We would give patient's 60 mg of morphine so we needed to reflect if it was working or if it was too much, such as if they are they just sleeping all day. Hugh did not think about these things, which he needed to do as a nurse. I would rereinforce* [sic] *these things daily with Hugh yet I never heard him ask a patient how their pain was unless I prompted him to."*

The panel determined that this makes clear that Mr Cairns required prompting from Witness 2, who was Mr Cairns' mentor at the time, to ask patients about their pain levels. The panel was satisfied that Witness 2 is clear and consistent in his evidence. The panel considered

Witness 2 a competent and conscientious professional mentor. Accordingly, the panel was satisfied that Witness 2's witness statement sufficiently supports this charge.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3b)xiii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

        xiii) *Between June 2020 and 22 January 2021 on one or more occasion failed to complete a paperwork contemporaneously."*

**This charge is found NOT proved.**

In reaching this decision, the panel took into account that, as this charge alleges a failure on Mr Cairns' part to complete a paperwork contemporaneously, the burden is on the NMC to prove that Mr Cairns was under the duty to do so.

The panel considered Witness 3's witness statement, which stated:

> *"Hugh then ended up having to go down with the patient, as he hadn't written his notes. When he returned sometime later he came back with something written that wasn't even comprehensive."*

The panel also considered Witness 2's witness statement, which stated:

> *"Hugh was unable to manage to his workload, he was unable to prioritise his documentation. He would always leave it until last minute to start writing his notes so I always had to step in and help him. He also wouldn't record the important information in his notes, such as if a pain relief was working or if that person had been in unexpected pain that day and that we've increased their medication. It was basic recording and evidencing of the work that had been done for a patient that day, which wasn't being put into the notes by Hugh or it wasn't clear. He just started to write the same thing for every patient because this was easier."*

The panel also had sight of the documentation compiled as part of Mr Cairns' Formal Capability Programme, under the header "*Working with [Witness 5]*", which stated:

> *"It was 1830 before he started writing notes and I had prompted several times. I had to do half so we finished on time."*

Taking all of the above, the panel was satisfied that Mr Cairns' management of his paperwork was poor. The panel took into account that all three of Mr Cairns' mentors recalled issues with his paperwork, particularly with his delay in completing his patient notes.

However, taking the wording of the charge, the panel was unable to ascertain from the evidence before it that any of these notes, or any other documentation, needed to be completed contemporaneously. The panel acknowledged that some information in patient notes ought to be completed as soon as possible, but it was unable to determine if this was the case based on the evidence from Witnesses 3, 2 or 5. The panel noted that more than four years have passed since these incidents and whilst the witnesses were able to make generalised comments on Mr Cairns' poor paperwork, none could indicate a specific piece of paperwork which Mr Cairns failed to complete contemporaneously. In the absence of specific information indicating a duty for Mr Cairns to complete his paperwork

contemporaneously from any of the witnesses, the panel was not satisfied that the NMC has discharged its burden based on the wording of this charge.

Accordingly, the panel found this charge not proved.

**Charge 3b)xiv)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*b) Patient Care/Organisation, in particular;*

*xiv) In June 2020 on one occasion or more took two hours to complete a medication round."*

**This charge is found NOT proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"The time it took for Hugh to do a medication round was far too long. We would start at 8am and sometimes it took him 2 hours to do 8 to 10 patients medication. This was far too long and put him and the rest of the team under pressure as you have other tasks to do in a morning, including assessing your patients and doing their observations …"*

The panel also had sight of the Weekly Review Assessment Documentation, dated 21 June 2020, which stated:

*"Drug round was very slow – took 40 mins to do 2 pts"*

The panel then considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, under the header "*Working with [Witness 5]*", which stated:

*"Medicine round was better in that he knew more drugs, but it did take a considerable time."*

Taking all of the information above, the panel found that Mr Cairns was unacceptably slow with his medication rounds. However, the panel considered that Witness 2's evidence contained within his witness statement – which refers to the rounds taking over two hours – does not specify a date when this occurred. The panel had sight of the documentation which commented on Mr Cairns' drug rounds in June 2020 (per the wording of the charge), and it concluded that the evidence indicated that Mr Cairns was slow, but did not show that he took more than two hours. Taking the charge as it is worded, there is no evidence before the panel that in June 2020, Mr Cairns took more than two hours to complete his medication round.

Accordingly, the panel found this charge not proved.

**Charge 3b)xv)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

xv) *On or around 12 June 2020 did not administer medication/complete a medication round in a timely fashion."*

**This charge is found NOT proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 12 June 2020, which stated:

> *"He now realises how serious it is to administer medicines without knowing what they are, what they are for and side effects. This morning I have noticed a difference in that he has looked up medications without prompting, but these are medications which we have administered for 3 shifts, in some instances 6 shifts. He missed out a medication but no error as I pointed out."*

The panel took into account that there is nothing in the Assessment Documentation indicating the length of time Mr Cairns took to complete the medication round, albeit it was satisfied that Mr Cairns did undertake at least one round (based on the observation that he missed a medication).

The panel then considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, under the header "*Fri 12th"* which stated:

> *"Drug round was better, was looking up drugs he didn't know but this was 6th shift with this group of patients.*
> *Missed out 1 drug but not error as I pointed out*
> *Still missing out Alert score on news which I have pointed out every day."*

The panel considered that this indicates that, at that point, Mr Cairns' medication round was improving.

Taking all the above into account, the panel noted its earlier findings on Mr Cairns' extended duration in completing medication rounds (as outlined in charge 3b)xiv) above). However, there is no information before it suggesting that, on or about this particular day, 12 June 2020, (per the wording of this charge), Mr Cairns did not administer medication in a timely fashion. The panel determined that the feedback from Witness 5 on that day implied that Mr Cairns was improving in completing his medication rounds, rather than taking an excessively long time.

Accordingly, the panel found this charge not proved.

**Charge 3b)xvi)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*b) Patient Care/Organisation, in particular;*

*xvi) On or around 21 June 2020 unnecessarily delayed calculating NEWS scores."*

**This charge is found NOT proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 21 June 2020, which stated:

*"Hugh still needs to work on time management + prioritising his workload. He was doing routine swabs when NEWS was overdue"*

The panel was of the view that "*NEWS was overdue*" implied that NEWS observations (such as respiratory rate, temperature, and so on) were due to be conducted on a patient, rather than the calculation of the NEWS score in itself. Based on the wording of the charge, the panel was not satisfied that this evidence indicated that Mr Cairns delayed calculating the NEWS score (having been appraised of all the observation scores from which the NEWS score is calculated). In the absence of any additional evidence, the panel determined that the NMC has not discharged its burden in relation to this charge.

Accordingly, the panel found this charge not proved.

**Charges 3b)xvii)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*b) Patient Care/Organisation, in particular;*

*xvii) On or around 12 July 2020 required prompting on managing patient care including;*

*(1) Patient dressings.*

*(2) Removing a catheter."*

**This charge is found proved.**

In reaching this decision, the panel considered Weekly Review Assessment Documentation, dated 12 July 2020, which stated:

*"Hugh is still requiring prompting on managing some patient care ie he will ask me what I would do when I would expect him to make these decisions himself.*

*ie – a patient dressing*
*removing a catheter."*

The panel determined that the Weekly Review Assessment Documentation, dated 12 July 2020, noted that Mr Cairns required prompting on both patient dressings and removing a catheter. The panel considered that these are the contemporaneous notes of Witness 5, who was Mr Cairns' mentor at the time. The panel was satisfied that this sufficiently supports this charge, as worded.

However, in reaching this decision, the panel considered that there is no information before it in relation to the context surrounding this patient's care, or the exact nature or extent of prompting required. The panel was unable to determine whether the prompting was reasonable, particularly in relation to the removal of a catheter.

Accordingly, the panel found charges 3b)xvii)1) and 3b)xvii)2) proved. However, the panel considered that it would be impossible for it to ascertain any further use of this finding at the next stage.

**Charge 3b)xviii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

*xviii) On or around 15 August 2020 failed to do referrals marked as urgent."*

**This charge is found proved.**

In reaching this decision, the panel took into account the Weekly Review Assessment Documentation, dated 15 August 2020, which stated:

*"Failed to do referrals identified as urgent"*

Based on the wording of the charge, the panel was satisfied that the evidence before it sufficiently supports this charge.

However, in reaching this decision, the panel considered that there is no information before it in relation to the context surrounding this patient's care, how urgent the referral was and whether Mr Cairns was aware that it was urgent.

Accordingly, the panel found this charge proved. However, as this is so vague an allegation the panel considered that it would be impossible for it to ascertain any further use of this finding at the next stage, other than as part of an extensive list of competency issues.

**Charge 3b)xix)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

*xix) In August 2020 failed to reassess patients in appropriate timescales."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"Hugh would also fail to return to do observations on patients. He would do them once then that was it. I tried to prompt him to set alarms on his phone to remind himself but he didn't want to do this and declined the advice."*

The panel also took into account the Weekly Review Assessment Documentation, dated 15 August 2020, which stated:

> *"failed to reassess in appropriate timescale despite being advised to set alarms on phone to prompt him."*

Based on the wording of the charge, the panel was satisfied that the evidence before it sufficiently supports this charge.

However, in reaching this decision, the panel considered that there is no information before it in relation to the context surrounding this patient's (or patients') care, how urgent the reassessment was, the extent of prompting required or the exact nature of how busy the ward or Mr Cairns was at the time. The panel was unable to determine what timescale would be appropriate in these circumstances.

Accordingly, the panel found this charge proved. However, the panel considered that it would be impossible for it to ascertain any further use of this finding at the next stage, other than as part of an extensive list of competency issues.

**Charges 3b)xx)1), 2) and 3)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    b) *Patient Care/Organisation, in particular;*

        xx) *On or around 25 August 2020;*

            *(1) Were unable to identify an unknown patient with a NEWS of 10 was a priority.*

            *(2) Took a whole day to discharge an unknown patient without clinical justification.*

            *(3) Required to be prompted to contact the district nurse."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"We would sometimes have patients who were medically fit but were waiting on a nursing home and Hugh would go do their observations first rather than a patient who was scoring a high NEWS score.*
>
> *[…]*
>
> *Hugh would quite often calculate NEWS scores wrong, almost during ever round of observations. Hugh would find a patient with a high scoring NEWS but he*

*wasn't able to identify that this was an issue and needed attending too immediately."*

The panel also took into account the Weekly Review Assessment Documentation, dated 25 August 2020. Under the "*Patient Care Organisation*" header, it stated:

*"Very disorganised, unable to prioritise workload. Did not identify a patient with low stats resulting on a NEWS of 10 was priority before completing remaining observations … All day to discharge a patient whos* [sic] *medication was on the ward the day before and had own transport. Had to be prompted to contact District Nurses several times. Finally left voicemail after 8pm."*

The panel considered that Witness 3's witness statement was clear and consistent with the contemporaneous account within the Weekly Review Assessment Documentation. Taking both pieces of evidence above, the panel was satisfied that there is sufficient evidence supporting all three charges.

Accordingly, the panel found charges 3b)xx)1), 3b)xx)2) and 3)b)xx)3) proved on the balance of probabilities.

**Charge 3b)xxi)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*b) Patient Care/Organisation, in particular;*

*xxi) On or around 15 July 2020;*

*(1) Did not carry out fluid balances for patients in beds 4 and 5 despite being asked on more than one occasion to do so.*

*(2) Did not prioritise completing peripheral venous cannula ("PVC") charts for patients in beds 4 and 5."*

**These charges are found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 17 July 2020. Under the "*Patient Care Organisation*" header, it stated:

> *"Fluid charts not filled in correctly or in a timely fashion when having been asked several times.*
>
> *PVC chart not in evidence or completed in a timely fashion, having been asked several times.*
>
> *[…]*
>
> *Discussed these issues with Hugh and the potential impact on patient care"*

The panel then considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, under the header "*15/7/20 – working with [Witness 2]",* which stated:

> *"Having identified which patients needed fluid balances first thing, I asked Hugh on a couple of occasions to put one in for patient in bed 4 and bed 5. One patient had a catheter the other was on IV fluids: Two other patients had charts but these were not fully filled in as the weight were missing as part of patients' info. During mid-*

*afternoon Hugh was asked again, but these actions were still not carried out. The respiratory ANP actually started one at 5pm for him for the patient on IV fluids. It was also identified that PVC charts were not completed for patients on bed 4 and 5. It was after 4pm before this was resolved."*

The panel considered that both of the documents above were contemporaneous accounts from Witness 2, who mentored Mr Cairns at the relevant time and directly witnessed these incidents. Taking both pieces of evidence above, the panel was satisfied that there is sufficient evidence supporting both charges.

Accordingly, the panel found charges 3b)xxi)1) and 3b)xxi)2) proved on the balance of probabilities.

**Charge 3c)i)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    c) *Documentation and record keeping, in particular:*

        i) *Between 22 May 2020 and 22 January 2021 on one or more occasions were unable to complete fluid and water charts correctly and/or adequately."*

**This charge is found proved.**

In reaching this decision, the panel took into account its findings in relation to charge 3b)xxi)1) above.

The panel considered this charge is vague. There is no reference to a particular patient or patients and an extended time period. There are no patient notes or other documentary evidence supporting it. However, the panel was satisfied that there is sufficient evidence before it to find the charge proved on the balance of probabilities. Notwithstanding this, the panel noted its similarities to charge 3b)xxi)1) (found proved) and that it appeared to concern the same unidentified patient. On this basis, the panel accepted the evidence in respect of that charge equally applies to this charge.

However, the panel would bear in mind the potential duplication between this charge and charge 3b)xxi)1) above in determining Mr Cairns' fitness to practise at a later stage in these proceedings. It noted that it should not use duplicated charges to indicate a higher level of lack of competence on Mr Cairns' part.

Accordingly, the panel found this charge proved on the same basis as charge 3b)xxi)1) above.

**Charge 3c)ii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    c) *Documentation and record keeping, in particular:*

        ii) *On or around 16 July 2020 failed to record a spine x-ray on unknown patient's SBAR and/or nursing notes."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 17 July 2020. Under the "*Patient Care Organisation*" header, it stated:

> *"Nursing notes didn't reflect patient spine x-ray or the nurse S.BAR. Completed next day.*
>
> *Discussed these issues with Hugh and the potential impact on patient care"*

The panel then considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, under the header "*15/7/20 – working with [Witness 2]* which stated:

> *"Patient who had spinal x-ray for previous back pain, investigation not recorded on patient nursing notes or handover. Asked to record retrospectively the following day."*

The panel also heard live evidence from Witness 2, who confirmed his account with the panel. The panel determined that he was clear and consistent, and that there are no contradictions between his live evidence with any of the documentary evidence before the panel.

