Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
17 – 21 January 2022

Virtual Hearing

Name of registrant:	**Garikayi Bwerinofa**
NMC PIN:	99E0227E
Part(s) of the register:	Registered Nurse – Sub Part 1 RNMH: Mental Health – 20 May 2002
Area of registered address:	West Sussex
Type of case:	Misconduct
Panel members:	Nicola Jackson (Chair, Lay member) Susan Tockley (Registrant member) Claire Cheetham (Lay member)
Legal Assessor:	Fiona Moore
Hearings Coordinator:	Jumu Ahmed
Nursing and Midwifery Council:	Represented by Mary Ellen Stewart, Case Presenter
Mr Bwerinofa:	Not present and not represented
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e, 2 and 3.
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Bwerinofa was not in attendance and not represented and that the Notice of Hearing letter had been sent to Mr Bwerinofa's registered email address on 13 December 2021. In all, a number of letters and emails were sent, and an attempted phone call was undertaken as well as an address trace process.

Ms Stewart, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and GoToMeeting link of the virtual hearing and, amongst other things, information about Mr Bwerinofa's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Bwerinofa

The panel next considered whether it should proceed in the absence of Mr Bwerinofa. It had regard to Rule 21 and heard the submissions of Ms Stewart who invited the panel to continue in the absence of Mr Bwerinofa. She submitted that Mr Bwerinofa had voluntarily absented himself.

Ms Stewart submitted that there had been no engagement at all by Mr Bwerinofa with the NMC in relation to today's proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor who referred to the relevant legal principles.

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

- No application for an adjournment has been made by Mr Bwerinofa;
- Mr Bwerinofa has not engaged with the NMC and has not responded to any of the letters or emails sent to him about this hearing;
- There is no reason to suppose that an adjournment would secure his attendance at some future date;
- 2 witnesses are scheduled to attend today to give live evidence, 1 witness is due to attend tomorrow;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and

- There is a strong public interest in the expeditious disposal of the case.

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

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

Details of charge

That you, a registered nurse,

1. On or around 6 June 2019:

    a) administered to Patient A, a dose of Flupentixol, by injection, which was not due until 13 June 2019; **[PROVED]**

    b) failed to follow the correct procedure for administering Flupentixol, in that you did not have a second member of staff check before administering depot injection medication; **[PROVED]**

c) failed to record that you administered Flupentixol to Patient A on 6 June 2019; **[PROVED]**

d) deleted an entry dated 13 June 2019 from Patient A's medication administration record; **[PROVED]**

e) failed to immediately report the early administration of Flupentixol injection to the nurse in charge and/or the ward manager. **[PROVED]**

2. Your actions at charge 1e) were contrary to your duty of candour. **[PROVED]**

3. Your actions at 1c) and/or 1d) were dishonest in that you sought to conceal your error of early administration of Flupentixol by injection, to Patient A. **[PROVED in relation to 1c only]**

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Stewart under Rule 31 to allow the written statements of Mr 1, Ms 2, and Ms 3 into evidence. She submitted that the statements refer to previous oral statements made by Mr Bwerinofa in relation to comments made to his manager, and to that extent are hearsay. She submitted that Mr Bwerinofa had received notice of the hearing and the bundles that the NMC will rely on. In his absence in the proceedings, she submitted that Mr Bwerinofa had an opportunity to make a response to those comments but has chosen not to.

Ms Stewart invited the panel to admit the hearsay evidence and to allow questions to be asked concerning the witness's oral testimonies. She submitted that there would be no

prejudice as the hearsay evidence does not regard a party who was not invited to take part in this hearing.

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

The panel gave the application serious consideration. The panel noted that all the witness statements had been prepared in anticipation of being used in these proceedings and contained the paragraphs, *'This statement … is true to the best of my information, knowledge and belief'* and signed by each witness.

The panel considered whether Mr Bwerinofa would be disadvantaged by the panel's decision to allow hearsay testimony into evidence. However, it considered that Mr Bwerinofa had been provided with a copy of all the statements and the NMC bundle. As the panel had already determined that Mr Bwerinofa had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine these witnesses in any case.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Mr 1, Ms 2, and Ms 3, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

On 21 June 2019, the NMC received a referral about Mr Bwerinofa's fitness to practise from The Priory Hospital. At the time of the concerns raised, Mr Bwerinofa was working as a Locum Registered Mental Health Nurse. The agency for this placement was TXM Healthcare Ltd.

On 6 June 2019, Mr Bwerinofa administered a depot injection to Patient A. This injection was prescribed on a fortnightly basis and was not due until 13 June 2019. It was, therefore, administered a week early.

On the day in question, Mr Bwerinofa was on shift on the ward, along with Ms 2, a trainee nurse who he was supervising for the morning medication round. Ms 2 was not permitted to administer injections without supervision from a registered nurse. Ms 2 checked patient records to determine who was due an injection that day. She divided the charts into those of patients who were due injections and those who were not.

In her evidence, Ms 3 stated that Mr Bwerinofa had reported to her that Ms 2 had handed Patient A's medication chart to him along with the other patients' charts for injections, and that this was why he had given the patient the depot early. Ms 2 in her evidence stated that Mr Bwerinofa double checked the medication charts she had organised and had then realised that Patient A was not due his medication that day. She also stated that Mr Bwerinofa then transferred Patient A's medication chart into the other pile, containing charts for patients not scheduled to receive an injection that day. Ms 2 was not present at the time that the depot injection was given.

