Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 29 March 2022 – Monday 4 April 2022
Resuming Hearing
Monday 6 June 2022 – Friday 10 June 2022

Virtual Hearing

Name of registrant:	**Michael John Morgan**
NMC PIN:	65J1069E
Part(s) of the register:	Registered Nurse – Sub Part 1 RN1 Adult nurse L1 – April 1969
Relevant Location:	Cornwall
Type of case:	Misconduct
Panel members:	Richard Youds (Chair, lay member) Susan Field (Registrant member) June Robertson (Lay member)
Legal Assessor:	Michael Bell
Hearings Coordinator:	Shela Begum
Nursing and Midwifery Council:	Represented by Kevin Brown, Case Presenter
Mr Morgan:	Present and unrepresented
Facts proved by admission:	Charges 1a, 1c, 1d, 1e and 3
Facts proved:	Charges 1b, 2, 4a, 4b, 4c, 4d, 5a, 5b, 5c, 5d
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Suspension order with review (12 months)**
Interim order:	**Interim suspension order (18 months)**

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

At the outset of the hearing, Mr Brown, on behalf of the Nursing and Midwifery Council (NMC) made a request that parts of this case be heard in private on the basis that proper exploration of your case involves making reference to matters relating to your health. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You indicated that you 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) 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.

Having heard that your case is intrinsically linked to matters relating to your health, and that you will be exploring such matters throughout the course of the hearing, the panel determined to hold the entirety of the hearing in private in order to protect your privacy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Brown under Rule 31 to allow the written statements of Witness 2 and Witness 3 into evidence. Witness 2 and 3 were not present at this hearing and Mr Brown provided written submissions on the application to admit the statements of the witnesses as hearsay evidence.

"Introduction

1. *These are written submissions produced at the request of the Practice Committee to address the following issues:*

a. *Whether the evidence of Witness 2, comprising a witness statement and 3 exhibits, should be admitted.*
b. *Whether the evidence of Witness 3, comprising a witness statement and 4 exhibits, should be admitted.*

2. *The submissions are supported by the appended documentary evidence insofar as this is available. References to [A1] are references to page numbers in the appendix.*
3. *Unfortunately the case coordinator … is currently on annual leave and therefore cannot directly provide a statement.*

Legal framework

4. *The relevant rule when considering admission of evidence into Fitness to Practice Committee proceedings is Rule 31 of the consolidated Fitness to Practice Rules 2004:*

   "31. - (1) Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in the appropriate Court in that part of the United Kingdom in which the hearing takes place)."
5. *The Practice Committee must therefore consider whether the requirements of relevance and fairness are met to admit the evidence in this case. That is a context specific balancing exercise.*
6. *With regard to the requirement of fairness, the Practice Committee must consider both fairness to the registrant, and fairness to the NMC. The NMC's interest, and therefore a relevant matter for fairness, is in putting its case fully to enable the panel to consider and determine the regulatory charges, ensuring the protection of the public and upholding the public interest and public confidence in the profession.*
7. *In the case of Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin) the High Court considered the relevant legal precedents and set out the relevant principles as follows at para. [45]:*

" 1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.

1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.

1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.

1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.

In my judgment, unless the Panel is given the necessary information to put the application in its proper context, it will be impossible to perform this balancing exercise."

Submissions

8. *These submissions will address each of the factors above to ensure that the panel has the necessary information to apply the above rules.*
9. *Although the admission of evidence of an absent witness is not a routine matter, the NMC submits that the evidence of both witnesses should be admitted in full for the reasons below.*

Witness 2

10. *Witness 2 engaged with the NMC's investigation throughout the process of gathering information. Witness 2 is not a registered nurse. She produced and signed a witness statement dated 21 February 2021. She confirmed her belief in the statement and willingness to attend a hearing. She has not indicated any intention to withdraw her statement.*
11. *There is a good, cogent reason why Witness 2 is not giving evidence in person:*
    a. *A notice of the hearing was sent to Witness 2 on 1 March 2022 [A2].*
    b. *Witness 2 has changed employers since the events took place in 2018. Having changed employers, the details which she provided to the NMC of her telephone number and work address were no longer correct. However, she did not inform the NMC of the change.*
    c. *The NMC attempted to contact Witness 2 to give notice of the hearing but were unable to because her details had changed [A9]. Her previous employer also did not respond to requests for details of her current whereabouts and contact details.*
    d. *The NMC therefore conducted a trace using an external company to attempt to locate Witness 2 but this was unsuccessful [A1].*
12. *The NMC therefore requests that her evidence be admitted in documentary form because it is relevant and fair to do so.*
13. *The information is relevant because it provides details of the investigation and Mr Morgan's explanations of his actions at the time. The exhibits are relevant because they provide documentary evidence of [your] behaviour and state of mind following the event. They also include an interview with the healthcare assistant although that may be of limited weight.*
14. *Furthermore, it is fair to both parties to admit the evidence.*
    a. *Witness 2's statement is not the only evidence relating to the investigation. Witness 1 was present at the first interview and gives details of her involvement. If he chooses, Mr Morgan will be able to ask her questions to challenge the evidence of what was said.*
    b. *The exhibits to Witness 2's statement include correspondence with Mr Morgan, and in particular a number of letters he sent to her following the*

incident. It is fair to include them as they are clear evidence of Mr Morgan's statements. Mr Morgan can challenge or explain them himself as he has direct knowledge of their contents. With regard to the notes of the interview, Witness 1 produced them and can also give evidence of their reliability.