The panel considered that both of the documents above were contemporaneous accounts from Witness 2, who mentored Mr Cairns at the relevant time and directly witnessed these incidents. Taking both pieces of evidence above and Witness 2's live evidence, the panel was satisfied that there is sufficient evidence supporting this charge to find on the balance of probabilities that it is proved.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3c)iii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    c) *Documentation and record keeping, in particular:*

        iii) *On or around 22 July 2020 failed to record assessment of pain and/or pain management for an unknown palliative patient."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"Hugh's daily records were very often routinely a repeat of the previous day. But the main issue was that if a patient had pain as an issue, very often he had not reflected on how their pain was and did not evidence whether or not he had evaluated if any analgesia given was effective. Some of these patients were on high dose analgesia for cancer related pain and noting if breakthrough analgesia had been given and whether it was effective or needed to be reviewed by the medics was an essential element of the nurse's responsibility."*

The panel also considered the Weekly Review Assessment Documentation, dated 22 July 2020, which stated:

> *"Discussed with Hugh not recording any assessment of pain or pain management for patient who is palliative and on controlled analgesia."*

The panel also heard live evidence from Witness 2, who confirmed his account to the panel. The panel determined that he was clear and consistent, and that there are no contradictions between his live evidence with any of the documentary evidence before the panel, including his contemporaneous account on 22 July 2020. Based on all the above, the panel was satisfied that there is sufficient evidence supporting this charge to find it proved on the balance of probabilities.

Accordingly, the panel found this charge proved.

**Charge 3c)iv)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    c) *Documentation and record keeping, in particular:*

        iv) *On or around 22 July 2020 in relation to an unknown asthmatic patient failed to record:*

            *(1) medication administered.*

            (2) *whether the medication was beneficial*."

**These charges are found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 22 July 2020, which stated:

*"Discussed not recording giving meds to patient who is asthmatic and whether or not these were beneficial"*

The panel noted that this was a contemporaneous record of Mr Cairns' failure to record the medication administered to an asthmatic patient, and whether that medication was beneficial, as witnessed by Witness 2. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 2 was his mentor and this feedback was provided in context of Mr Cairns' Formal Capability Programme, that this evidence is of sufficient weight to find these charges proved on the balance of probabilities.

Accordingly, the panel found charges 3c)iv)1) and 3c)iv)2) proved.

**Charge 3c)v)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*
    c) *Documentation and record keeping, in particular:*
        iii) *On or around 15 July 2020 failed to correctly complete a cannula chart."*

**This charge is found proved.**

In reaching its decision, the panel considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, under the header "*Monday 15th July Formal Stage Working with [Witness 5],* which stated:

*"Charts were filled in correctly today apart from 1 cannula chart."*

The panel noted that this was a contemporaneous record of Mr Cairns' failure to correctly complete a cannula chart, as witnessed by Witness 5. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 5 was his mentor, and this feedback was provided in context of Mr Cairns' Formal Capability Programme, that this evidence is of sufficient weight to find these charges proved on the balance of probabilities. When considering whether Mr Cairns' fitness to practise is impaired by reason of lack of competence the panel will bear in mind that the other charts that day were completed satisfactorily.

Accordingly, the panel found this charge proved.

**Charges 3c)vi)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    c) *Documentation and record keeping, in particular:*

        vi) *In December 2020 in relation to Patient C;*

            (1) *Recorded 3 different respiratory rates for the same set of observations.*

            (2) *Incorrectly calculated the NEWS score from the recordings recorded."*

**These charges are found proved.**

In reaching this decision, the panel considered the documentation compiled as part of Mr Cairns' Formal Capability Programme completed by Witness 3. Under the header "*Patient Assessment",* it stated:

> *"Patient C had 3 different respiratory rates recorded for same set of observations and NEWS calculated did not match any of the recordings. The 4 remaining NEWS scores from the room were added wrongly also. I took SN Cairns round the charts to explain where he had gone wrong and why he could not put 3 respiratory rates for the same patient."*

The panel noted that it did not have Patient C's NEWS chart before it, or any other documentation prepared at the time of the issue.

However, the panel considered that this was a near contemporaneous record of Mr Cairns recording three different respiratory rates for Patient C and incorrectly calculating the NEWS score from those recordings. This contemporaneous record was prepared by a mentor, Witness 3, as part of a Formal Capability Programme. The panel was satisfied that, given these circumstances this evidence is of sufficient weight to find these charges proved on the balance of probabilities.

Accordingly, the panel found charges 3c)vi)1) and 3c)vi)2) proved.

**Charges 3c)vii)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    c) *Documentation and record keeping, in particular:*

        iii) *Between 1 September 2020 and January 2021 on one or more occasions your written handovers*

            *(1) contained insufficient detail.*

            *(2) did not contain patient plans for the next day."*

**These charges are found proved.**

In reaching this decision, the panel had sight of Witness 3's witness statement, which stated:

> *"Hugh's written handovers were really poor. I had numerous concerns raised from members of staff within the ward with regards to the quality of Hugh's handovers. It got to the point I had colleagues phoning me at home asking for a fuller update as they couldn't understand Hugh's documentation within the nursing notes. His verbal handovers were also so poor that at times I had to stay behind after Hugh left to do it again … Hugh was very quick to blame others. Hugh's handover's were staggered, again with long pauses with nothing said. It almost got to the point that everyone around him felt uncomfortable … He would miss really important aspects of a patient's care or plans for the next day if we weren't due back in."*

Additionally, the panel considered the documentation compiled as part of Mr Cairns' Formal Capability Programme completed by Witness 3. Under the header "*Documentation and Record Keeping",* it stated:

> *"Important patient information missed from nursing notes and handover."*

The panel also considered the Weekly Review Assessment Documentation, dated 2 October 2020, which stated:

> *"First night I was not able to supervise report as I had to deal with other issues. He failed to tell night shift that a patient had been violent. The second night the report was very poor and I had to prompt on several issues.*
>
> *[…]*
>
> *Major concern if safety issues not passed on."*

The panel determined that Witness 3's witness statement was clear and consistent with the contemporaneous records of Mr Cairns' handovers, as observed by his mentors. The panel was satisfied that Mr Cairns' handovers were consistently of poor quality, lacked sufficient detail and did not contain patient plans for the next day.

Accordingly, the panel found charges 3c)vii)1) and 3c)vii)2) proved on the balance of probabilities.

**Charge 3d)i)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    d) *Communication with colleagues, in particular:*

*i) On or around 27 May 2020 failed to handover an unknown patient was at high risk of stroke."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 27 May 2020, which stated:

> *"Communication during the morning huddle. There have been [illegible] where important information has not been passed on. Hugh has in these cases been responsible for ensuring such information is passed on. This has been brought to his attention eg not addressing new male patient at high risk of stroke."*

However, in reaching this decision, the panel considered that there is no information before it in relation to the context surrounding this patient's care or the level of detail Mr Cairns provided for handover in respect of this patient. The panel noted that the handover notes for this patient have not been made available, and it is unable to ascertain further contextual information in relation to this charge.

Accordingly, the panel found this charge proved. However, the panel noted that it would be impossible for it to ascertain any further use of this finding at the next stage, other than as part of an extensive list of competency issues.

**Charge 3d)ii)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    d) *Communication with colleagues, in particular:*

        ii) *On or around 12 June 2020 in relation to an unknown patient failed to handover that;*

            *(1) They had low blood pressure.*

            *(2) That Bisoprolol and/or Furosemide had been withheld."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"Hugh's verbal communication was poor with staff and colleagues … I would encourage Hugh to give the handover but he would always miss vital information when passing information and not be clear. An example is we had a patient who had very low blood pressure and I had advised Hugh to withhold Bisoprolol and Furosemide as they both could cause to lower her blood pressure even more."*

The panel noted that this account details Mr Cairns' failure to hand over appropriately that an unknown patient had low blood pressure. Further, that both Bisoprolol and/or Furosemide had been withheld from the patient, as witnessed by Witness 2. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 2 was his mentor and this feedback was provided in context of Mr Cairns' Formal Capability Programme, that this evidence is of sufficient weight to find these charges proved on the balance of probabilities.

Accordingly, the panel found charges 3d)ii)1) and 3d)ii)2) proved.

**Charges 3d)iii)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*d) Communication with colleagues, in particular:*

*iii) On or around 12 July 2020 in relation to an unknown patient;*

*(1) Failed to handover that their cannula had tissued.*

*(2) Failed to document that their cannula had tissued."*

**These charges are found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 12 July 2020, which stated:

*"Hugh is still missing out documenting about relevant aspects of patient care […] A cannula had tissued and arm very oedematous as a result and wasn't mentioned or passed on to following shift"*

Additionally, the panel considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header "*10/7/20 Working with [Witness 5]",* it stated:

*"A pts cannula had badly tissued which he didn't document in notes or pass on to night shift. I feel he is getting patients and their problems mixed up which could have serious consequences."*

The panel was satisfied that, despite the dates on the two contemporaneous documents being different, this related to the same patient which Mr Cairns was caring for that week. In any event, the panel determined that both 10 and 12 July 2020 fell within "*on or around 12 July 2020*", per the wording of the charge.

The panel considered that these are contemporaneous records of Mr Cairns' failure to handover and document that the patient's cannula had tissued, as witnessed by Witness 5. The panel acknowledged that it has not had sight of the patient's handover notes. However, it was satisfied that, given Witness 5 was his mentor and this feedback was provided in context of Mr Cairns' Formal Capability Programme, that this evidence is of sufficient weight to find these charges proved on the balance of probabilities. The panel understood that "*tissued*" meant that the cannula had failed, such that it was not capable of delivering medication into the vein into which it had been inserted but had become engaged with surrounding tissue. The panel understood that this had two issues, first that it would fail to administer medication or fluids into the patient's vein, and secondly that the cannula required attention as its displacement had the potential to cause infection or discomfort for the patient at the site it had been inserted.

Accordingly, the panel found charges 3d)iii)1) and 3d)iii)2) proved on the balance of probabilities.

**Charge 3d)iv)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    d) *Communication with colleagues, in particular:*

iv) *On or around 16 July 2020 when giving handover/s in relation to unknown patient/s provided information that was not up to date*."

**This charge is found NOT proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 17 July 2020, which stated:

> *"Nursing notes didn't reflect patient spine x-ray on the nurse S.BAR. Completed next day"*

Additionally, the panel considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header "*15/7/20 Working with [Witness 2]",* it stated:

> *"Patient who had spinal x-ray for previous back pain, investigation not recorded on patient nursing notes or handover. Asked to record retrospectively the following day."*

The panel considered that these contemporaneous records indicated that Mr Cairns' handover was not of satisfactory standard and he had missed relaying information in parts of his handover. However, the panel was not satisfied that the information he provided was not up to date. The panel was unable to ascertain whether the information that Mr Cairns did handover was out of date, as the panel did not have sight of the handover notes for this patient. The panel determined that there is insufficient evidence supporting this charge, and that the NMC has not discharged its burden of proving the charge on the balance of probabilities.

Accordingly, the panel found this charge not proved.

**Charge 3d)v)1)a) and b)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    d) *Communication with colleagues, in particular:*

        v) *Between 1 August 2020 and 30 August 2020*:

            *(1) On one or more occasion gave verbal handover/s;*

                *(a) That were disjointed.*

                *(b) Where information was missed."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"When it came to recording the ward rounds, Hugh didn't always reflect fully in the nursing notes to be able to provide a thorough handover to the next shift. The handovers by Hugh was disjointed. He would never maintain eye contact and would look at the floor. He wasn't clear about what he was trying to handover."*

The panel also considered Witness 5's witness statement, which stated:

> *"There were incident's when Hugh didn't raise or pass over important information. For example, he had checked the blood pressure of a patient and recorded a very low reading…"*

.

The panel also considered the Weekly Review Assessment Documentation, dated 14 August 2020, which stated:

> *"I feel his verbal handovers have been poor past 2wks, very disjointed + missing out important information"*

Taking all the above into account, the panel was satisfied that Mr Cairns' handovers, in addition to being of general poor quality, were both disjointed and missing important information. The panel considered that two of his mentors remarked on the poor quality of his handovers and recorded this contemporaneously. The panel was satisfied that the evidence is clear and consistent and sufficiently supports the charges to find them proved on the balance of probabilities.

Accordingly, the panel found charges 3d)v)1)a) and 3d)v)1)b) proved.

**Charge 3d)vi)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*
    d) *Communication with colleagues, in particular:*
        vi) *Went on a break and did not give colleagues a handover on patients."*

**This charge is found proved.**

In reaching this decision, the panel had sight of the Weekly Review Assessment Documentation, dated 14 August 2020, which stated:

*"He went for tea + did not give myself or colleague a report on his pts"*

The panel also considered the Weekly Review Assessment Documentation, dated 15 August 2020, which stated:

*"Avoids conversation including professional. Failed to hand over to other staff members before going on break"*

Whilst the panel noted that the charge specifies an extended relevant time period, the panel has taken this charge to mean in and around 14/15 August 2020, based on the evidence before it.

The panel determined that both the Assessment documents on 14 and 15 August 2020 stated that Mr Cairns went on a break without giving his colleagues a handover. The panel considered that these documents were made contemporaneously, and by his mentors who were supervising him at the time, and were reliable evidence.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charges 3d)vii)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    d) *Communication with colleagues, in particular:*

vii) *On or around 2 October 2020 failed to handover in respect of an unknown patient:*

(1) *That they had been aggressive and/or violent;*

(2) *The extent of their aggression."*

**Charge 3d)vii)1) is found proved, but Charge 3d)vii)2) is found NOT proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 2 October 2020, which stated:

> *"First night I was not able to supervise report as I had to deal with other issues. He failed to tell night shift that a patient had been violent"*

The document also stated:

> *"A pt was moved* [illegible] *s/r due to violent incident; when I came back from break Hugh was outside 323 writing his notes – he told me he thought he was going to wander during night, I asked why – he's in 323. So not only had High allowed him to go into 323 past him but he was lying on another patients* [sic] *bed"*

Further, it noted:

> *"Failed to document pt was violent"*

Taking all the information before it, the panel was satisfied that Mr Cairns failed to document that a patient was violent on 2 October 2022, when the mentors had noted that the patient was violent. The panel noted that, as this is an "*and/or*" charge, it may make a finding of either aggressive or violent, or both. Based on the contemporaneous account from Mr Cairns' mentors, the panel was satisfied that the patient had been violent, and it had been a "*violent incident*".

Therefore, the panel found charge 3d)vii)1) proved.

In relation to sub-charge 2), the panel determined that there is no information before it from Mr Cairns' mentors about the extent of the patient's aggression (or violence, given the panel's decision in sub-charge 1)). The panel determined that there is no information before it on the extent of the patient's violence, and subsequently, Mr Cairns' failure to handover that information. The panel does not have sufficient information before it that this information would have been available to Mr Cairns in any event.

Accordingly, the panel found charge 3d)vii)1) proved, but charge 3d)vii)2) not proved.

**Charge 3d)viii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*d) Communication with colleagues, in particular:*

*viii) On 28 July 2020 were unable to explain to an unknown colleague what a Higher Resolution Computed Tomograph ("HRCT") scan was."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 30 July 2020, which stated:

*"An agency nurse asked x3 when an HRCT was – he didn't answer"*

The document also stated:

*"Hugh has been in respiratory ward for almost 4 months, patient was awaiting HRCT – Hugh did not know what an HRCT was and didn't ask what it was"*

Additionally, the panel considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header "*Tuesday 28th July working with [Witness 5]",* it stated:

*"He was getting report from agency nurse who asked him 3 times what an HRCT was .... he didn't answer, since he has been in ward he has sent several patients for HRCT scans."*

Taking all the information above, the panel was satisfied that the contemporaneous records of Mr Cairns' inability to explain to colleagues what a high-resolution computed tomography ('HRCT') scan was is clear and consistent. The panel determined that there is sufficient evidence before it supporting this charge to find it proved on the balance of probabilities.