The panel heard evidence that the proper procedure was for the nurse to sign the Medication Administration Record (MAR) chart on the appropriate date when they administered the depot injection. The administering nurse should also cross check the details of the depot injection, such as its name and correct dosage, with another Registered Mental Health Nurse. When asked why he had not done this by Ms 3, Mr Bwerinofa stated that he was unaware of this practice policy.

On Patient A's MAR chart, a rectangle was drawn around the date 13 June 2019. This was to indicate when the next injection was due. It is alleged that Mr Bwerinofa signed Patient A's chart next to 13 June 2019 and that he subsequently crossed out the signature

when he realised his mistake. He did not re-sign the chart to show that the drug was administered on 6 June 2019, or at all.

On 10 June 2019, Mr 1 was completing the multi-disciplinary team (MDT) ward round with a consultant psychiatrist, when Patient A disclosed that he had been given his depot injection the previous week and was not due another one. In his evidence, Mr 1 stated that he went to check the patient's MAR chart and that Mr Bwerinofa followed him and told him that he had given Patient A his depot injection earlier than it should have been given. Mr 1 then reported this to the ward manager.

Despite the injection being administered too soon, the overall dosage remained within therapeutic guidelines. The panel heard evidence that Patient A suffered no harm as a result.

Decision and reasons on facts

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

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

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

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

- Mr 1: Registered Mental Health Nurse and Charge Nurse at the Priory Hospital at the relevant time;

- Ms 2: Student Nurse Associate at the Priory Hospital at the relevant time;

- Ms 3: Registered Mental Health Nurse and ward manager at the Priory Hospital at the relevant time.

The panel also received in evidence written statements from Mr 1, Ms 2, and Ms 3.

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

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

Charge 1a)

That you, a registered nurse, on or around 6 June 2019:

a) administered to Patient A, a dose of Flupentixol, by injection, which was not due until 13 June 2019;

This charge is found proved.

In consideration of this charge, the panel had regard to Mr 1's and Ms 3's oral evidence and written statements. The panel also had regard to the 'Safeguarding Referral form' which was completed by Ms 3 on 17 June 2019.

The panel took into account Mr 1's oral evidence where he had stated that Patient A had informed him and the consultant psychiatrist about the depot injection being administered.

He then went to the clinic room to check on the MAR chart. He told the panel that Mr Bwerinofa had followed him into the room and informed him that he had administered the depot injection on 6 June 2019.

The panel also took into account Ms 3's evidence where she told the panel that Mr Bwerinofa had told her that he had written his initials in the box on the MAR chart corresponding to the date of 13 June 2019 and then crossed it out.

The panel was of the view that the oral evidence by Mr 1 and Ms 3 were consistent as it was said by both witnesses that Mr Bwerinofa had admitted having administered the depot injection on 6 June 2019, which was earlier than the due date. It was also of the view that both Mr 1 and Ms 3 were consistent in their oral evidence and in their written statements, in that Patient A first reported on 10 June 2019 that the injection had already been administered on 6 June 2019, which was earlier than the due date of 13 June 2019.

Moreover, the panel bore in mind the absence of a marking to show that the depot injection had been administered on 6 June 2019 in the MAR chart. It also bore in mind that there was a marking which had been scribbled out on the 13 June 2019 entry on the MAR chart.

The panel was therefore of the view, that on the balance of probability, it is more likely than not that on or around 6 June 2019, Mr Bwerinofa administered a dose of Flupentixol to Patient A by injection, which was not due until 13 June 2019.

Charge 1b)

That you, a registered nurse, on or around 6 June 2019:

b) failed to follow the correct procedure for administering Flupentixol, in that you did not have a second member of staff check before administering depot injection medication;

This charge is found proved.

In reaching this decision, the panel took into account Mr 1's and Ms 3's oral evidence and written statements, the Priory Healthcare Medicine and Management Policy and Mr Bwerinofa's competency framework.

The panel bore in mind Ms 3's evidence that Mr Bwerinofa told her on 10 June 2019 that he did not know that a second registered nurse needed to check the administration of medication when being questioned about it that day. The panel considered Mr 1's and Ms 3's evidence on the procedure and practice. This was to have a second registered nurse to check whether a medication should be administered, and the details of that particular medication such as the dose.

The panel took into account Mr 1's oral evidence where he informed the panel that it is standard practice to have another registered nurse to check the depot injection which is to be administered. He informed the panel that Mr Bwerinofa should have come to him and asked him to check, but that he did not. The panel had regard to Mr 1's written statement which states:

> *'It is standard procedure on the ward that all depots must be checked by two Registered Mental Health Nurses before being administered. On that day, the Registrant did not check with me when this was standard procedure. I am not sure why he did not check with me, he should have been aware of the procedure.'*

The panel also took into account Ms 3's oral evidence where she stated that it is standard practice on the ward to have another registered nurse check before administering medication. The panel bore in mind Mr Bwerinofa's competency training record, which was 'ticked' as completed by Ms 3 on the section stating *'assure cross checking/double checking of medication against prescription as per medicines code'*. It took into account Ms 3's evidence that such medication would have included the drug Flupentixol, and that

Mr Bwerinofa had completed his competency training on medication administration. He therefore would have been aware of what the correct procedure was.

