Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday 16 May 2019

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

Name of registrant:	**David Harrison**
NMC PIN:	76B2489E
Part(s) of the register:	Nursing – Sub Part 1 Registered Nurse – Adult (18 June 1993) Nursing – Sub Part 2 Registered Nurse – Adult (4 January 1980)
Area of registered address:	South Humberside
Type of case:	Misconduct
Panel members:	Deborah Jones (Chair, lay member) Lorna Taylor (Registrant member) Gregory Hammond (Lay member)
Legal Assessor:	Jane Rowley
Panel Secretary:	Sara Page
Nursing and Midwifery Council:	Represented by Susan Jean, Case Presenter
Mr Harrison:	Not present and represented in his absence by Laura Steel (Royal College of Nursing) via telephone
Consensual Panel Determination:	Accepted
Facts proved, by admission:	Charges 1 – 11, in their entirety
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision on service of Notice of Hearing:

The panel was informed at the start of this hearing that Mr Harrison was not in attendance and that written notice of this hearing had been sent to Mr Harrison's registered address by recorded delivery and by first class post on 9 April 2019.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mr Harrison's registered address on 10 April 2019. It was signed for in the name of 'HARRISON'.

Further, the panel noted that the Notice of Hearing was also sent to Mr Harrison's representative at the Royal College of Nursing (RCN) on 9 April 2019.

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 Harrison's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Ms Jean, 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.

In the light of all of the information available, the panel was satisfied that Mr Harrison has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Decision on proceeding in the absence of Mr Harrison:

The panel next considered whether it should proceed in the absence of Mr Harrison. The panel had regard to Rule 21(2), which states:

> "**21.—** (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—
>
> (a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;
>
> (b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or
>
> (c) may adjourn the hearing and issue directions."

Ms Jean invited the panel to continue in the absence of Mr Harrison on the basis that he had voluntarily absented himself. She informed the panel that a provisional Consensual Panel Determination (CPD) agreement had been reached and signed by Mr Harrison on 15 May 2019.

Ms Jean also referred the panel to the documentation from the RCN, dated 15 May 2019, which states, "We can confirm that [Mr Harrison] is happy for the CPD to proceed in his absence".

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 further noted the case of *R (on the application of Raheem) v Nursing and Midwifery Council [2010] EWHC 2549 (Admin)* and the ruling of Mr Justice Holman that:

> "...reference by committees or tribunals such as this, or indeed judges, to exercising the discretion to proceed in the person's absence "with the utmost caution" is much more than mere lip service to a phrase used by Lord Bingham of Cornhill. If it is the law that in this sort of situation a committee or tribunal should exercise its discretion "with the utmost care and caution", it is extremely important that the committee or tribunal in question demonstrates by its language (even though, of course, it need not use those precise words) that it appreciates that the discretion which it is exercising is one that requires to be exercised with that degree of care and caution."

The panel has decided to proceed in the absence of Mr Harrison. In reaching this decision, the panel has considered the submissions of Ms Jean, the representations made on Mr Harrison's behalf, 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 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 Harrison;
- Mr Harrison has engaged with the NMC and has signed a provisional CPD agreement which is before the panel today;
- Mr Harrison and his representative will endeavour to be available by telephone should any clarification on any point be required;
- There is no reason to suppose that adjourning would secure his attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

Additionally, the panel noted that it would also be in Mr Harrison's interest for the matter to be heard today as he has confirmed he is content for it to proceed in his absence. In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Harrison.

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

At the outset of the hearing, Ms Jean made a request that parts of this case be held in private on the basis that proper exploration of Mr Harrison's case involves reference to his health. The application was made pursuant to Rule 19 of '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.

Rule 19 states:

"**19.—** (1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.

(2) Subject to paragraph (2A), a hearing before the Fitness to Practise Committee which relates solely to an allegation concerning the registrant's physical or mental health must be conducted in private.

