Conduct and Competence Committee

Substantive Hearing

8 – 9 September 2016

NMC, 2 Stratford Place, Montfichet Road, London

Name of Registrant Nurse:	Albert Tabilog
NMC PIN:	99L1318O
Part(s) of the register:	RN1, Registered Nurse (sub part 1) Adult – 17 December 1999
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Nicholas Cook (Chair Lay member) Thomas Bingham (Lay member) Diane Rawstorne (Registrant member)
Legal Assessor:	Robin Hay
Panel Secretary:	John Barker
Representation:	Albert Tabilog represented by Chloe Binding, Counsel instructed by the RCN.
Nursing and Midwifery Council:	Represented by Tanya Murshed, Counsel, NMC Regulatory Legal Team.
Facts proved:	1 (in its entirety), 2, 3
Facts not proved:	4
Fitness to practise:	Currently Impaired
Sanction:	**Suspension Order – 6 months**
Interim Order:	18 month interim suspension order

Charges

That you:

1. On 21 May 2014:
    a. administered blood of an incorrect blood group to Patient A.
    b. upon Dr 1 being called to examine the patient, failed to inform Dr 1 that the patient had been given an incorrect blood transfusion.
    c. failed to inform your nursing colleagues of the error in a timely manner and/ or failed to complete a Datix form.
    d. incorrectly disposed of the unit of blood.
    e. incorrectly amended the transfusion prescription sheet.
    f. upon being asked by Colleague 2 and/ or Colleague 3 if you had administered the incorrect unit of blood to Patient A, you stated that you had not.
2. Your actions at charges 1.b, 1.c, 1.d, 1.e and/or 1.f were dishonest in that you deliberately sought to represent that you had not administered the incorrect blood unit to Patient A when you knew that you had.
3. Did not, prior to 29 January 2016, inform Guy's and St Thomas' Staffabnk that you were the subject of a fitness to practise referral.
4. Your actions at charge 3 were dishonest in that you sought to conceal from Guy's and St Thomas' Staffbank that your fitness to practise had been called into question.

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

NMC offering no evidence in relation to charge 4

At the outset of the hearing Ms Murshed, on behalf of the NMC, informed the panel that the NMC would be offering no evidence in relation to charge 4. She further said that due to the alleged mischief in charge 3 being inextricably linked to the alleged dishonesty in charge 4, the NMC would not be relying on charge 3 to support the allegation of misconduct.

In the light of this the panel found charge 4 not proved.

Admissions

Miss Binding, on your behalf, told the panel that you admit the factual allegations contained within charges 1 (in its entirety), 2 and 3. She also said that you admit that your fitness to practice is currently impaired, albeit she recognised this to be a decision for the panel.

Accordingly the panel announced that it found charges 1 (in its entirety), 2 and 3 proved by way of admission.

Background

The charges arose whilst you were employed as a Registered Nurse by Barts Royal London Hospital. You were at the time a Band 6 Charge Nurse. The alleged incident took place on 21 May 2014, while you worked in the Haematology Day Unit. You qualified in 1999.

It is alleged that you gave blood of the wrong type to Patient 1 whilst performing a blood transfusion and subsequently attempted to cover up the error by disposing of the

incorrect blood bag, failing to inform the treating doctor and/or colleagues of your mistake, falsifying the medical notes, failing to complete the Datix report and denying the mistake when asked directly.

You admitted the incident two weeks later in a signed statement to the Trust, dated 3 June 2014. The incident was then investigated and in August 2015 the Trust referred the matter to the NMC. You are currently working as a Staff Nurse at Guys and St Thomas' NHS Trust.

Decision on misconduct

In reaching its decision the panel considered all the evidence, both oral and documentary, together with the submissions of both Ms Murshed and Ms Binding. It heard and accepted the advice of the legal assessor.

The panel first considered whether the facts found proved amount to misconduct. The panel accepts that there is no burden or standard of proof. In reaching its decision, it has exercised its own professional judgment.

The panel had regard to the case of *Roylance v GMC [2001] AC 311* in which Lord Clyde gave guidance, stating that *"misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."* This test, of course, has equal application to a nurse.

In the light of its previous findings and the evidence adduced by the NMC, the panel considered only whether your actions as set out in charges 1 and 2 amounted to misconduct.

The panel determined your actions, namely the administration of an incorrect blood group to Patient A and your subsequent attempts to conceal your mistake, to have been a basic clinical error followed by a gross lapse in professional judgment.

In reaching its decision, the panel has had regard to the terms of *the Code: Standards of conduct, performance and ethics for nurses and midwives (2008)* (the Code) which was in force at the relevant time. The panel is satisfied that your actions fell short of the standards expected of a registered nurse, and further that your actions amounted to a breach of the preamble to the Code as follows:

The people in your care must be able to trust you with their health and wellbeing
To justify that trust, you must:

- *make the care of people your first concern, treating them as individuals and respecting their dignity*
- *work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community*
- *provide a high standard of practice and care at all times*
- *be open and honest, act with integrity and uphold the reputation of your profession.*

As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions.

