Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Thursday, 25 January 2024 – Friday, 26 January 2024

Monday, 29 January 2024 – Wednesday, 31 January 2024

Tuesday, 7 May 2024 – Wednesday, 8 May 2024

Virtual Hearing

Name of Registrant:	**John Robert Cobb**
NMC PIN:	12C0518E
Part(s) of the register:	Registered Nurse - Adult RNA (16 March 2012)
Relevant Location:	Stockport
Type of case:	Misconduct
Panel members:	Debbie Hill (Chair, Lay member) Melanie Lumbers (Registrant member) Alison Hayle (Lay member)
Legal Assessor:	Richard Tyson (25 - 26, 29 - 30 January 2024) Tracy Ayling (31 January 2024) Paul Housego (7 – 8 May 2024)
Hearings Coordinator:	Christine Iraguha (25 - 26, 29 - 31 January 2024) Opeyemi Lawal (7 – 8 May 2024)
Nursing and Midwifery Council:	Represented by Rowena Wisniewska, Case Presenter
Mr Cobb:	Not present and unrepresented
Facts proved:	Charges 1) a) i) ii), b), c), 2) a) b), 3) a), b), 4), 5), 6) a), b), 7) a), b), 8
Facts not proved:	None

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 Cobb was not in attendance and that the Notice of Hearing (NoH) letter had been sent to his registered email address by secure email on 19 December 2023.

Ms Wisniewska, on behalf of the Nursing and Midwifery Council (NMC), referred the panel to a statement from the NMC officer who confirmed that the NoH had been sent on 19 December 2023. She 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 allegations, 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 Cobb'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 Cobb 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 Cobb

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

Ms Wisniewska said the last contact the NMC had with Mr Cobb was on 19 January 2024 and referred to the email from him. Mr Cobb did not provide a response to the NMC's email [PRIVATE]. [PRIVATE]. She informed the panel that no formal request for an adjournment has been made by Mr Cobb and he is aware of hearing today. She submitted that he has voluntarily absented himself and invited the panel to proceed in his absence.

Ms Wisniewska submitted that there is a public interest in the expeditious disposal of this case. The incidents date back to 2019/2020 and any delay would mean that witnesses may find it harder to remember and would erode the quality of the evidence. Adjourning the hearing is also likely to cause inconvenience to the witnesses who have made themselves available for the next few days and there is no certainty that they will attend at a date in the future. Although, Mr Cobb states in his email of 19 January 2024 [PRIVATE], [PRIVATE] and has not stated that he is unable to attend today. Notwithstanding Mr Cobb's absence, Ms Wisniewska invited the panel to proceed today.

The panel accepted the advice of the legal assessor who referred to the cases of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5, *General Medical Council v Adeogba* [2016] EWCA Civ 162, and *R (Raheem) v NMC* [2010] 2549 (Admin).

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 *Jones.*

The panel decided to proceed in the absence of Mr Cobb. In reaching this decision, the panel has considered the submissions of Ms Wisniewska, and the advice of the legal assessor. It has had regard to the factors set out in the cases of *Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mr Cobb, in his last email to the NMC on 19 January 2024, said [PRIVATE], [PRIVATE];

- The panel is satisfied that Mr Cobb is aware that the hearing was commencing today, and despite correspondence with the NMC, and his last email on 19 January 2024, he has made no application for an adjournment;
- The panel had sight of the two email addresses and telephone notes that evidence the attempts made by the NMC to contact Mr Cobb;
- The panel noted Mr Cobb's historical sporadic engagement with the NMC and could not therefore be assured of his further engagement with this case;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A number of witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the patients who need their professional services;
- The charges relate to events that occurred in 2019/2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case, and it is also in Mr Cobb's interest.

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

Details of charge

That you, a registered nurse, whilst working at Stockport NHS Foundation Trust:

1) On 25 October 2019, having informed Patient A's General Practitioner about Patient A's deterioration and collected Patient A's prescription, did not:

    a) Record in Patient A's notes and/or inform colleagues that:

        i) Patient A had deteriorated

        ii) Medications had been prescribed to Patient A

    b) Record the prescription in Patient A's medication sheet

    c) Document the reason for collecting the prescription in the patient's records.

2) As a result of your actions in charge 1 above, were unable to account for the following missing medication:

    a) 10mgs/1ml x 10 ampoules of Morphine sulphate

    b) 10mgs/2mls x 10 ampoules Midazolam.