The panel was of the view that Mr 1 and Ms 3's evidence was consistent in that it was standard procedure in the ward to have a second registered nurse cross check depot injections before administration. The panel determined that Mr Bwerinofa knew that this was expected of him, especially taking into account the competency training record.

Further, the panel took into account Mr 1's oral evidence where he stated that Mr Bwerinofa had asked him to check other depot injections before administration prior to this incident.

The panel noted that Mr 1 spoke highly of and in support for Mr Bwerinofa and had stated that *"his heart sank"* when discovering that Mr Bwerinofa had put himself in this position. Mr 1 described him as *"a good nurse"*, *"good with patients"* and *"always professional."*

The panel took into account the Priory Healthcare Medicine and Management Policy. On 6.6, it states:

> *'The medicines shall be administered according to local procedure, with the professional ascertaining that the prescription is unambiguous, the medicines have not already administered, the identity of the patient is correct, […]'.*

The panel was therefore of the view, that on the balance of probability, it is more likely than not that Mr Bwerinofa had the knowledge of the correct procedure and had failed to follow it as he did not have a second member of staff check before administering depot injection medication to Patient A.

Charge 1c)

> That you, a registered nurse, on or around 6 June 2019:

c) failed to record that you administered Flupentixol to Patient A on 6 June 2019;

This charge is found proved.

In reaching this decision, the panel took into account Mr 1's evidence, Ms 3's evidence, and Patient A's MAR chart.

The panel took into account Mr 1's oral evidence. He told the panel that Mr Bwerinofa had admitted to administering the depot injection in error on 6 June 2019. The panel noted that this was consistent with Mr 1's written statement:

> *'I retrieved the patient's medication chart to check when he had received his injection. I then went to the treatment room, and the Registrant followed me in. When I looked at the patient's medication chart, I believe something had been crossed out and changed however I cannot remember exactly.'* [sic]

The panel also took into account Ms 3's oral evidence. She stated that Mr 1 had informed her that Mr Bwerinofa had admitted to him that he had administered the depot injection early. This was confirmed in the safeguarding concern form Ms 3 had completed and in her written statement:

> *'I went to look for the patient's drug chart. As I was doing this, I saw another RMN, […] told me that the Registrant had just informed him that he had given Patient A his depot injection early. The Registrant had told […] that he did not tell anyone about this because he was scared, but was concerned that the patient would be given another dose […] I received the patient's drug chart and could see that the Registrant had not signed in the appropriate box to indicate he had given Patient A his depot injection.'*

The panel took into account Patient A informing Mr 1 and Ms 3 of the early administration of the depot injection. It also took into account the MAR chart, where it showed that the depot injection being administered by Mr Bwerinofa was not signed for on 6 June 2019. The panel noted that the MAR chart covered the full date range and exhibited that there had been an entry for 13 June 2019, but this was scribbled out.

The panel was of the view that the evidence given by Mr 1 and Ms 3 was consistent. The panel considered Patient A reporting to Mr 1 and Ms 3, though as hearsay, as credible evidence that the depot injection was administered.

The panel was therefore satisfied that on the balance of probability, Mr Bwerinofa failed to record that he had administered Flupentixol to Patient A on 6 June 2019.

Charge 1d)

That you, a registered nurse, on or around 6 June 2019:

d) Deleted an entry dated 13 June 2019 from Patient A's medication administration record;

This charge is found proved.

In reaching this decision, the panel took into account Ms 3's oral evidence where she stated that Mr Bwerinofa had told her that he scribbled his initials out when he realised that it was the wrong date. It had regard to Ms 3's written statement:

'[…] There is a pen scribbled through this section of the chart, as the Registrant had signed for the drug, and crossed this out when he realised this was not the correct date. A nurse should always sign when a drug is administered […]'

The panel had regard to Mr 1's written statement which said:

'[…] When I looked at the patient's medication chart, I believe something had been crossed out and changed however I cannot remember exactly.' [sic]

The panel also took into account the Safeguarding Referral form completed on 17 June 2019, which states:

'Patient A was given his depot medication a week earlier than prescribed an error which was not disclosed or escalated by staff GB. Staff GB signed wrong date 15.6.19 [sic] *on the chart and the scribbled but did not sign for giving the deport on the 6.6.19 hence there was no documentation that Patient was given the depot injection. Staff GB was interviewed by […] ward consultant […] ward manager in the presence of Charge Nurse […] where he stated that when he realised that he had made an error by giving the depot a week earlier he panicked and did not know what to do that was the reason why he scribbled on the signed date since he could not sign for future date and left it.'* [sic]

The panel was of the view that the oral evidence is consistent between Mr 1, Ms 3 and is corroborated by the written evidence. The panel was therefore of the view, that on the balance of probability, it is more likely than not that that Mr Bwerinofa deleted an entry on 13 June 2019 from Patient A's medication administration record.

Charge 1e)

That you, a registered nurse, on or around 6 June 2019:

e) failed to immediately report the early administration of Flupentixol injection to the nurse in charge and/or the ward manager.