The panel noted that the Weekly Review Assessment Documentation was dated 30 July 2020, and this charge concerns an incident which occurred on 28 July 2020. However, the panel was satisfied that, as these Assessment Documentation reports were completed on a weekly basis, 30 July 2020 is the date in which the documentation was completed, as opposed to the date of the incident. The panel relied on the date given in the typed documentation compiled as part of Mr Cairns' Formal Capability Programme, which stated that it occurred on 28 July 2020.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3d)ix)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    d) *Communication with colleagues, in particular:*

        ix) *On 29 July 2020 incorrectly told Colleague D that an unknown patient was on 24% Oxygen."*

**This charge is found NOT proved.**

In reaching this decision, the panel considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header "*Wed 29th",* it stated:

> *"When I returned from Ayr he told me a patient was on 24% o2 at 1l it is written on mask that its 2l."*

The panel determined that, based on the evidence before it, Mr Cairns incorrectly told Colleague D that an unknown patient was on 24% oxygen at one litre, when the patient was on 24% oxygen delivered at two litres. Whilst the panel noted that this was an error in Mr Cairns' handing over of information in relation to how much oxygen the patient was on, the wording of the charge indicates that the error was that the patient was on 24% oxygen and does not charge that he gave the wrong information about the rate of delivery of oxygen to the patient. This was not charged, as the charge refers only to 24% oxygen.

Accordingly, the panel found this charge not proved.

**Charge 3d)x)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    d) *Communication with colleagues, in particular:*

        x) *On or around 30 July 2020 in relation to an unknown patient who was awaiting a blood patch were unable to explain what a blood patch was."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 30 July 2020, which stated:

> *"Patient awaiting QEH transfer for blood patch – after 2 days he didn't know what this was or ask what it was"*

The panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header "*Thursday 30th July",* it stated:

> *"I asked him what a patient was awaiting QEH hospital for he said it was for MRI this was 3rd day with this patient. She has has* [sic] *MRI it was a blood patch she is waiting for and he did not know what it was."*

The panel determined that these contemporaneous accounts are clear and consistent, and originated from mentors who were working closely with Mr Cairns at the time in a

formal capability process. The panel was satisfied that Mr Cairns was unable to explain what a blood patch on 30 July 2020.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 3e)i)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    e) *Communication with patients and/or patient's relatives, in particular;*

        i) *On or around 15 August 2020 discussed in the presence of one or more patient that [PRIVATE]."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"Hugh had been on holiday [PRIVATE] and just returned to work so I tried to make a bit of small talk to try break down the sort of barrier he had up. I asked [PRIVATE] if it was nice etc. Hugh came back with this huge story about [PRIVATE]. It all became very awkward bearing in mind there were 5 patients in the room. I wasn't expecting this, I thought he would say something like, 'It was nice' [PRIVATE]. I felt it was really inappropriate so I really tried to end the conversation and dismiss it. Hugh kept referring back to it in front of the patients going on about [PRIVATE' …"*

The panel noted that Witness 3 did not specify a date in her witness statement. However, the panel was satisfied that this evidence relates to the incident as outlined in the charge given the specificity of her account, and considered Witness 3's evidence as referring to an incident on and around the date specified in the charge, 15 August 2020.

The panel noted that this was an account of the incident as witnessed by Witness 3. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 3's credibility, that this evidence is of sufficient weight to find this charge proved on the balance of probabilities.

Accordingly, the panel found this charge proved.

**Charge 3e)ii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    e) *Communication with patients and/or patient's relatives, in particular;*

        ii) *On or around 15 August 2020 on one or more occasion unnecessarily repeated questions to patients."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

*"Hugh had a tendency to ask patients the same question multiple times. It was if*

*he had forgotten that he had already asked the question. This would put doubt and confusion on the patients."*

The panel also considered the Weekly Review Assessment Documentation, dated 15 August 2020, which stated:

*"He aggravated a patient by asking him multiple time* [sic] *(6+) about his fence being painted by a relative when the patient had already told him there was currently a family argument so it could not be done. He failed to pick up on social ques* [sic] *that the patient did not want to discuss it despite the patient eventually saying to him he continued to comment with the same question"*

The panel determined that the witness statement and contemporaneous account are both clear and consistent. The panel was satisfied that Mr Cairns did unnecessarily repeat questions about the patient's fence to them. The panel noted that the question had no relevance to clinical treatment, and so there was no reason to repeat a conversational question many times.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charges 3e)iii)1), 2) and 3)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    e) *Communication with patients and/or patient's relatives, in particular;*

        iii) *On or around 15 August 2020 in relation to an unknown patient:*

*(1) Did not notice they were uncomfortable with the content of your conversation.*

*(2) Were unable to count their respiratory rate.*

*(3) Were unable to identify if their pulse was regular or irregular."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"There was an instance where Hugh was talking to a patient who told him about their fence being painted by a relative and that there had been a fallout by the family members. Hugh kept going back to this conversation with the patient and it was really upsetting the patient. Hugh didn't seem to pick up on the social cues or the body language that the patient was getting distressed by the conversation. During this period of time, Hugh should have been carrying out observations so checking the patient's blood pressure etc. He was so consumed by conversation that he wasn't actually counting the respiratory rate or pulse properly. When I highlighted this to him he didn't seem to understand the importance of these things. He couldn't identify to me the purpose of it and what it would indicate if the respiratory rate was too high or too low. When he was checking a pulse he wasn't able to tell me if it was regular or irregular."*

In relation to sub-charge 1), the panel was satisfied that this is in respect of the same unknown patient in charge 3)e)ii). The panel bore in mind its findings in relation to that charge, and it was satisfied that Mr Cairns' repeated questions about the fence was "*upsetting*" the patient. Accordingly, the panel found this charge proved on the balance of probabilities.

In relation to sub-charges 2) and 3), the panel noted that this was an account of the incident as witnessed by Witness 3. The panel acknowledged that this is the sole evidence which relates to these charges, and it has not been supported by contemporaneous accounts. However, it was satisfied that, given Witness 3's credibility as a witness, that this evidence is of sufficient weight to find the charges proved on the balance of probabilities.

Accordingly, the panel found charges 3e)iii)1), 3e)iii)2 and 3e)iii)3) proved.

**Charges 3e)iv)1), 2) and 3)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    e) *Communication with patients and/or patient's relatives, in particular;*

        iv) *On or around 15 August 2020 communicated poorly with patients' relatives in that;*

            (1) *You lacked knowledge on patients as individuals;*

            (2) *Your updates were vague;*

            (3) *Your feedback of information to relatives was disjointed and/or did not follow a logical pattern."*

**These charges are found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 15 August 2020, which stated:

*"Poor communication over the phone. With relatives over the phone he lacked knowledge on the patients as individuals. His updates were vague and lacked confidence. His speech was delayed/broken. The feedback of information to relatives was disjointed and didn't follow a logical path."*

In relation to sub-charge 3 in particular, the panel also considered the Weekly Review Assessment Documentation, dated 25 August 2020, which stated:

*"Avoids relatives but when he is approached by them gives inaccurate information in a disjointed manner"*

The panel determined that these contemporaneous accounts are clear and consistent, and originated from Witness 3, who was mentoring Mr Cairns at the time in a formal capability process. Whilst the charge does not specify a date in which this incident occurred, the panel was satisfied that this occurred on or around August 2020, based on the dates on the two Weekly Review Assessment Documentation. The panel was satisfied that these accounts support all three charges to the extent necessary to prove them on the balance of probabilities.

Accordingly, the panel found charges 3e)iv)1), 3e)iv)2) and 3e)iv)3) proved.

**Charges 3e)v)1), 2) and 3)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*e) Communication with patients and/or patient's relatives, in particular;*

*v) On or around 25 August 2020;*

*(1) You did not enter an unknown palliative patient's room your entire shift.*

*(2) Used informal language when asking two unknown patients about a laxative which they did not understand.*

*(3) Gave an unknown patient's relative incorrect information about their condition."*

**These charges are found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 25 August 2020, which stated:

*"… Had palliative patient but did not go in the room for entire shift. Family were present for several hours but did not see named nurse.*

*[….]*

*Non-verbal communication & verbal communication with patients very awkward, poor eye contact. Patients frequently not understanding what he mean.* [sic] *eg Are things moving – He was asking if they needed laxido. Both patient* [sic] *did not know what he meant*
*[…]*

*Unable to provide basic description of routine investigations frequently carried out with respiratory patients in turn told a relative we were considering a urinary tract infection when it was acute coronary syndrome which was being considered. He did*

*not identify link with Trop T; ECG; ECHO from these investigations he told her possible UTI"*

The panel determined that these contemporaneous accounts are clear and consistent. The panel considered that this document originated from Witness 3, who was mentoring Mr Cairns at the time in a formal capability process and who directly witnessed and recorded these incidents.

In relation to sub-charge 3, the panel also had sight of Witness 1's witness statement, which stated:

*"There were also concerns with his communication. Such as a time when he was passing on information via telephone to a worried relative (as some of this was during COVID). Hugh explained to the relative about the patient having a urinary tract infection but in fact the medical team were querying an acute coronary syndrome. The relative phoned back, spoke to another nurse and told them the conversation with Hugh was, 'Hopeless.'"*

The panel noted that sub-charge 3 did not specify a patient. However, it was satisfied that, based on the account above and Witness 1's witness statement, this patient is the subject of the charge.

The panel was satisfied that this Weekly Review Assessment Documentation supports all three charges, and Witness 1's witness statement additionally supports sub-charge 3.

Accordingly, the panel found charges 3e)v)1), 3e)v)2) and 3e)v)3) proved on the balance of probabilities.

**Charge 3f)i)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    f) *Infection control, in particular;*

        i) *On or around 22 May 2020 breached health and safety procedures in relation to a patient with MRSA and ESBL."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 22 May 2020, which stated:

> *"Hugh breached health + safety protocol for managing a patient with MRSA and ESBL. This resulted in him having to go get his nurse tunic changed before [illegible] with other patients + staff. Hugh accepts what he did was not acceptable practice and placed him and others at risk of infection"*

The panel noted that this was an account of the incident as witnessed by Witness 5. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 5's credibility as a witness, that this evidence is of sufficient weight to find this charge proved on the balance of probabilities.

Accordingly, the panel found this charge proved.

**Charge 3f)ii)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    f) *Infection control, in particular;*

        ii) *On or around 27 May 2020 did not challenge a visitor who entered the ward to see a relative without prior consent being given."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation, dated 27 May 2020, which stated:

> *"Recent situation when a relative came on ward without prior permission to see grandparent and collect belongings. Hugh did not challenge individual as pressurised to let her in as a hospital employee. I have asked Hugh to ensure the present visitation policy is adhered to and communicated to the visitor"*

The panel noted that this was an account of an incident as witnessed by Witness 2. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 2's credibility as a witness, that this evidence is of sufficient weight to find this charge proved, on the balance of probabilities. The panel noted that the date of the charge falls within the COVID-19 pandemic, much of it pre-vaccines, and that infection control (while always important) was of very great importance

at the time, as an outbreak of COVID-19 in a ward caring for patients with respiratory ailments could have had catastrophic consequences.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charges 3f)iii)1), 2) and 3)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*f) Infection control, in particular;*

*iii) Between 17 June 2020 and 25 August 2020 on one or more occasion took a Covid-19 swab from an unknown patient without donning:*

*(1) Goggles.*

*(2) A Visor.*

*(3) An Apron."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"Hugh was witnessed by myself to take a Covid swab from a patient without the protective PPE for his personal safety. This was at a time when Covid concerns were at their highest and staff were taking every precaution. I asked him to stop*

*and go get the proper PPE on and then start again. I asked Hugh later if he knew that he should have worn the PPE he confirmed he did know. I stated then that this was a serious breach of our infection control precautions and should never be repeated."*

The panel also considered the Weekly Review Assessment Documentation completed by Witness 5, dated 17 July 2020, which stated:

*"Hugh witnessed to be taking a COVID swab from patient without goggles or visor. No apron being worn. Previously been advised by co-member [Witness 5] to use correct PPE in a previous breach of infection control precautions."*

Considering both of the accounts, the panel was satisfied that Mr Cairns, on at least one occasion, took a COVID-19 swab from a patient without donning goggles, a visor or an apron. The panel determined that both Witness 2 and Witness 5 are clear and consistent in their evidence. The panel also considered that Witness 5's evidence was written contemporaneously, which detailed the exact Personal Protective Equipment ('PPE') Mr Cairns failed to wear when he conducted this swab.

The panel noted that the charge was, as was the last, during the COVID-19 pandemic.

Accordingly, the panel found charges 3f)iii)1), 3f)iii)2) and 3f)iii)3) proved on the balance of probabilities.

**Charge 3f)iv)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*f) Infection control, in particular;*

*iv) In or around July 2020 did not wear Personal Protective Equipment("PPE") when you entered an unknown patient's room when there were infection control precautions in place."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

> *"A few weeks later I witnessed Hugh leaving a patients room who was on barrier precautions for Covid with a meal tray. Again he had no PPE on and had been placing the tray in a clear bag prior to putting in the trolley. I had witnessed this rubbing all over his nurse tunic. Again I asked Hugh if he knew he should be taking PPE precautions. He again acknowledged he did. I advised him to get a set of scrubs and change his nurse outfit so that he could be sure not to contaminate himself or others further. I advised Hugh this was another serious incident regarding infection control."*

The panel noted that this was an account of an incident as witnessed by Witness 2. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 2's credibility as a witness, that this evidence is of sufficient weight to find this charge proved on the balance of probabilities.

Accordingly, the panel found this charge proved.

**Charge 3f)v)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

3) *Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

    f) *Infection control, in particular;*

        v) *On or around 30 July 2020 did not dispose of a used visor in an appropriate receptacle."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 30 July 2020, which stated:

*"Has taken notice of previous advice re ppe, but then left used visor on case note trolley"*

The panel considered that this is a contemporaneous account that Mr Cairns left a used visor on the case note trolley, when it should have been disposed of appropriately. The panel determined that this account is clear and consistent, and originated from Witness 5, who was mentoring Mr Cairns at the time in a formal capability process. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 5's credibility as a witness, that this evidence is of sufficient weight to find this charge proved on the balance of probabilities. As with previous charges, this was during the COVID-19 pandemic.

Accordingly, the panel found this charge proved.

**Charges 3f)vi)1) and 2)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*f) Infection control, in particular;*

*vi) On or around 2 October 2020 when carrying out a foot dressing on an unknown patient;*

*(1) Did not have suitable surface to work on;*

*(2) Did not have the necessary dressings;*

**These charges are found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 2 October 2020, which stated:

*"Poor planning when doing foot dressing didn't have a suitable surface to work on + didn't have necessary dressings with him, therefore interrupted sterile field"*

The panel considered that this is a contemporaneous account that Mr Cairns did not have a suitable surface to work on and did not have the necessary dressings when attempting to carry out a foot dressing for an unknown patient. The panel determined that this account is clear and consistent, and originated from Witness 5, who was mentoring Mr Cairns at the time. The panel acknowledged that this is the sole evidence which relates to these charges. However, it was satisfied that, given Witness 5's credibility as a witness,

that this evidence is of sufficient weight to find both these charges proved on the balance of probabilities.