The panel also considered that you breached the following specific parts of the Code:

> ***21*** *You did not keep your colleagues informed when you are sharing the care of others.*
>
> ***22*** *You failed to work with colleagues to monitor the quality of your work and maintain the safety of those in your care.*

28 *You must make a referral to another practitioner when it is in the best interests of someone in your care.*

32 *You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.*

42 *You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.*

44 *You must not tamper with original records in any way.*

61 *You must uphold the reputation of your profession at all times.*

The panel took into account the particular circumstances of the breaches of the Code identified above.

The panel accepted that breaches of the Code would not automatically result in a finding of misconduct. However, given the fundamental breaches of the Code identified above, the panel determined that your conduct demonstrated a serious departure from the standards expected of a registered nurse.

On 21 May 2014 you were responsible for a series of poor clinical decisions and then dishonestly attempted to conceal your mistake. The panel concluded that the combination of these factors amounted to serious professional misconduct.

Decision on impairment

Having found that your actions amounted to misconduct, the panel then considered whether the misconduct was so serious that your fitness to practise is currently impaired.

In considering whether your fitness to practice is currently impaired the panel took account of your substantial reflective piece and the certificates you provided indicating the successful completion of online courses in: the Safe Administration of Medicines; Record Keeping; Communicating Effectively; and Confidentiality. You have also undertaken an acute transfusion course at Kings College Hospital comprising of six modules in 2015/16. The panel also considered the positive references and testimonials you provided, in particular that where the Matron of St Georges Renal Unit described you on 7 September 2016 as a *"very competent and skilled nurse"* and she *"did not have any concerns about* [your] *honesty and integrity".*

In reaching its decision, the panel has had regard to the public interest and to the observations of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).* In paragraph 76 she cites the approach of Dame Janet Smith in the Fifth Shipman Enquiry to the following effect:

> *"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;

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

The panel found that limbs a, b, c and d of this test were engaged.

The panel found that by your actions you were in breach of the aforementioned paragraphs of the Code including a fundamental tenet of the nursing profession, namely that a nurse should provide a high standard of practice and care at all times and be open and honest and act with integrity. Patient A was a patient in crisis and you failed to provide him with adequate care. He suffered some physical harm as a result of your failure, although there were no long term adverse consequences. However, there was the possibility of serious harm. Your actions put him at unwarranted risk of harm and your failures have brought the nursing profession into disrepute. Your clinical error was compounded by your dishonest attempts to conceal your mistake from Dr 1, your colleagues, your falsification of patient records and your failure to report the matter as an adverse incident.

Your dishonest attempts to conceal a basic nursing error led the panel to conclude that your misconduct damaged the reputation of the profession. Members of the public expect nurses to work together in the best interests of patients, and not to conceal clinical errors in order protect themselves from criticism.

The panel therefore concluded that your fitness to practice was impaired at the time of the incident.

The panel next considered whether your misconduct was remediable and if so, to what extent it had been remedied and whether it was likely to be repeated. The panel was aware that the level of insight, remediation and the risk of repetition is important when considering the issue of current impairment.

With regard to your level of insight into your failings on 21 May 2014 you have accepted that you made a mistake and that your actions in its aftermath were dishonest. Moreover you have made full admissions at this hearing. You conceded during your evidence that your actions could have led to the death of Patient A. You further said in your oral evidence and in your reflective piece that your attempts at concealment were due to embarrassment and pride, and that these emotions *"got the better of you"*. The panel was satisfied that you have expressed sincere remorse and that if you were confronted with a similar situation in the future you would act differently, namely by involving your colleagues in the aftermath of a clinical error.

With regard to remediation the panel considered your failings to be remediable. It also was aware that there is nothing to indicate any instances of poor practice before the incident or of any issues with your practice in the last two years. However, the panel was not satisfied that the courses that you have completed fully address your clinical deficiencies. Furthermore, although you have assisted colleagues in checking blood transfusions, you have not administered blood to a patient since the incident and the panel had concerns over the likelihood of your repeating an error of the kind you made on 21 May 2014. Your training course on medicines administration was an online course completed very recently. In the light of these factors the panel was not satisfied that you have fully remedied your clinical failings and therefore there remains a risk of your putting a patient at unwarranted risk of harm in the future.

Furthermore, in regard to the public interest considerations in *Grant,* the panel concluded that given the seriousness of your clinical error, compounded by your subsequent dishonesty, the need to uphold proper professional standards, public confidence in the profession and the NMC as its regulator would be undermined if a finding of impairment were not made in the particular circumstances of this case.

For all these reasons, the panel has determined that your fitness to practise is currently impaired by reason of your serious misconduct.

Decision on sanction and reasons

The panel has considered very carefully the question of what if any sanction to impose in this case and has decided to make a suspension order for 6 months.

In reaching this decision the panel has had regard to all the information that has been placed before it. The panel has accepted the advice of the legal assessor.

Ms Murshed referred to what she described as the aggravating and mitigating features in this case. She referred the panel to the Indicative Sanctions Guidance, but made no submission as to which particular sanction would be appropriate in this case. She reminded the panel that it should approach the sanctions in ascending order of seriousness.