This charge is found proved.

In reaching this decision, the panel took into account Mr 1 and Ms 3's oral evidence and written statements.

It had regard to Mr 1's oral evidence where he told the panel that on a date after 6 June 2019, he had a meeting with Patient A and the consultant. After Patient A had reported to him and the consultant that the depot injection was administered, Mr 1 had gone to the clinic room to check the MAR chart. He told the panel that Mr Bwerinofa had followed him to the clinic room and told him that he had administered the depot injection early. Mr 1 told the panel that he had asked Mr Bwerinofa as to why he did not tell him immediately, and the response was that he was worried and panicked. This was corroborated in Mr 1's written statement where he stated:

> *'I first because aware, approximately a week after 6th June, that Patient A had been given his depot injection of Flupenthixol early. I think I was completing the MDT ward round with a consultant when the patient disclosed that he had received it the previous week […] I retrieved the patient's medication chart to check when he had received his injection. I then went to the treatment room, and the Registrant followed me in […] The Registrant then pulled me to the side in the treatment room and told me that something had been bothering him. He informed me that he had given Patient A his depot injection earlier than it should have been given.'* [sic]

It also had regard to Ms 3's written statement: *'The Registrant had told* Mr 1 *that he did not tell anyone about this because he was scared, but was concerned that the patient would be given another dose.'* [sic]

The panel was of the view that the oral evidence is consistent between Mr 1, Ms 3 and is corroborated by the written evidence. Therefore, on the balance of probability, the panel finds that Mr Bwerinofa had failed to immediately report the early administration of Flupentixol injection to the nurse in charge and/or the ward manager.

Charge 2

That you, a registered nurse, on or around 6 June 2019:

2. Your actions at charge 1e) were contrary to your duty of candour;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 1 and Ms 3's oral evidence and written statements. The panel also took into account section 14 of the NMC's code.

The panel bore in mind section 14 of the NMC's code: *'Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place'.*

The panel determined that openness in the healthcare setting is significantly important, as there is a great risk of potential harm if errors are not reported. It is a nurse's duty to recognise that errors may take place and, if so, should be dealt with promptly in order to protect patients.

The panel took into account Mr 1's written evidence which stated:

> *'The Registrant then pulled me to the side in the treatment room and told me that something had been bothering him. He informed me that he had given Patient A his depot injection earlier than it should have been given. The Registrant seemed visibly shaken at this point. I asked the Registrant why he had not told me this sooner. I am not sure when exactly the Registrant had realised his mistake, however he told me that he had panicked. He repeatedly told me that he had been panicking about this.*'

The panel had regard to Ms 3's oral evidence which corroborated with her written statement which stated '*The Registrant had told […] that he did not tell anyone about this because he was scared [...]'.*

The panel also took into account the Safeguarding Referral form completed on 17 June 2019, which stated: *'Patient A was given his depot medication a week earlier than prescribed an error which was not disclosed or escalated by staff GB. Staff GB signed wrong date 15.6.19* [sic] *on the chart and the scribbled but did not sign for giving the deport on the 6.6.19 hence there was no documentation that Patient was given the depot injection. Staff GB was interviewed by […] ward consultant […] ward manager in the presence of Charge Nurse […] where he stated that when he realised that he had made an error by giving the depot a week earlier he panicked and did not know what to do that was the reason why he scribbled on the signed date since he could not sign for future date and left it.'* [sic]

The panel determined that Mr Bwerinofa had known that he had administered the depot injection early and he would have known that he had a duty to report the error but did not comply with this duty. The error came to light when Patient A informed Mr 1, Ms 3, and the consultant in a meeting on 10 June 2019 that he had already had the depot injection. It is unclear as to when Mr Bwerinofa had realised that he had made an error, but from the comprehensive evidence before the panel, it determined that it was between 6 and 10 June 2019. This is corroborated by the evidence of Mr 1 and Ms 3 that on 10 June 2019 they had discovered that the entry had been scribbled out on the MAR chart for 13 June 2019.

As Charge 1e was found proved, the panel determined that the act of Mr Bwerinofa scribbling out the entry indicates that he knew he had made a mistake. It was the duty of Mr Bwerinofa to report the error.

The panel was therefore of the view, that on the balance of probability, it is more likely than not that Mr Bwerinofa's actions at Charge 1e) was contrary to his duty of candour.

Charge 3)

That you, a registered nurse, on or around 6 June 2019:

3. Your actions at 1c) and/or 1d) were dishonest in that you sought to conceal your error of early administration of Flupentixol by injection, to Patient A.

This charge is found proved in relation to 1c only.

In reaching this decision, the panel took into account Ms 3 evidence.

The panel had regard to Ms 3's written statement, which stated:

> *'[…] By way of explanation as to why he had not reported the early administration of the injection, the Registrant repeatedly told me that he had panicked. He said that when he realised the depot had not been due on that date, he told a healthcare worker what had happened, who told him to report this to the nurse in charge. The Registrant failed to do this immediately however.'* [sic]

Having found Charge 1c proved, the panel determined that Mr Bwerinofa had failed to record that he administered Flupentixol to Patient A on 6 June 2019. The panel determined that Mr Bwerinofa could have corrected the record of the administration of the depot injection at a time before 10 June 2019 when the error was discovered, but chose not to.