Accordingly, the panel found charges 3f)vi)1) and 3f)vi)2) proved.

**Charge 3f)vi)3)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*3) Between 10 April 2020 and 22 January 2021 failed to satisfactorily complete the Supportive Improvement Programme ("SIP") and/or Formal Capability Programme in the following areas:*

*f) Infection control, in particular;*

*vi) On or around 2 October 2020 when carrying out a foot dressing on an unknown patient;*

*(3) Had to be prompted to change gloves."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 2 October 2020, which stated:

*"Was doing a dressing … was in PPE and came out to pick something up. Was no longer sterile – I told him he had to change gloves – he pointed out gloves in pack were too small – told him he had to get + get others.*

*[…]*

*Hugh didn't seem to think it was an issue that he had contaminated his gloves."*

The panel considered that this is a contemporaneous account that Mr Cairns required prompting to change his gloves after he was no longer clinically sterile. The panel determined that this account is clear and consistent, and originated from Witness 5, who was mentoring Mr Cairns at the time. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 5's credibility as a witness, that this evidence is of sufficient weight to find both these charges proved on the balance of probabilities.

Accordingly, the panel found this charge proved.

Before moving on to consider charge 4, the panel noted that competency charges assert that Mr Cairns was not able to meet the standards needed to be a Band 5 nurse, although he had received extensive support over a prolonged period. The documentary and witness evidence proves this to be the case.

The panel noted that there were issues with the precise drafting of the charges and the specificity of dates and patients. The panel considered that the key charge is the stem of charge 3 and the major sub-headings of charge 3. The stem of charge 3 refers to a period between 10 April 2020 and 22 January 2021. During that period Mr Cairns failed satisfactorily to complete a Supportive Improvement Programme and (having failed to do so) also failed to complete satisfactorily a Formal Capability Programme and resigned.

The areas of concern raised in charge 3 are the administration of medication, organising patient care, documentation and record keeping, communication with colleagues, patients and relatives, and infection control.

Mr Cairns was supernumerary throughout that lengthy period and was always directly supervised. He was supported at all times by one of two mentors. At his request, one of those mentors was changed. The panel accepted the evidence of those three mentors. All

were supportive of Mr Cairns, but despite their best efforts to assist Mr Cairns he made very little progress towards being competent. It determined all the areas where he had been found wanting might have serious consequences for patients and colleagues. The panel was particularly concerned at the lack of competence in medication administration, which, had he not been supervised closely, the evidence of his mentor was that it would have resulted in the death of a patient. The panel does not accept that these failings were a matter of lack of confidence but instead show that Mr Cairns was not competent to practise unsupervised as a Band 5 nurse. The evidence of the mentors was that the errors were very frequent, that he did not improve even with extensive help, that the errors were over an extended period and affected all aspects of his practice. The panel accepted that evidence.

While the charging framework is unsatisfactory, the evidence makes it absolutely clear that despite a sustained period of support Mr Cairns was not competent to practise as a Band 5 nurse in any aspect of practice, as alleged.

**Charge 4**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

4) *On or around 28 July 2020 did not move an unknown patient to the discharge lounge for an urgent transfer when requested to do so by a Deputy Charge Nurse."*

**This charge is found proved.**

In reaching this decision, the panel considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header "*Tuesday 28th July working with [Witness 5]",* it stated:

*"He was asked by DCN to move patient to discharge lounge, to get an urgent transfer. An hr later nothing had been done and I moved patient.*
*Pt was on daily wgts and by mid afternoon wgt was done (aux done first thing) hugh was not aware whether up or down."*

The panel considered that this is a contemporaneous account that Mr Cairns did not move an unknown patient to the discharge lounge after being asked to do so by the Deputy Charge Nurse ('DCN') for at least an hour (before Witness 5 moved the patient). The panel determined that this account is clear and consistent, and originated from Witness 5, who was mentoring Mr Cairns at the time. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 5's credibility as a witness, that this evidence is of sufficient weight to find both these charges proved on the balance of probabilities.

Accordingly, the panel found this charge proved.

**Charge 5**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

5) *On or around 9 August 2020 did not follow your mentor's instruction to examine patients' groins before issuing cream."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 9 August 2020, which stated:

*"It was aux that pointed out oral thrush + sticky eyes. I asked him to look at patient's groins before issuing cream, and he didn't."*

The panel considered that this is a contemporaneous account that Mr Cairns did not follow Witness 5's instructions to "*look at*" the unknown patient's groin before issuing cream. The panel was satisfied that this amounted to examining, per the wording of this charge.

The panel determined that this account is clear and consistent, and originated from Witness 5, who was mentoring Mr Cairns at the time in a formal capability process. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 5's credibility as a witness, that this evidence is of sufficient weight to find both these charges proved on the balance of probabilities.

Accordingly, the panel found this charge proved.

**Charges 6a) and b)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

6) *On or around 17 July 2020 in relation to an unknown patient:*
    a) *Failed to place them on oxygen immediately when requested to do so by an Advanced Nurse Practitioner*
    b) *On one or more occasions had to be prompted to carry out observations."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

*"There was another incident again at the huddle, the ANP approached to say that a patient's oxygen levels had dropped and that they wanted them on oxygen immediately. The ANP directed this at Hugh, asking him to do it. Hugh didn't acknowledge the request. She then said it to Hugh again and he didn't acknowledge it again. I was waiting for him to say, 'Yes, I can go get them on oxygen' but he didn't. Eventually the ward manager raised her voice slightly and said, 'Hugh, the ANP has asked you multiple times' and he just looked clueless. The Sister then stepped in and went to do it. After, I took a step back as I was waiting to see if Hugh would go back and review the patient later to see how they were responding with the oxygen. I waited and I waited but eventually I had to ask Hugh, 'Are you going to do observations on that patient'. Hugh agreed to do the observations but then proceeded to go to the wrong patient and take another patient's observations so I had to tell Hugh he had just assessed the wrong patient. In this situation, I had expected Hugh to use his initiative and prioritise this patient due to the urgency of putting them on the oxygen."*

The panel also had sight of the Weekly Review Assessment Documentation completed by Witness 2, dated 17 July 2020, which stated:

*"Asked by ANP to put patient on oxygen also asked by ward manager a further 2 times to ask an instruction. Ward manager felt compelled to ask for him.*

*[…]*

*Further close supervision to ensure compliance with ANP/medics instructions in timely fashion"*

The panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header "*15/7/20 – working with [Witness 2]",* it stated:

*"When asked to put patient on oxygen by ANP Hugh 9id not respond, he was then asked by Ward Manager to put patient on 1 liter* [sic] *as per [Ms 3]'s request, he still did not act. Eventually the ward manager acted and put patient on Oxygen."*

Taking all the above into account, the panel determined that Witness 2's witness statement is clear and consistent with both pieces of contemporaneous evidence before it. The panel was satisfied that an ANP did request Mr Cairns to put the unknown patient on oxygen, but he failed to respond to this immediately. The panel found that the ward manager ended up putting the oxygen mask on this patient.

Further, the panel determined that Witness 2 prompted Mr Cairns to carry out the observations for this patient by directly asking him to do so, following which Mr Cairns did conduct the observations.

Accordingly, the panel found charges 6a) and 6b) proved on the balance of probabilities.

**Charges 7a), b) and c)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

7) *Between 4 December 2020 and 5 December 2020:*
    a) *Did not carry out patient personal care tasks when delegated to do these tasks by your mentor.*
    b) *Did not carry out skin assessment checks personally as requested by your mentor.*
    c) *Refused to help an unknown patient to the toilet."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"Hugh would refuse to put women on bed pans, take them to commodes or to take them to the bathroom. Hugh said it was because he didn't feel it was right for a male nurse to do personal care for women. I raised this as a concern with Hugh numerous times and we spoke about what's the difference in myself taking a male patient to the toilet and him taking a female patient to the toilet. I highlighted if the female is consenting to him taking her to the toilet then there is no issue apart from his own personal view, knowing that it is a career where you are going to have to carry out these kind of tasks. Hugh wouldn't even check a female patient's skin care. If you were in a 6 bedded female room, Hugh would do nothing because he wouldn't do skin checks, personal care or take them to the toilet. He therefore wouldn't carry out any of their care needs. He refused to do it. I pointed out that there is no difference between him and [Witness 2], and that [Witness 2] does do all these tasks regardless if it is a male or female patient."*

In relation to sub-charge c), the panel determined that Witness 3's account is clear and consistent, in that Mr Cairns would not take patients (in particular, female patients) to the toilet. The panel took into account that Witness 3, who was mentoring Mr Cairns at the time, directly witnessed this incident. The panel was satisfied that, given Witness 5's credibility as a witness, that this evidence is of sufficient weight to find sub-charge c) proved on the balance of probabilities.

In relation to sub-charges a) and b), the panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, dated 4/5 December 2020. Under the header "*Patient Care"* it stated:

> *"SN Cairns did not carry out any personal care during this shift. I had allocated him patients to carry out their morning personal care, but he delegated these tasks to Nursing Assistants. During skin bundle checks he made no assessment and had the*

*Nursing Assistants do this. When a patient asked him to help him to the toilet, he left the room and asked a Auxiliary to do it."*

Taking all the above into account, the panel determined that Witness 3's witness statement is clear and consistent with the contemporaneous evidence before it. The panel was satisfied that Mr Cairns did not carry out patient personal care and did not carry out skin assessment checks personally, when requested to do both tasks by Witness 3. The panel found that Mr Cairns would, in these circumstances, not carry out the instruction but delegated personal care, skin checks and taking patients to the toilet to other lower-banded members of staff, such as nursing assistants.

Accordingly, the panel found charges 7a), 7b) and 7c) proved on the balance of probabilities.

**Charge 8**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*8) On 22 July 2020 in relation to an unknown patient placed a surgical mask below an oxygen mask."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 1's witness statement, which stated:

*"Another time, we were transferring a patient to high care. The oxygen dependency of this patient was going up and they were querying COVID. However, prior to transferring the patient to the area of high care, Hugh put a surgical face mask on the patient, and then put on the oxygen mask on top. This*

*thought process by Hugh was really worrying."*

The panel also considered Witness 2's witness statement, which stated:

> *"There was an issue once where we had a patient who we were escalating up to the high dependency unit. … I told Hugh to just make sure that when the patient gets to the unit, they go straight back onto 60% oxygen. Hugh said that was fine and didn't ask any questions. I went away for a minute and when I came back I found Hugh putting a surgical mask over the patient's nose and mouth having removed their oxygen mask, then putting the oxygen mask back on top of the surgical mask. I had to stop Hugh and ask him what he was doing. … Hugh's response was that he didn't know what to do because he had never done it before."*

The panel then considered the Weekly Review Assessment Documentation, dated 22 July 2020, which stated:

> *"When transferring patient to SB on oxygen therapy Hugh initially put surgical mark below venturi mask for a patient on 40% with trouble maintaining SB. Advised Hugh this was unsafe and incorrect …"*

The panel also heard live evidence from both Witness 1 and Witness 2. Both witnesses confirmed their accounts that Mr Cairns had placed a surgical mask on the patient before placing an oxygen mask on top of it. The panel determined that their live evidence was clear and consistent with their respective witness statements, as well as their contemporaneous evidence. The panel accepted both Witness 1 and Witness 2's evidence.

Accordingly, the panel found this charge proved on the balance of probabilities. The panel considered that issues likely to arise from this action are very concerning and serious.

**Charges 9a) and b)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*9) On or around 9 August 2020;*

*a) Attempted to connect an extension set to venflon without flushing first.*

*b) Failed to check an unknown patient's pulse manually when reviewing for bradycardia."*

**These charges are found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 9 August 2020, which stated:

*"Was going to connect extension set to venflon without flushing first. Did not check pulse manually in a pt he wanted reviewed for bradycardia."*

The panel considered this contemporaneous account and determined, on the balance of probabilities, that Mr Cairns was going to connect an extension set to a venflon without flushing first and failed to manually check the pulse of an unknown patient who was going to be reviewed for bradycardia. The panel determined that this account is clear and consistent, and originated from Witness 5, who was mentoring Mr Cairns at the time. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 5's credibility as a witness, that this evidence is of sufficient weight to find both these charges proved on the balance of probabilities.

Accordingly, the panel found charges 9a) and 9b) proved.

**Charge 10**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*10) On or around 25 August 2020 were unable to provide basic descriptions of routine investigations frequently used/carried out with respiratory patients."*

**This charge is found proved.**

In reaching this decision, the panel considered the Weekly Review Assessment Documentation completed by Witness 5, dated 25 August 2020, which stated:

> *"Unable to provide basic description of routine investigations frequently carried out with respiratory patients."*

The panel noted that this was feedback in relation to the unknown patient in charge 3e)v)3). The panel considered that this is a contemporaneous account that Mr Cairns was unable to provide basic descriptions of routine investigations. The panel determined that this account is clear and consistent, and originated from Witness 3, who was mentoring Mr Cairns at the time. The panel acknowledged that this is the sole evidence which relates to this charge. However, it was satisfied that, given Witness 3's credibility as a witness, that this evidence is of sufficient weight.

The panel also took into account that Mr Cairns told Witness 3, at the time, that:

> *"He was told he did not need to learn respiratory illness or investigation."*

The panel acknowledged that Mr Cairns is absent from these proceedings and that, consequently, the panel was unable to explore this further. The panel noted that Mr Cairns

denies this charge. However, the panel considered that, by August 2020, Mr Cairns had been working on Ward 3B, which is a respiratory ward, for approximately four months. The panel determined that in any event, a registered nurse working within a respiratory ward over a period of a few months would be expected to learn respiratory illnesses and routine respiratory investigations and procedures. Therefore, the panel did not accept Mr Cairns' explanation.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charges 11a) and b)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*11) On 10 October 2020 in respect of an unknown patient:*

*a) Did not carry out a full set of observations.*

*b) Documented a full set of observations when you had not carried out a full set of observations."*

**These charges are found NOT proved.**

In reaching this decision, the panel considered Witness 3's witness statement in relation to the incident on 10 October 2020, which stated:

> *"At 10.15am, Hugh was due to go on his breakfast break, but I said to him to go check his sick patient and do a set of observations first. Hugh went away to do this, and reported back that he had done the observations and that they were fine. He didn't report any concerns. He then went on his break.*

*It wasn't until later that I checked the patient notes and found that Hugh had recorded the patient's respiratory rate as 18 and saturation levels at 74%. It is almost impossible for someone with this saturation to have a respiratory rate of 18. Hugh did not action or feedback that the patient's saturation levels were 74% - no medical staff were alerted.*

*[…]*

*When I noticed the notes entered by Hugh, I then did a set of observations. This was only 1 hour and 25 minutes after Hugh had done his. I found the patient's respiratory rate was 44%. This meant that patient immediately went from requiring 35% oxygen to 15 L of oxygen via a trauma mask."*

The panel also considered Witness 3's contemporaneous statement in relation to this incident, dated 10 October 2020, which stated:

*"Whilst SN Cairns was carrying out observations Unit Co-ordinator [Ms 4] informed me that both myself and SN Cairns were to self-isolate as a result of risks from the positive swab result. SN Cairns had administered medication without apron or gloves. I had gone over to the patient to answer a question that SN Cairns was unable to answer. Since SN Cairns was supernumerary he was to go home immediately and I would stay looking after the Annex only and the remaining staff would attend to the 6 bedded room. I was not to enter the room as I had had no contact to this point with the patients to minimize risk. Before speaking to SN Cairns the emergency buzzer was pulled for Patient X, going down to the room SN Cairns could be seen behind the curtain. He stated Patient X oxygen saturations were 62%. I asked [Ms 4] to go in and supervise and support SN Cairns as I could not go in the room. I remained outside the room, a nursing assistant came out the room and stated they had been attended to Patient X personal care and she was concerned how breathless the patient was and raised the alarm to SN Cairns. I*

*passed this information to [Ms 4] who was assisting SN Cairns with the patient. SN [Ms 5] took over the care of Patient X."*

Based on the above, the panel then considered the patient's observation chart. The panel noted the relevant time scale is 10:15 onwards on 10 October 2020. The panel noted the slight inconsistencies on who cared for the patient following Mr Cairns (whether it was Witness 3 herself, Ms 3 or Ms 4), but it was satisfied that another member of staff took over responsibility for the patient's observations. Nonetheless, both of Witness 3's statements indicated that another person took over responsibility for recording the patient's observation an hour and 25 minutes after Mr Cairns' observation (at 10:15), the panel was satisfied that entries from 11:40 onwards would be another person's observation.