3) On 28 October 2019 did not carry out visits to:

    a) Patient B;

b) Patient C.

4) Did not document and/or escalate to anyone that you did not carry out the visits set out in charge 3 above.

5) On the morning of 19 February 2020, incorrectly administered Patient D's evening medication.

6) Having visited Patient E in their home, failed to record your visits and/or document any observations on:

a) 24 February 2020;

b) 2 March 2020.

7) [PRIVATE]

AND in light of the above, your fitness to practise is impaired by reason of your misconduct as set out in charges 1-7

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

Ms Wisniewska made a request that parts of this case that refer to individual patients' health and Mr Cobb's health be held in private. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined to go into private session as and when those matters that relate to patients' and Mr Cobb's health are mentioned and mark those parts of the transcript as private.

Decision and reasons on application to admit hearsay evidence

Ms Wisniewska made an application on behalf of the NMC to admit a complaint email as hearsay evidence under Rule 31. She referred the panel to Ms 1's witness and supplementary statements which refer to a complaint email dated 3 March 2020 from Patient E's husband. The complaint email contains hearsay evidence. Patient E's evaluation notes were exhibited in Ms 1's witness statement. Ms Wisniewska said that it was not possible to approach Patient E's husband for a statement given the patient's condition.

Ms Wisniewska informed the panel that although the complaint email is not the sole evidence in this matter, she was making the application out of an abundance of caution in pursuant to Rule 31(1) of the Nursing and Midwifery Fitness to Practice Rules 2004. She invited the panel to admit the hearsay evidence and submitted that it is fair and relevant.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel balanced fairness to Mr Cobb against fairness to the NMC. It was of the view that the complaint email introduced by Ms 1 in her witness and supplementary witness statements was not the sole and decisive evidence in this case. Any disadvantage to Mr Cobb in allowing this evidence would be mitigated by the live and documentary evidence before the panel which could be tested under cross examination. The panel was of the

view that there would be no unfairness to Mr Cobb in admitting the complaint email as hearsay evidence.

In these circumstances, the panel determined that it would be fair and relevant to accept the complaint email as hearsay evidence.

Background

The background facts as found by the panel are that Mr Cobb was referred to the NMC on 31 July 2020 by the Human Resources (HR) Business Manager, at Stockport NHS Foundation Trust (the Trust). At the time of the concerns, he was employed as a Band 5 Community Staff Nurse and was based in the Cheadle Hulme Clinic. He was required to visit and deliver home care to patients who had a wide variety of health issues; updating care plans, and ensuring documentation was accurate, and up to date.

These patients included Patient A who was terminally ill, Patients B and C who required daily care, Patient D whose medication was wrongly administered, and Patient E who was a terminally ill patient.

On 25 October 2019, Mr Cobb visited Patient A at home. Patient A was receiving end of life care and Mr Cobb noticed that they had deteriorated. He spoke to the General Practitioner (GP) who arranged end-of-life medication for the weekend. This medication included morphine sulphate, midazolam, glycopyrronium bromide and cyclizine ampoules. Mr Cobb offered to collect the medications, because Patient A's wife was too upset and wanted to remain with Patient A. Mr Cobb collected the medication from the pharmacy and took it to Patient A's address, contrary to the Trust's policy. He failed to record in the patient's medication sheet the name of each drug, ampoule amount, the batch number, and the date on which the drugs were collected and what was administered. He did not advise the team that he had collected medication or that the patient had deteriorated. He did not update the electronic records or inform the weekend nurse of his actions.

On 29 October 2019, the GP visited Patient A at home and discovered that ampoules of morphine and midazolam were missing and not accounted for. A local investigation was

initiated, and Mr Cobb was interviewed by Ms 1 on 19 November 2019. During this meeting, he could not explain how the medications had gone missing or why he had not followed appropriate procedures with regards the collection, storage and record keeping of the controlled drugs. During the investigation, further concerns came to light, that on 28 October 2019, he had missed his scheduled visits to Patients B and C. Mr Cobb was due to visit Patient B in the morning. Patient B had a pilonidal sinus which was scheduled for daily packing, this was a *'red priority'* due to the risk of infection. Mr Cobb failed to visit Patient C in the afternoon. Patient C was [PRIVATE]. Mr Cobb did not escalate his failure to attend these appointments to his Band 6 superior, as he was required to do. Staff only became aware of the missed visits when the patients phoned the following day.