The panel determined that Mr Bwerinofa would have known, as an experienced nurse, that he must correctly record all drug administration as it allows other colleagues to keep up to date with the care of the patient and to protect patients from harm. In the absence of a marking to show that the depot injection had been administered on 6 June 2019, Mr Bwerinofa omitted to record the error he had made. Further, Mr Bwerinofa continued to not

record that error between 6 June 2019 and 10 June 2019 and this error only came to light when Patient A told Mr 1 and Ms 3 on 10 June 2019. The panel determined that the failure to record the error on Mr Bwerinofa's part was a conscious decision and therefore constituted dishonesty.

In relation to Charge 1d, the panel was of the view that Mr Bwerinofa, in deleting the entry dated 13 June 2019 from Patient A's medication administration record, was correcting an incorrect entry. The panel determined that as Mr Bwerinofa did not administer the depot injection on 13 June 2019, deleting that incorrect entry was not a dishonest act.

The dishonest act was the failure to record the erroneous depot injection on 6 June 2019, which the panel has already found proved Charge 1c.

The panel was therefore satisfied that, on a balance of probabilities, that Mr Bwerinofa failing to record that he administered Flupentixol to Patient A on 6 June 2019 was dishonest in that he sought to conceal that error. Therefore, the panel finds this charge proved.

Fitness to practise

Having reached its determination on the facts, the panel then moved on to consider whether the facts found proved amount to misconduct and if so, whether Mr Bwerinofa's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Bwerinofa's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

Ms Stewart submitted that Mr Bwerinofa's actions fell significantly short of the standards expected of a registered nurse. She submitted that the initial errors in the depot injection administration made by Mr Bwerinofa were due to him not adhering to guidance and standard practice, which was to get a registered nurse to check the details before any administration of depot injection. The reasons for his noncompliance were not relevant as the guidance is not there for best or optimum practice, but to be complied with at all times to ensure patient safety and public confidence. Ms Stewart submitted that safe administration of medication and appropriate record keeping are fundamental areas of safe nursing practice.

Ms Stewart referred the panel to section 18 of the Code and submitted that in relation to Charge 1a and 1b, Mr Bwerinofa fell short of the standard expected of him as safe administration of medication and appropriate record keeping are fundamental skills that a

nurse should have. She submitted that Mr Bwerinofa did not adhere to the guidance or standard procedure for administering the depot injection.

In relation to Charge 1c and 1d, Ms Stewart submitted that a nurse's duty is to keep clear and accurate records that are relevant to their practice. She submitted that it is an essential part of a nurse's duty to ensure patient safety and to ensure public confidence. Further, she submitted that in deleting an entry from the MAR chart, Mr Bwerinofa was not keeping an accurate record. She submitted that these actions went against section 10 of the Code.

In relation to Charge 1e, Ms Stewart submitted that Mr Bwerinofa's action in failing to immediately report to the charge nurse or ward manager that he had administered the depot injection early went against section 14 of the Code. She submitted that Mr Bwerinofa had a duty to be open and candid about the error he had made. Failing to do this, at a time when it was of the upmost importance and urgency, resulted in a delay of any necessary treatment for Patient A. This could have had an impact on Patient A's safety and their wellbeing.

Ms Stewart submitted that Mr Bwerinofa, in failing to report that he had administered the depot injection early, was contrary to his duty of candour, relating to Charge 2. She submitted that as a result of his failure, Patient A could have received another dose of Flupentixol on 13 June 2019 when it had been originally due. There was a marking made on the MAR chart for 13 June 2019 for the depot injection originally to be administered. This did not happen as the error was discovered on 10 June 2019 when Patient A told the consultant psychiatrist, Mr 1, and Ms 3 that it had been administered early. However, this could have potentially happened, and actual harm could have been caused.

In relation to Charge 3, Ms Stewart referred the panel to sections 1, 7 and 14 of the Code. She submitted that ordinary and decent people would find Mr Bwerinofa's action of concealing his error, of administering the depot injection early, to be dishonest.

In light of all this, Ms Stewart submitted that Mr Bwerinofa's actions fell far below those standards expected of a registered nurse and are sufficiently serious to constitute misconduct.

Submissions on impairment

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

Ms Stewart submitted that Mr Bwerinofa, in failing to ask another registered nurse to check the depot injection before he administered it, was misconduct serious enough to mean that he is impaired. She submitted that in administering the depot injection before it was due means that his practice is impaired.

However, she submitted that the most serious aspect of all the charges is in relation to Mr Bwerinofa failing to uphold his duty of candour and concealing his error. She submitted that this lack of candour and concealment happened at various stages. She submitted that it happened when Mr Bwerinofa failed to mark on the MAR chart that he administered the depot injection on 6 June 2019, when he crossed out an entry on 13 June 2019, and when he failed to tell the charge nurse or ward manager of his error. She submitted that this concealment continued for four days. This only came to light when Patient A had told the consultant psychiatrist, Mr 1, and Ms 3 in a medication round on 10 June 2019. She submitted that had there not been a coincidence of each of these aspects coming together, Mr Bwerinofa's error might not have been discovered. She submitted that it took Mr 1 and Ms 3 looking for the MAR chart and effectively starting an investigation for the error to be discovered. Only when the error was on the cusp of being discovered, had Mr Bwerinofa disclosed the error.