(2A) All or part of the hearing referred to in paragraph (2) may be held in public where the Fitness to Practise Committee—

(a) having given the parties, and any third party whom the Committee considers it appropriate to hear, an opportunity to make representations; and

(b) having obtained the advice of the legal assessor, is satisfied that the public interest or the interests of any third party outweigh the need to protect the privacy or confidentiality of the registrant.

(3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied—

(a) having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and

(b) having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.

(4) In this rule, "in private" means conducted in the presence of every party and any person representing a party, but otherwise excluding the public."

Having heard that there will be reference to Mr Harrison's health, the panel determined to hold such parts of the hearing in private as and when such issues are raised.

Details of charge:

"That you a registered nurse

1. On the 27 February 2018 made an inappropriate comment regarding Resident D

2. On the 29 November 2017administered a Buprenorphine Patch to Resident A when it was not due.

3. On the 24 December 2017 did not administer Resident B's Buprenorphine patch which was due

4. On the 16 February 2018 did not administer Resident C's Buprenorphine patch which was due

5. On the 9 April 2018 did not administer Resident G's Buprenorphine patch which was due.

6. On the 8 April 2018 did not ensure that Residents E and/or F took their medication

7. On the 8 April 2018 signed the MAR chart to indicate that Residents E and/or F had taken her medication when they had not done so

8. Your actions at charge 7 were dishonest in that you knew the resident(s) had not taken their medication but you created a record indicating that they had

9. On the 9 April 2018 did not ensure that Residents E and F took their medication

10. On 9 April 2018 signed the MAR chart to indicate that Residents E and/or F took their medication when they had not done so.

11. Your actions at charge 10 were dishonest in that you knew the resident(s) had not taken their medication but you created a record indicating that they had

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

Consensual Panel Determination:

At the outset of this hearing, Ms Jean informed the panel that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the NMC and Mr Harrison.

The agreement, which was put before the panel, sets out Mr Harrison's full admission to the facts alleged in the charges, that his actions amounted to misconduct, and that his fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a striking-off order.

To assist with its decision, the panel contacted Mr Harrison's RCN representative over the telephone who provided further detail regarding Mr Harrison's health.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

"The Nursing and Midwifery Council ("the NMC") and Mr David Harrison, ("the Registrant"), PIN 76B2489E, (collectively, "the Parties") agree as follows:

Notice

1. The Registrant, PIN 76B2489E, has been provided with proper notice of the CPD hearing.

Absence

2. The Registrant is aware of the CPD hearing. The Registrant does not intend to attend the hearing and is content for it to proceed in his absence. The Registrant will endeavour to be available by telephone should any clarification on any point be required.

The Charge

3. The Registrant admits the following charges (as amended):

That you a registered nurse

1. *On the 27 February 2018 made an inappropriate comment regarding Resident D;*

2. *On the 29 November 2017 administered a Buprenorphine Patch to Resident A when it was not due;*

3. *On the 24 December 2017 did not administer Resident B's Buprenorphine patch which was due;*

4. *On the 16 February 2018 did not administer Resident C's Buprenorphine patch which was due;*

5. *On the 9 April 2018 did not administer Resident G's Buprenorphine patch which was due;*

6. *On the 8 April 2018 did not ensure that Residents E and/or F took their medication;*

7. *On the 8 April 2018 signed the MAR chart to indicate that Residents A and/or E and/or F had taken her medication when they had not done so;*

8. *Your actions at charge 7 were dishonest in that you knew the resident(s) had not taken their medication but you created a record indicating that they had;*

9. *On the 9 April 2018 did not ensure that Residents E and F took their medication;*

10. *On 9 April 2018 signed the MAR chart to indicate that Residents E and/or F took their medication when they had not done so;*

11. *Your actions at charge 10 were dishonest in that you knew the resident(s) had not taken their medication but you created a record indicating that they had.*

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

Background

6. The Registrant qualified as a Registered Adult Nurse and joined the NMC Register on 4 January 1980.

7. The Registrant starting working at Foxby Hill Care Home ('the Home') on 31 May 2017 until 16 April 2018. Whenever the Registrant worked at the Home, he was the only nurse on duty and nurse in charge. Between 29 November 2017 and 9 April 2018 a number of concerns were raised in relation to the Registrant's practice which give rise to the charges set out above.