Mr Cobb was interviewed about these further concerns on 26 November 2019. He said that Patient B was not in when he visited on 28 October 2019, and that he did not have time to visit Patient C. He confirmed that he did not escalate that he had not completed these visits or make appropriate records.

At a disciplinary hearing held on 23 December 2019, Mr Cobb was issued with a final written warning.

Further concerns came to light in 2020, these were as follows:

- On 19 February 2020, Mr Cobb visited Patient D at home and incorrectly administered the patient's evening medication instead of their morning medication.

- On 24 February 2020 and 2 March 2020, Mr Cobb failed to record the observations of Patient E when visiting them at home. Although he was accompanied by a student nurse on the visits, it was his responsibility to complete accurate records, but he did not do so. Patient E's husband, a former trained nurse, later discovered that Mr Cobb had made no record in his wife's notes. In addition, the electronic records contained no details of the findings but just recorded that he had visited.

Other healthcare professionals did not have up to date and accurate records when they made subsequent visits.

Thereafter, [PRIVATE], so these particular concerns did not result in any further substantive action being taken. He subsequently resigned from his position on 18 May 2020.

Decision and reasons on facts

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

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

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

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

- Ms 1: District Pathway Lead at the Trust (at the time the concerns were raised).
- Ms 2: District Nurse Team Lead at the Trust.

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

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

Charge 1

1) On 25 October 2019, having informed Patient A's General Practitioner about Patient A's deterioration and collected Patient A's prescription, did not:
    a) Record in Patient A's notes and/or inform colleagues that:

        i) Patient A had deteriorated
        ii) Medications had been prescribed to Patient A

Charge 1) a) i) and ii) are found proved.

In reaching this decision, the panel considered Ms 1's oral and written evidence, Mr Cobb's investigation interview on 19 November 2019 and the Trust's record keeping policy for community staff.

Ms 1 in her statement stated:

> *'John had gone to visit Patient A on Friday 25 October 2019 and had noticed the patient had deteriorated. He then spoke to their GP who had arranged a prescription for end-of-life medication for the weekend, which included secretions, pain relief and other medications*.'
>
> *John did not let his team know that the patient had deteriorated or he had needed to organise end-of-life care and drugs by the GP; the nurse working the weekend was completely unaware that this patient had been prescribed controlled drugs. As such, the weekend nurse had no reason to look for these drugs and administer them to the patient which presents a risk of harm. Moreover, nothing had been inputted to (Egton Medical Information Systems) EMIS records so nothing had been*

recorded electronically to notify staff of the end-of-life care or drugs had been put in place.'

Mr Cobb in the investigation interview stated:

'*went to the GP back at my base to discuss his condition and express my concerns. He had been to see him previously … He prescribed the end of life drugs and sent it to the pharmacy. I went over to the pharmacy but the first didn't stock them and they gave me a paper copy of the prescription and I took them to Cheadle Boots and collected them and took them to Patient A'.*

Mr Cobb in the investigation interview stated that he was '*late for handover, I got the back end of it'*.

The panel noted that, although Mr Cobb was late for handover, he had the opportunity and time to inform his team and make appropriate note of Patient A's deterioration and the medication that was prescribed.

The panel noted that Ms 1 was the Pathway Lead District Nursing at the time and was the investigating officer.

Ms 1, in her oral and written evidence, set out the correct procedure to be followed in relation to the collection, handling and recording of controlled drugs, including signing at the pharmacy. Checking the drugs upon receipt, recording the amount and type, and then keeping an ongoing record of what was used and how much was discarded. The panel reminded itself that Mr Cobb was an experienced nurse of some eight years, knowledgeable in end-of-life care and was aware of the Trust's record keeping policy. Ms 1

explained that the policy was to there to track controlled drugs in the community and ensure patient and staff safety. The panel accepted Ms 1's evidence that Mr Cobb breached the record keeping policy through his actions.

In view of the evidence before it, and on the balance of probabilities, the panel was satisfied that Mr Cobb did not record in Patient A's notes and/or inform colleagues that the patient had deteriorated and that medications had been prescribed for him. The panel therefore found this charge proved.

b) Record the prescription in Patient A's medication sheet

This sub charge is found proved.

In reaching this decision, the panel took into account Ms 1's evidence, and the Trust's Controlled Drugs policy for community staff.