Ms Stewart submitted that Mr Bwerinofa failed to note on the MAR chart that he had administered the depot injection on 6 June 2019, and in so doing, he had been dishonest. His actions risked the patient getting a further unnecessary dose, which could have caused actual harm. Mr Bwerinofa failed to inform the charge nurse or ward manager immediately of his error. In so doing, he ran the risk of causing Patient A harm. Ms Stewart submitted that Mr Bwerinofa had opened up further risks to Patient A if he had suffered from ill effects from the early dose. She submitted that the error may not have ever been discovered if it had not been disclosed by Patient A. If Mr Bwerinofa had reported the error, actions could have been taken for immediate treatment and to safeguard Patient A's health and wellbeing.

Ms Stewart submitted charges 1c, 1d, 1e, 2 and 3 relate to the actions Mr Bwerinofa took and actions he did not take. She submitted that the fact that Mr Bwerinofa's failings were omissions and not a commission does not affect the seriousness of what has been done or not done.

Ms Stewart referred the panel to the case of *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and submitted that misconduct incudes acts or omissions which fall short of what is proper in the circumstances. She submitted that Mr Bwerinofa is impaired as he deliberately tried to cover up the error of administering the depot injection, which seriously undermined Patient A's safety and damaged public trust in the profession. She further submitted that the regulatory concerns are serious, and it raises concerns about Mr Bwerinofa's trustworthiness as a registered professional.

Ms Stewart submitted that Mr Bwerinofa's fitness to practise must be gauged by looking at his past conduct and how he is likely to behave in the future. When considering whether Mr Bwerinofa's misconduct impairs his practice, it is necessary to determine whether any impairment present at the time of the incident is still present today. In this regard, Ms Stewart submitted that Mr Bwerinofa had not engaged with the NMC process nor with this substantive hearing. She submitted that the panel had no information and had heard no evidence concerning Mr Bwerinofa's insight into the matter. She submitted that the panel

did not have any evidence of any remediation with regard to the regulatory concerns. Further, there is no evidence from Mr Bwerinofa to confirm that the concerns have been remedied and that the conduct will not be repeated.

In light of the above, Ms Stewart invited the panel to find Mr Bwerinofa's fitness to practise as a registered nurse as currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *General Medical Council v Meadow* [2007] QB 462 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Decision and reasons on misconduct

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

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

> ***'2 - Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
>
> *2.5 - respect, support and document a person's right to accept or refuse care and treatment*
>
> ***10 - Keep clear and accurate records relevant to your practice***
>
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*

To achieve this, you must:

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

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

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

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

14 - Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1- act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

14.2 - explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 - document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

To achieve this, you must:

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

20 - Uphold the reputation of your profession at all times

To achieve this, you must:

20.2 - act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it determined that Mr Bwerinofa's failings and dishonesty amounted to misconduct.

The panel considered that Mr Bwerinofa's failings and omissions which included dishonesty and a lack of duty of candour demonstrated significant departures from the standards expected of a registered nurse. The panel considered that nurses may make errors, but it is their duty to report that error, in order to protect the patient. Mr Bwerinofa knew that he had made an error by administering the depot injection on the 6 June 2019, which was a week earlier than when it was due. He did not disclose this error to the ward manager nor the nurse in charge as soon as he realised. It had only come to light when Patient A disclosed this information to the consultant psychiatrist, Mr 1, and Ms 3 when reviewing his medication. The panel had found Mr Bwerinofa had misled colleagues by failing to report the error made on 6 June 2019. There was no harm caused to Patient A, but had there been, this would have resulted in a delay in treating him which could have potentially caused actual harm.

The panel considered that Mr Bwerinofa, in deleting an entry on the MAR chart on 13 June 2019, may have been attempting to correct an incorrect entry. It considered that, if Patient A had not told the consultant psychiatrist, Mr 1, and Ms 3 about having had the depot injection early, and had a review meeting not taken place on 10 June 2019, Patient A could have been given another depot injection on 13 June 2019, when it had originally been due.

Further, the panel bore in mind that Mr Bwerinofa was an experienced nurse who had the knowledge of the standards expected of him as a registered mental health nurse. The panel considered that it was Mr Bwerinofa's duty to identify and report such errors immediately. It determined that in Mr Bwerinofa making an attempt to conceal that error by failing to record the entry on 6 June 2019 on the MAR chart, and *"scribbling"* out an entry on 13 June 2019, the level of dishonesty shown by Mr Bwerinofa was not at the lower end of the spectrum of seriousness.

Therefore, the panel determined that Mr Bwerinofa's failure to record and report the error put a vulnerable patient at real risk of significant harm. It also determined that his actions in Charges 1a, 1b, 1c, 1d, 1e, 2 and 3 did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct. Further, it also determined that Mr Bwerinofa's misconduct would not promote and maintain public confidence in the nursing profession.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust,

nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

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

The panel determined that all four limbs of the Grant test were engaged in this case.

