Nursing and Midwifery Council

Fitness to Practise Committee

Restoration Hearing

Friday, 10 September 2021

Nursing and Midwifery Council
Virtual Hearing

Name of Applicant:	Michael George Wray
NMC PIN:	00C0223E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – March 2003
Area of Registered Address:	Derbyshire
Panel Members:	Bryan Hume (Chair, Lay member) Terry Shipperley (Registrant member) Susan Ellerby (Lay member)
Legal Assessor:	Ben Stephenson
Panel Secretary:	Xenia Menzl
Mr Wray:	Present and represented by Oliver Renton, Counsel instructed by the Royal College of Nursing (RCN)
Nursing and Midwifery Council:	Represented by Tracy Brown, Case Presenter
Outcome:	Application granted subject to satisfying the NMC's return to practice standards as set out in Article 19(3)

Decision and Reason on the application for the hearing to be heard in private

Mr Renton, on your behalf, made an application that parts of the hearing be held in private on the basis that your case involves reference to personal circumstances and your health. The application was made pursuant to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (the Rules).

Ms Brown, on behalf of the Nursing and Midwifery Council (NMC) supported the application.

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) provides that hearings may be held, wholly or partly, in private if the committee is satisfied that this is justified by the interests of any party.

Having heard that there will be reference to your health and personal circumstances, the panel decided to hold those parts of the hearing in private. It is satisfied that this is justified by the need to protect the confidentiality of those matters and that this outweighs any prejudice to the general principle of public hearings.

Determination of application for Restoration to the Register:

This is a hearing of your first application for restoration to the NMC Register. A panel of the Conduct and Competence Committee directed on 9 October 2015 that your name be removed from the register based on its findings with regard to the facts of your case and the impairment of your fitness to practise (FtP).

This application is made by you in accordance with Article 33 of the Nursing and Midwifery Order 2001 (“the Order”), as at least five years have now elapsed since the date of the striking-off order.

At this hearing the panel may reject your application or it may grant your application unconditionally. It may grant your application subject to your satisfying the requirements of Article 19(3) and it may make a conditions of practice order.

The panel has considered your application for restoration to the NMC's register.

Background (as set out in the substantive hearing)

'1.1. Mr Wray commenced employment with the Chesterfield Royal Hospital NHS Foundation Trust ("the Trust") on 7 November 2011 as a staff nurse. He worked on the Pearson Ward ("the Ward") at Chesterfield Hospital ("the Hospital") from July 2012.

1.2. Mr Wray worked a day shift on the Ward on 23 March 2013. At the end of this shift, he was due to handover the condition of the 9 patients for whom he had been responsible to Ms 4 and Ms 5, two Staff Nurses due to work on the night shift. These patients included Patients H, M and S.

1.3. It is accepted that, at the time, Mr Wray's handover was vague and did not contain detailed information regarding the treatment and condition of every patient under his care. With regards to Patient H, a patient on the Ward who had been administered a second unit of blood during the day, Mr Wray handed over that Furosemide had been prescribed for administration alongside the infusion of the second unit of blood. He stated that he had been unable to ascertain the dose due from the Patient's prescription and had not therefore administered the prescribed Furosemide alongside the second unit of blood when he had commenced its infusion. Mr Wray did not mention any issues regarding the care of Patient S, an epileptic and diabetic patient due to receive varying doses of insulin to be administered via a sliding scale. With regards to Patient M, a diabetic patient on the Ward, he handed over that Patient M's blood sugar readings had been regular during the day.

1.4. Ms 4 and 2 commenced their rounds of the Ward to familiarise themselves with each patient allocated to them.

1.5. Ms 5 noticed upon attending to Patient H that the blood prescription chart outlined that 40mg of Furosemide was due to be administered, and that no

record had been made on the blood prescription chart to demonstrate that this had been carried out. Ms 5 contacted Mr Wray by telephone to ascertain why he had not clearly documented his omission to administer the Furosemide nor documented the course of treatment that needed to be followed afterwards. Mr Wray explained that he had not administered Furosemide as he had not been able to ascertain the correct dose from the Blood Component Transfusion Care Pathway for Patient H.