Based on the patient's charts, the panel observed that, for the entry at 10:15, a dot appears between the box marked "*16*" and "*20*" on the "*resp rate*" rows. Further, a number appears – albeit the panel acknowledged this is mostly illegible – on the "*Sp02*" rows. The panel also had sight of a dot between the boxes marked "*37.5*" and "*38*" on the "*temp*" row, and that an entry of "*96*" as well as a dot between the boxes marked "*90*" and "*100*" appear on the "*pulse*" rows.

The panel noted that the next entry after 10:15 was at 11:55. The panel was satisfied that this entry was made by another practitioner, and that Mr Cairns only made one entry at 10:15.

Taking all the above into account, the panel was satisfied that Mr Cairns did carry out a full set of observations and did document that he had done so, completely, on the patient's charts. As the panel was not concerned, at this stage, as to whether these observations were correct or accurate, the panel determined that the evidence before it shows that Mr Cairns did conduct and document a full observation on the patient at 10:15.

Accordingly, the panel found charges 11a) and 11b) not proved.

**Charge 11c)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*11) On 10 October 2020 in respect of an unknown patient:*

*c) Incorrectly recorded their respiratory rate as 18.*

**This charge is found proved.**

In reaching this decision, the panel considered its findings in relation to the patient's chart in charges 11a) and 11b) above.

The panel was satisfied, given the location of the dot (namely between "*16*" and "*20*") that Mr Cairns had recorded the patient's respiratory rate at 18.

The panel then considered Witness 3's witness statement, which stated:

> *It wasn't until later that I checked the patient notes and found that Hugh had recorded the patient's respiratory rate as 18 and saturation levels at 74%. It is almost impossible for someone with this saturation to have a respiratory rate of 18. Hugh did not action or feedback that the patient's saturation levels were 74% - no medical staff were alerted.*

The panel also heard live evidence from Witness 3. She told the panel that it was impossible for the patient to have a respiratory rate of 18 and a saturation level of 74%. She explained that a patient with such a low blood oxygen saturation rate would inevitably breathe fast to try to increase oxygen uptake, and that a respiration rate of 18 would be virtually impossible

with an oxygen saturation level of 74%. The panel was of the view that her oral evidence was clear, credible and consistent with her witness statement, and the panel accepted her evidence. The panel determined that Mr Cairns did record the patient's respiratory rate at 18, which was incorrect and medically virtually impossible.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charges 11d) and e)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*11) On 10 October 2020 in respect of an unknown patient:*

*d) Incorrectly documented temperature of 37.8.*

*e) Documented the above temperature when there was no thermometer present in their room."*

**These charges are found NOT proved.**

In reaching this decision, the panel considered its findings in relation to the patient's chart in charges 11a) and 11b) above.

The panel was satisfied, given the location of the dot (namely between "*37.5*" and "*38*") that Mr Cairns had recorded the patient's temperature at 37.8.

The panel then considered Witness 3's witness statement, which stated:

*"In addition, the patient's temperature was 37.8, however I found the observation trolley that was in the room had no thermometer on it so I do not*

*know how Hugh took the recorded temperature."*

The panel was satisfied, based on Witness 3's clear and consistent evidence, that it was likely that there was no thermometer in the patient's room when another practitioner conducted the observations at 11:55. However, the panel was of the view that this does not mean there was no thermometer in the room when Mr Cairns was conducting his observations (at 10:15), or that the temperature of 37.8 was incorrect. The panel concluded that there was no evidence before it suggesting that, at 10:15, there was no thermometer in the room or that Mr Cairns' recording of a 37.8 temperature was incorrect. The panel determined that the NMC has not discharged its burden of proving the charge on the balance of probabilities.

Accordingly, the panel found charges 11d) and 11e) not proved.

**Charges 11f) and g)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*11) On 10 October 2020 in respect of an unknown patient:*

*f) Failed to act on information within the NEWS.*

*g) Failed to alert/escalate to medical and/or nursing staff to the deterioration in their condition."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

*"… Hugh did not action or feedback that the patient's saturation levels were*

*74% - no medical staff were alerted.*

*[…]*

*When Hugh first took the set of observations, he should have alerted me then contacted the ANPS and F1 junior doctor, and with a saturation level of 74 I would have put a peri arrest call and he did not do any of this. We had safety measures in place with NEWS and MEWS charts as they tell you exactly what to do, so there was no reason for Hugh to have not acted on the observations he took."*

The panel also heard live evidence from Witness 3. The panel was of the view that her live evidence was clear and consistent with her witness statement, and the panel accepted her evidence. The panel determined that Mr Cairns did not act on the information within the NEWS following his observation of the patient.

Accordingly, the panel found charges 11f) and 11g) proved on the balance of probabilities.

**Charge 11h)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*11) On 10 October 2020 in respect of an unknown patient:*

*h) Failed to reassess the patient."*

**This charge is found NOT proved.**

The panel considered that, given the wording of this charge (alleging failure), it must first be satisfied that Mr Cairns was under a duty to reassess the patient, and secondly, that he had not done so.

In reaching this decision, the panel considered the nursing notes for this patient, dated 15 October 2020, which stated:

> *"ANP and medical staff on ward when emergency buzzer pulled by SN Cairns Assessed by ANPs, see medical notes"*

The panel was satisfied that, at some point during Mr Cairns' care of this patient, he pulled the emergency buzzer, following which the patient was assessed by other medical staff.

The panel concluded that there is no evidence before it suggesting Mr Cairns was instructed to, or was under a duty to, reassess the patient, either by Witness 3 or other medical practitioners. The panel was not satisfied that Mr Cairns was under a duty to reassess this patient.

Accordingly, the panel found this charge not proved.

**Charges 12a), b), c), d), e), f), g), h), i) j)i), j)ii), j)iii) and k)**

*"That you, a registered nurse, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse, in that you:*

*12) In or around December 2020 in relation to discharging an unknown patient:*

*a) Failed to complete nursing notes to satisfactory standard.*

*b) Delayed attending to personal care.*

*c) Sought to inappropriately delegate personal care.*

*d) Did not complete the transfer letter.*

e) *Requested a discharge porter to attend before patient had been showered.*

f) *Failed to dress them in underwear.*

g) *Failed use an incontinence pad.*

h) *Failed to write in the nursing home transfer letter that they were doubly incontinent.*

i) *Required prompting to remove their cannula.*

j) *Removed their cannula;*

   i. *Without wearing gloves.*

   ii. *Without wearing an apron.*

   iii. *In the corridor.*

k) *Failed to enter into the nursing notes that they were going to a nursing home and/or being discharged.*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

*"…Hugh was given the task of discharging a patient. Most of the work had been done, Hugh only had to get the patient ready for discharge such as washed, dressed, transferred into the chair that would take them to the discharge lounge and ensure the documentation was correct. The patient was going to a nursing home so Hugh also had to phone the home to give them a handover and to make sure they were expecting the patient. As it transpired Hugh didn't get passed the washing and dressing of the patient. Hugh was given the time that he needed to have the patient ready for when the discharge lounge were coming for the patient but he failed to meet that time, despite it being the only task he had. Hugh had ample time to complete the task, there was no reason he couldn't do it within the given time frame. By luck, myself and the ward*

*manger had time to transfer the patient into the chair for discharge but when I felt round the side I realised the patient didn't have an incontinence pad on. When I asked Hugh if the patient had an incontinence pad on, he said she did but I said I would take her to the toilet to check anyways. I found she did not have an incontinence pad on despite being grossly incontinent. She would not have been in any fit state to go in the ambulance by the time she came out of the discharge lounge without one on. Hugh didn't recognise this as an issue. Hugh also hadn't taken the cannula out for discharge, which he then carried out the task without any gloves or apron on in the corridor. Hugh then ended up having to go down with the patient, as he hadn't written his notes. When he returned sometime later he came back with something written that wasn't even comprehensive."*

The panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, dated December 2020. Under the header "*Patient Care and Documentation"* it stated:

*"SN Cairns allocated the task of discharging a patient to a Nursing Home. He was allocated only that patient until the patient was transferred to the discharge lounge.*

*He was asked to prioritise his workload, made aware the patient wanted a shower before going, a transfer letter to Nursing Home along with a final phone update to Nursing Home were to be completed by him. The patient was leaving via discharge lounge who were arranging transport he was to notify them when the patient was ready to go down. The Nursing notes were to be completed by him also.*

*He failed to complete this to a satisfactory standard.*

*One hour after being set this task he had not attended to personal care but had tried to get Auxiliary to do it instead, she was bed bathing another patient at the time. He stated he had completed the transfer letter and put it in a sealed envelope.*

*On checking this letter had in fact not been completed and minimal information had been written with most sections with no entry.*

*He asked discharge lounge to collect patient before he had showered him. Discharge porter was waiting on patient to come out the shower. Transferred on to chair for porter by another member of staff and was noted to have no underwear on when trousers slid down due to being to* [sic] *big. Patient also is doubly incontinent and wears an incontinence pad, SN Cairns had not put this on. SN Cairns had been looking after the patient for 3 shifts and information was provided at handover and should have been written in the Nursing Home transfer letter."*

Taking all the above into account, the panel determined that Witness 3's witness statement is clear and consistent with the contemporaneous evidence before it. The panel accepted her evidence in its entirety in relation to this charge and all its sub-charges.

Accordingly, the panel found charges 12a), 12b), 12c), 12d), 12e), 12f), 12g), 12h), 12i) 12j)i), 12j)ii), 12j)iii) and 12k) proved on the balance of probabilities.

**Charge 13)a)**

*"That you, a registered nurse,*

*13) On or around 15 July 2020:*

a) Said to an unknown female staff member in relation to an unknown patient "What has she got chlamydia?" or words to that effect."

**This charge is found NOT proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

*"Another occasion was when there was a female member of staff who had mentioned that she needed to get ointment for a lady to help with her thrush and Hugh loudly shouted, 'What has she got chlamydia' in a way that he could be over heard by the patient and other staff members. The staff member told me that she was so affronted that she didn't know what to say to Hugh. I didn't witness this but she had come to tell me about it. She got made to feel uncomfortable by Hugh's actions."*

The panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header "*15/7/20 – working with [Witness 2]",* it stated:

*"A further female colleague stated she was unhappy that when looking for clotrimazole cream for female patient he asked "Does the patient have Clamydia"??.* [sic] *Colleague found this offensive but didn't feel she could say to him."*

The panel also considered the Weekly Review Assessment Documentation completed by Witness 2, dated 22 July 2020, which stated:

*"Hugh still to meet with other female colleague regards chlamydia comment and will apologise"*

The panel also heard live evidence from Witness 2. He confirmed his account, namely that a female colleague reported that Mr Cairns had said these words to her. He accepted that he did not witness Mr Cairns making the comment. The panel was satisfied that his live evidence was clear and consistent with both his witness statement as well as both pieces of contemporaneous evidence before the panel.

However, the panel considered that Witness 2, who is the only witness in these proceedings who comment on this charge, was not a direct witness to Mr Cairns making the comment. Therefore, his evidence is hearsay. The panel noted that the female colleague to whom Mr Cairns directed his comment has not appeared before the panel.

The panel had regard to the decision in *Thorneycroft* in considering this charge. The panel considered the following principles:

1. Whether the statements were the sole and decisive evidence in support of the charges;
2. The nature and extent of the challenge to the contents of the statements;
3. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;
4. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;
5. Whether there was a good reason for the non-attendance of the witnesses;
6. Whether the NMC had taken reasonable steps to secure the attendance of the witness;
7. …

The panel considered the above principles in turn. Firstly, the panel determined that Witness 2's hearsay evidence is the sole and decisive evidence in support of this charge. Secondly, the panel considered that Mr Cairns denies this charge. Thirdly, whilst the panel is not of the view that Witness 2 would fabricate the allegations and he would have no reason to do so, the panel took into account that the female colleague – who told Witness 2 of the allegation – is unknown to the panel. Accordingly, her motivations, relationship with Mr Cairns and whether she would fabricate the allegations is unknown to the panel. The panel next determined that this is a misconduct charge of a serious nature, for which the NMC is seeking the imposition of a striking-off order.

The panel determined that it has no information before it on whether there was good reason for the non-attendance of the female colleague, or whether the NMC has taken reasonable steps to secure her attendance. This factor is an indicator that the evidence should not be given substantial weight.

Balancing all the above, the panel determined that there is insufficient evidence to support this charge. The panel accepted that Witness 2, as a general witness, is credible and is not likely to fabricate allegations against Mr Cairns. However, given that Witness 2 did not witness this interaction himself, taken together with the unknown nature of the female colleague, the panel was not satisfied that the NMC has discharged its burden of proving the charge.

Accordingly, the panel found this charge not proved.

**Charge 13)b)**

*"That you, a registered nurse,*

*13) On or around 15 July 2020:*

*b) Said to an unknown colleague "that as it wasn't raining out, she wouldn't win a wet t-shirt competition" or words to that effect."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 2's witness statement, which stated:

*"… There was a day when I was stood in the day room with a female member of staff and she was heading downstairs. Hugh came in and mentioned the rain and went, 'Just as well it's not raining today as you'll not want the wet t-shirt competition today'. Hugh had said this to her, about her and I heard him say it. I was shocked and she gave a fake giggle. I spoke to her and she confirmed it had made her feel embarrassed. I had to go speak to Hugh and tell him he can't make these kind of jokes, that he is a professional member of staff and we are in the work place. We did have some light hearted jokes on the ward but we wouldn't joke about other people's body parts or appearance."*

The panel also considered the Weekly Review Assessment Documentation completed by Witness 2, dated 17 July 2020, which stated:

> *"Heard to be making comments that [illegible] colleague wouldn't win wet t-shirt context as it wasn't raining out"*

The following week, on 22 July 2020, within the Weekly Review Assessment Documentation, Witness 2 documented:

> *"Advised High that female colleague had agreed with mentor on conversation he had indicating she would not win wet t-shirt contest. Hugh has now apologised to the individual, apology accepted and that is the end of matter."*

The panel had sight of the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header "*15/7/20 – working with [Witness 2]"* it stated:

> *"Hugh was heard to comment to a female colleague "that as it wasn't raining she wouldn't win the wet T-shirt contest".*

The panel also heard live evidence from Witness 2. He confirmed his account, and told the panel that he directly witnessed Mr Cairns making these comments. The panel was satisfied that his live evidence was clear and consistent with both his witness statement as well as both pieces of contemporaneous evidence before the panel.