The panel finds that Patient A was put at a real risk of harm as a result of Mr Bwerinofa's misconduct. Whilst there is no evidence to suggest that Mr Bwerinofa's actions caused actual harm to Patient A, his dishonesty and failure to report his error prevented the potential for other intervention to be made in respect of Patient A's care. Furthermore, having breached multiple provisions of the Code, the panel determined that Mr Bwerinofa's misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find Mr Bwerinofa's failures and omissions to constitute misconduct and the charges relating to dishonesty as serious.

The panel did not have any documentation or other evidence before it addressing Mr Bwerinofa's insight on the impact his actions could have had on Patient A, colleagues, the nursing profession and the wider public as a whole. Therefore, the panel was of the view that Mr Bwerinofa had not demonstrated any insight into the misconduct. The panel could not be satisfied, in the absence of any evidence, that Mr Bwerinofa understands and appreciates the seriousness of his failure to act appropriately and his dishonesty.

In considering whether Mr Bwerinofa had remediated his nursing practice, the panel noted that it did not have any information before it. It bore in mind that dishonesty is often more difficult to remediate than clinical concerns.

Therefore, in having regard to the above, the panel considered there to be no evidence to demonstrate that Mr Bwerinofa had remediated his misconduct, or whether he has any level of insight into the concerns identified. The panel also did not have any evidence to allay its concerns that Mr Bwerinofa may currently pose a risk to patient safety. In the

absence of any evidence to the contrary, it considered there to be a risk of repetition of Mr Bwerinofa's lack of candour and dishonesty and a risk of unwarranted harm to patients in his care, should adequate safeguards not be imposed on his nursing practice. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered there to be a public interest in the circumstances of this case. Whilst it noted that this was a one-off incident, the panel found that the charges found proved are serious and include dishonesty and a lack of duty of candour. It was of the view that a fully informed member of the public would be concerned by its findings on facts and misconduct. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mr Bwerinofa's fitness to practise as a registered nurse is currently impaired on the grounds of public protection and public interest.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mr Bwerinofa's registration has been suspended.

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

Submissions on sanction

The panel bore in mind that in the Notice of Hearing, dated 13 December 2021, the NMC had advised Mr Bwerinofa that it would seek the imposition of a strike off order if the panel found Mr Bwerinofa's fitness to practise currently impaired.

Ms Stewart submitted that the only suitable sanction was to impose a striking off order.

Ms Stewart submitted that neither taking no further action nor a caution order would be appropriate in the particular circumstances of this case due to the seriousness of the misconduct. She also submitted that proportionate and workable conditions of practice could not be formulated to mitigate the risk to patient safety. She submitted that a conditions of practice order is not appropriate in cases where the concerns include lack of candour and of dishonesty. She submitted that in the absence of clear and identifiable areas of clinical nursing practice which need to be addressed, a conditions of practice order would not be a sufficient or appropriate response as it would not reflect the severity of Mr Bwerinofa's misconduct.

Ms Stewart submitted that Mr Bwerinofa did not engage with the NMC process, from which a conclusion can be made that Mr Bwerinofa does not think that the matter is serious enough to warrant engagement. She submitted that Mr Bwerinofa did not provide any evidence to demonstrate that he has insight into the severity of his misconduct, whether he has taken steps to remediate the concerns and whether he had taken further training in medication management and administration. She submitted that Mr Bwerinofa has not sought to reassure the panel that his actions will not be repeated in future. Ms Stewart submitted that temporary removal from the NMC Register by way of a suspension order will not be sufficient nor appropriate in the particular circumstances of this case.

Ms Stewart submitted dishonesty charges are always serious. She invited the panel to have regard to the NMC guidance issued on dishonesty which gives pointers in assessing the severity of a registrant's dishonest conduct. She submitted that Mr Bwerinofa deliberately breaching duty of candour by concealing the error, as well as the vulnerability of the victim, are important factors to take into account when assessing seriousness.

Ms Stewart submitted that the dishonest conduct included Mr Bwerinofa trying to conceal an error in an acute setting in the hospital where patients are vulnerable. Further, she submitted that Mr Bwerinofa's dishonesty is difficult to remediate as it is directly linked to his practice and relates to a failure to record an entry on the MAR chart when the depot injection was administered on 6 June 2019. She submitted that the purpose of this action was dishonesty, and the motivation was concealment.

Ms Stewart submitted that the dishonesty persisted until Mr Bwerinofa's error was disclosed by Patient A, and when it was on the cusp of being discovered, it was only then when Mr Bwerinofa had confessed. Further, she submitted that the failure to report the error to the charge nurse and/or ward manager about the early administration of the depot injection was also motivated by the desire to conceal the error. She submitted that this is dishonesty of the most serious kind.

Ms Stewart, therefore, invited the panel to impose a strike off order.

The panel heard and accepted the advice of the legal assessor, who reminded the panel of the need to consider mitigating and aggravating factors, of the need to act proportionately, and that it should consider all sanctions starting with the least restrictive and working through until an appropriate and proportionate sanction was reached.

Decision and reasons on sanction

Having found Mr Bwerinofa'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 NMC Sanctions Guidance (the SG) and the guidance issued by the NMC on dishonesty. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The misconduct included a vulnerable patient in an acute setting.
- Mr Bwerinofa's misconduct put Patient A at a risk of harm.
- Mr Bwerinofa had breached his professional duty of candour and the trust of Patient A and his employer.
- There is evidence of dishonesty linked to his professional practice.