c. *It is relevant that Mr Morgan does not appear to dispute the majority of the factual evidence contained in Witness 2's statement.*
    i. *He admits that he did not carry out CPR.*
    ii. *He admits that he did not record his notes properly.*
    iii. *He has given an equivocal response on the carrying out of observations.*
    iv. *He has given an equivocal response to the statements he made about what the doctor said to him.*
    v. *He has denied dishonesty.*
d. *Witness 2's evidence covering the investigation is relevant to Charge 4 concerning dishonesty. It is important in order to establish the facts of what occurred during the investigation. However, it is not the only evidence on this charge and indeed, her statement does not directly accuse Mr Morgan of dishonesty.*
e. *Mr Morgan has been provided with all of the statements and exhibits in advance and has had time to respond to them appropriately.*

15. *Finally, the panel may decide, having heard all of the evidence, on the weight it should place on her evidence in the circumstances and may take account of the fact that it has not been given or tested orally. Admitting the evidence would allow the panel to have a fuller picture of the events.*

Witness 3

16. *Witness 3 was contacted by the NMC in the course of its investigation and signed a witness statement on 6 January 2021. He confirmed his belief in the statement and willingness to attend a hearing.*
17. *However, there is a good and cogent reason for Witness 3's absence.*

a. *He was given sufficient notice of the hearing by being sent a notice on 21 January 2022 [A18]. A further formal notice was sent by email on 1 March 2022 [A10]. However, Witness 3 replied on 3 March 2022 stating that he was unavailable on the hearing dates because he had booked a holiday several months ago and that the notice given was not sufficient.*
b. *The NMC called Witness 3 on 18 March 2022 and explained that he could give evidence by video link, but he informed them that he would be hiking and therefore "off grid" – as such it would not be possible for him to participate in this way as he would not have internet access [A17]*

18. *The NMC therefore requests that his evidence be admitted in documentary form because it is relevant and fair to do so.*
19. *The evidence of Witness 3 is relevant because it establishes the conversations which were had between him, the Out of Hours GP, and Mr Morgan, in relation to Patient A and the care that should be provided. The exhibits are transcripts of the exact content of those conversations. The evidence is relevant to the question of whether Mr Morgan's statements about the content of those conversations were factually untrue. It is therefore relevant to the question of dishonesty, but not sufficient to prove it because the NMC must also prove he had the requisite intent.*
20. *It would be fair to admit this evidence because:*
    a. *Mr Morgan has been provided with all of the statements and exhibits in advance and has had time to respond to them appropriately.*
    b. *Mr Morgan does not deny that the conversations took place. He has not challenged the provenance of the transcripts. He also admits that he did not take notes of the conversation.*
    c. *The transcripts which are produced as exhibits have been transcribed from recordings of the phone conversations. They are therefore not based on the recollection of Witness 3 which may be challenged in some way.*
    d. *The transcripts are very important to the NMC's case that Mr Morgan gave a false account of the conversations.*
21. *Again, the panel may also decide on the weight to give the evidence if it does choose to admit it.*

Hearing date

22. *Having reviewed the availability of witnesses and considered all the relevant factors, the NMC decided to continue with the hearing and apply to admit the evidence of the two witnesses above.*
23. *It was not considered necessary or desirable to re-arrange the hearing.*
24. *The following matters are relevant to whether it would have been reasonable to postpone the hearing:*
    a. *Postponement would not have increased the chances of Witness 2 attending as it was impossible to contact her.*
    b. *Postponement may have increased the chances of Witness 3 attending, however it is clear from his statement that he does not recall the exact conversations which took place. The most relevant part of his evidence are the telephone transcripts. It would arguably add little to the proceedings for him to appear.*
    c. *This case relates to events which took place nearly 4 years ago, in 2018. There is a public interest in dealing expeditiously with the case. It is also arguably in Mr Morgan's interest to deal with the case at the earliest opportunity; Mr Morgan previously indicated to the NMC that he wished the hearing to go ahead despite other setbacks.*

Conclusion

25. *In light of all of the above, the NMC submits that it is relevant and fair, having regard to the principles in Thorneycroft, to admit the evidence of both of these witnesses for the NMC.*
26. *In the alternative, the NMC submits that it is relevant and fair to admit the witness statements insofar as the facts are not in dispute, and/or insofar as they refer to the exhibits which should also be admitted."*

You submitted that you would like to admit any evidence before the panel which would assist it in considering your case. You stated that you intend for the panel to have all details out in the open.

You indicated that you would liked to have questioned Witness 2 and Witness 3 on their written statements and indicated that you are not happy with some of the contents of statements and found them to be unpleasant.

It was explained to you that you would be able to challenge anything within the statements of Witness 2 and Witness 3 in your own evidence and address any concerns you may have during this time, and you indicated that you are therefore content with the application to admit both statements as hearsay evidence.