1.6. Ms 5 further noticed that Patient H's medical documentation had not been signed. In particular, Mr Wray had made no record of having undertaken checks of the Patient's pump used for infusing blood and fluids or having undertaken any observations in the Patient's Evaluation of Care Record or the Patient's Fluid Balance Chart to record the infusion of blood.

1.7. Ms 5 continued her rounds and checked Patient S. Upon checking Patient S, she noticed that he had not been given Epilim, his epilepsy treatment, and that no record of this had been made in any of his medical notes, including the Patient's Kardex. She further noted that the Kardex was very brief and vague as it failed to provide the requisite level of detail required of medical documentation, such as any observations taken.

1.8. Ms 5 telephoned Mr Wray again and asked if he had administered Patient S's Epilim medication and had failed to document this, or whether it had not been administered at all. Mr Wray informed Ms 5 that the Epilim treatment required was not in stock and that the Patient was drowsy, and therefore unable to swallow tablets. Ms 5 informed Mr Wray of the necessity of administering Epilim as prescribed, further informing him that the required epilepsy treatment was kept in tablet form and in intravenous form on the Ward so that it could be given to a patient as prescribed in any circumstances. Mr Wray also stated that he did not realise that he was not allowed to omit the administration of the medication to Patient S. He further stated in a telephone call made 10 minutes later that he had consulted Dr 1, the on-call doctor for the shift, who had informed him that he could omit to administer the Epilim if Patient S was drowsy.

1.9. At this time, the on-call team was called for attendance. Dr 1, who was still on duty at the time, attended the Ward and spoke with Ms 5 regarding Mr Wray's actions. Dr 1 stated that Mr Wray had not contacted him regarding the Epilim due to Patient S. He further stated that, had he provided Mr Wray with any instructions, he would have documented these instructions in Patient S's notes to indicate that he had authorised the suspension of the drug. Ms 5 was instructed to administer the Epilim intravenously to Patient S via a cannula.

1.10. While Ms 5 attended to Patients H and S, Ms 4 also undertook rounds of the patients to ascertain their current conditions. Upon attending Patient M, she noticed that Patient M's prescribed insulin had not been signed as having been administered at teatime on Patient M's Insulin Prescription Chart or Diabetes Monitoring Chart. As a diabetic, Patient M should have been given a dose of insulin at tea time, around 17:00 which was during Mr Wray's shift. Patient M's blood glucose before Patient M was put to bed and it was noticed that, when she went to record the reading on the Prescription and Diabetes Monitoring Chart, Mr Wray had made no record in Patient M's chart that insulin had been given. Ms 5 also recalled that Mr Wray's handover with regard to Patient M was poor as there was no mention of the fact that Patient M's blood sugar levels had been high which would indicate that Patient M was unstable and required monitoring.

1.11. Ms 4 telephoned Mr Wray to query this, who informed her that Staff Nurse Ms 4 on duty alongside Mr Wray on the day shift, had offered to support Mr Wray in his medication rounds and had therefore been responsible for administering the insulin to Patient M. Ms 4 further contacted Staff Nurse Ms 4 to verify this information, who informed her that she had not administered the insulin as Mr Wray had not informed her that Patient M was due to receive a dosage. On the basis of this information, Ms 4 concluded that the insulin had not been administered and consulted a Matron, who instructed her to administer the insulin as prescribed and document on Patient M's Insulin Prescription Chart that this had been administered later than prescribed.

1.12. Ms 4 further noted that Mr Wray had not undertaken any blood sugar readings for Patient M during the day as there were no documented readings or entries charted on Patient M's Insulin Prescription Chart or Diabetes Monitoring Chart. She also noted that there were no records documenting the administration of insulin to Patient M during the day shift. Ms 5 and Ms 4 submitted web incident reports documenting their concerns regarding the care of the Patients H, M and S at the end of their shifts. Following this, a Trust investigation was instigated. The Deputy Director of the Trust, instructed the Senior Matron, to undertake this investigation into the care-based concerns raised by Ms 5 and Ms 4.

1.13. Mr Wray was initially interviewed by the Senior Matron on 28 March 2013, at which he was informed of each allegation against him. Following this meeting, Mr Wray was suspended pending the conclusion of the internal investigation.