Ms Binding submitted that a conditions of practice order or a short suspension order would be the most appropriate sanction. She reminded the panel that you have always accepted the seriousness of your mistakes, but highlighted the fact that they were contained to a single day and were not representative of your unblemished 20 year nursing career. Ms Binding submitted that you are an asset to the profession and it is in the public interest that you maintain your PIN.

Ms Binding referred to your full unqualified admissions as to your misconduct and your sincere and genuine remorse. She stated that there is no evidence of any harmful deep seated altitudinal problems and she reminded the panel it was a single episode of misconduct.

The panel has borne in mind that any sanction imposed must be sufficient, appropriate and proportionate. The purpose of any sanction is not intended to be punitive even though it may have a punitive effect. The panel had careful regard to the Indicative Sanctions Guidance (revised 2016) published by the NMC. It has recognised that the

decision on sanction is a matter for the panel exercising its own independent judgement.

The panel considered the aggravating factors:

- There were very serious potential consequences for Patient A as a result of your clinical error
- Your dishonesty was multifaceted, albeit over a short period of time
- You made a basic clinical error despite your some 20 years of nursing experience

The panel considered the mitigating factors:

- The very positive references and testimonials, including one from the Matron you were working with at the time of the incident
- You have expressed sincere and genuine remorse
- You understand that your actions were fundamentally wrong and you now fully recognise that patient safety is paramount
- You have completed several relevant training courses
- You are clearly devoted to providing healthcare
- You have demonstrated that you understand the importance of challenging unsafe practice and escalating your concerns
- You have fully engaged with your regulator

Further, the panel accept the events on 21 May 2014 were not representative of your clinical ability over 20 years and your oral evidence that your dishonest conduct occurred at a moment when you *"panicked"*

The panel first considered whether to take no action but concluded that this would be insufficient in view of the findings set out regarding your current impairment. Further, it would be neither proportionate nor in the public interest to take no further action. Misconduct of this nature requires a sanction.

The panel then considered whether it would be sufficient to impose a caution order. It concluded that the misconduct found was not “at the lower end of the spectrum” of impaired fitness to practise. Your attempt to conceal your clinical error was serious and the error itself could have had fatal consequences. The panel is therefore not satisfied that a caution order would provide adequate protection to the public nor would it serve the wider public interest. Such an order would be insufficient as a sanction.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took account of the following paragraphs of the Indicative Sanctions Guidance.

63 This sanction may be appropriate when some or all of the following factors are apparent:

63.1 No evidence of harmful deep-seated personality or attitudinal problems

63.3 No evidence of general incompetence

63.7 The conditions will protect patients during the period they are in force

Although conditions could be formulated that would protect patients, they would not satisfy the high public interest in this case. The panel reminded itself that having made a serious clinical mistake you then attempted to conceal it by misleading two colleagues, a doctor and then retrospectively amending the transfusion prescription sheet. The panel concluded that this concerted, albeit short, period of dishonesty demanded a higher sanction to satisfy the public interest.

The panel then considered whether a suspension order would be an appropriate sanction. The panel took into account the following sections of the Indicative Sanctions Guidance:

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

71.2 The misconduct is not fundamentally incompatible with continuing to be a registered nurse or midwife in that the public interest can be satisfied by a less severe outcome than permanent removal from the register.

The panel recognised your genuine remorse for the incident and it was satisfied that you would act appropriately if confronted with a similar situation in the future. The panel concluded that a suspension order struck the correct balance between satisfying the public interest in this case and allowing you, an otherwise component nurse, to return to safe practice.

The panel concluded that a 6 month suspension order was the appropriate length as it would send a serious message to the profession that this type of dishonesty is utterly unacceptable.

In the light of your genuine insight, remorse and previously unblemished career the panel concluded that a striking off order would be disproportionate.

The panel recognises that there is a public interest for a nurse who can practise safely to return to the register and it hopes that you will be able to demonstrate this to a future reviewing panel.

At the end of the period of suspension a further panel will review this order. At the review hearing that panel may revoke the order, or it may confirm the order, or it may replace the order by another order.

This panel suggests that a future review panel would be greatly assisted by you:

- Providing details of any employment you have undertaken either paid or unpaid during the period of suspension
- Providing evidence that you have kept your nursing skills up to date, with reference to online courses and articles, in particular in relation to blood transfusions

- A further reflective piece focusing on the importance of honesty and candour in the nursing profession, in the context of the current Code of Conduct

Decision on Interim Order and reasons

The panel has considered the submissions made by Ms Murshed that an interim suspension order for 18 months should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

Ms Binding made no submissions.

The panel has accepted the advice of the legal assessor.

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

The panel considered whether an interim conditions of practice order was appropriate, but concluded for the reasons set out above that conditions were not appropriate.

The panel concluded that an interim suspension order was appropriate and necessary for the reasons set out in its substantive decision to suspend you for 6 months.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made then the interim order will be replaced by the substantive suspension order 28 days after you are sent the decision of this hearing in writing. That concludes this case.