Ms 1 in her statement stated:

> *'Should a nurse collect a patient's prescription, they would then take the medication to the patient's home and make an entry into the patient's medication sheet (the name of each drug and ampoule amount, batch number, the date, which pharmacy the drugs were collected from, and what had been administered that day). The paperwork would then be left in the patient's home. John did not do any of this … the nurse working the weekend was completely unaware that this patient had been prescribed controlled drugs. As such, the weekend nurse had no reason to look*

for these drugs and administer them to the patient which presents a risk of harm'.

Ms 1 clarified that a patient's medication sheet and written care notes should always be in the patient's house, so that any professionals that come in have a clear picture of care delivered and evidence of medication usage and how much remains. She said it was only when a patient is deceased, that they would remove the records.

During the investigation interview, Mr Cobb confirmed that he did not record the medication in the patient's notes.

In view of the evidence before it, and on the balance of probabilities, the panel was satisfied that Mr Cobb did not record the prescription in Patient A's medication sheet. The panel therefore found this sub charge proved.

c) Document the reason for collecting the prescription in the patient's records

This charge is found proved.

In reaching this decision, the panel took into account Ms 1 and Ms 2's evidence, and the Trust's Controlled Drugs policy for community staff.

Ms 1 in her statement stated,

‘John offered to pick up the prescription from the chemist as the patient’s wife was too tired and did not want to leave her husband alone. Where possible, we would not pick up any prescribed controlled medication for patients. The first port of call would be the patient’s family to go and pick them up and only if the family were unable to pick up the prescription would we then go and collect it in extenuating circumstances this would not be routine.’

Should a nurse collect a patient’s prescription, they would then take the medication to the patient’s home and make an entry into the patient’s medication sheet (the name of each drug and ampoule amount, batch number, the date, which pharmacy the drugs were collected from, and what had been administered that day). The paperwork would then be left in the patient’s home. John did not do any of this …’

The Trust’s Controlled Drugs Policy on Transportation and Receipt, states:

‘7.1 *The patient’s family/carers should arrange to collect and transport the controlled drugs from the pharmacy.*

7.3 In exceptional circumstances, healthcare professionals may transport CDs, when patients or their career/representatives are unable to collect them, provided the nurse is conveying the CD to a patient for whom the medicine has been prescribed, e.g. from a pharmacy to the patient’s home. The reason for this action should be documented in the patient's care plan/record. The healthcare professional will need to provide evidence of identification to the community pharmacy at the point of receipt, as well as providing their name, address, and professional registration number.’

7.5 On receipt of controlled drugs the quantity received must be checked and the quantity entered onto the Stock Control Record for Controlled and Non-controlled Drugs. The new balance must equate to the total of the old and new stock.

9.1 On receipt of controlled drugs the quantity received must be checked and the quantity entered onto the Stock Control Record for Controlled and Non-controlled Drugs. The new balance must equate to the total of old and new stock.

9.3 The name, form, strength, dose, quantity and expiry date of the drug must be recorded on the Stock Control Record for Controlled and Non-controlled Drugs and signed by the registered community nurse. This must be done even if the drugs are not currently being administered to the patient.'

Ms 2, who was Mr Cobb's team manager, at the time confirmed that he would have been trained on the Trust's drug policy. Ms 1 and Ms 2 both confirmed that Mr Cobb was an experienced nurse. Ms 2 stated that Mr Cobb was knowledgeable in end-of-life care as this was his specialist area of interest. He would have completed all the medicine management training, the online modules, e-learning in palliative care and worked through all the relevant documents as this was standard practice across the Trust. Mr Cobb would have dealt with controlled drugs as a community staff nurse. Although, Ms 2 was not certain, she estimated that Mr Cobb would have spent around a third of his working day dealing with end-of-life care.

The panel was satisfied from the evidence before it, that Mr Cobb would have known as an experienced nurse in end-of-life care, that he was expected to document the reason for

collecting the prescription in the patient's records. It therefore found this sub charge proved.

2) As a result of your actions in charge 1 above, were unable to account for the following missing medication:

    a) 10mgs/1ml x 10 ampoules of Morphine sulphate

    b) 10mgs/2mls x 10 ampoules Midazolam.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the Ms 1's evidence, investigation interview and the Trust's Controlled Drugs policy for community staff.

Ms 1 in her written statement stated:

> '*When the GP came to visit the patient on Tuesday 29 October 2019, they discovered that ampoules of morphine and midazolam were missing – these drugs still have not been accounted for. John was very flippant when we discussed this during his investigation interview and did not take responsibility for the fact that these ampoules were now missing*.'