1.14. In the process of her investigation, The Senior Matron identified and interviewed other members of staff involved in the incidents and obtained their witness evidence. She further examined the documentation of the Patients involved and noted that Mr Wray had made a number of retrospective entries on 24 March 2013 recording the actions he had taken the previous day. The Senior Matron further discovered from examination of the drug infusion checklist for Patient H that Mr Wray had obtained a countersignature from Staff Ms 5 on the Ward, for a retrospective entry made by Mr Wray on 24 March 2013 in relation to the infusion of a unit of blood administered a day earlier.

1.15. The further concerns regarding Mr Wray's record keeping were raised with Mr Wray at an investigatory meeting on 30 April 2013, and discussed in addition to the care-based allegations originally highlighted for investigation.

1.16. With regards to the alleged omission to administer the medication required by Patient S, Mr Wray stated that he did not administer the required Epilim as the box available displayed no information regarding the medication dosage or administration; additionally, that Patient S was not sufficiently alert to take the tablet. He further stated that he had spoken to Dr 1 and been advised to order

another box. He acknowledged that he could have intravenously administered the medication but that he had not considered this at the time. Mr Wray was unable to recall whether he had completed Patient S's medical documentation on 23 March 2013. With regards to the handover of Patient S's condition, Mr Wray denied that his handover had been deficient and stated that he recalled explaining the difficulties that he had encountered in administering medication to Patient S.

1.17. Mr Wray's alleged failings regarding the care of Patient H were further considered. He stated that he was unable to make out the correct dosage or method of administration of Furosemide due to Patient H from the Patient's care transfusion pathway and that he had delayed in administering the medication as a result. He stated that he had attempted to bleep Dr 1 to confirm the dosage due to the Patient but that this had been unsuccessful, and that he had sought the advice of another nurse regarding the dosage of Furosemide outlined on the care transfusion pathway, who he alleged had said that he needed to speak to the doctor. With regards to the completion of Patient H's medical documentation, Mr Wray admitted to retrospectively writing on the parenteral drug infusion checklist on 24 March 2013, but could not recall recording any other entries in the Patient's medical documentation. He lastly stated with regards to Patient H that he had stated during handover the issue with the dosage of Furosemide due to Patient H.

1.18. When questioned regarding Patient M, Mr Wray explained that he had been advised by Staff Nurse Ms 4 that she would undertake the drugs round and therefore administer the insulin due to Patient M whilst Mr Wray was occupied with arranging the transfer of another patient. With regards to handover, Mr Wray stated that he had advised the staff coming onto duty that Patient M had been alert and orientated. Mr Wray was unable to recall any details regarding the completion of the Patient's medical documentation.'

The panel at the substantive hearing concluding on 9 October 2015, considered the following charges:

That you, whilst employed as a Staff Nurse by Chesterfield Royal Hospital NHS Foundation Trust between 7 November 2011 and 23 July 2013:

1. [not proved]
   1.1. [not proved]

2. [not proved]
   2.1. [not proved]

3. *On or around 28 March 2013 told [Ms 2] that on or around 23 March 2013 you had told your colleagues in handover that M's blood sugar readings had been regular when there was no evidence you had taken any such readings*
   3.1. [not proved]

4. *In relation to the administration of Furosemide to patient H, on one or more dates between 23 March 2013 and 11 July 2013 you indicated to one or more staff members at the trust that you spoke with [Dr 6] about the dosage to be given to the patient, when you did not speak with [Dr 6].*
   4.1. Your conduct as set out at charge 4 was dishonest

5. [not proved]
   5.1. [not proved]

6. *Between 23 March 2013 and 11 July 2013 you stated to one or more staff members and/or made a retrospective entry in patient S's notes indicating you were told by [Dr 6] not to dispense epilim to patient S if he was drowsy, when you were not given this advice.*
   6.1. Your conduct as set out at charge 6 was dishonest

7. [No case to answer]

7.1. [No case to answer]

8. On or around 24 March 2013 asked [Ms 3] to countersign a Kardex to verify it was your signature on it whereas she was actually countersigning to say a unit of blood had been infused.