The panel then considered Mr Cairns' response at the time, which was recorded as:

> *"Hugh insists he had been misheard by me and colleague regards wet t-shirts. He will ensure she knows no offence was meant and that he was making joke about self."*

The panel also had sight of the Staff Nurse Transitional Support Questionnaire, filled out by Mr Cairns, which stated:

*"In regard to comments to female staff. The first was about me not about her. This was in regard to earlier weeks ago when I got soaked through. These two incidents where totally out of character and I will make a point to apologise to both staff members."*

The panel noted that Mr Cairns is absent from these proceedings and, consequently, it was unable to explore this further. However, the panel considered that Mr Cairns, at the time, apologised to the female colleague regarding the comment, albeit he insisted that no offence was meant by it, and it was "*out of character*". The panel considered that there would be no reason for him to apologise had he said the comment was made in relation to himself. Nonetheless, the panel was satisfied that there is sufficient evidence, on the balance of probabilities, indicating Mr Cairns did say the words as charged to an unknown female colleague.

Accordingly, the panel found this charge proved.

**Charges 14)a), b) and 15**

*"That you, a registered nurse,*

*14) In December 2020;*

*a) Stated to Colleague C and Colleague B that you had not recorded 3 respiratory rates for Patient C.*

*b) Told Colleague A that you admitted that you said you had not, to cover up your mistake or words to that effect.*

*15) Your actions at charge 14 above were dishonest in that you knew when you denied recording the 3 respiratory rates that you had recorded the 3 respiratory rates and the reason you said you had not was to cover up your mistake."*

**These charges are found NOT proved.**

The panel noted that, for the purposes of this charge, Colleague A is also identified within this document as Witness 3 and Colleague B is also identified within this document as Witness 1. Colleague C did not appear before this panel.

In reaching this decision on charge 14a), the panel considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, completed by Witness 3. Under the header "*Patient Assessment*", it stated:

> *"Patient C had 3 different respiratory rates recorded for same set of observations and NEWS calculated did not match any of the recordings. The 4 remaining NEWS scores from the room were added wrongly also. I took SN Cairns round the charts to explain where he had gone wrong and why he could not put 3 respiratory rates for the same patient. He then went on to lie and state he did not do this when I highlighted this to him with Colleague C and [Witness 1]. Only when I left the room to obtain the chart to show him again that he admitted he had lied to cover him* [sic] *mistake."*

The panel was of the view that this contemporaneous evidence is unclear. The panel was unable to ascertain whether Mr Cairns left the room with Witness 3 (as she left the room), or to whom Mr Cairns made the admission. Further, the panel noted that this was not explored in either Witness 1 or Witness 3's live evidence, and the panel did not hear from Colleague C in these proceedings.

The panel also considered that, based on the format of the patient charts, it is implausible that Mr Cairns might record three separate respiratory rate readings. The panel noted that it does not have sight of the specific chart relating to Patient C.

The panel was of the view that there is insufficient evidence to find this charge proved on the balance of probabilities. Accordingly, the panel found charge 14a) not proved.

Based on its findings in relation to charge 14a), the panel determined that charges 14b) and 15 fall away. Accordingly, the panel found both charges 14b) and 15 not proved.

**Charge 16**

*"That you, a registered nurse,*

*16) On or around 4/5 December 2020 disobeyed an instruction not to store [PRIVATE] in your tunic pocket when you had been told to keep them in your locker."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

*"On two separate occasions, Hugh told me he had [PRIVATE] in his uniform pocket. [PRIVATE].*

The panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, completed by Witness 3, dated 4/5 December 2020. Under the header "*Communication with Colleagues*", it stated:

*"Today SN Cairns spoke openly about [PRIVATE] and that they were in his uniform tunic pocket and then went on to show me them. He has previously been asked to keep these in the locker provided on the ward. [PRIVATE]."*

The panel also heard live evidence from Witness 3, where she confirmed her account [PRIVATE] when he was told by Witness 3 to store it in his locker. The panel determined

that Witness 3's live evidence was clear and consistent with both her witness statement and the contemporaneous account she gave in relation to this. The panel accepted her evidence in relation to this charge.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 17**

*"That you, a registered nurse,*

*17) On or around 4/5 December 2020 having [PRIVATE] refused to go home when requested to do so by your mentor.*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"When Hugh was doing the drug round, a lot of the time he was just standing staring at the trolley. This didn't just happen during drug rounds, other times as well he would just pause and not do or say anything. When I asked what he was doing he would say that he was thinking [PRIVATE]. I found this quite concerning as it was for really prolonged periods of time where he was staring at the drugs trolley and nothing was happening … [PRIVATE] I told Hugh [PRIVATE] I would have to send him home because I didn't feel he could function appropriately [PRIVATE] and be in charge of patients. [PRIVATE] he refused to go home so I refused to give him any further work and he sort of hung about. I am not sure what he did."*

The panel also heard live evidence from Witness 3, where she confirmed her account in relation to Mr Cairns refusing to go home after he was requested to do so by Witness 3 [PRIVATE]. The panel determined that Witness 3's live evidence was clear and consistent

with her witness statement in relation to this. The panel accepted her evidence in relation to this charge.

Further, the panel also heard from Witness 3 of the potential impact [PRIVATE]. The panel determined, based on this evidence, that [PRIVATE] could have impacted Mr Cairns' ability to conduct his nursing duties, and may have worsened Mr Cairns' apparent inability to progress his drug round expressed by Witness 3 in her witness statement. The panel accepted that it was this potential impact on Mr Cairns' ability to conduct his duties which led to Witness 3 requesting him to go home, and was satisfied that, on the balance of probabilities, he refused to do so.

Accordingly, the panel found this charge proved.

**Charges 18a), b), c), d) and e)**

*"That you, a registered nurse,*

*18) On 4 December 2020 and/or 5 December 2020 said to an unknown patient:*

*a) "You're one of them" or words to that effect.*

*b) That his tattoos were "IRA tattoos" or words to that effect.*

*c) Spoke to him about being in the army.*

*d) Stated to him "you lot" or words to that effect.*

*e) Disobeyed Colleague A's instruction to stop speaking to the patient in that way."*

**These charges are found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

*“There was an instance he was making comments about the IRA as a gentleman had a tattoo and Hugh noticed it whilst doing observations and commented on it. Hugh then spoke at length about it with the gentleman as he had very strong views on the IRA as I believe he was previously in the army. This conversation aggravated the patient quite a lot.”*

The panel also considered the documentation compiled as part of Mr Cairns’ Formal Capability Programme, completed by Witness 3, dated 4/5 December 2020. Under the header “*Communication with Patients*”, it stated:

*“SN Cairns was checking patients' blood pressure. Patient had several tattoos SN Cairns stated to patient 'you're one of them?' The patient had complex mental health issues and possible cognitive impairment. The patient did not know what SN Cairns meant. SN Cairns then went on to state 'you're one of them' again and then referred to his tattoos. The patient still did not understand. SN Cairns then went of* [sic] *to say IRA tattoos. I asked him to stop that it was inappropriate and that as medical professionals we are not to pass comment of judge. He continued to tell the patient about him being in the Army and stating, 'you lot'. I asked SN Cairns to stop and leave the room. Out with the room I asked him why the conversation was wrong. He was not interested and continued to state the IRA and his history makes this upsetting for him. I offered* [him] *reassurance. I advised if he felt he was unable to care for this patient then he should say but he could not conduct himself like this with a patient.”*

Taking all the information before it, the panel was satisfied that Witness 3 was clear and consistent in her witness statement and in the contemporaneous account in relation to this incident. The panel took into account that Witness 3 was Mr Cairns’ mentor and had observed this conversation directly. The panel determined that the contemporaneous account, in particular, detailed the exact nature of Mr Cairns’ conversation with the patient, as worded in the charge. The panel accepted Witness 3’s evidence in relation to these charges.

In relation to sub-charge e), the panel found that Witness 3 told Mr Cairns to stop speaking to the patient in relation to the IRA tattoos twice, and Mr Cairns did leave the room with Witness 3 after the second request. However, he failed to stop speaking to the patient after Witness 3's first request.

Accordingly, the panel found charges 18a), 18b), 18c), 18d) and 18e) proved on the balance of probabilities.

**Charge 19**

*"That you, a registered nurse,*

*19) Your actions at all or part of charge 18 above were discriminatory."*

**This charge is found proved.**

In reaching this decision, the panel considered its findings in relation to charge 18 above.

The panel decided that the meaning of the word "*discrimination*" was an allegation of harassment as it is defined in the Equality Act 2010. However, the panel noted that the charge did not refer to the Equality Act 2010 or refer to "*unlawful discrimination*". The panel, therefore, decided that the charge did not require the NMC to prove that the conduct alleged related to a protected characteristic, but did require the NMC to prove that Mr Cairns' conduct was harassing the patient.

Accordingly, the panel assessed the evidence before it against the test below:

*Equality Act 2010 S26. Harassment*

*(1) A person (A) harasses another (B) if—*

*(a) A engages in unwanted conduct [omitted - related to a relevant protected characteristic], and*

*(b) the conduct has the purpose or effect of—*

*(i) violating B's dignity, or*

*(ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.*

The panel accepted Witness 3's evidence in relation to the conversation. In particular, the panel accepted that the conversation "*aggravated the patient quite a lot*". The panel noted that this patient had complex mental health needs and considered this vulnerability relevant. The panel decided that this met the definition above.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 20**

*"That you, a registered nurse,*

*20) On 4 December 2020 and/or 5 December documented patient skin care when you had not assessed any patients' skin throughout the shift."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

*"Hugh wouldn't even check a female patient's skin care. If you were in a 6 bedded female room, Hugh would do nothing because he wouldn't do skin checks, personal care or take them to the toilet. He therefore wouldn't carry out any of their care needs. He refused to do it."*

The panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, completed by Witness 3, dated 4/5 December 2020. Under the header "*Patient Care*", it stated:

> *"During skin bundle checks he made no assessment and had the Nursing Assistants do this."*

The panel noted that the patient's chart or documentation in relation to skin care has not been made available before it.

The panel also heard live evidence from Witness 3, where she confirmed her account in relation to Mr Cairns documenting that he had assessed patients' skin when Witness 3 knew he had not. The panel determined that Witness 3's live evidence was clear and consistent with her witness statement and contemporaneous account in relation to this. The panel accepted her evidence in relation to this charge.

The panel took into account that Witness 5, who also gave live evidence, told the panel that, to her knowledge, this was not an issue raised in relation to Mr Cairns. The panel considered its findings in relation to this in charge 3b)viii) and concluded that Witness 5 said she was unaware of him refusing.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 21**

*"That you, a registered nurse,*

*21) Your actions at charge 20 above were dishonest as you knew you had not assessed patients' skin and you sought to mislead others to believe that you had assessed patients' skin when you had not."*

**This charge is found proved.**

In reaching this decision, the panel had regard to its findings in relation to charge 20 above, as well as the test of dishonesty, pursuant to *Ivey v Genting Casinos* [2017] UKSC 67.

The panel considered Witness 3's witness statement, which stated:

> *"I know for a fact he hadn't checked patient's skin integrity as Hugh had a belief that male staff shouldn't do personal care with female patients. It was explained to him that we are responsible for any patient, be it male, female or any gender, and it was his responsibility to do personal care, but he refused and would not do personal care for female patients. Yet, he was commenting on female patients records that their skin was intact.*
>
> *Hugh also wasn't left unsupervised so he wouldn't have had any opportunity to do skin checks without me knowing. This is also how I know he wasn't doing personal care."*

The panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, completed by Witness 3, dated 4/5 December 2020. Under the header "*Documentation and Record Keeping*", it stated:

> *"Falsely documented patient skin care. He had not assessed any patients skin throughout these shifts. Remaining documentation remains poor. Important patient information missed from nursing notes and handover."*

The panel also heard live evidence from Witness 3, who told the panel that Mr Cairns was never left unsupervised given the nature of his mentorship. The panel heard the same from Witness 1 and from Witness 5, who both told the panel that Mr Cairns was never left unsupervised.

The panel determined that Witness 3 is clear and consistent in both her live evidence and witness statement that Mr Cairns could not have conducted the skin integrity checks as he was never left to do so unsupervised, alongside his refusal to do them in any event given his refusal to do personal care for patients (per charge 3b)viii)).

The panel noted that the patient's chart or documentation in relation to skin care has not been made available to it. However, the panel accepted Witness 3's evidence that she had sight of them, and Mr Cairns had recorded he had conducted the skin integrity checks. The panel determined that, given the level of supervision Mr Cairns was under, he could not have conducted the skin integrity checks without Witness 3, or any other mentor, noticing. The panel, therefore, concluded that he had not conducted these checks.

The panel was satisfied that Mr Cairns, in documenting the skin integrity checks had been completed by him, when he knew he had not conducted them, was dishonest by the ordinary standards of reasonable and honest people. Although not necessary for the finding of dishonesty, the panel further determined that Mr Cairns, as a registered nurse, would have known that false documentation of patient checks was dishonest.

This would be the case even if the skin integrity checks had been carried out by others on his instruction, because he had recorded that he had done them himself, when he had not. If it had been carried out by someone else, Mr Cairns should have documented the person who carried this out.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 22**

*"That you, a registered nurse,*

22) *On date/s unknown made entries in unknown patient/s fluid balance charts when you had not measured fluid intake/outtake*."

**This charge is found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"Hugh stated on many occasions it was not his job to take patients to the toilet. He would have been unable to accurately measure a patients output as he was not attending to that aspect of patients care, yet he would fill in the charts in retrospect. This brings concerns for patient safety. It was explained to Hugh on many occasions the importance and reasoning behind monitoring input and output ... There are various reasons for patient's fluid balance to be monitored failure to monitor and accurately document can have a detrimental effect on patient wellbeing.*
>
> *When Hugh completed fluid balance it was often done in retrospect. The values written could not have been accurate as he did not assist patients with oral intake or attend to their elimination needs. It was highlighted on many occasions to Hugh directly during feedback sessions. Despite this Hugh appeared to be disinterested in improving his quality of work or retaining the information being given."*

The panel also considered Witness 2's witness statement, which stated:

> *"Fluid balance charts were identified as an issue. Often Hugh did not complete them properly or there was no chart completed or he used the previous days in error and had to be asked to get a new chart and transfer any recordings that he had made. When he did not complete them properly it was mistakes such as he had miscalculated the score as an arithmetic error. On top of that I*

*highlighted to Hugh on several occasions that the patients who had fluid charts needed to be accurate in every level. For example, I had identified a patient with an acute kidney injury and they were of concern. … I had to say to Hugh that it was about how much she was actually drinking, that we should be encouraging her to drink more and show her how much she is drinking vs how much she is passing… When I went back later, Hugh hadn't input anything into the patient's chart, so I reminded him and went off again. I then went back again later, around lunch time and he still hadn't put anything into the chart. We got to 4pm and there was still nothing input my Hugh so I said to him that I was trying to stand back and let him do it, that I had explained the task and that he only had 6 patients in the room to complete the fluid charts for … Hugh would be focussed for the morning but in the afternoon it would be 3 hours since he had recorded any fluid intake on a patient's chart so I would have to ask Hugh if that was right as I could see an empty water jug on a patient's table. I would have to remind him we are trying to encourage their intake so if we see an empty jug, we should be filling it up and that the jug should be recorded that it's been drunk on the chart."*

The panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme. Under the header "*15/7/20*", it stated:

*"I asked Hugh on a couple of occasions to put one in for patient in bed 4 and bed 5. One patient had a catheter the other was on IV fluids: Two other patients had charts but these were not fully filled in as the weight were missing as part of patients' info. During mid-afternoon Hugh was asked again, but these actions were still not carried out. The respiratory ANP actually started one at 5pm for him for the patient on IV fluids."*

The panel then considered the Weekly Review Assessment Documentation, dated 17 July 2020, which stated:

*"Fluid charts not filled in correctly or in a timely fashion when having been asked several times"*

The panel also heard live evidence from Witness 2. The panel determined that his evidence was clear and consistent with his witness statement and the contemporaneous accounts in relation to Mr Cairns not measuring fluid intake and outtake properly and subsequently making unknown entries at a later time.

