Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 24 February – Friday 28 February 2025

Monday, 3 March 2025

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

Virtual Hearing

Name of Registrant:	**David Ambrosio Don**
NMC PIN	20C0628O
Part(s) of the register:	Registered Nurse – Adult – RN1 (12 March 2023)
Relevant Location:	Northern Ireland
Type of case:	Misconduct
Panel members:	Penelope Titterington (Chair, Lay member) Jennifer Childs (Registrant member) Jan Bilton (Lay member)
Legal Assessor:	Christopher McKay
Hearings Coordinator:	Sharmilla Nanan
Nursing and Midwifery Council:	Represented by Beverley Da Costa, Case Presenter
Mr Don:	Not present and not represented at the hearing
Facts proved:	Charges 1a, 2i, 2ii, 3a, 4i, 4ii, 5i, 6, 9, 10, 12i, 12ii, 13, 14 and 15
Facts not proved:	Charges 1b, 3b, 7, 8 and 11

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 Don was not in attendance and that the Notice of Hearing letter had been sent to Mr Don's registered email address by secure email on 15 January 2025.

Ms Da Costa, 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 venue of the hearing and, amongst other things, information about Mr Don's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Don

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

Ms Da Costa submitted that there had been no recent engagement by Mr Don with the NMC in relation to this hearing and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion. She submitted that Mr Don informed the NMC that he is residing in the Philippines.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mr Don;
- Mr Don has not recently engaged with the NMC and has not responded to the recent correspondence sent to him about this hearing;
- There is no reason to suppose that adjourning would secure Mr Don's attendance at some future date;
- One witness is expected to attend the hearing today to give live evidence;
- Not proceeding may inconvenience the witness, their employer and the clients who need their professional services;
- The charges relate to events that occurred between 2021-2023;
- Further delay may have an adverse effect on the witness's ability to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Don in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email address, he will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not

be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Don's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge (as amended)

That you, a registered nurse:

In relation to Resident A

Between 7 October 2022 and 30 October 2022:

1a. Failed to administer Resident A's Zolpidem medication on one or more of the dates set out in Schedule 1.

Schedule 1

i *10 October 2022*
ii *11 October 2022*
iii *14 October 2022*
iv *15 October 2022*
v *19 October 2022*
vi *20 October 2022*
vii *21 October 2022*
viii *25 October 2022*
ix *26 October 2022*
x *29 October 2022*

1b. Failed to document/record any missed dosages of Zolpidem on one or more dates as set out in Schedule 1.

2. Documented/recorded Zolpidem as being “out of stock” and did not:

i. Follow up and or escalate this.
ii. Write an entry in the diary to reflect this.

In relation to Resident B

Between 19 October 2022 to 31 October 2022:

3a. Failed to administer Resident B’s Zolpidem medication on one or more of the dates set out in Schedule 2.

Schedule 2

i *20 October 2022*
ii *21 October 2022*
iii *25 October 2022*
iv *26 October 2022*
v *29 October 2022*

3b. Failed to document/record any missed dosages of Zolpidem as set out on one or more dates as set out in Schedule 2.

4. Documented/recorded Zolpidem as being ‘out of stock’ and did not:

i. Follow up and or escalate this.
ii Write an entry in the diary to reflect this.

In relation to Resident C

Between 11 and 14 December 2022:

5. On one or more occasions, failed to administer prescribed medication Mirtazapine to Resident C:

i. Did not make an entry on the Medication Administration Record ("MAR") chart to reflect this.

In relation to Resident D

Between 11 and 14 December 2022:

6. On one or more occasions failed to administer prescribed medication Apixaban to Resident D.

7. Signed the MAR chart to falsely reflect that Apixaban had been administered to Resident D on 12 December 2022.

8. Signed the MAR chart to falsely reflect that Apixaban had been administered to Resident D on 13 December 2022.

In relation to Resident E

Between 22 and 29 January 2023:

9. Failed to administer Resident E's Diazepam medication on one or more of the dates set out in Schedule 3.

Schedule 3

i. 24 January 2023

ii. 25 January 2023

iii. 27 January 2023

iv. 28 January 2023

10. Did not document an entry on the MAR chart in relation to one or more dates as set out in Schedule 3.

11. Did not document/make an entry in the diary to reflect that Diazepam medication was out of stock.

In relation to Resident F

12. On 22 October 2021 made false entries in the Controlled Drugs ("CD") destruction book:

i. Made a signature entry to falsely represent that Temazepam medication, prescribed for Resident F, had been destroyed.

ii. Falsified the second witness signature in the CD destruction book.

13. Took medication including Temazepam from Milesian Manor Care Home without consent.

14. Your actions in charge 12 i and or 12 ii above were dishonest in that you created an impression Resident F's Temazepam medication had been destroyed when you knew that it had not been.

15. Your actions in charge 13 were dishonest in that you took medication which you were not entitled to take.

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

Background

The charges arose whilst Mr Don was employed as a registered nurse by Milesian Manor Care Home (the Home). The NMC received a referral from the Home on 13 November 2023.

Between October 2022 and January 2023, it is alleged that Mr Don made a number of medication errors and most of the medication errors relate to a failure to administer prescribed medication to residents. The medication errors relate to five residents (Resident A, Resident B, Resident C, Resident D and Resident E). The Home Manager, Witness 1, has stated that whilst no patient harm occurred to the residents there was a risk of harm.

Mr Don admitted to these errors in the local disciplinary meetings conducted by the Home. He indicated that there were a number of personal problems at home during these meetings.

In October 2023, it is alleged the Home received a telephone call from the police who received information to suggest that Mr Don had stolen medication from the Home. During the police investigation, the police searched Mr Don's home address and recovered medication boxes (Temazepam and Citalopram). The pharmacy label on the medication contained details of a resident at the Home, Resident F. The police did not conclude their investigation as Mr Don left the UK and returned to the Philippines.

Mr Don resigned from his role at the Home in October 2023, just prior to the Home receiving the call from the police.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Da Costa to amend the wording of Schedule 1.

The proposed amendment was to correct a typographical error to the date listed at ix, namely '*6 October 2022*'. It was submitted by Ms Da Costa that the proposed amendment, to include the '*2*' before the '*6*' would provide clarity and more accurately reflect the evidence.

Original wording of Schedule 1:

"Schedule 1
…
ix 6 October 2022
…"

Proposed amendment to the wording of Schedule 1:

"Schedule 1
…
ix ***2****6 October 2022*
…"

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Don and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mr Don.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will

be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Home Manager at the Home and a registered nurse.

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

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

Charge 1a

"That you, a registered nurse:

In relation to Resident A
Between 7 October 2022 and 30 October 2022:

1a. Failed to administer Resident A's Zolpidem medication on one or more of the dates set out in Schedule 1."

This charge is found proved.

In reaching this decision, the panel took into account Mr Don's training and competency records, Resident A's Medication Administration Record (MAR), the evidence of Witness 1 and the undated Meeting Minutes.