In the investigative interview when Mr Cobb was asked where he thought the medication was, he said, '*Haven't got a clue. I think were they in the bag.*'. The panel reminded itself that Ms 1 was a credible, knowledgeable, and a reliable witness who was the investigating officer. The panel adopted her statement in considering Mr Cobb's response and attitude to be flippant and disregarding of the Trust's Controlled Drugs policy for community staff.

Ms 1 in her oral evidence stated that had Mr Cobb checked the bag and made a note of the medication as expected by the Trust's drug policy, he would have known that the drugs were missing. Instead, when asked at his local interview where he thought the medication had gone, he said, *"Haven't got a clue. I think they were in the bag. I didn't at the time think this was small."*

The panel reminded itself that Mr Cobb was an experienced nurse in end-of-life care and would have undertaken all the relevant training and knew the required policy on managing controlled drugs.

The panel was satisfied from the evidence before them, that Mr Cobb had failed to account for the missing medication, it therefore found this charge proved.

3) On 28 October 2019 did not carry out visits to:

    a) Patient B;

    b) Patient C.

This charge is found proved.

In reaching this decision, the panel took into account Mr Cobb's mobile diary, investigation interview, Ms 1 and Ms 2's evidence.

The panel had sight of Mr Cobb's mobile diary and noted his schedule regarding visits to Patients B and C. On 28 October 2019, it showed that he was due to make visits to these patients on that day. Ms 1 and Ms 2 in their oral evidence explained that Mr Cobb had

time capacity to visit both Patient B and C as time had been allocated in his diary for this. Ms 1 said that both patients rang the following day to say they had not been visited.

Regarding Patient B, Ms 1 in her statement, stated:

> *'If we look at John's visit allocations for the day prior to the visit of Patient B, he had an 08:30 insulin administration to do (which would take around 20 minutes), a 09:20 catheter change (takes around 20 minutes), and a pressure check at 10:20 (takes around 40 minutes). It would have been unlikely that John could not manage this workload and would thus have to postpone his visit of …*'

Regarding Patient C, Ms 1 in her statement stated:

> '*John did not have a particularly busy day, especially when you look at his afternoon visit allocations so I am unable to explain why John would need to miss his visit of at 14:00. We would expect a nurse of John's competence and banding to be able to take 18 units comfortably (with each unit representing a 20-minute interval). If John had completed all of his visits for this day, then he would have, being generous, completed approximately 14 units which would not constitute a very heavy workload.'*

Ms 1 explained in oral evidence that by not visiting Patient B and C, Mr Cobb had only ten units of work that day.

During the investigation interview, when asked regarding Patient B, Mr Cobb said, *'He didn't answer the door. I tried to ring him on his landline and he didn't answer'.* Regarding

Patient C he said, *'I didn't get time to go. I know she was daily but I also knew her legs were improving.'*

The panel reminded itself that Patient B had a [PRIVATE] which was scheduled for daily packing, this was a 'red priority' due to the risk of infection. 'Red priority' means that the patient had to be seen daily and cannot be deferred. [PRIVATE].

From the evidence before it, the panel was satisfied that Mr Cobb did not carry out his visits to Patient B and C on 28 October 2019. It therefore found this charge proved.

4) Did not document and/or escalate to anyone that you did not carry out the visits set out in charge 3 above.

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's evidence, and the investigation interview.

Ms 1 in her statement stated:

> '*If John was unable to carry out a patient visit, then he would need to escalate this to the Band 6 nurse and schedule a postponement. John did not follow any escalation procedure; .... Following an escalation to the Band 6 nurse, they could then make a decision on whether to postpone the visit for the next day, or depending on the patient's condition and priority, would allocate the visit to another member of staff*.'

In the investigation interview, when Mr Cobb was asked why he had failed to escalate the missed visits, regarding Patient B, he said:

> *'I didn't get back to the office that day and I told … the next day. I thought it was okay to leave this visit as nothing made me think otherwise' … 'I didn't escalate to evening service as I knew they could have waited. Again I told … the next day prior to him telling me she had rung*.'

Regarding Patient C, Mr Cobb stated that the did not escalate his failure to attend the appointments to his Band 6 because he knew the patient's legs were improving.