8. The names of the residents referred to in the charges are set out in an Anonymity Schedule **[Appendix 1]**.

Charge 1

9. On 27 February 2018 the Care Leader was working on the shift with the Registrant. The Registrant came out of the Home's office and told the Care Leader as she stood by the resident's lounge, which was about a metre away from Resident D, that '*that*

man is a complete waste of space he eats, sleeps, pisses and shits and that's it'. The Care Leader states in her witness statement that Resident D heard the conversation as he looked upset.

10. Following this incident, the Deputy Manager of the Home and another colleague spoke to the Resident D, who had capacity and who confirmed he had heard the comment made by the Registrant.

11. On speaking with the Registrant about the incident he denied to the Deputy Manager that he had said these words.

Charge 2

12. On 29 November 2017, the Registrant administered a Buprenorphine patch to Resident A two days before it was due.

13. A Buprenorphine patch is an opiate relief medication which slowly releases morphine over either 2, 4 or 7 days and is used for arthritic conditions. The patch would therefore run out after 2, 4, or 7 days.

14. On 29 November 2018, the Registrant was working a long shift from 07.30 to 20.45 as the nurse in charge and was responsible for administering medication. Resident A was prescribed 35mcg/hr Buprenorphine patch every 4 days. Resident A had been prescribed a patch on 27 November 2017 and therefore did not require a new patch until 1 December 2017.

15. The Deputy Manager at the Home states in her witness statement that whilst she was on duty at the Home on 30 November 2017 she reviewed the controlled drug book and Resident A's MAR chart and noticed that Resident A had been given a 4 day patch on 27 November 2017 but that the Registrant had recorded and signed that he had administered another patch on 29 November 2017.

16. The Registrant failed to follow prescription and should have checked the MAR chart and controlled drug book to determine that Resident A did not require a new patch. The Registrant did not record the reason for giving Resident A a patch early. If a patch is changed early, the Deputy Manager confirms that it is good practice at the Home to record this in the controlled drugs book. No harm came to Resident A.

17. On the Deputy Manager questioning the Registrant about this, his response was '*well she wasn't overdosed*'. The Deputy Manager reminded the Registrant of the importance of checking the controlled drugs prescription carefully and that had the medication been oral, Resident A would have been overdosed.

Charge 3

18. On 24 December 2017 the Registrant was working as the nurse in charge and was responsible for administering medication. Resident B was prescribed Buprenorphine 12mg/hr patch every 3 days. A patch was given to Resident B on 21 December 2017 and therefore required a new patch on 24 December 2017.

19. The Deputy Manager in her witness statement states that she became aware on reviewing the controlled drug book that Resident B had not been given a patch when due on 24 December 2017. The Registrant, as responsible for administering medication to patients, failed to administer the Buprenorphine patch to Resident B.

20. As the nurse in charge and responsible for the administration of the medication on 24 December, the Registrant is expected to have reviewed Resident B's MAR chart to determine if the patch required to be changed.

21. The nurse on duty on 25 December 2017 noticed that Resident B had not been given a new patch the previous day and so administered the patch herself. The Resident had been without a new patch for a day.

22. The Deputy Manager confirms in her statement that if the Registrant had administered the patch but had failed to record this, the stock would reflect the

running total of what was recorded in the controlled drug book minus one less patch, however the level of stock in the Home did not reflect this.

23. Following these incidents in respect of charge 2 and 3, the Deputy Manager instructed the Registrant to complete a medicines competency assessment. The Registrant completed this assessment successfully on 19 January 2018. The Deputy Manager reminded the Registrant he had to ensure he watched the residents consume their medication before signing the MAR chart as concerns had also been raised by staff at the Home about this.