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 in regard to Witness 2 serious consideration. The panel noted that Witness 2's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by her.

It determined that the statement of Witness 2 meets the criteria of relevance to charges 2, 3 and 4. The panel considered the evidence before it, demonstrating the attempts to secure the attendance of Witness 2 at this hearing and, based on the information before it, the panel was not satisfied that sufficient efforts to secure her attendance were made. The panel is of the view that the attempts to trace Witness 2 were made considerably close to the date of the hearing and that more steps could have been taken in advance of the hearing to secure her attendance. It considered that attempts made by the NMC to trace Witness 2 have been late and insufficient.

The panel next considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 2 to that of allowing hearsay testimony into evidence. The panel noted that you did not have prior notice of the non-attendance of Witness 2 at this hearing but that you have had regard to the statement of Witness 2 prior to the hearing. The panel further noted that you are content for the statement of Witness 2 to be admitted as hearsay evidence as you indicated your desire for the panel to have regard to all of the information available to it. The panel further noted that you stated you would like the opportunity to address and explore the issues raised within the statements and out of fairness to you, the evidence of Witness 2 should be admitted.

In coming to its decision, the panel considered the findings in the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)* and debated those at length. The panel also considered the public interest in the issues being explored fully, which supported the admission of this evidence into the proceedings.

The panel is mindful of the need to take due caution regarding hearsay evidence and in these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Witness 2 and would be mindful of giving the evidence appropriate weight once the panel had heard and evaluated all the evidence before it.

The panel next gave the application in regard to Witness 3 serious consideration. The panel noted that Witness 3's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by him.

The panel is of the view that there is no cogent reason for Witness 3's attendance not to be secured at this hearing. The panel noted that Witness 3 informed the NMC of his unavailability during these dates due to a holiday which was prescheduled. The panel did

not have regard to any evidence demonstrating the NMC's attempts to reschedule the dates of the hearing in which Witness 3 would be required to give live evidence and is therefore not satisfied that the NMC has made sufficient efforts to secure Witness 3's attendance at this hearing.

The panel considered the relevance of the statement of Witness 3 and considered that the statement was provided a significant period of time after the incident and Witness 3 has highlighted that he is unable to remember many details from the incident. However, the panel noted that the transcripts of conversations which had taken place during the time of the incident were detailed within the statement and this would be a relevant aspect in the consideration of your case.

The panel considered that as you had been provided with a copy of Witness 3's statement and that neither the NMC or you would be disadvantaged if the statement of Witness 3 were allowed into evidence. The panel noted you would not be in a position to cross-examine this witness but that you would have the opportunity to address issues raised within the statement and that you indicated your desire to do so.

The panel considered that the potential for unfairness related to all parties in that it would not be possible to hear live evidence from Witness 3 or to question and probe that testimony. However, having borne this in mind, the panel noted that further exploration would not be required as they are direct transcripts of audio recordings. The panel noted that Witness 3 has stated he has provided the statement as accurately as he believed them to be. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In light of all of the above, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 3 but would give what it deemed appropriate evidential weight once the panel had heard and evaluated all the evidence before it.

Details of charge

That you, a registered nurse, whilst working a nightshift on 4 October 2018 at the Windmill Court Care Home ('the Home') and having been made aware that Patient A had an unobserved fall:

1) Failed to commence / administer CPR to Patient A when it was clinically appropriate / justifiable for you to do so:

    a) due to Patient A's clinical presentation;

    b) due to the absence of a completed Treatment Escalation Plan ('TEP') providing instructions to the contrary;

    c) due to the absence of a completed DNAR form / documentation, providing instructions to the contrary;

    d) in accordance with the Home's 'Do Not Attempt DNAR Policy';

    e) in accordance with the 'Decisions relating to cardiopulmonary resuscitation' guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016)' policy.

2) On one, or more, occasion, stated / maintained that Doctor A advised / instructed you not to do CPR on Patient A;

3) Failed to record the advice / instructions provided to you by Doctor A as set put in charge 2 above;

4) Your conduct at any, or all, of charges 2 and / or 3 above was dishonest in that you:

a) you knew that Doctor A did not advise / instruct you not to do CPR on Patient A;

b) intended to create a misleading account of the advice / instructions that Doctor A provided to you;

c) intended to give a misleading account of / conceal the reasons for, your failure to commence CPR on Patient A;

d) knew that you were required to carry out CPR on Patient A, but failed to do so;

5) Failed to undertake and / or record adequate observations, including:

a) “Neuro Obs” in accordance with the Home’s “Service User Fall” policy and “Post Fall Injury Assessment and Management” policy;

b) a “24 Hours Post Fall Observation Log”;

c) a “Care Plan”

d) in line with Patient A’s clinical presentation;

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

Decisions and reasons to adjourn under Rule 32

This substantive hearing was scheduled for 5 days. On 4 April 2022, you provided the panel with written submissions which address the charges relating to dishonesty. [PRIVATE]. The panel made a request under Rule 22 (5) of the Nursing and Midwifery

Council (Fitness to Practise) Rules Order of Council 2004 (as amended), for you to provide further evidence, [PRIVATE]. [PRIVATE].