The panel had regard to Mr Don's training logs and competency records. The panel took into consideration that Zolpidem was a prescribed medication for Resident A. The panel heard oral evidence from Witness 1 that she checked the rota and that Mr Don was the only registered nurse on the night shift starting 10, 11, 14, 15, 19, 20, 21, 25, 26 and 29 October 2022. The panel was of the view that in light of Mr Don's training and competency and as the only registered nurse on duty on the unit, Mr Don knew that he had a duty to administer Zolpidem to Resident A on each of the dates set out in Schedule 1.

The panel took into consideration Resident A's (MAR) with the start date Monday 3 October 2022. It noted on the MAR for Zolpidem, there is an entry of 'O/S' for the entries dated 10, 11, 14, 15, 19, 20, 21, 25, 26 and 29 October 2022. It noted that Mr Don's initials were not marked on this part of the MAR. However the panel accepted that Mr Don was the only nurse on duty and it was satisfied that it was Mr Don completing the chart.

The panel considered the evidence of Witness 1. In Witness 1's NMC statement, she stated *"For Resident A, David had omitted to administer Zolpidem 5mg for 21 days. This medication was due to be administered at 22:00. This occurred from 8 to 29 October 2022 as can be seen from the Medication Administration Chart (MAR). It is noted that David omitted medication on 10, 11, 14, 15, 19, 20, 21, 25, 26 and 29 October. The other omitted dates were by another agency nurse. Between this time period, David had documented the medication as being 'out of stock', and he did not try to follow this up or write it in the diary."*

The panel bore in mind that in Witness 1's oral evidence, which was consistent with her NMC statement, she said that the code 'O/S' means that the medication is out of stock.

The panel took into account the 'Meeting of Minutes', undated which stated

> *"[Witness 1] commenced by asking DD what happened and why was Resident A… medications omitted…?*
> *DD's response: I ignored it, it's my negligence. I should have put it in the diary and followed up"*

The panel considered the evidence before it and that the Zolpidem medication was unavailable for Mr Don to administer to Resident A on each of the dates set out in Schedule 1. It had regard to Witness 1's evidence along with Mr Don's local admission to the Home. The panel concluded that between 7 October 2022 and 30 October 2022, Mr Don failed to administer Resident A's Zolpidem medication on each of the dates set out in Schedule 1. The panel therefore find charge 1a proved.

Charge 1b

> "1b. Failed to document/record any missed dosages of Zolpidem on one or more dates as set out in Schedule 1."

This charge is found NOT proved.

In reaching this decision, the panel took into account Mr Don's training and competency records, Resident A's MAR, the evidence of Witness 1 and the undated Meeting Minutes.

The panel had regard to Mr Don's training logs and competency records. The panel took into consideration that Zolpidem was a prescribed medication for Resident A. The panel heard oral evidence from Witness 1 that she checked the rota and that Mr Don was the only registered nurse on the night shift starting 10, 11, 14, 15, 19, 20, 21, 25, 26 and 29 October 2022. The panel was of the view that in light of Mr Don's training and competency and as the only registered nurse on duty on the unit, Mr Don knew that he had a duty to document or record any missed dosages of Zolpidem to Resident A on each of the dates set out in Schedule 1.

The panel took into consideration the evidence before it and noted that Mr Don made 'O/S' entries on Resident A's MAR (with the start date Monday 3 October 2022) to indicate that the medication was out of stock. The panel bore in mind, it heard evidence from Witness 1, that this is a valid code. The panel was of the view that the 'O/S' code provides a

reason as to why the medication has been omitted to be administered to Resident A. It determined that Mr Don did not fail to document or record the missed dosages of Zolpidem on one or more dates as set out in Schedule 1. The panel therefore find charge 1b not proved.

Charge 2.i

> "2. Documented/recorded Zolpidem as being "out of stock" and did not:
> i. Follow up and or escalate this."

This charge is found proved.

In reaching this decision, the panel took into account the evidence outlined in charges 1a and 1b. It also took into consideration the evidence of Witness 1 and the incident report completed by Mr Don at the material time.

The panel considered Witness 1's evidence. In Witness 1's NMC statement, she stated *"As David was working night shifts, night staff are unable to order further medication, so once there are three tablets remaining in the box for any medication it should be written in our diary. Once it has been written up, the day staff will follow this up and order more medication from the GP and receive it from the pharmacy… Day staff only usually concentrate on the medication that needs to be administered during their shift, so the omitted medication had not been spotted by them."*

Witness 1 said in her oral evidence that Mr Don should have followed up when he noted that the medication had not arrived at the Home. Witness 1 told the panel that on the third day before the medication was due to run out, the medication should be ordered as it would take between two to three days to arrive at the Home. She noted in her oral evidence, that Mr Don should have escalated to the day staff in the Home's diary when the medication had run out and she said that when she checked the diary there were no

entries made by Mr Don following up and escalating to the day staff that Resident A's Zolpidem was out of stock.

The panel noted that it did not have the relevant pages of the Home's diary available to it to consider.

The panel considered the Incident Report completed by Mr Don for Resident A dated between October 9-29 2022. The incident report states "*During the 7th of October the last stock of dose of Zolpidem 5mg tablet a sleeping medication was given at night by the assigned staff nurse. It was evident in the Nurse's diary that an order has been made on the 10th of October since the following day is non-office day. On that date, the prescription of the order was made by the day staff nurse but nothing has arrived even on the following day is non-office day… I didn't follow up the order because I took for granted that it was clearly ordered to the GP. I admit my mistake to overlook the action which had to be taken. I should have frequently followed up and wrote in the diary until medication has arrived.*"

The panel took into consideration the evidence before it and that Mr Don recorded on all 10 dates of the MAR, as listed in schedule 1, that the Zolpidem medication was out of stock. The panel was of the view that each the day that the medication was out of stock, Mr Don should have followed this up with the day staff to ensure that this medication was ordered. The panel was of the view that Mr Don should have done this each day until the medication was back in stock, even if he considered the medication to be on order. The panel took into account Mr Don's admission in the incident report that he completed in relation to this incident at the material time. The panel determined that Mr Don documented or recorded Zolpidem as being "out of stock" and did not follow up and or escalate this. The panel therefore find charge 2.i proved.

Charge 2.ii

"2. Documented/recorded Zolpidem as being "out of stock" and did not:

ii. Write an entry in the diary to reflect this."

This charge is found proved.

In reaching this decision, the panel took into account the evidence and findings made at charge 1a, 1b and 2.i. It also took into consideration Witness 1's evidence, the incident report completed by Mr Don at the material time and the meeting minutes in relation to this incident.

The panel considered Witness 1's oral evidence. Witness 1 said in her oral evidence, that Mr Don should have escalated to the day staff in the Home's diary when the medication had run out and that when she checked the diary there were no entries made by Mr Don following up and escalating to the day staff that Resident A's Zolpidem was out of stock.

The panel noted that it did not have the relevant pages of the Home's diary available to it to consider.