24. The Deputy Manager and another colleague had a further conversation with the Registrant about his poor medication practices on 24 January 2018 following further complaints from members of staff. A letter was sent to the Registrant on 2 February 2018 regarding this meeting and an agreement made to meet with the Registrant four weeks from the date of the letter to review whether there had been an improvement to his practice and attitude.

Charge 4

25. On 16 February 2018 the Registrant failed to administer a Buprenorphine patch to Resident C. The Deputy Manager in her witness statement states that she became aware on reviewing the controlled drug book that Resident C had not been given a patch when due on 16 February 2018. Resident C was prescribed Buprenorphine 25mcg/hr patch every 3 days. Resident C had been given a patch on 13 February 2018 and required another patch on 16 February 2018.

26. The Deputy Manager states that an ‘X’ was placed on the MAR chart for 16 February 2018 to indicate when the next patch was due to be administered. There is no entry within the controlled drug book or MAR chart to confirm that the patch had been administered to Resident C. On the Deputy Manager checking the Home’s stock on 19 February 2018, the stock matched with the running total in the controlled drug book, indicating that a patch had not been administered to Resident C.

27. The Registrant, as being solely responsible for administering medication to residents on 16 February 2018, failed to administer the Buprenorphine patch to Resident C. The Registrant should have checked the MAR chart whilst on duty. Resident C did not receive a patch until 17 February 2018 at 12.05pm.

Charge 5

28. On 9 April 2018 it is alleged that the Registrant failed to administer a Buprenorphine patch to Resident G.

29. On 9 April 2018 the Registrant was working as the nurse in charge and was responsible for administering medication to residents. Resident G was prescribed Buprenorphine 5mcg/hr patch and Buprenorphine 10mcg/hr patch every 7 days.

30. The Deputy Manager states in her witness statement that the controlled drugs book for 10mcg/hr patch shows that Resident G was given a patch on 2 April 2018 and that another patch should have been administered on 9 April 2018.

31. There is no entry within the controlled drugs book or MAR chart for Resident G that a patch was administered on 9 April 2018 by the Registrant or at all. The Deputy Manager counted the Home's stock on 10 April 2018 and the stock count matched the controlled drug book, meaning that the medication had not been administered.

32. Resident G did not receive a new patch until 10 April 2018 at 08.30am, on this error being noticed by the Deputy Manager. The Deputy Manager states that the resident could have been in pain since the previous day when a new patch should have been administered. Resident G has dementia and would not have been able to tell anyone that he was in pain.

Charge 6 and Charge 7

33. On 8 April 2018 the Registrant did not supervise or witness Residents E and F take their medication before signing their MAR charts to say they had.

34. On 8 April 2018 the Registrant left white medication in front of Resident E on a white napkin and walked away without watching and ensuring that Resident E had consumed them.

35. The Senior Carer states in her witness statement that she witnessed the Registrant leaving Resident F's white medication on a white napkin and walk away without ensuring Resident F had consumed them. The Senior Carer noticed that it was difficult for Resident F to see the tablets on the table. Resident F is a resident who can become confused and fall asleep at the table and requires assistance in taking medication.

36. Resident E, who was sitting next to Resident F, then attempted to pick up Resident F's medication and consume them. The Senior Carer intervened to stop Resident E from doing so.

37. The Deputy Manager states in her witness statement that on reviewing both Resident E's and Resident F's MAR chart, the Registrant had signed both MAR charts on 8 April 2018 to confirm that the residents had consumed their medication.

38. The Registrant should have placed the tablets in each resident's hand, given them a glass of water and witnessed both residents consume the tablets before signing their respective MAR charts.

Charge 8

39. The Registrant was dishonest in signing Resident E and Resident F MAR charts on 8 April 2018. The Registrant did not witness the residents consume their medication and therefore knew the residents had not taken their medication when creating a record in the residents MAR charts indicating that they had taken their medication.