[PRIVATE].

Mr Brown submitted that he opposes adjourning the hearing at this stage on the basis of the public interest in resolving these issues and in your interests in concluding this case as quickly as possible. Mr Brown submitted that there is a strong interest in making as much progress as possible with hearing the case using the time that is available to the panel.

[PRIVATE]. Mr Brown acknowledged that this evidence is relevant, however he submitted that it primarily relates to your defence in this case and therefore will not change the NMC's position on their submissions on dishonesty.

In closing, Mr Brown informed the panel that the NMC is in a position to make final submissions to the facts of this case and invited the panel to consider the evidence from your [PRIVATE] at the impairment stage.

You indicated that you are eager to conclude these proceedings as soon as possible. You informed the panel of the impact the NMC's investigation and the time that it has taken to be carried out has had on you.

The panel accepted the advice of the legal assessor who referred the panel to Rule 32 (4) of the Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (as amended) (Rule 32), which sets out a number of factors which panels should consider when deciding an application for an adjournment. These include the public interest in the expeditious disposal of the case, the potential inconvenience caused to any party, and fairness to the registrant.

The panel considered the nature and the seriousness of this case and is of the view that it would be unfair to proceed… [PRIVATE]. The panel considered that this evidence may

have bearing on the entirety of your case and it will need to have regard to this information before determining the facts of the case.

The panel considered whether proceeding without this presents a potential injustice for either or both parties, and on the contrary determined that adjourning to afford the time to present this evidence provides justice to both parties. The panel noted that the further evidence requested could potentially provide further relevant information to the parties.

The panel considered that you are eager to conclude these proceedings and determined that any inconveniences that adjourning this hearing may cause you, must be balanced with having all of the right and relevant information before the panel so that it may consider the case carefully.

The panel also considered that Mr Brown opposed adjourning the hearing at this stage and invited the panel to hear closing submissions on facts. However, it noted that once the panel has heard submissions on facts, further evidence cannot be adduced into the hearing which would potentially disadvantage the parties.

In serving the public interest, it considered that the public would expect this case to be considered with all the relevant evidence.

The panel took into account fairness to both parties, and the public interest in the expeditious disposal of this case, as well as the interests of justice, and decided to adjourn today's hearing. In all the circumstances, the panel determined it is in the interest of justice and fairness to adjourn today's proceedings.

Prior to adjourning, the panel considered in terms of 32(5) whether it should impose an interim order. Mr Brown advised the panel that there was no existing interim order and that the NMC was not seeking for any interim order to be imposed at this stage.

You accepted the position of the NMC.

The panel accepted the advice of the legal assessor.

Given that the NMC did not seek an interim order, and that the panel has yet to make any findings in relation to the remaining live allegations, the determined that it was not necessary to make an interim order at this stage.

[This hearing went part heard on 4 April 2022 due to a lack of time. Proceedings came to a close following witness evidence and prior to the NMC closing its case.

The hearing resumed on 6 June 2022].

Background

The charges arose whilst you were employed as a registered nurse by Windmill Court Care Home ('the Home') from 31 July 2017 initially as a bank nurse and latterly as a permanent staff member.

The charges relate to events that had taken place during a night shift at the Home on 3 October 2018 to 4 October 2018.

A resident of the home (Patient A) was found after having had what is believed to be an unobserved fall from his bed. You attended as the nurse in charge of this shift and undertook a preliminary assessment of Patient A. Following the fall, as per the Home's policy, observations should have been undertaken by you every 15 minutes for the first hour, every 30 minutes for two hours and then every hour for the next two hours.

During the night, Patient A's health deteriorated and you called the out of hours GP. It was noted that there was no Treatment Escalation Plan ('TEP') or Do Not Attempt Resuscitation ('DNAR') in the patients file. The GP instructed that due to an absence of a TEP, that this patient was for escalation.

Patient A subsequently deteriorated and he passed away in the early hours of 4 October 2018.

The Home carried out an investigation and an investigatory meeting was held on 24 October 2018. On 30 October 2018 your employment at the home was terminated.

The regulatory concerns relate to you failing to perform Cardio Pulmonary Resuscitation (CPR) despite there being no DNAR or TEP form on file for the patient. There are further concerns around dishonesty associated with the events during that shift.

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

- Witness 1: Home Manager, Windmill Court Care Home

The panel also heard evidence from you under oath.

Submissions on behalf of the NMC on facts

Mr Brown made submissions on behalf of the NMC in relation to the facts of the case which were also provided in writing. The submissions were as follows.