Ms 1, in her oral evidence, described the escalation procedure in the event of a visit not taking place. She said the procedure is to report either at the safety huddle at lunch, or if there are any issues in the afternoon, to ring back and escalate to the evening nursing service or to a Band 6. The patient could be placed on the next day's list or seen by the evening nurse. Ms 1 further explained why escalation is important and the risks associated when a visit is missed. Ms 1 found out that Mr Cobb did not keep a record or escalate the missed visits because the patients rang the next day to ask why they were not seen.

Ms 1 confirmed that even if a community nurse felt that a patient's condition was improving, they did not have the authority to miss a scheduled daily visit. They should report the improvement to the Band 6 team leader, who could then make a decision to reduce visit frequency in the future, if appropriate.

The panel was satisfied from the evidence before it that Mr Cobb did not document and/or escalate to anyone that he did not carry out the visits set out in charge 3 above. It therefore found this charge proved.

5) On the morning of 19 February 2020, incorrectly administered Patient D's evening medication.

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's evidence, photos of Patient D's blister pack, the key to Patient D blister pack, the Datix report, and Patient D's evaluation notes.

Ms 1 in her evidence stated,

> *'Following my investigation, John went on to make another error. John had gone to visit a patient to administer medication in the morning of 19 February 2020 and had incorrectly administered the patient's evening medication instead of the morning medication*. … . *On the blister pack, the colours correspond to the time of day; red 'blisters' are for morning and the blue 'blisters' are for bedtime*'.

Ms 1 in her oral evidence confirmed that one of the nurses on the evening service had realised that Patient D's morning medication was still in the blister pack and the night medication had been given instead. The panel had sight of the photos of Patient D's blister pack which clearly showed that the blister pack for the evening medication was broken and open. The morning medication remained intact in the pack. The key to Patient D's blister pack confirmed that the patient was prescribed more medication for the night, which was another way to distinguish between the day and the night doses.

The panel had sight of the Datix report which details the incident and has Ms 1 as the reviewer and Ms 2 as the approver of the report. The incident regarding Patient D had been noted and reviewed. This is further supported by the handwritten entry in Patient D's evaluation notes.

The panel considered the Datix report, photos of Patient D's blister pack, and Patient D's evaluation notes to be contemporaneous records. They support that on the morning of 19 February 2020, Mr Cobb incorrectly administered Patient D's evening medication. It was satisfied that there is evidence to support this charge and therefore found this charge proved.

6) Having visited Patient E in their home, failed to record your visits and/or document any observations on:

    a) 24 February 2020,

    b) 2 March 2020.

This charge is found proved.

In reaching this decision, the panel took into account Ms 1 's evidence, Patient E's handwritten (evaluation notes) and electronic notes, and the complaint email from Patient E's husband.

Ms 1 in her statement stated:

> '*When looking at the written notes there is no entry from John detailing his evaluations during the visits on 24 February 2020 and 2 March 2020. The appropriate process is to write thoroughly the condition of the patient, in addition to the date of visit and the time in which the note is written*. …

It is not common for relatives of patients to make complaints relating to record keeping, however, Patient E's husband was a nurse himself and found that no record was made in his wife's notes. The husband wanted to ensure that the next nurse visiting had all of the relevant information, especially given that multiple readings of Patient E's temperature was taken. The husband thus recorded Patient E's temperature reading in the written notes retrospectively.

… If you look at other entries from other nursing staff, you see in-depth patient descriptions, however in John's record there is no information present.

The NMC's Code of Conduct says that if a visit is not documented, then it did not happen. The dangers of not recording patient observations are that we would not know the baseline condition of a patient, or if they have deteriorated in any way. A future visiting nurse would be visiting a patient 'blind' and not aware that this patient could have become unwell. Of course, the risk of harm would be dependent on the patient and their type of condition.'

The panel considered the email of complaint on 3 March 2020, from Patient E's husband, which read, '*On 24th February, and again on 2nd March a male Nurse and a colleague visited my wife. There is no record on file of their visit and observations made at the time*.'

Ms 1 provided a detailed response when asked what the risks or dangers of not recording patient observations. She explained that Patient E was receiving palliative care due to [PRIVATE] and had had repeated lung infection with numerous hospital admissions. This was reflected in the complaint email from the patient's husband.