8.1. Your conduct as set out at charge 8 was dishonest in that you intended to mislead [Ms 3] as to the purpose of her signature

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

The substantive hearing panel, in making its decision on impairment, stated the following with regard to impairment:

The substantive hearing panel stated the following with regard to sanction:

'The panel noted that your actions did not result in any actual harm to Patients S, M and H. However, there was an element of risk in light of the evidence heard by the panel to the effect that Patients S, M and H could have suffered significant harm as a result of the failure to monitor their condition and administer medication to them.

In the panel's view you had also breached fundamental tenets of the nursing profession in the requirements to make the care of people your first concern, work with others to protect and promote the health and wellbeing of those in your care, provide a high standard of practice and care at all times and to act openly and honestly.

The public justifiably expect that registered nurses should act openly and honestly when discharging their duties. Honesty, integrity and trustworthiness are

bedrocks of the nursing profession and form the basis of the therapeutic relationship between nurse and patient. Your dishonest behaviour in Charges 4, 6 and 8 has, in the panel's view, brought the nursing profession into disrepute.

The panel went on to consider the question of insight and paid careful attention to the evidence that you gave before it at the facts stage. In the panel's judgment, your answers to the panel demonstrated that you have reflected upon the nightshift in question although not to a significant degree. While your answers recognised your personal faults, you were still prone to apportion blame to others and the panel judged that there was no significant expression of remorse or recognition of the impact which your actions could have had on the patients concerned or the reputation of the profession.

The panel did, however, recognise that you have made significant admissions at the outset of the hearing in relation to both facts and impairment and have engaged with the process fully. The panel concluded that you have demonstrated some insight.

The panel went on to consider remediation and had regard to the case of Ronald Jack Cohen v General Medical Council [2008] EWHC 581 (Admin). It considered that the misconduct relating to the clinical deficiencies admitted within the CPD is remediable as it related to discrete areas of nursing practice in the administration of medication, record keeping, monitoring patients and handovers. The panel was of the view that each of these areas could be the subject of appropriate remediation. With respect to the additional charges, however, the panel considered that dishonesty is inherently difficult to remediate, although not impossible.

The panel had regard to the testimonials and references you presented to the panel. The references demonstrate that you have been a competent and caring nurse and it is clear that there have been no concerns with your practice or probity save for the incidents on the Ward. The panel noted, however, that you have not completed any relevant training and nor have you produced any

significant reflection such as would allay any concerns that you pose a risk looking forward.

The panel considered that your clinical errors were compounded by your later dishonest behaviour in attempting to justify what you had done by falsifying records and indicating that you had gained the approval of Dr 6 for actions which you alone were responsible for. You misled your employers during the investigatory process and the panel considered that your dishonesty persisted for a considerable period of time. In the panel's view you have displayed some attitudinal failings which exacerbates the risk of you repeating your dishonest behaviour again.

With respect to both the clinical failings and the dishonest behaviour the panel was not satisfied that you would not repeat your actions in the future. You were therefore liable in the future to expose patients to a risk of harm, bring the profession into disrepute, breach fundamental tenets of the profession and act dishonestly.

The panel had at the forefront of its mind not only the issue of public protection but also that the public interest includes the declaration and upholding of proper standards of conduct and behaviour and the maintenance of confidence in the profession and the NMC as regulator.

The panel noted that the clinical errors were serious, wide-ranging and exposed Patients S, H and M to a risk of harm. Your subsequent dishonest behaviour sought to justify these clinical errors and implicated other professionals. These actions raise significant questions about your honesty, integrity and trustworthiness which are justifiably recognised as the bedrock of the nursing profession and form the basis of the therapeutic relationship between nurse and patient.

The panel concluded that public confidence in the profession and its regulation would be undermined if a finding of impairment was not made in these

circumstances. The panel also considered the maintenance and declaration of proper standards of conduct and behaviour. The panel concluded that this element of the public interest would also be undermined if a finding of impairment was not to be made.

Therefore panel determined that your fitness to practise is currently impaired.'

Submissions and evidence

The panel took into account the documentary evidence before it, including the contents of your application for restoration, three written references dated in January and April 2021 and the decision from the substantive hearing which concluded on 9 October 2015. You further submitted a bundle containing several reflective pieces, various training certificates dated between March 2019 and February 2021, further testimonials and references dated between November 2020 and September 2021.