1. *The panel needs to be satisfied on the balance of probabilities, that is, that it is more likely than not that the factual allegations took place.*
2. *The panel has heard and read the witnesses' evidence relating to the events of 4 October 2018, the death of Patient A, and the subsequent investigation into Mr Morgan's conduct that evening.*
3. *The background to the events is set out in the witness statement of [Witness 1] at paras 4 – 8. P6 (bundle of exhibits).*

4. *The panel is familiar with the incident with led to Patent A's death. There is much agreement on the events which took place.*
5. *Mr Morgan has admitted to a number of the charges against him. However, I invite you to scrutinise the evidence carefully and make your own conclusions in relation to each charge.*

Charge 1

6. *Mr Morgan admits under charge 1 that he failed to perform CPR on Patient A when it was clinically appropriate or justifiable to do so …*

a) Due to Patient A's clinical presentation;

(…)

c) due to the absence of a completed DNAR form / documentation, providing instructions to the contrary;

d) in accordance with the Home's 'Do Not Attempt DNAR Policy';

e) in accordance with the 'Decisions relating to cardiopulmonary resuscitation' guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016)' policy.

7. *With regard to the patient's clinical presentation, there is no dispute as to the fact that his condition indicated resuscitation would be required, as the patient deteriorated, he had low O2 saturation and stopped breathing at 4.15am. Prior to this, he had been relatively healthy and mobile although he had Huntington's Chorea.*
8. *Mr Morgan did not admit charge (b), that it was appropriate to commence resuscitation due to the absence of a completed TEP.*
9. *However, it is evident that in context and on basis of evidence, this charge must also be found to be proved. There was no completed TEP in the file at the time. [Witness 1] has told you that that was quite normal at the time for patients who*

did not have DNARs in place. The understanding was that resuscitation should be attempted for such patients.

10. *DNAR instructions now form part of the TEP form as standard.*
11. *The DNAR form at p148 of the bundle was in fact signed on 3 October 2018. However, it is common ground that it was not on the premises at the time.*
12. *Mr Morgan said that he operated under the presumption that the TEP form had been concluded because this information was given to him by [the day staff member] at the handover at 9pm. However, in his telephone calls, Mr Morgan explicitly stated to [Doctor A] that there was no TEP.*
13. *He told us that he consulted the chart at around 3am and noticed there was only a piece of paper that said 'No DNR'.*
14. *He therefore could not have been sure at the time whether the TEP had been signed, nor was he fully aware of its contents. He had been told the family wanted a DNAR, but he had no proof of that.*
15. *The BMA guidance referred to in charge E makes clear that the most senior person in charge of their care (in this case the GP) is the one who makes the decision P77. That means it was not for the family, or for Mr Morgan, to decide. It also states that there is a presumption in favour of CPR P84.*
16. *[Witness 1] told you that in her opinion as a practitioner, she would have wanted to see the TEP form before withholding CPR. The care home's policy, which Mr Morgan admits that he breached, also explicitly provides that there is a presumption in favour of starting CPR. P51 – exceptions. There is no claim on Mr Morgan's behalf that the exceptions apply. Indeed, he has admitted that the homes policy required DNAR to be performed under charge 1(d).*
17. *Taking into account all of the evidence, and the admissions of Mr Morgan in relation to the majority of the counts, the panel should find that charges 1 a) to e) are proved.*

Charge 2

18. *Mr Morgan did not admit charge 2, and explained that in his view this was inextricably linked with charge 4 of dishonesty. In my submission, a finding of fact*

under charge 2 is not sufficient to make a finding under charge 4, and nor is it necessary (since charge 4 refers to charge 3 as well).

19. *Charge 2 is a separate factual question which the panel must determine.*
20. *Charge 2 is as follows:*

"2) On one, or more, occasion, (Mr Morgan) stated / maintained that Doctor A advised / instructed you not to do CPR on Patient A; "

21. *The evidence is very straightforward. The precise meaning and/or motivation of the phrase is a separate issue which is relevant to Charge 4.*
22. *In the written statement which he produced prior to his interview with [Witness 2] (P157/186) Mr Morgan clearly states the Doctor instructed him not to do CPR. That in itself is sufficient for the panel to make a finding that charge 2 is proved.*
23. *In addition to the first written statement of Mr Morgan, he maintains in a letter of 15 December 2018 P145/174 that he was told not to perform CPR.*
24. *[Witness 2] also states in her witness statement that Mr Morgan said this during his interview para 11, p17. The notes of the interview P122/149/151 prepared by [Witness 1] clearly refer to this statement.*
25. *Mr Morgan has suggested [Witness 1] may be misremembering or only recorded part of the conversation, but she said in her evidence that it was clear what was being spoken about, and the notes which were made were contemporary. The notes were confirmed as accurate by [Witness 2] in her statement para 36. P21.*
26. *It is more likely than not that he did make this statement, in particular because it was repeated in writing. The witnesses' evidence is consistent in their statements and in the contemporaneous documents.*
27. *He also maintained this version of events when the NMC investigation began.*
28. *There is therefore ample, consistent evidence for the panel to find that these statements were made by Mr Morgan. There is clear evidence that the statement was made on a number of occasions.*