The panel took into account the following mitigating features:

- [PRIVATE].
- Positive comments regarding Mr Bwerinofa's practice previous to the incident.

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 Bwerinofa'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 Bwerinofa's

misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 Bwerinofa's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable, and workable.

As Mr Bwerinofa has not engaged with the NMC process, nor with this substantive hearing, the panel is of the view that there are no practical or workable conditions that could be formulated at this stage, given the nature of the findings and all the circumstances in this case. The panel has had no information to suggest that Mr Bwerinofa has insight into his misconduct, has remediated the concerns and whether he understands the impact his actions have had on Patient A's family, colleagues, and the nursing profession. Further, the panel determined that Mr Bwerinofa's misconduct which included dishonest conduct would be difficult to remediate. Therefore, the panel concluded that the placing of conditions on Mr Bwerinofa's registration would not adequately address the seriousness of this case. The panel determined that a conditions of practice order would not protect the public, nor would it satisfy the public interest considerations.

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:

- The seriousness of the misconduct requires a temporary removal from the NMC Register;
- A single instance of misconduct but where a lesser sanction is not sufficient;
- No evidence of harmful deep-seated personality or attitudinal problems;
- No evidence of repetition of behaviour since the incident.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register and that a suspension order would protect the public.

When considering seriousness, the panel determined that the level of seriousness was not at the lower end of the spectrum, nor was it at the top end of the spectrum.

The panel had regard to Ms 3's written statement, which stated:

[PRIVATE].

[PRIVATE].
However, it did not have further information on this.

The panel also had regard to Mr 1, Ms 2 and Ms 3's oral evidence stating that Mr Bwerinofa was a good and caring nurse. It had regard to Mr 1's written statement, which stated:

'I feel it relevant to mention that my prior experience of working with the Registrant had always been positive. He seemed to make every effort to support patients and was very eager to learn, since he had come from working in different type of setting.'

These sentiments were supported by evidence presented by the other witnesses who confirmed that they had had no previous concerns about Mr Bwerinofa's practice.

The panel determined that, albeit serious, Mr Bwerinofa's misconduct was not fundamentally incompatible with ongoing registration and that the public interest considerations can be satisfied by a less severe outcome than permanent removal from the NMC register. The panel did consider this to be a finely balanced decision, but it reminded itself that the purpose of a sanction is not to be punitive, and it decided that Mr Bwerinofa should be afforded the opportunity to demonstrate insight, remorse, and

remediation for his misconduct, having regard to the good comments given by the witnesses and the personal issues he may have been facing at the material time.

Taking account of all the information before it, and of the positive comments given by Mr 1 with regard to his previous practice, the panel determined that a striking-off order would be disproportionate in Mr Bwerinofa's case. It was of the view that Mr Bwerinofa's dishonesty was not motivated by personal gain. In making this decision, the panel carefully considered the submissions of Ms Stewart in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a striking off order at present would be disproportionate. The panel was of the view that the sanction of a maximum term of 12 months' suspension would satisfy the public protection and public interest concerns identified in this case.

Whilst the panel acknowledges that any sanction may have a punitive effect, it considered that it would be disproportionately punitive in Mr Bwerinofa's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction to mark the seriousness of Mr Bwerinofa's misconduct. It decided that public confidence in the nursing profession and the NMC can be maintained by the imposition of a suspension order for 12 months, subject to a review. The panel determined that this would give time for Mr Bwerinofa to address the concerns through engaging with the NMC, developing his insight, demonstrating remorse and remediation. The panel considered that a suspension for the maximum term of 12 months would satisfy the public interest in this case.

The panel had no specific information before it relating to Mr Bwerinofa's current employment status. It noted the hardship such an order will inevitably cause Mr Bwerinofa. However, this is outweighed by the public interest in this case. The panel considered that this order is 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.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mr Bwerinofa's full engagement with the NMC in the future;
- Attendance at any future hearing;
- A detailed reflective piece to demonstrate Mr Bwerinofa's insight into his misconduct and the impact it had on Patient A, colleagues and public confidence in the nursing profession;
- Evidence of remediation and any relevant testimonials from Mr Bwerinofa's current employer, whether in paid or unpaid employment. This must have particular regard to his failings found proved; and
- Any other relevant information relating to the circumstances of the incident.

This will be confirmed to Mr Bwerinofa in writing.

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

Ms Stewart made a request that references related to Mr Bwerinofa's personal and family issues in the determination should be in private. The application was made pursuant to Rule 19 of the Rules.

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

The panel considered this application carefully. The panel did not grant the Rule 19 application at this late stage in the proceedings, as the rule relates to discussion of any personal matters within the hearing as opposed to in the written determination. The panel also noted that reference to any personal matters had been entirely generic. There had been no discussion of specific personal matters as there had been no such information before the panel.

Interim order application

As the suspension order cannot take effect until the end of the 28 day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Bwerinofa's own interest until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Stewart. She submitted that an interim order is necessary to protect the public for the reasons identified by the panel earlier in their determination and in the wider public interest until the suspension order comes into effect. She therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28-day appeal period and any period of appeal.

The panel heard and accepted the advice of the Legal Assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the

facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to cover the 28-day appeal period and any period of appeal.

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

That concludes this determination.