The panel had sight of Patient E's local record which showed that Mr Cobb had recorded the fact of the visits (on the electronic system), but he did not complete any patient observations, details of visits or evaluations. This contrasted with a visit made on 25 February 2020 by another staff member which contained a thorough record and

observations of the visit. Patient E's handwritten notes also make no reference to the visits made on 24 February 2020 and 2 March 2020 by Mr Cobb, despite there being entries before and after those dates.

The panel considered Patient E's records, both handwritten and electronic, to be contemporaneous notes which support this charge. It considered that there was enough evidence to support this charge and therefore found this charge proved.

7) [PRIVATE]

This charge is found proved.

[PRIVATE]

That you, a registered nurse, in relation to your period of employment with Bowerfield Court care in October 2020:

8) On 13 March 2021 received a police caution for theft of controlled drugs from your employer

This charge is found proved.

At the handing down of the determination regarding the previous seven charges, the panel were advised under Rule 29(2) of charge 8 and presented with evidence of the caution which it then found 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 Cobb'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 Cobb fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Ms Wisniewska identified specific standards which she said were breached and where Mr Cobb's actions amounted to misconduct, in particular Codes; 1, 1.2, 10.1, 10.2, 10.3, 10.4, 10.5, 10.6, 19, 19.1, 20, 20.1, 20.2, 20.4 and 23.

Taking into account the standards and requirements imposed by the code, Ms Wisniewska submitted that Mr Cobb's actions do amount to serious professional misconduct, which is a route to impairment under Article 22 of the 2001 order.

Submissions on impairment

Ms Wisniewska moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Ms Wisniewska referred the panel to the four tests set out by Dame Janet Smith in her Fifth Shipman report, cited with approval in the case of *CHRE v (1) NMC (2) Grant* [2011] EWHC 927 at paragraph 74: Mrs Justice Cox

> *'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.'*

> *"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"

Ms Wisniewska submitted that all the limbs of the *Grant* test are engaged in this case and the panel may be justified in finding Mr Cobb is liable in the future to repeat the same behaviour which has not been remediated. In particular, the tendency towards theft and dishonesty, is not a behaviour easily capable of remediation and is indicative of a serious attitudinal failing, which conflicts with the standards expected of a registered nurse.

Ms Wisniewska submitted that there is a real risk of repetition given the serious failings in patient care, the incident regarding the theft of the drugs and the police caution. Ms Wisniewska further submitted that Mr Cobb has not shown any insight or reflection, and these are serious failings. Ms Wisniewska submitted that the theft of controlled drugs for which he received a caution is particularly egregious.

Ms Wisniewska therefore invited the panel to find Mr Cobb currently impaired by virtue of his past misconduct and the serious risk of harm that he presents to patients, both at the present time and going forward, given there has been no remediation and there are serious attitudinal failings.

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.

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

'1 Treat people as individuals and uphold their dignity

1.1 treat people with kindness, respect and compassion.

1.2 make sure you deliver the fundamentals of care effectively.

8 Work co-operatively

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.

10 Keep clear and accurate records relevant to your practice

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.

10.5 take all steps to make sure that records are kept securely.

10.6 collect, treat and store all data and research findings appropriately.

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

18.4 take all steps to keep medicines stored securely.

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

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

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.

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

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

23 Cooperate with all investigations and audits

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

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

The panel considered misconduct collectively and identified a pattern of behaviour that was motivated only by Mr Cobb's own needs, detrimentally affecting numerous patients in various settings. He demonstrated a lack of care and understanding to his patients or their families, with no recognition or acceptance regarding the implications his actions had on the care he delivered. His actions were deplorable, falling seriously short of the expected standard when he admitted to the police that he stole controlled drugs from an employer. This act of dishonesty directly affected patients and their care. Stealing property that

belonged to patients and taking it to his own home resulted in vulnerable patients in a nursing home not having access to the controlled drugs which had been prescribed for them.

Mr Cobb was unable to account for controlled drug medication, for end of life care he had collected on behalf of the patient. The patient went days without this medication as a result of this. Mr Cobb failed to ensure that patients who had been identified as clinically requiring daily visits received these visits. Mr Cobb failed to document or escalate any missed visits resulting in a real risk of patient harm.

The panel was of the view that Mr Cobb's actions and conduct fell seriously short of the expected standards of a registered nurse, given the vulnerable high-risk patients that were in his care.

The panel was of the view that Mr Cobb's actions and conduct fell seriously short of the expected standards of a registered nurse, given the vulnerable high-risk patients that was in his care.