Charge 3

29. *Mr Morgan has admitted during these proceedings that he did not record the advice provided by the doctor.*
30. *He has produced no notes or evidence of recording that conversation. The only written reference to what was said was produced after the events in the statements and letters I have referred you to.*
31. *At para 17/p9 of her statement, [Witness 1] sets out the expectations of a nurse to record conversations with medical professionals. Those requirements were not met.*
32. *The notes are p34/63 mention that the out of hours doctor had been called. It does not record that no CPR should be attempted, despite how important that is. It says an ambulance was called.*
33. *[Witness 1] stated that when she arrived at the home in the morning, she saw Mr Morgan filling out some forms. It is not clear what they were, however, in my submissions there is evidence of post-hoc note-taking.*
34. *The notes at p34/63 of the bundle mention observations at 21.30, 3am and 4am. Mr Morgan states that they would have been added to. However, they are not signed and they do not properly note the time. The entry for 21.30 is repeated in other documents. None of the notes are recorded in the contemporaneous daily notes which are at page 29/58. They are variously written on separate pages. As Mr Morgan has accepted, they were not made at the right time.*
35. *This charge should be found proved accordingly.*

Charge 4 - Dishonesty

36. *I refer the panel to my written submissions which set out the position of the NMC. P388.*
37. *I would draw the panel's attention to the need to consider in particular Mr Morgan's subjective knowledge at the time when he failed to record the conversation and he made the statements.*
38. *The behaviour was dishonest insofar as it was false to state that he had been told by the doctor not to perform CPR either at all, or at a time when it was relevant*

because Patient A could still have benefitted from it. It was factually incorrect to make the statement.

39. *I submit that Mr Morgan knew it to be factually incorrect, or did not have a reasonable belief that it was correct. The transcripts of the telephone call are clear. At no point was he told not to perform CPR. The only time an instruction was given, it was after the patient died, and was clearly directed to the paramedic. In the circumstances, he could not have had a genuine and reasonable belief that it was true.*
40. *It was also dishonest to fail to record a conversation insofar as this allowed him to present his own version of the events later, which created confusion and misled the investigation due to his claims about the instructions received from the doctor. Those are relevant background circumstances to consider.*
41. *He was informed on 10 October 2018 that he was suspended for investigation. P133/162. During the investigation, he stated he had made administrative errors of record keeping. He refused to accept that he had made clinical errors. At the time, he clearly felt the investigation was unfair – letters p159/188 and 162/191. He has now made admissions that he did not meet the required clinical standard. He admitted in a letter of 16 July 2021 that the doctor had not told him to withhold CPR, p323. [Witness 1] and [Witness 2] give consistent accounts of the interview in their statements. In my submission they are credible. They should be given considerable weight.*
42. *However, you do not need to find that he intended to mislead the investigation or had any other specific reason for the dishonesty. If you are convinced that he knowingly made a false statement, that is sufficient to find the conduct was dishonest.*
43. *However, the panel must consider the other possible explanations which Mr Morgan has raised or which may be indicated by the facts. In the NMC's submission, it was not an innocent or negligent mistake.*

Charge 5

44. *There are effectively two limbs to each of the charges under charge 5. First, did he carry out adequate observations, and second, did he record them adequately.*

Making observations

45. *The post falls policy at p108/137 states clearly that for an unwitnessed fall, the following should be done:*

“ Monitor and record observations e.g. Vital signs, bruising, swelling, pain, breathing, circulation, level of consciousness, verbal responses, motor responses (Neuro Obs)”

46. *Mr Morgan has stated on a number of occasions that he made observations and recorded them in his black book.*
47. *However, under oath during cross examination he admitted that he did not do the examinations on a regular basis. He admitted also that he did not take a blood pressure reading. He said that is because the machine was not working as of 9.30pm.*
48. *However, it appears he did not try to carry out manual readings in place of the machine. He did not ask anyone for assistance with the machine or report the problem to the home manager till the morning.*
49. *He did not take a blood pressure reading at any time before the conversation with the doctor after 2am. He suggested at one point that the patient made it difficult to get a manual reading but that would not explain the failure to do BP tests on every occasion required.*
50. *It is clear that he did not follow the post-falls plan, in part because he did not have a copy of it. If he had, he could and should have made his notes on the proper form.*
51. *He raised the fact that the resident had been on the floor for some time before being discovered. That is irrelevant to the procedure to be followed. The post-falls procedure is clear that observations must be made starting from the time that a resident is found following an unobserved fall P108/137. They must be every 15 minutes, then 30 minutes, then 1 hour, and so on.*

52. *Mr Morgan said in his interview P120/149 that he did not carry out neurological observations, although he suggests he was referring to full neurological assessment. The required observations in post-falls policy are set out at paras 23-24/10 of [Witness 1's] statement.*
53. *There are very specific tests which need to be done, these are set out clearly in post falls policy. It is not sufficient to keep an eye on the patient as the HCA's did. A nurse must make the observations to determine the patient's place on the Glasgow coma scale and must record them to identify any trends. [Witness 1] also made clear that neuro observations should be in addition to the standard observations.*
54. *[Witness 1] noted that the post-falls record would have been available at the nurse's station and clearly sets out what needs to be done and provides space to make notes. Mr Morgan has accepted that he did not follow that procedure. He did not have a copy of the forms.*
55. *In the telephone call to the doctor P172/201, Mr Morgan did not mention the coma scale. He gave vague descriptions of the patient's state. He said that he had not been able to get blood pressure.*
56. *He produced a statement afterwards on 23 October 2018 which refers to some specifics P124/153. These may have been taken from his notebook. Even so, they demonstrate only irregular observations being done at 22.45 and 23.45.*
57. *Even if you find that he did do the required additional neuro observations, Mr Morgan admitted that he did not do them as regularly as required. These observations were insufficient to give a clear picture of the patient's presentation.*
58. *For those reasons, the panel should find charge 5 a, b, c and d proved in relation to undertaking observations.*