The panel bore in mind that Mr Don stated in the undated 'Meeting of Minutes', "*I ignored it, it's my negligence. I should have put it in the diary and followed up"* and in the Incident Report he completed dated between October 9-29 2022, "*I should have frequently followed up and wrote in the diary until medication has arrived."*

The panel considered the evidence before it, including Witness 1's evidence along with his signed Mr Don's local admissions. The panel determined that Mr Don documented or recorded Zolpidem as being "out of stock" and did not write an entry in the diary to reflect this. The panel therefore found charge 2.ii proved.

Charge 3a

"3a. Failed to administer Resident B's Zolpidem medication on one or more of the dates set out in Schedule 2."

This charge is found proved.

In reaching this decision, the panel took into account Mr Don's training and competency records, Resident B's MAR, the evidence of Witness 1 and the undated Meeting Minutes.

The panel had regard to Mr Don's training logs and competency records. The panel took into consideration that Zolpidem was a prescribed medication for Resident B. The panel heard oral evidence from Witness 1 that she checked the rota and that Mr Don was the only registered nurse on the night shift starting 20, 21, 25, 26, and 29 October 2022. The panel was of the view that in light of Mr Don's training and competency and as the only registered nurse on duty on the unit, Mr Don knew that that he had a duty to administer Zolpidem to Resident B on each of the dates set out in Schedule 2.

The panel took into consideration Resident B's MAR with the start date Monday 3 October 2022. It noted on the MAR for Zolpidem, there is an entry of 'O/S' for the entries dated 20, 21, 25, 26 and 29 October 2022. It noted that Mr Don's initials were not marked on this part of the MAR.

The panel considered the evidence of Witness 1. In Witness 1's NMC statement, she stated *"For Resident B, David had omitted to administer Zolpidem 5mg for 10 days. This medication as due to be administered at 22:00. This occurred from 20 to 30 October 2022 as can be seen from the MAR chart. It is noted that David omitted medication on 20, 21, 25, 26, and 29 October. The other omitted dates were by another agency nurse. David was the last nurse to administer the medication to this resident on 19 October. Between this time period, David had documented the medication as being 'out of stock', and he did not try to follow this up or write it in the diary."*

The panel bore in mind that in Witness 1's oral evidence, which was consistent with her NMC statement, she said that the code 'O/S' means that the medication is out of stock.

The panel took into account the 'Meeting of Minutes', undated which stated

> *"[Witness 1] commenced by asking DD what happened and why was … Resident B's medications omitted…?*
> *[the registrant]'s response: I ignored it, it's my negligence. I should have put it in the diary and followed up"*

The panel considered the Incident Report completed by Mr Don for Resident B dated between October 20-29 2022. The incident report states "*From the 20th of October to 29th October 2022, Zolpidem 5mg tablet, a course of sleeping medication were not given due to unavailability in the medication cupboard. I unintentionally forgot to write in the nurse's diary to order the said medication to the GP. I honestly admit my mistake to overlook the action to be taken and take responsibility of my negligence. I sincerely apologize for my irresponsible behaviour."*

The panel considered the evidence before it and that that the Zolpidem medication was unavailable for Mr Don to administer to Resident B on each of the dates set out in Schedule 2. It had regard to Witness 1's evidence along with Mr Don's signed local admission to the Home. The panel concluded that Mr Don failed to administer Resident B's Zolpidem medication on each of the dates set out in Schedule 2. The panel therefore find charge 3a proved.

Charge 3b

> "3b. Failed to document/record any missed dosages of Zolpidem as set out on one or more dates as set out in Schedule 2."

This charge is found NOT proved.

In reaching this decision, the panel took into account Mr Don's training and competency records, Resident B's MAR, the evidence of Witness 1 and the undated Meeting Minutes.

The panel had regard to Mr Don's training logs and competency records. The panel took into consideration that Zolpidem was a prescribed medication for Resident B. The panel heard oral evidence from Witness 1 that she checked the rota and that Mr Don was the only registered nurse on the night shift starting 20, 21, 25, 26 and 29 October 2022. The panel was of the view that in light of Mr Don's training and competency and as the only registered nurse on duty on the unit, Mr Don knew that he had a duty to document or record any missed dosages of Zolpidem to Resident B on each of the dates set out in Schedule 2.

The panel took into consideration the evidence before it and noted that Mr Don made 'O/S' entries on Resident B's MAR (with the start date Monday 3 October 2022) to indicate that the medication was out of stock. The panel bore in mind it heard evidence from Witness 1, that 'O/S' is a valid code. The panel was of the view that the 'O/S' code provides a reason as to why the medication has been omitted to be administered to Resident B. It determined that Mr Don did not fail to document or record any missed dosages of Zolpidem as set out on the dates in Schedule 2. The panel therefore found charge 3b not proved.

Charge 4.i

"4. Documented/recorded Zolpidem as being 'out of stock' and did not:
i. Follow up and or escalate this."

This charge is found proved.

In reaching this decision, the panel took into account the evidence outlined at charges 3a and 3b. It also took into consideration the evidence of Witness 1 and the incident report completed by Mr Don at the material time.

The panel considered Witness 1's evidence. In Witness 1's NMC statement, she stated *"As David was working night shifts, night staff are unable to order further medication, so*

once there are three tablets remaining in the box for any medication it should be written in our diary. Once it has been written up, the day staff will follow this up and order more medication from the GP and receive it from the pharmacy… Day staff only usually concentrate on the medication that needs to be administered during their shift, so the omitted medication had not been spotted by them."

Witness 1 said in her oral evidence that Mr Don should have followed up when he noted that the medication had not arrived at the Home. Witness 1 told the panel that on the third day before the medication was due to run out, the medication should be ordered as it would take between two to three days to arrive at the Home. She noted in her oral evidence, that Mr Don should have escalated to the day staff in the Home's diary when the medication had run out and she said that when she checked the diary there were no entries made by Mr Don following up and escalating to the day staff that Resident B's Zolpidem was out of stock.

The panel noted that it did not have the relevant pages of the Home's diary available to it to consider.

The panel considered the Incident Report completed by Mr Don for Resident B dated between October 20-29 2022. The incident report states "*From the 20th of October to 29th October 2022, Zolpidem 5mg tablet, a course of sleeping medication were not given due to unavailability in the medication cupboard. I unintentionally forgot to write in the nurse's diary to order the said medication to the GP. I honestly admit my mistake to overlook the action to be taken and take responsibility of my negligence. I sincerely apologize for my irresponsible behaviour."*

The panel took into account the 'Meeting of Minutes', undated which stated

> *"[Witness 1] commenced by asking DD what happened and why was … Resident B medications omitted…?*
> *[the registrant]'s response: I ignored it, it's my negligence. I should have put it in the diary and followed up"*

The panel took into consideration the evidence before it and that Mr Don recorded on all five dates of the MAR, as listed in schedule 2, that the Zolpidem medication was out of stock on Resident B's MAR. The panel was of the view that Mr Don should have followed up with the day staff to ensure that this medication was ordered, especially as he was the last person to administer medication to Resident B. The panel took into account Mr Don's signed admission in the incident report, that he forgot to write in the nurse's diary for the medication to be ordered, and that he completed in relation to this incident at the material time. The panel determined that Mr Don documented or recorded Zolpidem as being "out of stock" and did not follow up and or escalate this. The panel therefore find charge 4.i proved.