The panel acknowledged that the charge does not specify dates or patients. However, the panel determined that on at least one occasion, on or around 15 July 2020, and on many others, Mr Cairns failed to monitor and subsequently made unknown entries in relation to a patient's fluid intake and outtake (which is what "*outtake*" in the charge means). The panel accepted the evidence of Witnesses 2 and 3 in relation to this charge.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 23**

*"That you, a registered nurse,*

*23) Your actions at charge 22 above were dishonest in that you knew you had not measured unknown patients' fluid intake/outtake and you sought to mislead others to believe that you had measured unknown patient/s fluid intake/outtake when you had not."*

**This charge is found proved.**

In reaching this decision, the panel had regard to its findings in relation to charge 22 above, as well as the test in *Ivey*.

The panel noted that the patient's fluid chart has not been made available before it. However, the panel accepted Witness 2's evidence that Mr Cairns had recorded unknown entries, after having failed to monitor the fluid intake and output (which is what "*outtake*" in the charge means) appropriately (per charge 22).

The panel was satisfied that documenting fluid intake and output entries, when Mr Cairns knew he had not properly monitored them despite being instructed to do so by Witness 2, was dishonest by the ordinary standards of reasonable and honest people. The panel further determined that Mr Cairns, as registered nurse, knew that false documentation of fluid intakes was dishonest. The panel considered that the accurate monitoring of fluid intake and output is an essential element of patient care and could impact on the patient's care plan.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Charge 24**

*"That you, a registered nurse,*

*24) Between 4 August 2020 and 22 January 2021 on one or more occasion in relation to female patient/s refused to undertake personal care."*

**This charge is found proved.**

In reaching this decision, the panel considered Witness 3's witness statement, which stated:

> *"Hugh would refuse to put women on bed pans, take them to commodes or to take them to the bathroom. Hugh said it was because he didn't feel it was right for a male nurse to do personal care for women. I raised this as a concern with Hugh numerous times and we spoke about what's the difference in myself taking a male*

*patient to the toilet and him taking a female patient to the toilet. I highlighted if the female is consenting to him taking her to the toilet then there is no issue apart from his own personal view, knowing that it is a career where you are going to have to carry out these kind of tasks. Hugh wouldn't even check a female patient's skin care. If you were in a 6 bedded female room, Hugh would do nothing because he wouldn't do skin checks, personal care or take them to the toilet. He therefore wouldn't carry out any of their care needs. He refused to do it."*

The panel also considered the documentation compiled as part of Mr Cairns' Formal Capability Programme, completed by Witness 3, dated 4/5 December 2020. Under the header "*Patient Care*", it stated:

*"SN Cairns did not carry out any personal care during this shift. I had allocated him patients to carry out their morning personal care, but he delegated these tasks to Nursing Assistants. During skin bundle checks he made no assessment and had the Nursing Assistants do this. When a patient asked him to help him to the toilet, he left the room and asked a Auxiliary to do it."*

The panel also considered the Weekly Review Assessment Documentation, dated 15 August 2020, which stated:

*"He does not feel he should assist females"*

The panel also heard live evidence from Witness 3, Witness 2 and Witness 1 in relation to Mr Cairns' refusal to conduct personal care for female patients. All three witnesses confirmed to the panel that Mr Cairns would refuse and state that he did not feel that should be providing personal care to female patients.

The panel took into account that Witness 5, who also gave live evidence, told the panel that Mr Cairns had not refused to do personal care, to her knowledge. However, the panel

considered its findings in relation to this in charge 3b)viii) and charge 20 and concluded that it is likely that Mr Cairns was not asked by Witness 5 to carry out such care.

The panel determined that all three witnesses' oral evidence was clear and consistent with their own witness statements, the contemporaneous evidence as well as with each other on Mr Cairns' refusal to conduct personal care for female patients.

The panel considered Mr Cairns' response to the NMC. It was unclear from this whether he would have thought it was inappropriate for male nurses to conduct personal care on female patients or whether he thought other, lower-banded members of staff should carry it out. In light of Mr Cairns' absence, the panel was unable to conclude whether this action was a point of principle for him. Nonetheless, given the wording of this charge, the panel was satisfied that Mr Cairns refused to undertake personal care for female patients, despite being asked to do so by his mentors.

Accordingly, the panel found this charge proved on the balance of probabilities.

**Fitness to practise**

The panel bore in mind that some of the charges brought by the NMC are charges in relation to Mr Cairns' lack of competence (Charges 1 to 12), and some are in relation to his misconduct (Charges 13 to 24).

The panel noted that its decision on lack of impairment must be considered in stages, namely it must consider whether the facts found proved in relation to charges on competence amounted to a lack of competence, and whether the facts found proved in relation to charges on misconduct amounted to misconduct. If so, the panel must then consider whether Mr Cairns' fitness to practise is currently impaired on each 'set' of charges.

The panel considered both in turn below.

**Lack of Competence**

Having reached its determination on the facts of this case in relation to Charges 1 to 12, the panel then moved on to consider whether those facts it found proved amount to a lack of competence and, if so, whether Mr Cairns' fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

**Submissions on lack of competence and impairment**

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Ms Da Costa, on behalf of the NMC, invited the panel to take the view that the facts found proved in charges 1 to 12 amount to a lack of competence. She submitted that the

charges relate to a range of competencies central to the nursing role, including medication errors and near misses which could have resulted in severe consequences for the patients, inability to prioritise his work, poor record keeping, a failure to deliver care safely and effectively, as well as poor communication with both Mr Cairns' colleagues and patients.

Ms Da Costa referred the panel to the decision of *R (on the application of Calhaem) v General Medical Council* [2007] EWHC 2606 (Admin) and the considerations for the panel in its decision on whether the facts found proved amounted to a lack of competence on Mr Cairns' part, namely that the performance must be unacceptably low, and should represent a fair sample of the practitioner's work. She submitted that a single incident is unlikely to amount to a lack of competence. She further referred the panel to the NMC Guidance, "*Lack of Competence*" (FTP-2b), which stated:

> *"Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk."*

Ms Da Costa submitted that the facts found proved indicated that Mr Cairns displayed an unacceptably low standard of performance. She submitted that he was working in a supernumerary capacity in a Supported Improvement Programme before being placed on a Formal Capability Programme. Throughout he was supported and supervised by three different mentors at different times (and at all times by one of the three mentors). She reminded the panel that, despite this, Mr Cairns failed to improve his competencies, and issues with his nursing practice persisted. She further submitted that all three mentors outlined Mr Cairns' errors and how they presented a risk of harm to the patients, despite the support he received and the fact that he, at this stage, had been a qualified nurse for many years.

Ms Da Costa further submitted that this support, and Mr Cairns lack of improvement, spanned a number of months. She submitted that the charges found proved relate to

issues surrounding several fundamental areas of nursing, and that this amounts to a fair sample of Mr Cairns' work. She submitted that this clearly shows Mr Cairns' unacceptably low standard of the work required of a registered nurse, and consequently, his lack of competence.

Ms Da Costa referred the panel to The Code: Professional standards of practice and behaviour for nurses and midwives 2015 ('the Code'). She submitted that paragraph 1.2 is engaged, as Mr Cairns failed to effectively administer medication, struggled with his caseload, had poor record keeping, and had issues with delivering care effectively. She further submitted that paragraph 2.1 is engaged, as Mr Cairns struggled with communication with his colleagues, which is key in working in partnership with others whilst delivering care. She further submitted that paragraph 4 is engaged, alongside paragraph 6.2, 7, 8 and 9.1. In respect of paragraph 9.1, she submitted that Mr Cairns was receiving regular feedback from his mentors during the period of supervision, which he failed to act upon. She also submitted that Mr Cairns is in breach of paragraph 10, 13.1 (on account of Mr Cairns' failure to identify patients' issues and conditions), 18, 19 and 20.

Ms Da Costa moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. She submitted that the lack of competence displayed by Mr Cairns is so significant that it engages the public interest. She submitted that a member of the public would be very concerned to learn that Mr Cairns' lack of competence continued over several months, despite the support he was receiving. She submitted that this has the potential to bring the profession into disrepute.

Ms Da Costa further submitted that Mr Cairns' lack of competence continues to present a risk of harm to members of the public. She submitted that there is no evidence before the panel of Mr Cairns' sufficient remediation, or a safe period of practice. She submitted that Mr Cairns' lack of insight into his actions means that there is a real and high risk of harm and of repetition given his lack of remediation.

Accordingly, Ms Da Costa invited the panel to find Mr Cairns' fitness to practise impaired by way of his lack of competence on both public protection and public interest grounds.

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

**Decision and reasons on lack of competence**

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

*'**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.*

*1.3 avoid making assumptions and recognise diversity and individual choice.*

*1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*

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

*To achieve this, you must:*

*2.6 recognise when people are anxious or in distress and respond compassionately and politely.*

***6 Always practise in line with the best available evidence***

*To achieve this, you must:*

*6.2 maintain the knowledge and skills you need for safe and effective practice.*

***8 Work co-operatively***

*To achieve this, you must:*

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

*8.2 maintain effective communication with colleagues.*

*8.3 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***

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

***13 Recognise and work within the limits of your competence***

*To achieve this, you must:*

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

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

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

*To achieve this, you must:*

*18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge*

*of that person's health and are satisfied that the medicines or treatment serve that person's health needs.*

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

*To achieve this, you must:*

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

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

The panel bore in mind, when reaching its decision, that Mr Cairns should be judged by the standards of the reasonable average Band 5 registered nurse and not by any higher or more demanding standard.

The panel had regard to the NMC Guidance on lack of competence, and considered whether Mr Cairns' conduct was at "*an unacceptably low standard*". The panel considered that the charges found proved spanned several areas of fundamental nursing practice, including medication management (such as identifying the purpose of medication, being able to calculate the correct dosage, and the correct dispensing and administering of medication), prioritisation of workload, escalation of deteriorating patients, effective communication with both colleagues and patients and the general delivery of safe and effective care. The panel also considered that, throughout the relevant time period, Mr Cairns was subject to, successively, a Supported Improvement Programme and a Formal Capability Programme, and at all times was supported by three mentors (one of whom changed midway through the process). The panel determined that, despite this help, Mr Cairns failed to improve his clinical performance and continued to make errors in the same identifiable areas. The panel was satisfied that Mr Cairns' performance was at an unacceptably low standard.

The panel next considered whether the charges found proved were a fair sample of Mr Cairns' work as a registered nurse. The panel determined, as the charges spanned a period of approximately nine months, that this is a fair and thorough representation of Mr Cairns' clinical practice.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mr Cairns' practice was far below the standard that one would expect of the average registered nurse acting in Mr Cairns' role.

Accordingly, the panel determined that Mr Cairns' performance demonstrated an extensive and severe lack of competence.

**Decision and reasons on impairment**

The panel next went on to decide if, as a result of the lack of competence, Mr Cairns' fitness to practise is currently impaired. In reaching this decision, the panel bore in mind the NMC Guidance on lack of competence (FTP-2b).

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. Patients and their families must be able to trust nurses with their lives and

the lives of their loved ones. They must make sure that their competence always justifies both their patients' and the public's trust in the profession.

The charges found proved in relation to competence showed that at that time Mr Cairns' fitness to practise was impaired by reason of that lack of competence. The panel is assessing today whether Mr Cairns' fitness to practise remains impaired by reason of lack of competence. Mr Cairns has provided no information or evidence to indicate that his level of competence has improved subsequent to the matters found proved.

The panel took into account that Mr Cairns has been qualified for many years and was receiving ample support from the Board (as defined) to ensure that he is competent. However, despite this support, he failed to improve his nursing practice, and his mentors were of the opinion that he was unable to deliver safe and effective care.

In particular, there is no evidence of further training, practice or sufficient reflection by Mr Cairns since the matters found proved. He has not shown that he is currently capable of safe practice.

Accordingly, the panel was of the view that, in the absence of any evidence of his safe practice since the matters found proved, there is a high risk of repetition.

The panel therefore concluded that Mr Cairns' fitness to practise remains impaired by reason of the lack of competence found proved. The panel considered that should Mr Cairns return to practice unrestricted he would be highly likely to make further similar and repeated errors and so place patients at risk of harm. Therefore, it decided that his fitness to practise is currently impaired. The panel was satisfied that a finding of impairment on public protection grounds is necessary.

Further, the panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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 considered that Mr Cairns' incompetence spanned multiple areas of nursing practice and was over a prolonged period of time, despite the extended efforts of his three mentors, who were constantly engaged in supporting him. The panel was of the view that Mr Cairns had not improved throughout this time, and his mentor's evidence that his level of competence was no better at the end of the Formal Capability Programme than when he had started it. The panel determined that Mr Cairns' lack of competence is so serious that a member of public would be extremely concerned if a finding of impairment was not made, particularly with the finding that, but for the intervention of his mentors, real and significant harm would have come to patients as a result of his lack of competence. The panel determined that, in this case, a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mr Cairns' fitness to practise is currently impaired by way of his lack of competence.

**Misconduct**

Having reached its determination on the facts of this case in relation to Charges 13 to 24 and all sub-charges, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Cairns's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

**Submissions on misconduct and impairment**

In relation to charges 13 to 24, Ms Da Costa referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* She also referred the panel to the decision in *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) for its consideration.

Ms Da Costa submitted that these charges involved both discriminatory and dishonest conduct on the part of Mr Cairns. She submitted that his conduct falls far short of what is proper in the circumstances, and it is conduct that other nurses would find deplorable.

Ms Da Costa referred the panel to the Code, specifically paragraphs 1, 4, 10, 19 and 20. She submitted that Mr Cairns failed to treat people with dignity, was dishonest in his record keeping, and failed to act in the best interest of patients or to uphold the reputation of the nursing profession.

In relation to the discriminatory comment made (charge 18), she reminded the panel that Mr Cairns was specifically instructed not to speak to the patient in that manner, which instruction he ignored. Alongside indicating that his mentor found Mr Cairns' comments unacceptable, Ms Da Costa submitted that this is also indicative of an attitudinal concern. She further submitted that Mr Cairns displayed a lack of awareness in a professional setting of how to treat and engage with patients from other walks of life, which is a fundamental tenet of the nursing profession. She drew the panel's attention to the NMC

Guidance on seriousness (FTP-3) and submitted that discriminatory behaviour can negatively impact public protection as well as the trust and confidence the public have in nurses.