This panel has had regard to the submissions of Ms Brown on behalf of the NMC and from Mr Renton on your behalf. It also took into account the oral evidence it heard from you today.

Ms Brown outlined the background of the case and referred the panel to the relevant pages of the bundle. She also referred the panel to the substantive decision that led to your striking-off order.

The panel heard evidence under oath from you.

You told the panel that you have changed completely since you have been struck off the register and that you made a promise to yourself to never be dishonest again. You stated that you are taking accountability for your actions and that you are honest and transparent about any errors or mistakes that occur. You told the panel how much you value honesty and that you are also teaching this to your children. You stated that you want to put your mistakes right and that you can only do so if you are open and honest

with people. You explained that your current employer is aware of why you have been struck off the register and that they are aware of the hearing today.

You outlined to the panel your path to nursing and your professional career since you have been struck off the register. You stated that you first started working as a lorry driver and that you remained in that line of profession for four and a half years. However, you told the panel that you had an experience where you helped a person while waiting for an ambulance and that this event reminded you how much you miss caring for people and that this was your passion. You told the panel that after that incident you decided to apply for positions as a carer in a Home and that you have since moved up to the position of senior carer. You explained that this is very fulfilling, but that you miss the responsibility of being a nurse, helping others not only the patients but also being a mentor for colleagues and junior staff.

You explained to the panel your personal circumstances and health issues at the time of your misconduct. You acknowledged that you were not doing well at that time and that accepted that you should have sought help. You accepted that at the time of your misconduct including dishonesty you were [PRIVATE}. You expressed remorse about your behaviour and explained how you would do things differently now. You told the panel that your situation now has changed, [PRIVATE]. You also stated that you have a support network that is available to you and that your wife plays a dominant role in this.

[PRIVATE]. You told the panel how you deal with this and what coping mechanisms you have in this regard to ensure that your work is to the required standard.

You told the panel that as a senior carer you also have responsibility to administer medication. You told the panel about two recent medication errors and how you dealt with these. You stated that you were immediately open and honest with the patient, their family, your colleagues and your employer. You followed the necessary procedures and reflected on these errors and have remediated these.

You explained to the panel why you are passionate about nursing and why you want to have your registration restored. You stated that you want to grow, prove yourself, lead

and take on the responsibility that comes with the position of a registered nurse. You stated that it was not until you returned to working in the role as carer that you realised how much you missed being a nurse. You acknowledged that whilst being a carer still involves caring for people, being a registered nurse would enable you to assist patients and residents about other aspects in their lives that you are not able to at the moment.

You acknowledged that you now recognise how important honesty and transparency is and that it is the 'cornerstone' of nursing and caring for people. You stated that it is most important as the profession of nursing requires a level of trust and that dishonesty can damage the trust of the public and the public's trust in the profession and the NMC as a regulator.

When asked by Ms Brown what skills you can add to the nursing profession you replied that you are open, honest and transparent at all times, you know how to utilise your skills and how to transfer your experience as a carer. You stated that you can use your skills as a guide not only for yourself but also colleagues. You stated that you would ensure that people value the importance of nursing.

You explained that the nursing home you are currently employed with is supportive of your endeavour, and agreed to support you should you regain your nurse registration and will continue to support you. You explained to the panel that you have informed yourself about return to practice courses in your area and that you have found two potential universities that offer courses starting shortly. However, you stated that you have not yet applied as you were awaiting the results of today's hearing.

Ms Brown submitted that you have had time to reflect and have demonstrated remorse. She commended that you have demonstrated significant insight and remediation. Ms Brown submitted that you have completed training within the restrictions of a care assistant and have shown your commitment to the nursing profession. She submitted that you reflected on medication errors you have made as a carer and that you understand the impact of your current actions and that of the past.

Ms Brown further acknowledged that the testimonials and references provided show that you are a valuable member of society, that you are committed to returning to nursing and that you were transparent about the reasons as to why you were struck of the register.

Ms Brown submitted that it is for the panel to consider if it is satisfied that you are a fit and proper person to practise as a registered nurse. She further submitted that, should your application be granted, it is a matter for the panel to determine whether you should be subject to a conditions of practice order in addition to satisfying the NMC's return to practice standards.