Charge 4.ii

> "4. Documented/recorded Zolpidem as being 'out of stock' and did not:
> ii. Write an entry in the diary to reflect this."

This charge is found proved.

In reaching this decision, the panel took into account the evidence and findings made at charge 3a, 3b and 4.i. It also took into consideration Witness 1's evidence, the incident report completed by Mr Don at the material time and the meeting minutes in relation to this incident.

The panel considered Witness 1's oral evidence. Witness 1 said in her oral evidence, that Mr Don should have escalated to the day staff in the Home's diary when the medication had run out and that when she checked the diary there were no entries made by Mr Don following up and escalating to the day staff that Resident B's Zolpidem was out of stock.

The panel noted that it did not have the relevant pages of the Home's diary available to it to consider.

The panel bore in mind that Mr Don stated in the undated 'Meeting of Minutes', "*I ignored it, it's my negligence. I should have put it in the diary and followed up"* and in the Incident Report he completed dated between October 20-29 2022, "*I unintentionally forgot to write in the nurse's diary to order the said medication to the GP. I honestly admit my mistake to overlook the action to be taken and take responsibility of my negligence."*

The panel considered the evidence before it, Witness 1's evidence along with Mr Don's signed local admissions. The panel determined that Mr Don documented or recorded Zolpidem as being "out of stock" and did not write an entry in the diary to reflect this. The panel therefore found charge 4.ii proved.

Charge 5

> "**In relation to Resident C**
> Between 11 and 14 December 2022:
>
> 5. On one or more occasions, failed to administer prescribed medication Mirtazapine to Resident C:
> i. Did not make an entry on the Medication Administration Record ("MAR") chart to reflect this."

This charge is found proved.

In reaching this decision, the panel took into account Mr Don's training and competency records, Resident C's MAR (with the start date Monday 28 November 2022), Witness 1's evidence and the undated Incident Report completed by Mr Don for Resident C.

The panel had regard to Mr Don's training logs and competency records. The panel took into consideration that Mirtazapine was a prescribed medication for Resident C. The panel heard oral evidence from Witness 1 that she checked the rota and that Mr Don was the

only registered nurse on the night shift on 11 and 12 December 2022. The panel was of the view that in light of Mr Don's training and competency and as the only registered nurse on duty on the unit, Mr Don knew that he had a duty to administer Mirtazapine to Resident C and record the administration as an entry on Resident C's MAR.

The panel took into consideration Resident C's MAR with the start date Monday 28 November 2022. It noted another nurse signed for the Mirtazapine administration on 11 December 2022 and recorded that there were 26 tablets remaining. The panel noted Mr Don signed for the administration of the Mirtazapine on the MAR for the entries of 12 and 13 December 2022. The panel noted on Mr Don's entry, dated 12 December 2022, he recorded that there were 25 tablets remaining. It also took into consideration that on his entry, dated 13 December 2022, he recorded that there were 24 tablets remaining. The panel took into account that on 14 December 2022, the same nurse who made the entry on 11 December, recorded on the MAR that there were 25 tablets remaining. The panel was of the view that this evidence proved that Mr Don probably did not administer a tablet to Resident C on either the 12 or 13 December 2022.

The panel also had regard to the oral evidence of Witness 1 who stated the signature on Resident C's MAR for the dates of 12 and 13 December 2022 for the Mirtazapine medication was Mr Don's signature. She said in her oral evidence, that she checked this in the staff signature book.

The panel considered the undated signed Incident Report completed by Mr Don for Resident C. The incident report states "*This is to report an incident of negligence in part of Resident C medication administration. This happened on 12-13 of December this year. Mirtazapine 30 mg tab were not given during those days at night time due to my negligence. I accidentally overlook the medication that should have administered. I admit my mistake and regret on my actions to my nursing practice. I promise I will be more careful in future."*

The panel considered the evidence before it, Mr Don's signed local admissions that he did not give Resident C their prescribed Mirtazapine and the oral evidence of Witness 1. The panel determined that between 11 and 14 December 2022, on one occasion, Mr Don failed to administer prescribed medication Mirtazapine to Resident C and did not make an entry on the MAR chart to reflect this. The panel therefore find charge 5.i proved.

Charge 6

> "**<u>In relation to Resident D</u>**
> Between 11 and 14 December 2022:
> 6. On one or more occasions failed to administer prescribed medication Apixaban to Resident D."

This charge is found proved.

In reaching this decision, the panel took into account Mr Don's training logs and competency records, Resident D's MAR, Witness 1's evidence and the undated, Incident Report completed by Mr Don for Resident D.

The panel had regard to Mr Don's training logs and competency records. The panel took into consideration that Apixaban was a prescribed medication for Resident D. The panel heard oral evidence from Witness 1 that she checked the rota and that Mr Don was the only registered nurse on the night shift of 12 and 13 December 2022. The panel was of the view that in light of Mr Don's training and competency and as the only registered nurse on duty on the unit, Mr Don knew that he had a duty to administer Apixaban to Resident D between 11 and 14 December 2022.

The panel took into consideration Resident D's MAR with the start date Monday 28 November 2022. It noted on the MAR for Apixaban, there are handwritten dates beginning from the 12 December 2022. The panel took into consideration that there are dots for the entries dated 12 and 13 December 2022 at 10pm where there should have been a

signature. The panel bore in mind that the dots on the MAR were not valid entries and that another member of staff would not understand this entry on the MAR or know who made it. The panel took into consideration that on 12 December 2022 at 10am there were 27 tablets in the box and that the entry 10pm was empty. It noted that there were no entries on 13 December 2022 at 10am or 10pm. On 14 December 2022, at 10am, another nurse made an entry with their initials on the MAR that there were 26 tablets in the box. The panel noted that the correct count would have been 23 tablets in the box for that entry if all doses had been correctly administered to Resident D. The panel found that two doses of tablets were not administered on the 12 and 13 December 2022 at 10pm when Mr Don was on duty.

The panel considered the evidence of Witness 1. In her NMC witness statement, she stated *"For Resident D, David failed to administer Apixaban 2.5mg on 12 and 13 December 2022 at 22:00 hours. This medication should have been administered twice daily, at 10:00 and 22:00."*

The panel considered the undated and signed Incident Report completed by Mr Don for Resident D. The incident report states *"This is to report an incident of negligence in part of Resident D medication administration. This happened on 12-13 December this year. Apixaban 2.5mg tab were not given during those days at night time due to my negligence. I accidentally overlook the medication that should have administered. I admit my mistaken and regret on my actions to my nursing practice. I promise I will be more careful in the future."*

The panel considered the evidence before it and it concluded on the balance of probabilities that between 11 and 14 December 2022, Mr Don on one or more occasions failed to administer prescribed medication, Apixaban, to Resident D. The panel therefore found charge 6 proved.

Charges 7 and 8

"7. Signed the MAR chart to falsely reflect that Apixaban had been administered to Resident D on 12 December 2022.
8. Signed the MAR chart to falsely reflect that Apixaban had been administered to Resident D on 13 December 2022."