Recording

59. *In terms of recording the observations. Mr Morgan admitted during the investigation that he had made administrative failings with regard to note taking p122/151. Mr Morgan says he took notes in his black book intending to transfer them. That may be the case, but he never actually did transfer them.*

60. *Mr Morgan has had the opportunity to present them to the panel but has not. In this case, I submit that you can infer that the notes in the black book were not complete.*
61. *The only real evidence of notes and observations which the panel has before it are the documents in the care plan. P36/65 [Witness 1] collected these shortly after the events as part of her investigation It is not clear when they were filled out but the registrant accepts they were not filled out immediately. They are on separate forms and not in the care plan. They are not signed although they should have been. They may have been transferred from his notebook at a later stage. In any case, they give only a summary and are not adequate, given the events which took place.*
62. *In any case, part of the charge is to "record adequate observations". Have regard to the NMC code part 10. The failure to record the observations in any detail, shortly after the event, and the failure to record them in the care plan or on the post falls report which would therefore be accessible, means that he failed to make adequate records as set out in Charge 5a-d."*

[PRIVATE]

In relation to Charge 1, you submitted that Patient A had been frail and that his death was anticipated and this was the reason for the TEP being in place. You further submitted that a healthy mobile person would not be considered for a TEP. You stated that during the handover, you were told that a TEP had been done and that this patient was not for escalation. You submitted that in line with the Home's policy, you should have performed CPR but that by the time you came to this realisation it was too late.

You went on to address charge 2 and submitted that you were convinced that Doctor A said he could overturn a TEP and that your comments during the Home's interviews during the investigation related to this and not being instructed not to carry out CPR. You submitted that you recall Doctor A telling the ambulance crew not to perform CPR.

In relation to charge 4, you said that your actions were not dishonest. You stated that you failed to give the correct information but that your actions were not dishonest as you believed the information at the time to be true to the best of your knowledge. You acknowledged that you did not meet the clinical standards but that since this incident you have undertaken training.

In respect of charge 5, you accepted that you failed to record adequate observations. You submitted that you undertook all the normal observations when you found Patient A on the floor and stated that there were no obvious signs of injury. You submitted that these observations were recorded by you in your black note book. You stated this is not presentable to the panel as you could have recorded these observations at any point after the incident. You submitted that you offered this into evidence during the Home's internal investigation but this was refused. In respect of the neurological observations, you submitted that you carried out the standard observations that would be required for someone who had an unobserved fall.

You referred the panel to your written submissions on dishonesty dated 3 April 2022 which stated:

> *"The following is a true statement to challenge the question of dishonesty. I have prepared this document using the chronological presentation given by Mr Brown dated 1st April 2022.*
>
> - *My conduct and my account of the events in question has been interpreted as dishonest.*
>
> - *In over 50 years of dedicated nursing service I hold an unblemished record of professional behavior at all levels of my nursing practice. On arriving for a night shift I took over from [senior staff nurse], {senior staff nurse} and received a room by room methodical summery of the events of the day with special reference to any significant changes. During that hand-over, as I have said on many occasions, it was reported to me that*

the gentleman in room 12 had now been issued with a TEP and that resuscitation was not indicated. The TEP had been discussed and produced between [senior staff nurse], [A GP] {GP} and because the patient had no mental capacity, his Daughter-in law. The latter having power of attorney. On my initial safety check I found the patient on his bedroom floor. It is only an assumption that he had slipped or fallen.

- *I should have checked that the TEP form was in the patients notes. I failed to do so. Instead, I proceeded with my duties as the only nurse on duty in the mistaken knowledge that my patient now had a TEP in place. It never was, nor is it now, my intention to mislead anybody or to conceal the reasons for my poor professional behavior. Until several hours into the shift my honest belief was that a Treatment Escalation Plan was in place.*
- *During the intervening years the sole reason why I persisted in my belief that I was informed that A GP can over-rule a TEP was that I truly believed it to be true. The overall events of that night are extremely difficult for me to piece together in a logical time frame. Consequently, I find it impossible to adequately defend Mr Brown's assertion that I demonstrated dishonesty. I know that the OOH GP did ask the ambulance crew not to attempt resuscitation. I have wondered now if I took some ownership to that instruction and the answer is I do not know.*

- *I did write the daily report explaining the events of the night for all of the patients including my gentleman in room 12 so I am not sure what instructions Mr Brown is referring to.*

    - *I have on several occasions stated that I was guilty of not making an adequate contemporaneous report concerning the overall care of my patient for which I unreservedly apologize. It was true that I had a very busy night but I fully accept that it is not what one would expect of a trained professional nurse.*