40. The Deputy Manager states in her witness statement that signing the MAR charts confirmed the residents had consumed their medication, when they had not. The Deputy Manager states that the Registrant was aware that he was required to watch

residents consume medication before signing the MAR chart because he did it correctly during his competency assessment in January 2018.

Charge 9 and 10

41. On 9 April 2018 the Registrant again did not supervise or witness Residents E and F take their medication before signing their MAR charts to say they had.

42. On 9 April 2018, the Registrant left white medication in front of Resident E on a white napkin and proceeded to walk away without watching and ensuring that Resident E had consumed them.

43. The Senior Carer states in her witness statement that the Registrant left Resident F's white medication on a white napkin and walked away without ensuring Resident F had consumed them.

44. The Kitchen Supervisor states in her witness statement that she witnessed the Registrant do this on a number of occasions and confirms she would remind the Registrant that Resident F had not taken the medication. The Registrant would walk past Resident F, tell her to wake up, but would not stay to ensure the resident consumed their medication.

45. The Deputy Manager states within her witness statement that the Registrant signed both Resident E's and Resident F's MAR chart on 9 April 2018 to confirm that both residents had consumed their medication.

Charge 11

46. The Registrant was dishonest in signing Resident E and Resident F MAR charts on 9 April 2018. The Registrant did not witness the residents consume their medication and therefore knew the residents had not taken their medication when creating a record in the residents MAR charts indicating that they had taken their medication.

47. The Deputy Manager states in her witness statement that signing the MAR charts confirmed the residents had consumed their medication, when they had not. The Deputy Manager states that the Registrant was aware that he was required to watch residents consume medication before signing the MAR chart because he did it correctly during his competency assessment in January 2018.

48. The Deputy Manager and another colleague met with the Registrant on 5 March about his failure to watch residents consume medication and administer patches correctly. The Registrant denied leaving medication in front of residents, signing the MAR chart and walking away.

49. The Registrant was suspended from the Home on 10 April 2010 but submitted his resignation on 11 April 2018.

Misconduct

13. In the case of *Roylance v General Medical Council (No.2)* [2000] 1 AC 311, Lord Clyde stated that:

"*misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by the medical practitioner in the particular circumstances.*"

14. Not every breach of the code and not every falling short in the particular circumstances will amount to misconduct. It must be serious or, as Elias LJ put it in the case of *R (on the Application of Remedy UK Ltd) v GMC [2010] EWHC 1245 (Admin),* "*sufficiently serious….that it can properly be described as misconduct going to fitness to practise."*

15. The Parties agree that the Registrant's actions breached the following provisions of '*The Code, Professional standards of practice and behaviour for nurses and midwives*', effective from March 2015 ("*the NMC Code 2015*"):

The NMC Code 2015

1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively

10 Keep clear and accurate records relevant to your practice.
To achieve this, you must:
10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event.
10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care.

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

16. The Registrant accepts that his comments in respect of Resident D were highly inappropriate and offensive, and are demonstrative of a lack of kindness, care, respect and dignity towards patients and a lack of professionalism. The Registrant accepts that his actions humiliated the resident and caused distress and offence to the resident and his colleague. The Registrant accepts that his behaviour was

unacceptable and has fallen far below the standards expected of a registered nurse.

17. The Parties agree that the Registrant also failed to adhere to the standards expected of a registered nurse when he failed to ensure that residents were provided with their medication. It is a basic nursing requirement that timely and appropriate clinical care is provided to patients.

18. The Parties agree that the medication errors, which occurred on multiple occasions over long period of time, could have resulted in serious harm to the residents who had not consumed or had their medication administered to them but also to the resident who attempted to consume another resident's medication. The Registrant accepts that he has not provided a high standard of practice and care for residents.

19. The Parties agree that the Registrant's repeated actions in dishonestly recording on more than one occasion that residents had taken their medication when they had not has breached trust placed in nurses and the profession. The Registrant was aware of the process in respect of recording medication and knew what he was doing was dishonest. Acting with integrity and honesty are integral to the standards expected of a registered nurse and central to the code, which the Registrant accepts he has fallen seriously short of.