These charges are found NOT proved.

In reaching this decision, the panel considered these charges together. The panel took into consideration Resident D's Medication Administration Record (MAR) with the start date Monday 28 November 2022, and it noted on the MAR for Apixaban, that there are handwritten dates beginning from 12 December 2022. The panel took into consideration that there are dots for the entries dated 12 and 13 December 2022 at 10pm.

The panel considered the evidence before it and noted that Mr Don did not sign Resident D's MAR on 12 and 13 December 2022. The panel concluded that Mr Don did not sign the MAR chart to falsely reflect that Apixaban had been administered to Resident D on 12 and 13 December 2022. The panel therefore found charges 7 and 8 not proved.

Charge 9

"**In relation to Resident E**
Between 22 and 29 January 2023:

9. Failed to administer Resident E's Diazepam medication on one or more of the dates set out in Schedule 3."

This charge is found proved.

In reaching this decision, the panel took into account Mr Don's training logs and competency records, Resident E's MAR, Witness 1's evidence and the Disciplinary Meeting the Home held with Mr Don on 5 April 2023.

The panel had regard to Mr Don's training logs and competency records. The panel took into consideration that Diazepam was a prescribed medication for Resident E. The panel heard oral evidence from Witness 1 that she checked the rota and that Mr Don was the only registered nurse on the night shift starting 24, 25, 27, 28 January 2023. The panel was of the view that in light of Mr Don's training and competency and as the only registered nurse on duty on the unit, Mr Don knew that he had a duty to administer Diazepam to Resident E on each of the dates set out in Schedule 3.

The panel took into consideration Resident E's MAR commencing January 2023. It noted that on the MAR for 24, 25, 27 and 28 January 2023 there are no entries to indicate that Diazepam was administered to Resident E. There panel noted that a dot had been entered on the MAR for each of these dates and that this was not a valid or recognised entry on the MAR to indicate that the medication had been administered to Resident E.

The panel considered the evidence of Witness 1. In her NMC witness statement she stated *"For Resident E, David had failed to administer prescribed Diazepam 2mg on 23, 24, 25, 27 and 28 January 2023. This medication should have been administered at 22:00. David omitted to document anything on the MAR chart and left it blank. David worked 23 to 25 January. However, we did have an agency nurse work on the shifts following him that also omitted dosages for this resident on 26 January, which was dealt with by their agency. When David returned to work on 27 and 28 January, he continued to make the same omissions. The medication appeared to have been out of stock, but both he and the agency nurse did not document this in the diary, and the MAR chat[sic] were left blank."*

The panel bore in mind that it did not have the rota available to it.

The panel considered the Disciplinary Meeting record the Home held with Mr Don on 5 April 2023. During this meeting, Mr Don confirmed that he recalled this incident and stated that he *"thought the medication was only used when Resident E was agitated. It was a prn*

medication." He reiterated that it was not a *"regular medication"* but a *"prn it was on [sic] used for agitation".*

The panel considered the evidence before it. The panel noted Mr Don's explanation and that he confirmed that he was on duty on the dates set out in Schedule 3. Together, with Witness 1's evidence, the panel concluded that Mr Don failed to administer Resident E's Diazepam medication on each of the dates set out in Schedule 3. The panel therefore found charge 9 proved.

Charge 10

> "10. Did not document an entry on the MAR chart in relation to one or more dates as set out in Schedule 3."

This charge is found proved.

In reaching this decision, the panel took into account the evidence outlined at charge 9. It also had regard to Witness 1's evidence.

The panel took into consideration Resident E's MAR commencing January 2023. It noted that on the MAR for 24, 25, 27 and 28 January 2023 there are no entries to indicate that Diazepam was administered to Resident E and that a dot had been entered on the MAR for each of these dates. The panel took into consideration that a dot is not a valid and recognised entry on the MAR. It bore in mind that another member of staff would not understand this entry on the MAR or know who had entered it.

The panel considered the evidence before it and concluded that Mr Don did not document an entry on the MAR chart in relation to the dates as set out in Schedule 3. The panel therefore found charge 10 proved.

Charge 11

"11. Did not document/make an entry in the diary to reflect that Diazepam medication was out of stock."

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and the Investigation Meeting conducted by the Home, dated 15 February 2023.

The panel considered Witness 1's evidence. In her NMC statement, she stated that *"David omitted to document anything on the MAR chart and left it blank. David worked 23 to 25 January."*

Witness 1 made a general observation, during her oral evidence, that she checked the Home's diary and Mr Don had not made an entry in relation to ordering any out of stock medication.

The panel took into consideration that it did not have the Home's diary before it to consider.

The panel considered the Investigation Meeting notes conducted by the Home, dated 15 February 2023. During the meeting, Mr Don said in relation to Resident E, *"At the time she slept well, her medication was out of stock I had put it in the diary for the nurse the next day to get this ordered…"*

The panel considered the evidence before it and bore in mind that there was no admission from Mr Don regarding his omission to include an entry on the Home's diary that Resident E's Diazepam medication was out of stock, as there has been with other charges. The panel was not satisfied that the NMC had discharged its burden of proof in respect of this charge given that there was no copy of the Home's diary before it. The panel therefore found charge 11 not proved.

Charge 12.i

> "**<u>In relation to Resident F</u>**
> 12. On 22 October 2021 made false entries in the Controlled Drugs ("CD") destruction book:
> i. Made a signature entry to falsely represent that Temazepam medication, prescribed for Resident F, had been destroyed."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, the photographs of Temazepam, Resident F's MAR chart with the start date of Monday 4 October 2021, the record of call between Witness 1 and Mr Don, dated 15 November 2023, and the CD Destruction Book entry dated 22 October 2021.

The panel considered the evidence of Witness 1. In Witness 1's statement she stated

> *"The police had obtained pictures of medication boxes that were found at David's home, which were then sent to me. From the picture I could see that one of the boxes had a sticker on the side that stated the medication was for Resident F. From then, I was able to have a look at our archived Controlled Drugs (CD) books. Resident F was hospitalised and returned back to the Home on 22 October 2021. Upon their return to the Home, the Temazepam 10mg prescribed to them had been discontinued by the hospital and was due to be destroyed, as can be seen on the MAR chart. I could see from the CD destruction book that David had made an entry on 22 October 2021 that the Temazepam for Resident F was destroyed on that day. I could see David's signature in the first box at the bottom next to 'authorised signatory of person denaturing/destroying drugs'. However, I could not recognise the second witnesses' signature as any member of staff at the Home."*

The panel had regard to Witness 1's oral evidence. She said that the photographs of the Temazepam medication that she had exhibited as part of her evidence were provided to her by the police. Witness 1's oral evidence was consistent with her written NMC statement.

The panel considered the photographs, provided by the police, of the Temazepam medication found at Mr Don's home, exhibited by Witness 1. It noted that the date on the medication was '24 September 2021'.