Mr Renton acknowledged that dishonesty is difficult to remediate. However, he submitted that you have provided ample evidence that you are now an open, honest and transparent person. He submitted that you have reflected on yourself and your actions and acknowledge that you made gross errors during a difficult time in your life, however, you have been growing as a person. Mr Renton asked the panel to complete this process by allowing you to return to the profession you love.

Mr Renton summarised your journey of self-development and reflection and submitted that you have taken great steps to remediate your misconduct in relation to honesty and integrity. He submitted that your journey is documented by the positive testimonials and references that speak highly of you as a carer.

Mr Renton submitted that the panel can be assured that you are a fit and proper person to be readmitted to the register. He submitted that were you readmitted you would be a valued member of the profession and that it would be in the interest of the public to return a fit and proper nurse to the register.

Mr Renton submitted that the evidence does not suggest that a conditions of practice order would be required as you are planning on taking a return to nursing course. However, he submitted that it is a matter for the panel to determine.

Decision on the application for restoration

The panel has considered your application for restoration to the NMC register carefully. It has decided to allow the application subject to satisfying the NMC's return to practice standards as set out in Article 19(3).

In reaching its decision the panel recognised its statutory duty to protect the public as well as maintain public confidence in the reputation of the profession, which includes the declaring and upholding of proper professional standards. The panel bore in mind that the burden was upon you to satisfy it that you are a fit and proper person who is able to practise safely and effectively as a nurse.

The panel noted that you resumed working in the healthcare sector in 2019 and have been working as a carer for over two years now. It noted the references and testimonials that speak highly of you and your honesty. The panel was of the view that this demonstrates that you have been able to overcome your past behaviour and work with honesty and integrity. The panel also noted that you have been open and honest about your fitness to practise history and disclosed this to your employer. It was of the view that you are adhering to the standards of honesty expected of a registered nurse.

The panel heard from you explaining the mechanisms you have put in place should you find yourself in a similar situation, but also how to check the quality of your work whilst dealing with… [PRIVATE]. The panel was of the view that you were able to explain how you found yourself to be dishonest in the first place and that you had good insight into the circumstances that affected you. It noted that you were able to explain how you would now act differently, recognise your triggers and seek support from your personal support network, peers and your managers and would be open and honest under any circumstances.

The panel noted that you have told it that you have made two medication errors whilst working as a carer, that you were open and honest with your employer and that you were transparent in informing the panel about these errors.

In the panel's judgement, the extent to which you have demonstrated insight and remorse in your reflective piece and your oral evidence is commendable. The panel concluded that due to all your reflection, self-awareness and training you have gained full insight into your failings.

The panel noted the training certificates provided by you and determined that you have taken steps to keep up to date with current nursing practices and medication training whilst you were working as a carer.

In light of this and your fully developed insight, this panel determined that you are now not liable to repeat matters of the kind found proved.

In the panel's judgement, the extent to which you have demonstrated insight and remorse in your reflective piece and your oral evidence is commendable. The panel concluded that due to all your learning, reflection and admissions you have gained full insight into your failings.

The panel considered granting the application subject to a Conditions of Practice Order. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. However, it was of the view restricting your practice would not address the nature of your misconduct and that therefore conditions of practice would not be workable nor would they serve a useful purpose. The panel was of the view that a return to practice course or equivalent would be a robust framework to support your return to nursing and that in doing so you would receive support from a manager and/or supervisor in any case.

In determining to grant your application for restoration the panel bore in mind that you have not practised as a registered nurse since 2015 and that you no longer meet the requirements for registration with the NMC on this basis. However, the panel determined to allow your application for restoration subject to satisfying the NMC's return to practice standards and paying the prescribed fee which satisfies the requirements of Article 19(3) and Article 33(7)(a). This article states:

‘*The Council may by rules require persons who have not practised or who have not practised for or during a prescribed period, to undertake such education or training or to gain such experience as it shall specify in standards.”*

“(7) On granting an application for restoration, the Committee—

(a) shall direct the Registrar to register the applicant in the relevant part of the register on his satisfying any requirements imposed under paragraph (6) and on payment of the prescribed fee; and'

That concludes this determination.

This decision will be confirmed to you in writing.