The panel found that Mr Cobb's actions did amount to misconduct.

Decision and reasons on impairment

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

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

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

"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"

If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

Nurses occupy a position of privilege and trust in society and are expected 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 patients, in both the community setting and nursing home, were put at risk of harm as a result of Mr Cobb's misconduct. Mr Cobb's misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mr Cobb has not demonstrated an understanding of how his actions put the patients at a risk of harm, or demonstrated an understanding that what he did was wrong and how this impacted negatively on the reputation of the nursing profession. The panel has not been provided with any information as to whether he understands the impact his actions had on the patients and their families or to indicate that he has in any way sought to apologise, remedy his failings or learn from the situation.

The panel was satisfied that the misconduct in this case was difficult to address as it stemmed from attitudinal concern. The panel have not been provided with information regarding Mr Cobb attempting to strengthen his practice, nor was there any indication of insight.

Therefore, the panel determined that there is a risk of repetition due to the lack of remediation and reflection. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

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. For both reasons the panel also finds Mr Cobb's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel decided that Mr Cobb'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 Cobb off the register. The effect of this order is that the NMC register will show that Mr Cobb has been struck-off the register.

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

Submissions on sanction

Ms Wisniewska informed the panel that the NMC would seek the imposition of a striking-off order the panel having found Mr Cobb's fitness to practise currently impaired.

Ms Wisniewska outlined the following aggravating features.

Aggravating

- No previous disciplinary and regulatory findings but Mr Cobb accepted a Police Caution for theft of controlled drugs from his employer.
- Abuse of position of trust
- Lack of insight into failings and remediation.
- Mr Cobb has not engaged with the NMC proceedings/investigation.
- Mr Cobb's misconduct demonstrates serious attitudinal failings.
- Mr Cobb's conduct put patients at risk of harm.

Ms Wisniewska submitted that there are no mitigating features in this case.

Ms Wisniewska submitted that the panel found all of the eight charges proved relating to misconduct. There is a real risk of repetition of the issues, which means that a sanction was required to protect the public from harm and to maintain public confidence in the profession. The same arguments are also applicable in respect of a caution in that this would clearly not be appropriate in the circumstances.

With regard to a conditions of practice order, Ms Wisniewska submitted this would not appropriately address the concerns about public protection and would not appropriately address the concerns about protecting the public interest. In particular this would not maintain the confidence in the profession nor declare and uphold proper standards of conduct and behaviour. Ms Wisniewska further submitted that there are no workable, relevant, measurable and proportionate conditions that could address the misconduct, given Mr Cobb's failings amounted to serious misconduct and had a dishonesty component which was un-remediated.

Ms Wisniewska invited the panel to conclude that a suspension is not also appropriate in the circumstances. The misconduct committed by Mr Cobb is very serious and serious

enough to justify removing him from the register, given the egregious nature of the misconduct, the dishonesty component and the lack of insight.

In considering proportionality and balancing the public interest and need for protection of the public against Mr Cobb's own interests, Ms Wisniewska submitted that the most appropriate and proportionate sanction in all the circumstances is a striking off order.

Decision and reasons on sanction

Having found 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:

- Abuse of position of trust
- Lack of insight into failings and remediation.
- Pattern of misconduct happened over a period of time, in his capacity as a community nurse and whilst working in a nursing home.
- Mr Cobb's conduct put patients at risk of harm and will have caused emotional and physical harm.

The panel also took into account the following mitigating features:

- [PRIVATE]

The panel had regard to the NMC Guidance - Considering sanctions for serious cases (SAN-2) and to the Guidance relating to suspension (SAN-3d) and relating to striking-off (SAN-3e).

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 Cobb'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 Cobb'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 Cobb's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and the lack of insight and remediation. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Cobb's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel decided that suspension was not

appropriate and that the serious breach of the fundamental tenets of the profession evidenced by Mr Cobb's actions is fundamentally incompatible with Mr Cobb 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 Cobb'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 Cobb's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. Mr Cobb's misconduct brought the profession into disrepute by adversely affecting the public's view of how registered nurses should conduct themselves and 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 protect the public, to mark the importance of maintaining public confidence in the profession, to maintain the reputation of the profession and 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 Cobb in writing.

Interim order

As the suspension 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 Cobb's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Wisniewska. She submitted that an interim suspension order is appropriate to cover the appeal period, on the grounds of public protection and public interest.

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

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.

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

That concludes this determination.