The panel considered Resident F's MAR with the start date of Monday 4 October 2021. It noted that the last entry for Temazepam on Resident F's chart was made on 12 October 2021. It noted that Witness 1 stated in her evidence that Resident F went into hospital and returned to the Home on 22 October 2021. The Hospital discontinued Resident F's Temazepam medication, when they returned to the Home, as recorded on the MAR.

The panel took into account that the Temazepam medication, according to the MAR, had been received in September 2021 close to the date on the box of Temazepam, as portrayed in photograph provided by the police and exhibited by Witness 1. The panel noted that Temazepam in Witness 1's exhibit has been provided by the same pharmacy as named on Resident F's MAR. It also noted that the quantity of tablets on the photograph of the Temazepam medication boxes and Resident F's MAR were the same.

The panel considered the CD Destruction Book entry dated 22 November 2021. It noted that there was an entry which had been countersigned to indicate that the Temazepam for Resident F has been destroyed as it had been discontinued by the hospital. Witness 1 gave evidence to say that she had checked the record of all staff signatures and could identify Mr Don's signature.

The panel considered the record of call between Witness 1 and Mr Don, dated 15 November 2023. During this call Mr Don stated, *"…I was told temazepam was*

discontinued and needed to be destroyed. I later took the temazepam and I placed it in my bag instead of destroying it." He said that he documented it in the destruction book and *"destroyed alone but … asked the other nurse to sign for me so they did not know I had taken it".* He said that he *"can not remember when exactly"* he took the Temazepam. The panel took into consideration that a record of this call was made close to the time of the call.

The panel considered the evidence before it and took into consideration that the photographs provided by the police of the Temazepam medication found at Mr Don's home. It also took into account that Mr Don admitted to the Home that he had taken the Temazepan medication instead of destroying it. The panel determined that on 22 October 2021, Mr Don made false entries in the CD destruction book by making a signature entry to falsely represent that Temazepam medication, prescribed for Resident F, had been destroyed. The panel therefore found charge 12.i proved.

Charge 12.ii

> "12. On 22 October 2021 made false entries in the Controlled Drugs ("CD") destruction book:
> ii. Falsified the second witness signature in the CD destruction book."

This charge is found proved.

In reaching this decision, the panel took into account the evidence outlined at charge 12.1. It had regard to Witness 1's evidence, the CD Destruction Book entry dated 22 November 2021 and the record of call between Witness 1 and Mr Don, dated 15 November 2023.

The panel considered the CD Destruction Book entry dated 22 November 2021. It noted that there was an entry which had been countersigned to indicate that the Temazepam for Resident F has been destroyed as it had been discontinued by the hospital.

The panel considered Witness 1's evidence. She stated in her NMC witness statement that "*I could see David's signature in the first box at the bottom next to 'authorised signatory of person denaturing/destroying drugs'. However, I could not recognise the second witnesses' signature as any member of staff at the Home.*"

In Witness 1's oral evidence she said that she checked the signature log and did not recognise the second signature on the CD Destruction Book. She stated that it was not the signature of the only other nurse in the building at the material time.

The panel considered the record of call between Witness 1 and Mr Don, dated 15 November 2023. During this call Mr Don stated, *"he does not remember"* who the nurse was that he got to sign the CD destruction record. The panel took into consideration that a record of this call was made close to the time of the call.

The panel considered the evidence before it and it took into consideration that Mr Don could not recall who he asked to countersign the CD destruction book. The panel took into account that Witness 1 stated that there was only one other nurse in the Home, on the other unit, that he would be able to ask to countersign the form therefore it would be easier for him to remember who he asked. It also noted Witness 1's evidence that she did not recognise the signature of the staff member who countersigned the CD destruction book with Mr Don. The panel was of the view that it was in Mr Don's interest not to involve anyone in this incident as they would likely escalate that he had not followed the correct process of destroying the Temazepan medication. The panel determined that on the balance of probabilities that, on 22 October 2021, Mr Don made false entries in the CD destruction book by falsifying the second witness signature in the CD destruction book. The panel therefore found charge 12.2 proved.

Charge 13

> "13. Took medication including Temazepam from Milesian Manor Care Home without consent."

This charge is found proved.

In reaching this decision, the panel took into account the evidence outlined at charge 12.1 and 12.2. The panel also had regard to Policy Re: Receipt and Handling of Residents Medication dated April 2019.

The panel considered the Policy Re: Receipt and Handling of Residents Medication dated April 2019. The policy states *"Medication received for a resident, belongs to the patient and must be treated as you would any other possession that belongs to them."*

The panel considered the evidence before it and bore in mind that Resident F's prescribed Temazepan medication was found by the police at Mr Don's home address. It took into consideration Mr Don's admission that he took the Temazepan medication and it had regard to the Home's policy that the Temazepan medication belonged to the resident. Mr Don did not suggest that he had consent from Resident F and the panel found that this was not likely, in any event, the removal of any medication would be contrary to drugs policy. The panel determined that Mr Don took medication including Temazepam from Milesian Manor Care Home without consent.

Charge 14

> "14. Your actions in charge 12 i and or 12 ii above were dishonest in that you created an impression Resident F's Temazepam medication had been destroyed when you knew that it had not been."

This charge is found proved.

In reaching this decision, the panel took into account the evidence outlined in charges 12.i and 12.ii. The panel also had regard to judgment of *Ivey v Genting Casinos* [2017] UKSC 67.

The panel took into consideration that Mr Don should have been aware of the Home's Policy Re: Receipt and Handling of Residents Medication dated April 2019. This policy states *"Medication received for a resident, belongs to the patient and must be treated as you would any other possession that belongs to them."*

Further, Mr Don should have been aware of the Home's Policy Re: SOP for Management of Controlled Drugs, dated April 2019. This policy states

> *"**Record keeping for the disposal of controlled drugs***
> *A record of the disposal of a Schedule 2 controlled drug will be made in the homes controlled drug record book. This must be signed by the two members of staff responsible for the disposal.*
> *A further record will be kept in the drug for destruction book. A separate record of the destruction and disposal of any controlled drug will be kept. This record will include the name of the patient, the name, form and strength of the medicine, the quantity of medicine destroyed, the reason for destroying the medicine, the date of destruction, the method of destruction, the signatures of the two members of staff destroying the medicine."*

The panel considered the record of call between Witness 1 and Mr Don, dated 15 November 2023. The record of the call states *"I asked him to tell me how he took them and he said he said he came on shift in Moyola and after handover he then took the temazepam and put it in his bag as he knew it was due for distraction[sic] after 7 days post her death… He explained 'I came on to shift to Moyola and got handover from the day staff, I was told temazepam was discontinued and needed to be destroyed. I later took the temazepam and I placed it in my bag instead of destroying it. I asked him if he documented in the destruction book and he said yes."*

The panel noted that it had no alternative explanation for Mr Don's conduct found proved at charges 12.i and 12.ii.

The panel was of the view that Mr Don would have known that his conduct, as found proved in charges 12.i and 12.ii, was dishonest as he made a signature entry to falsely represent that Resident F's prescribed Temazepan medication had been destroyed (when it had not been but had actually taken from the Home by Mr Don) and he falsified the second witness signature in the CD destruction book. The panel was of the view that Mr Don's conduct in these charges would be considered dishonest by the standards of ordinary decent people.