Ms Da Costa referred the panel to its findings of Mr Cairns' dishonesty. She submitted that this also presents an attitudinal concern, and these concerns are difficult to remedy. She further submitted that honesty is of central importance in the nursing profession, and Mr Cairns' dishonest conducts brings into question his trustworthiness and professionalism, and consequently, whether he is able to practise kindly, safely and professionally. She invited the panel to find the charges found proved amounted to misconduct.

Ms Da Costa then moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. She invited the panel to consider the four limbs in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council and (2) Grant* [2011] EWHC 927 (Admin), and she submitted that Mr Cairns has continually put patients at risk of harm. She further submitted that he has engaged in conduct which could bring the nursing profession into disrepute – namely by acting in both a discriminatory and dishonest manner – and he has breached the fundamental tenets of the nursing profession, given his questionable professionalism and his attitudinal concerns. She submitted that Mr Cairns has also acted dishonestly, by recording the incorrect information on patients' charts.

Ms Da Costa submitted that there is before the panel insufficient evidence of reflection, remorse or remediation from Mr Cairns. She submitted that there is no evidence before the panel to indicate that Mr Cairns is not likely to repeat this conduct, particularly his dishonest conduct, in the future.

Accordingly, Ms Da Costa invited the panel to find Mr Cairns' fitness to practise impaired by reason of his misconduct on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor.

**Decision and reasons on misconduct**

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

In relation to charges 13 to 24, the panel was of the view that Mr Cairns's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Cairns's actions amounted to a breach of the Code. Specifically:

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

*To achieve this, you must:*

*1.1 treat people with kindness, respect and compassion.*

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

*To achieve this, you must:*

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

***20 Uphold the reputation of your profession at all times***

*To achieve this, you must:*

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

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

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

*20.5 treat people in a way that does not […] cause them upset or distress.*

*20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way.'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel considered that Mr Cairns was mentored by three registered nurses, all of whom found his conduct completely unacceptable. The panel agreed with this assessment. The panel also determined that Mr Cairns dishonest recordkeeping and his discriminatory conduct (against a patient who had complex mental health needs) were both particularly egregious.

The panel found that Mr Cairns' actions did fall seriously short of the conduct and standards expected of a nurse and were sufficiently serious to amount to misconduct.

**Decision and reasons on impairment**

The panel next went on to decide if as a result of the misconduct, Mr Cairns's fitness to practise is currently impaired. It had regard to the NMC's guidance on impairment (DMA-1) and on seriousness (FTP-3) and the Fitness to Practise Library (outlined above) guidance on impairment, namely whether a nurse, midwife or nursing associate practise kindly, safely and professionally.

The panel also considered the judgment of Mrs Justice Cox in the case of *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/their fitness to practise is impaired in the sense that S/He/They:*

*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.’*

Taking the above limbs in turn, the panel was satisfied that that patients were put at risk of harm as a result of Mr Cairns’s misconduct. Mr Cairns’s misconduct had breached the fundamental tenets of the nursing profession, namely to act with honesty and without discrimination, and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty serious.

The panel considered that impairment is a forward-looking exercise, and it next considered whether Mr Cairns is liable, in the future, to put patients at unwarranted risk of harm, bring the nursing profession into disrepute and breach one of the fundamental tenets of the nursing profession, pursuant to *Grant*. In reaching its decision, the panel also considered the principles derived from *R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin),* namely:

- Whether the concern is easily remediable;

- Whether it has in fact been remedied; and
- Whether it is highly unlikely to be repeated.

On whether the concerns are remediable, the panel considered that both dishonesty and discrimination are indicative of attitudinal concerns. The panel was of the view that these are concerns which are more difficult to remedy, albeit it was satisfied that this was not impossible.

On whether Mr Cairns has remedied the concerns, the panel considered that, since the incidents, Mr Cairns has not displayed sufficient insight or remorse into his conduct. The panel was not satisfied that he has remedied these concerns. It determined there was little or no evidence of Mr Cairns having insight into the matters of misconduct found proved.

Consequently, when considering whether the conduct is highly unlikely to be repeated, the panel took into account that there are circumstances in which an otherwise honest person can do a dishonest thing, and that some discriminatory remarks can be a one-off incident. However, the panel determined that this was not the case with Mr Cairns in either respect. The panel took into account that he denies his dishonesty, and the panel does not have any evidence before it that Mr Cairns has sufficiently developed insight, remorse or remediation into his conduct. Bearing in mind that these concerns are more difficult to remedy in any event, the panel was satisfied that there is a risk of repetition, given Mr Cairns' lack of sufficient insight, remediation or reflection.

Accordingly, the panel determined that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case, particularly given Mr Cairns' discriminatory and dishonest conduct. Accordingly, the panel also finds Mr Cairns's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Cairns's fitness to practise is currently impaired by way of his misconduct.

**Sanction**

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

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

**Submissions on sanction**

Ms Da Costa invited the panel to impose a striking-off order. She reminded the panel that it is required to consider sanction in ascending order, leading up to a striking-off order.

Ms Da Costa drew the panel's attention to the following aggravating factors in this case:

- Potential for serious harm to patients;
- Deep-seated attitudinal issues;
- Lack of insight or engagement from Mr Cairns;
- Conduct involving dishonesty and discrimination, which heightens the seriousness of this case.

Ms Da Costa further submitted that [PRIVATE] should be considered as a mitigating factor would be a matter for the panel's discretion.

Ms Da Costa drew the panel's attention to the NMC guidance, "*Considering sanctions for serious cases*" (SAN-2). On dishonesty, the guidance stated:

> *"Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register."*

In relation to discrimination, the guidance stated:

> *"We may need to take restrictive regulatory action against nurses, midwives or nursing associates who've been found to display discriminatory views and behaviours and haven't demonstrated comprehensive insight, remorse and strengthened practice, which addresses the concerns from an early stage.*
>
> *If a nurse, midwife or nursing associate denies the problem or fails to engage with the fitness to practise process, it's more likely that a significant sanction, such as removal from the register, will be necessary to maintain public trust and confidence."*

Ms Da Costa submitted that whilst the panel has found Mr Cairns' lack of competence could be remediated (potentially), the misconduct matters – including charges of dishonesty and discrimination found proved – indicate a deep-seated attitudinal issue, which warrants a striking-off order. She further submitted that this is conduct which is not compatible with remaining on the nursing register, particularly in light of Mr Cairns' lack of insight or remorse, as well as his failure to attend these proceedings. She acknowledged that the panel's powers on imposing sanction on Mr Cairns' lack of competency extends

only to a suspension order, but she reminded the panel to consider the misconduct involved in this case alongside it when considering sanction.

Accordingly, she invited the panel to impose a striking-off order on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor. He reminded the panel that there are two considerations before it today, namely the appropriate sanction for Mr Cairns' lack of competence, and the appropriate sanction for his misconduct. He advised the panel to not conflate the two, and to separate the two matters in its decision-making.

In relation to lack of competence, he advised the panel that it must consider the appropriate regulatory response to the concerns found proved. He told the panel that, in the circumstances where Mr Cairns was working supernumerary and supervised by senior members of staff, it would be difficult to devise conditions to impose upon his nursing practice which would adequately address all of the concerns found proved. He advised the panel that, nonetheless, a conditions of practice order cannot be so restrictive that it is tantamount to a suspension. He reminded the panel that it is not within its powers to impose a striking-off order for a finding of lack of competence, and that Mr Cairns must first be suspended for two years before he could be struck-off for his lack of competence.

In relation to misconduct, he advised the panel that Mr Cairns' misconduct is not made worse by impact of his lack of competence. He referred the panel to the NMC guidance on seriousness (FTP-3), factors to consider in its decision making (SAN-1) and seriousness (SAN-2). He advised the panel that it must consider sanction in an ascending order, starting with the imposition of no order, and ending with a striking-off order. He referred the panel to the NMC guidance on suspension orders (SAN-3d) and striking-off order (SAN-3e), and the corresponding guiding "*checklist*" within each guidance, which may assist it with its decision.

He further referred the panel to the decisions in, and principles derived from, the case of *Parkinson v Nursing and Midwifery Council [*2010] EWHC 1898. The court held that a nurse found to have acted dishonestly is always going to be at severe risk of having his or her name erased from the register. The nurse, who has acted dishonestly, who does not appear before the panel, either personally or by legal representation to demonstrate remorse, a realisation that the conduct criticised was dishonest and an undertaking that there will be no repetition, effectively forfeits the small chance of persuading the panel to adopt a lenient or merciful outcome, namely to suspend for a period rather than direct erasure.

He also referred the panel to the decision in *Lusinga v Nursing and Midwifery Council* [2017] EWHC 1458, which held that dishonesty may well lead to striking-off order because it is very serious and threatens public confidence in the profession, and that lack of insight and remorse from the registrant makes removal more likely.

**Decision and reasons on sanction**

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

The panel determined to consider sanction in stages, namely first to consider the appropriate and proportionate sanction to impose, if any, for Mr Cairns' lack of competence (for such of charges 1 to 12 as were found proved), before considering the appropriate and proportionate sanction to impose, if any, for Mr Cairns' misconduct (for such of charges 13 to 24 as were found proved). The panel reminded itself of the legal advice, namely, to not conflate the two.

The panel considered these in turn.

**Lack of Competence**

In relation to Mr Cairns' lack of competence, the panel took into account the following aggravating features:

- Lack of insight, remediation or engagement from Mr Cairns; and
- Conduct which put patients at serious risk of suffering harm.

In determining mitigating features, the panel took into account Mr Cairns' [PRIVATE] at the relevant time. However, the panel considered [PRIVATE]. The panel also considered that [PRIVATE]. Accordingly, the panel determined that this was not relevant for its choice of sanction. [PRIVATE]

The panel also took account of the documents provided by Mr Cairns, including the testimonials written by his colleagues at Ward 5D, which pre-dated the incidents in the charges.

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 Mr Cairns' practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Cairns' lack of competence was not at the lower end of the spectrum and as it had not been remedied

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

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

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

Taking the above guidance into account, the panel was of the view that Mr Cairns has displayed general incompetence, and that whilst the areas of his clinical practice are identifiable, the matters found proved spanned many areas of fundamental nursing practice over an extended period of time. Given Mr Cairns' absence from these proceedings, it was not satisfied that he has both the potential and willingness to engage with conditions imposed upon his practice.

Furthermore, the panel considered that these charges arose whilst Mr Cairns was working supernumerary within the Supported Improvement Programme and the later Formal Capability Programme and directly supervised by mentors for a period of approximately nine months. The panel was of the view that both the Supported Improvement Programme and the Formal Capability Programme are tantamount to the effect of a conditions of

practice order, but Mr Cairns failed to improve despite this support. The panel determined that, during this period, patients were put at risk of harm despite Mr Cairns being under supervision, and it was not satisfied that it could impose any conditions which would adequately address the public protection concerns identified which would also be both workable and measurable.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel noted that this is the most punitive sanction available to it in considering Mr Cairns' lack of competence.

Balancing all of these factors the panel concluded that a suspension order would be the appropriate and proportionate sanction to address Mr Cairns' lack of competence. The panel considered that his lack of competence spanned many areas of his nursing practice and did not improve despite the extensive support he received over many months. For these reasons the panel determined that a suspension order for a period of 12 months was necessary. However, the panel had first to consider the sanction appropriate for Mr Cairns' impairment arising from his misconduct.

**Misconduct**

In relation to Mr Cairns' misconduct, the panel took into account the following aggravating features:

- Lack of insight, remediation or engagement from Mr Cairns;
- Deep-seated attitudinal issues;
- Conduct which put patients at serious risk of suffering harm; and
- Conduct which related to both dishonesty and discriminatory behaviour on the part of Mr Cairns.

The panel reiterated its findings in relation to mitigating features and documentation above.

In relation to its findings on Mr Cairns' misconduct, 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 Mr Cairns' practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Cairns' misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Cairns' 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 concerns involve dishonesty and discrimination, both of which were not remediated. The panel determined that as Mr Cairns had not demonstrated insight, remorse and remediation no workable conditions could be imposed to address both these factors, as they are attitudinal in nature.

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;*

- …
- *The Committee is satisfied that the nurse … has insight and does not pose a significant risk of repeating behaviour;*
- …
- …

Taking the above guidance into consideration, the panel determined that these concerns were not a single instance of misconduct. The panel considered that the facts found proved indicated at least two separate instances of dishonesty, alongside a prolonged interaction with a patient which was discriminatory in nature.

The panel also determined that there is evidence of harmful, deep-seated attitudinal concerns, as Mr Cairns appeared to be willing to act dishonestly in a clinical setting and in a discriminatory manner despite being supervised and directly instructed not to do so (in the case of discrimination). Further, the panel also considered that Mr Cairns' misconduct also involved instances whereby he would always refuse to conduct key elements of patient care (personal care for female patients), which is a breach of a fundamental tenet of nursing practice. The panel was of the view that this is indicative of a deep-seated attitudinal issue, as Mr Cairns declined to carry out key elements of nursing practice (personal care for female patients).

In considering the legal advice on *Parkinson*, the panel was not satisfied that it has seen sufficient evidence of insight, remediation or remorse. The panel took into account the fact Mr Cairns has failed to attend his proceedings or send legal representation on his behalf to demonstrate that he has sufficient insight, remorse or remediation.

Taking all the above into account, the panel was not satisfied that a suspension order is the appropriate sanction to impose for Mr Cairns' misconduct.

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?*

Taking the above guidance, the panel was satisfied that Mr Cairns actions were significant departures from the standards expected of a registered nurse and raised fundamental questions about his professionalism. In particular, the panel considered his refusal to conduct patient care properly, his intention and dishonest recording of clinical findings, as well as his discriminatory behaviour towards a patient after being instructed not to speak to them by a senior member of staff raised such fundamental questions.

Further, the panel was not satisfied that public confidence in nurses can be maintained if Mr Cairns remained on the register following the panel's findings. The panel was of the view that a member of the public would be astounded to learn that a nurse who has engaged in both dishonest record keeping and in such discriminatory behaviour all whilst working supernumerary and being directly supervised, with no remorse or insight, was allowed to remain on the register.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Cairns' actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case. It was satisfied that a striking-off order is the only sanction which will

be sufficient to protect patients, members of the public, and to maintain professional standards.

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.

As this sanction is more punitive than the suspension order that would have been imposed on account of Mr Cairns' lack of competence, the effect of this order is that the NMC register will show that Mr Cairns has been struck-off the nursing register.

This will be confirmed to Mr Cairns in writing.

**Interim order**

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

**Submissions on interim order**

Ms Da Costa invited the panel to impose an 18-month interim suspension order to cover any relevant appeal period before the substantive striking-off order takes place. She submitted that, based on the panel's findings on impairment and sanction, this interim order would be on both public protection and public interest grounds.

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

**Decision and reasons on interim order**

The panel determined that not to impose an interim suspension order would be wholly incompatible with its earlier findings.

The panel considered the guidance on interim orders (SAN-5). 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 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 suspension order is consistent with its findings on impairment and sanction.

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, to cover any relevant appeal period and allow any appeal, if made, to conclude.

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

That concludes this determination.