20. The Registrant accepts that his practice was unacceptable and fell seriously short of the standards that were expected of him. The Parties agree that the Registrant's actions amount to serious misconduct.

Impairment

21. In the case of *CHRE v NMC & Grant [2011] EWHC 927 (Admin) ("Grant")* Mrs Justice Cox adopted the matters outlined by Dame Janet Smith in the Fifth Shipman report which invites panels to ask:

Do our findings of fact in relation to the misconduct show that the Registrant's fitness to practise is impaired in the sense that 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 professions 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 professions; and/or*

d) *Has in the past acted dishonestly and/or is liable to act dishonestly in the future?*

22. The Parties agree that all four limbs are engaged.

23. The Parties agree that the Registrant has put numerous vulnerable patients at unwarranted risk of harm and is likely to have caused direct harm in failing to administer pain medication when due.

24. Firstly, failing to administer pain relief is likely to have caused actual harm in this case because the residents were unable to articulate for themselves if they were in pain.

25. Recording that residents had consumed medication when they had not and leaving medication unattended for any resident to consume causes significant risk to patient safety.

26. Dishonest recording causes a risk of harm because it creates an unreliable record of the care provided, meaning no future carer can be confident how they should apply their own clinical care to the patient.

27. Lastly insulting a patient, who was visibly humiliated and would have been distressed and offended by the Registrant's comments, is a form of real harm.

28. The Parties agree that the Registrant has brought the nursing profession into disrepute. The Registrant's failings demonstrate wide ranging concerns in basic nursing skills and attitudinal concerns directed at residents. The Registrant made a highly inappropriate and degrading comment about a resident which was overheard by that resident and could have been overheard by other residents. Such failings call into question the reputation of the nursing profession. In addition, the Parties agree that the Registrant's dishonesty in recording that residents had taken their medication when they had not would bring the nursing profession into disrepute.

29. Acting in a patient's best interest and acting with integrity and honesty are cornerstones of the nursing profession. By failing to act in the best interests of vulnerable patients and by not acting with integrity, the Parties agree that the Registrant has breached fundamental tenets of the profession.

30. The Parties also agree that the Registrant has acted with dishonesty as he has made dishonest records on patient notes on more than one occasion.

Risk of Repetition

31. In the case of *Cohen v GMC [2008] EWHC 581 (Admin)* panels are invited to consider whether to the conduct is easily remediable, whether it has been remedied and whether it is likely to be repeated when making a determination on current impairment.

32. The Parties agree that the conduct in this case is so serious that it would be difficult to remediate. The concerns do not solely relate to clinical failings but are also attitudinal and dishonesty concerns, which were directed towards residents. In addition, despite being informed on a number of occasions by staff at the Home

about his conduct the Registrant continued to repeat his behaviour over a long period of time to multiple vulnerable patients.

33. The Parties agree that the concerns have not been remediated and the Registrant has not been able to demonstrate that he can work safely. Following the Registrant's resignation from the Home, he worked as a bank nurse at Lound Hall Care Home ('Lound Hall') between 10 and 20 May 2018. Ms Paula Newbert, Home Manager, stated in an email to the NMC dated 13 August 2018 that concerns were raised whilst the Registrant was employed at Lound Hall about not completing fridge temperature readings and a member of staff having to ask the Registrant twice to provide pain relief to a patient **[Appendix 2]**.

34. The Registrant has stated that in October 2018 he took permanent retirement [PRIVATE]. He has provided a letter to the NMC dated 7 May 2019 stating that he no longer wishes to be on the NMC register and will not ever be returning to nursing practice **[Appendix 3]**. The Registrant states he cannot perform his duties as a registered nurse [PRIVATE] without putting patients at risk of harm.

35. [PRIVATE] The Registrant states he would like to be removed from the NMC Register.