The panel determined that Mr Don's actions in charges 12.i and 12.ii above were dishonest in that he created an impression Resident F's Temazepam medication had been destroyed when he knew that it had not been. The panel therefore found charge 14 proved.

Charge 15

> "15. Your actions in charge 13 were dishonest in that you took medication which you were not entitled to take."

This charge is found proved.

In reaching this decision, the panel took into account the evidence and findings made at charge 13 and the judgment of *Ivey v Genting Casinos* [2017] UKSC 67.

The panel bore in mind that Mr Don was not entitled to take the Temazepam medication as per the Home's Policy Re: Receipt and Handling of Residents Medication dated April 2019.

The panel considered the record of call between Witness 1 and Mr Don, dated 15 November 2023. The record of the call states *"I asked him to tell me how he took them and he said he said he came on shift in Moyola and after handover he then took the*

temazepam and put it in his bag as he knew it was due for distraction[sic] after 7 days post her death…"

The panel was of the view that Mr Don would have known that his conduct, as found proved in charge 13, is dishonest as he took the Temazepan medication from the Home when he knew that it did not belong to him and this was contrary to drugs policy. The panel concluded that Mr Don's conduct would be considered dishonest by the standards of ordinary decent people.

The panel noted that it had no alternative explanation for Mr Don's conduct found proved at charge 13.

The panel concluded that Mr Don's actions in charge 13 were dishonest in that he took medication which he was not entitled to take. The panel therefore find charge 15 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Don'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, Ms Don's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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.'*

Ms Da Costa invited the panel to take the view that the facts found proved amount to misconduct. She submitted that Mr Don's conduct fell short of what is expected of a registered nurse in the circumstances. She referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision and she identified the specific, relevant standards where Mr Don's actions amounted to misconduct.

Ms Da Costa submitted that Mr Don's failure to administer medication to vulnerable patients (which was not administered for a number of days) was compounded by the theft of medication and his actions to conceal the theft. She submitted that his actions have the potential to bring the nursing profession into disrepute and that dishonesty is not always capable of being put right. She submitted that Mr Don's actions are on the higher end of the dishonesty spectrum as he attempted to conceal his initial dishonesty.

Submissions on impairment

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. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included applying the principles set out in the judgment of *Council for Healthcare Regulatory Excellence v (1) Nursing and*

Midwifery Council (2) and Grant [2011] EWHC 927 (Admin) to the circumstances of this case.

Ms Da Costa submitted that Mr Don's nursing practice is impaired due to his misconduct. She submitted that his actions demonstrate a serious departure from the standards expected from registered nurses in the circumstances. She submitted that his actions put multiple patients at risk of harm. She submitted that impairment is a forward-looking exercise.

Ms Da Costa submitted that Mr Don received further training and support from the Home in relation to the medication errors. She noted that Mr Don accepted his clinical errors immediately and that he said that these could have been caused by his personal circumstances. She submitted that he did not consider the impact his failings had on his patients. She submitted that his dishonest conduct brings into question his trustworthiness and his conduct would bring the profession into disrepute.

Ms Da Costa submitted that there is a risk of harm and there is no evidence before the panel that Mr Don has taken any steps to address and strengthen his practice. She submitted that there has been no insight, reflection or evidence of willingness to remediate his practice in relation to the concerns identified. She submitted that Mr Don has repeated his failures and that there is a risk of repetition.

Ms Da Costa submitted that there is no evidence to currently suggest Mr Don is capable of practising kindly, safely and professionally as a registered nurse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments (*Rylands v GMC* [1999] Lloyds REP MED 139, *CHRE v NMC and Grant* and *Cohen v GMC* [2008] EWHC 581 (Admin)).

Decision and reasons on misconduct

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

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

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.2 act with honesty and integrity at all times…

20.4 keep to the laws of the country in which you are practising'

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

The panel considered Mr Don's actions in charges 1a, 3a, 5, 6 and 9 together as these charges relate to a failure to administer prescribed medication for four residents. The panel noted that the residents are vulnerable and rely on the staff at the Home to administer their medication to them. The panel was of the view that missing the first two tablets when the medication was out of stock may not have in itself amounted to misconduct. However, the panel took into account the overall picture of medication failures including, the number of days the out of stock medication was missed, the number of patients impacted and the repeated errors over a number of months, not just when medication was out of stock. It took into account that it heard evidence, that if the medication was not administered, there was a risk of patient harm such as an increased likelihood of falls and increased chance of blood clots. It also heard evidence that after two days medication being missed the situation is considered serious enough that a GP should be notified so that a risk assessment could be made. It noted that Mr Don had been provided with support and training and had completed medication competency assessment but continued to make similar errors. The panel was of the view that the conduct identified in these charges was below the standards expected of a registered nurse. Further, the panel was of the view, Mr Don did not appear to recognise the

significance and impact of missed medication on residents. The panel was of the view that parts 1.2 and 1.4 of the Code were breached. The panel determined that Mr Don's conduct was negligent but that in these circumstances his persistent negligence was serious enough to amount to misconduct in these charges.

The panel next considered charges 2.i, 2.ii, 4.i and 4.ii together. Under these charges, the panel found that Mr Don did not take the appropriate action to ensure that the relevant medication for the respective resident was ordered by day staff. The panel noted that the residents were vulnerable and relied on the staff at the Home to administer their medication to them. The panel was of the view that not escalating the out of stock medication for the first two days may not have amounted to misconduct. However, the panel took into account the number of occasions that Mr Don did not follow up with ordering the medication for a resident. It took into account, that it heard evidence, that if the medication was not administered, there was a risk of patient harm. The panel was of the view that parts 1.2, 1.4, 8.2, 10.2 and 19.1 of the Code were breached. The panel determined that Mr Don's repeated negligent actions were serious enough to amount to misconduct in these charges.

The panel then considered Mr Don's actions in charges 5 and 10. These charges relate to a failure to make correct MAR chart entries regarding patient medication administration. The panel noted that the residents were vulnerable and relied on the staff at the Home to administer their medication to them. The panel took into account the importance not only of giving medication but completing the MAR charts accurately so that a clear audit is available and other staff are aware which drugs have been given or omitted. However, the panel took into account, that it heard evidence, that if the medication was not administered, there was a risk of patient harm (e.g. falls, agitation). It noted that Mr Don had recently been provided with support and training in this area however Mr Don made this error with Resident C despite this, and then made the same error shortly after with Resident E. The panel took into consideration the importance of record keeping and the potential risk to patients if it was not carried out in accordance with policy. The panel was of the view that parts 8.2, 10.1, 10.4 and 19.1 of the Code were breached. The panel

determined that Mr Don's actions were serious enough to amount to misconduct in these charges.

Next, the panel considered Mr Don's actions in charges 12.i, 12.ii and 14. These charges relate to his dishonesty of making a false entries on the Drugs for Destruction Record. The panel took into consideration the importance of keeping accurate and reliable records, particularly when it comes to controlled drugs and the seriousness of a nurse making fraudulent entries. It also took into consideration the potential impact of Mr Don's actions on another member of staff, he falsified the signature to cover his own actions and this could have had consequences for the other nurse on duty in the building. The panel was of the view that this type of conduct would bring the profession into disrepute. The panel was of the view that parts 10.3, 20.2 and 20.4 of the Code were breached. The panel determined that Mr Don's actions were serious enough to amount to misconduct.

Finally, the panel considered Mr Don's actions in charges 13 and 15. These charges relate to his dishonesty in taking medication without consent. The panel accepted that there was no risk to the patient in this instance as the patient was not deprived of the medication due to the medication being discontinued by the hospital. However, his conduct was illegal and was dangerous as the storage of controlled drugs are strictly regulated. The panel was of the view that parts 20.2 and 20.4 of the Code were breached. The panel determined that Mr Don's conduct in these charges are serious enough to amount to misconduct.

The panel found that Mr Don's actions when taken together, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library guidance, DMA1 which was updated on 27 February 2024, 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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

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

The panel found that all four limbs of Dame Janet Smith's “test” were engaged.

The panel finds that patients were put at risk of harm as a result of Mr Don’s misconduct. It bore in mind that Mr Don’s clinical misconduct affected several patients over a period of time. Mr Don’s misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel determined that Mr Don had demonstrated some insight, in that he completed three reflective pieces, at the time that the clinical failings took place. It took into account that Mr Don made local admissions to the Home and apologised for his conduct. However, it bore in mind that this did not materialise into changed or improved practice at the material time as he continued to make medication and record

administration errors. The panel bore in mind that Mr Don did not initially admit that he stole Resident F's medication from the Home (until the phone call with the Home in November 2023) nor did he make any admissions to the falsification of the second signature in the CD destruction book. The panel determined that Mr Don, at the material time or since, has not demonstrated an understanding of how his actions put patients at a risk of harm nor has he demonstrated an understanding of why what he did was wrong and how this impacts negatively on the reputation of the nursing profession. The panel was not satisfied that Mr Don has sufficiently demonstrated how he would handle the situation differently in the future.

The panel was satisfied that the clinical misconduct in this case is capable of being addressed. The panel noted that Mr Don made some attempts to remediate his clinical practise at the material time.

The panel took into account that dishonesty charges can be difficult to address and remediate. It took into consideration that Mr Don stole a controlled drug which did not belong to him but to a patient who had the controlled drug discontinued by the hospital. The panel accepted that there was no risk to the patient in these circumstances but that these drugs can be dangerous and they were removed from the controlled environment of the Home. However, in order to conceal his theft, Mr Don completed an entry in the Drugs for Destruction Record and falsified a second signature on the entry. The panel was of the view that Mr Don did not act in a trustworthy or professional manner. The panel concluded that Mr Don's conduct was at the upper end of the dishonesty scale having not only stolen the drugs, but falsified records to conceal this.

Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Don has taken steps to strengthen and remediate his practice. The panel took into account that Mr Don has not engaged with this hearing, it also took into account that it had no recent evidence of any relevant training that he has undertaken, nor has he provided a recent reflective piece addressing the concerns identified in the charges. It also noted that

there are no testimonials from his managers or colleagues regarding his work since the incident.

The panel determined that there is a high risk of repetition based on Mr Don's lack of in depth reflection addressing his insight, remorse, remediation and strengthened practice. It also noted that it had no evidence of any up to date training that Mr Don has completed in relation to the concerns. The panel was not satisfied that Mr Don is currently capable of practising as a registered nurse kindly, safely or professionally. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required. The panel was of the view that a fully informed member of the public would be concerned to learn that a registered nurse was allowed to practise, with no restrictions, in light of the charges found proved. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Don's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Submissions on sanction

Ms Da Costa invited the panel to impose a striking-off order as it found Mr Don's fitness to practise currently impaired. She submitted that Mr Don's conduct is not compatible with remaining on the NMC register. She provided the panel with submissions on the mitigating and aggravating factors of the case. She provided submissions on the sanctions available to the panel and the appropriateness of each sanction. She submitted that the panel should impose a sanction which is appropriate and proportionate. She submitted that a striking off order is the only order that would be sufficient to protect patients, the public and maintain professional standards.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Mr Don's actions demonstrate a pattern of misconduct over a significant period of time.
- Mr Don put vulnerable patients at risk of harm.
- Mr Don has not recently engaged with the NMC in relation to these proceedings.

- Mr Don has demonstrated a lack of insight into his failings.
- Mr Don's dishonesty took place during the course of his work as a nurse.
- Mr Don intentionally covered up his dishonest conduct.

The panel also took into account the following mitigating features:

- Mr Don made local admissions during the Home's investigations.
- Mr Don's personal mitigation [PRIVATE]

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 Don's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Don's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Don's registration would be a sufficient and appropriate response. The panel took into consideration that the clinical misconduct identified in this case could possibly be addressed through a conditions of practice order. However, the panel took into account that Mr Don received support and training, at the material time, from the Home and that he continued to make clinical errors in his nursing practice. The panel also took into account that Mr Don has not recently engaged in the NMC proceedings and there is no information before it to suggest that he would engage with any conditions imposed on his practice. The panel took into

consideration that the dishonesty charges, found proved, are serious and attitudinal in nature. The panel concluded that there are no practical or workable conditions that could be formulated which would address the concerns in this case. Further, the panel concluded that the placing of conditions on Mr Don's registration would not adequately address the seriousness of this case, address the public interest and would not protect the public.

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

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

The panel took into account that Mr Don's actions and behaviour did not amount to a single instance of misconduct. It took into consideration his misconduct related to several different types of misconduct including different types of repeated medication failures, dishonestly making false entries on the Drugs for Destruction Record and dishonestly removing medication that he was not entitled to take. The panel was of the view that Mr Don's dishonesty, which was unlawful and appeared to implicate other members of staff, demonstrated harmful attitudinal problems. The panel took into consideration that it did not have any information regarding Mr Don's activities since the dishonesty allegations at the Home came to light. The panel bore in mind its earlier findings that Mr Don has insufficient insight and that there is a high risk of repetition.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse The panel noted that the serious breaches of the fundamental tenets of the profession evidenced by Mr Don's actions is fundamentally incompatible with Mr Don remaining on the register.

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

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

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

Mr Don's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Don's actions were serious, particularly as he stole a controlled drug from the Home and implicated another member of staff by falsifying a counter signature on the Drugs for Destruction Record to conceal his dishonest actions. The panel was of the view that to allow Mr Don to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel are satisfied that Mr Don's actions have brought the profession into disrepute. The panel has concluded that nothing short of a striking-off order would be sufficient in this case. 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.

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

This will be confirmed to Mr Don 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 Don's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Da Costa. She submitted that an interim suspension order is necessary on the grounds of public protection and public interest for a period of 18 months to cover any potential period of appeal.

Decision and reasons on interim order

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

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

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

That concludes this determination.