36. [PRIVATE]

    [PRIVATE]

37. [PRIVATE]

38. [PRIVATE]

39. The Registrant will therefore be unable to ever remediate his practice and demonstrate that he can work safely.

40. The Parties agree that the Registrant has not demonstrated sufficient insight into his actions and has not been able to explain the impact it had on patients, colleagues and the profession and NMC as regulator.

41. The Parties agree that there is a clear risk of such failings occurring again and that there remains a risk to the public. The Parties agree that a finding of impairment on grounds of public protection ought to be made.

Public interest

42. Finally, as Mrs Justice Cox set out in *Grant* at paragraph 71:

"*it is essential, when deciding whether fitness to practise is impaired, not to lose sight of fundamentals, (namely) the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.*"

43. The facts of this case are serious and involved significant failings with risk to patient safety. The Parties, therefore, agree that a finding of impairment must be made in order to mark the serious misconduct, to uphold proper professional standards of conduct and behaviour and to uphold and maintain public confidence in the profession and the NMC as its regulator. Allowing the Registrant to practise unrestricted when he poses a real risk to patient safety would be a cause of serious concern to members of the public.

Sanction

44. The Parties agree that the appropriate sanction in this case is a striking off order.

45. The Parties have considered this is the appropriate sanction in light of the Sanctions Guidance.

46. The Parties agree that the following mitigating and aggravating features apply:

47. The aggravating factors are:

34.1. direct harm and risk of serious harm to patients;
34.2. dishonesty which occurred on more than one occasion, was related to clinical practice and which could have caused patients serious harm;
34.3. a highly inappropriate comment was said about a resident out loud in a clinical setting and within that resident and other residents' hearing;
34.4. involved multiple vulnerable patients;
34.5. attitudinal issues;
34.6. repeated misconduct despite concerns raised by several members of staff over a period of time to the Registrant about his conduct;
34.7. lack of insight and no remediation.

35. The mitigating factors are:
35.1. health concerns.

36. Dealing with the sanctions in ascending order, as this case concerns misconduct and attitude in a clinical context; to take no further action would clearly be inappropriate in light of public protection concerns and by virtue of the engagement of the public interest in light of the admitted dishonesty.

37. Likewise, a caution order would not serve to restrict the Registrant's practice, and as such, would not adequately protect the public.

38. The Parties agree that, in light of the seriousness of the charges, conditions of practice would be unsuitable. Further, given the Registrant has no intention to return to practice no workable conditions could be formulated. A conditions of practice order would also fail to adequately protect the public interest in this case.

39. The Parties agree that a suspension order would be unsuitable in light of the serious nature of the conduct. This is not a single instance of misconduct but occurred on a number of occasions over a long period of time to vulnerable residents and involves dishonesty in a clinical setting which occurred on more than one occasion. There was a serious risk of harm to patients and there was likely to

have been direct harm. There is evidence of attitudinal problems and towards residents, which continued despite concerns being continually raised to the Registrant about his conduct. This raises fundamental questions about the Registrant's professionalism. The Registrant has not shown sufficient insight into his conduct, and there is a significant risk of the Registrant repeating his behaviour. The Registrant has no intention of ever returning to nursing practice [PRIVATE]

40. There is no evidence that the Registrant's conduct and behaviour was linked to his health. It is the Registrant's opinion that his health is linked to his behaviour. In regulatory proceedings, where the purpose of sanctions is to protect the public and not to punish nurses and midwives, NMC guidance states that personal mitigation is likely to weigh less in the regulatory setting than in other jurisdictions.[1]

41. The Parties agree that a striking-off order is the only sanction which will be sufficient to protect patients, members of the public, maintain professional standards and uphold the reputation of the profession and the NMC as regulator. The Registrant has confirmed in his letter of 7 May 2019 that he wants to be struck off the NMC Register **[Appendix 3]**.

INTERIM ORDER

41. Due to the basis upon which impairment has been agreed by the Parties, it is further agreed that an interim order is necessary for the protection of the public and that it is otherwise in the public interest.

42. The Parties have determined that an interim suspension order for a period of 18 months would be appropriate to cover the 28 day period before the striking off order takes effect and also in the event of an appeal.

[1] Reference: SAN-1 : Factors to consider before deciding on sanctions
https://www.nmc.org.uk/ftp-library/sanctions/decision-making-factors/

43. The Parties understand that this provisional agreement cannot bind a panel and that the final decision on findings, impairment and sanction is a matter for the panel. The parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges set out at the first section above, and the agreed statement of facts set out at the second section above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.

Here ends the provisional CPD agreement between the NMC and Mr Harrison. The provisional CPD agreement was signed by Mr Harrison on 14 May 2019 and an officer of the NMC on 15 May 2019.

Decision and reasons on the CPD:

The panel decided to accept the CPD (noting the confused paragraph numbering).

Ms Jean referred the panel to the' NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. She reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Mr Harrison. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel heard and accepted the legal assessor's advice.

The panel noted that Mr Harrison admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of Mr Harrison's admissions as set out in the signed provisional CPD agreement.

Panel's decision on impairment

The panel then went on to consider whether Mr Harrison's fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Mr Harrison, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of misconduct, the panel determined that Mr Harrison had breached fundamental tenets of the profession, including multiple standards of the Code as detailed in the CPD.

In this respect, the panel endorsed paragraphs 13 to 20 under the heading "Misconduct" of the provisional CPD agreement.

The panel then considered whether Mr Harrison's fitness to practise is currently impaired by reason of the misconduct. The panel was satisfied that Mr Harrison's conduct placed patients at an unwarranted risk of harm as a result of his breaching fundamental tenets of the nursing profession. Coupled with his dishonesty, the panel determined that his conduct brought the profession into disrepute.

Administering pain relief, ensuring and recording that patients have consumed medication and securing medication are all necessary and fundamental elements of the nursing role. Being dishonest and insulting patients, whether or not they are in earshot, would be seen by fellow practitioners as deplorable conduct.

The panel noted that Mr Harrison has not been working and there has been no remediation of the misconduct; it further considered that dishonesty is difficult to remediate. Whilst Mr Harrison has demonstrated some insight into his failings, the panel could not be satisfied that this is sufficient to diminish the risk of repetition in the future.

In this regard, the panel determined that Mr Harrison's fitness to practise is currently impaired.

The panel agreed that acting in a patient's best interest and acting with integrity and honesty are cornerstones of the nursing profession. In this respect the panel endorsed paragraphs 21 to 44 under the heading "Impairment" of the provisional CPD agreement.

Panel's decision on sanction

Having found Mr Harrison'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 determined that there had been a clear breach of fundamental tenets of the profession and considered the aggravating features to be the following:

- Direct harm was caused to vulnerable patients as well as the potential to cause serious harm;
- Mr Harrison's dishonesty is directly related to his clinical practice and was not a single instance of dishonesty;
- There is evidence of attitudinal problems; and
- There is limited insight and no evidence of remediation.

The panel then considered the following mitigating feature:

- Mr Harrison's health condition.

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 Harrison'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 Harrison'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 Harrison'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. Furthermore, the panel concluded that the placing of conditions on Mr Harrison'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 SG states that a suspension order may be appropriate where some of the following factors are apparent:

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

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 breach

of the fundamental tenets of the profession evidenced by Mr Harrison's conduct is fundamentally incompatible with Mr Harrison 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 Harrison's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with his remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Harrison'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.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel agreed with the CPD that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mr Harrison's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

The panel also 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.

In this regard, the panel endorsed paragraphs 45 to 48 and 35 to 41 under the heading "Sanction" of the provisional CPD agreement.

Determination on interim order

The panel has considered whether an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor.

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

The panel agreed with the signed CPD 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 agreed with the signed CPD and therefore imposes an interim suspension order for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.