3. *I have read and tried to understand the section headed Legal Framework. My understanding is that dishonesty cannot be clearly defined. It is for the panel to consider the actual state of the individuals knowledge or belief as to the facts. I certainly held a strong belief in the honesty of my statements that I have on several occasions made. I will refer later to significant mitigating circumstances that dictated my actions, or lack of actions. I do consider myself to be an 'ordinary decent person' and knowing and reflecting on all of the evidence against me I would judge myself as having been dishonest and misleading of facts. However, I say that I was not dishonest and had made statements or comments which for a considerable time I believed were true.*

    - *I would implore the panel to give credence to my state of mind when the alleged misconduct took place. False representation was indeed given by me and I would readily accept that my statements were innocent based on my beliefs at the time.*
    - *[PRIVATE].*
    - *It is very true that I have given a confused account of my actions on the night in question but on my Oath I was not consciously dishonest.*
    - *I never set out to give misleading accounts of my actions.*
    - *I acted with the knowledge in my mind, albeit incorrectly, that I had been told that CPR was not an option.*

4. *Mr Brown, makes a number of assumption on the final page of his submission appertaining to dishonesty.*

    - *I would never resort to dishonesty in order to justify my actions or lack of actions. Mr Brown makes several accusations based upon 'maybe's' and 'perhaps' when interpreting what he believes took place.*
    - *Even when I saw the scribbled note saying no DNAR my initial thought was still that a TEP had been prepared.*
    - *The simple fact remains that I failed to perform CPR on my patient for which I will forever regret.*

- *I fully admit that I did not follow the policy and procedure for conducting the observations following an unobserved fall. The only basic observations I made were at 21.35, 10.45, 12.45, 02.00, 02.45 and 03.15 which falls short of the required frequency.*
- *His daughter in law was furious that [Patient A's] TEP hadn't been completed when I telephoned her at 04.30hrs. After the TEP meeting with the GP he had assured her that it would be in place that same day.*

The conclusion I would like to make are what are the elements of learning that I have gained from this event. They are as follows:-

- *I now never take 'on-faith' clinical or administrative information given to me.*
- *I now, always check on information given to me, especially something as important as treatment escalation.*
- *To write, wherever possible due to time constraints or priorities accurate and complete contemporaneous reports.*
- *Endeavor to always ask a 'check' question to ensure clear understanding both for myself and others.*
- *I now always incorporate the NEWS 2 assessment documentation to clearly recognize the declining patient. Furthermore to act according to the resultant score obtained.*
- *To readily seek help and advice if unsure or concerned about a situation.*
- *I now, when on duty, carry a list of all patients in my care that have a published escalation plan in their notes.*
- *To record all conversations with other health professionals in the Multidisciplinary section of the care plan."*

Decisions and reasons on application to hear further submissions under Rule 24

After the panel retired to make a decision on facts, you raised an application to make

further submissions. You submitted that you seek to address the contents of Mr Brown's submissions as you felt you did not have enough time to reflect on them before making your own submissions the day prior. You therefore made a request to make further submissions after having now had time to review the submissions from the NMC in depth.

Mr Brown submitted that he did not oppose your application, however he submitted that if anything arises from your submissions, the NMC would seek to address this.

The panel accepted the advice of the legal assessor.

The panel decided to grant your application to hear further submissions. The panel noted that the NMC's written submissions were provided to you a day prior and that you were asked whether you would like some time to review them before making your closing submissions on the facts. However, the panel took into account that you stated that you are seeking to clarify matters raised by the NMC in relation to the facts and therefore concluded that it would be fair to allow you the opportunity to properly present your case by allowing you to make further submissions.

Further submissions on facts

In response to Mr Brown's submissions, you reiterated that Patient A was frail and his death was anticipated and that this was the reason for the TEP being created for him. You stated that you now agree completely that CPR should be attempted in the absence of a TEP. You acknowledged that you stated during handover you were told there is a TEP in place but told Doctor A that there is not a TEP for this patient. You explained that this was due to confusion on your part.

You stated that the NMC did not reach out to the family of Patient A to clarify whether the family wanted a DNAR in place for this patient or appear as a witness at this hearing.

In relation to charge 2, you submitted that your comments during the Home's interview

were in relation to the Doctor A stating he could overturn a TEP. You submitted that the staff conducting the interview made an assumption based on your comments which was interpreted as you saying the Doctor A instructed you not to attempt CPR. You submitted that the minutes of this interview were taken by Witness 1 and described these minutes as 'suspicious'.

You referred to the dishonesty allegations and submitted that you feel that your accounts of the events are never considered credible and said that you found the accounts of others to be 'indulgent'. You submitted that there was no dishonesty on your part and you made comments of what you believed to be true at the time.

Further submissions from the NMC on facts

In response to you, Mr Brown invited the panel to scrutinise the admissions made by you in relation to the charges that have not been found proved at this stage. Mr Brown further invited the panel to make findings on all of the disputed facts rather than to accept the admissions which were made by you in your later submissions.

In relation to the NMC reaching out to the family of Patient A, Mr Brown informed the panel that you were asked whether you wish to call any witnesses to these proceedings. He informed the panel that when approached about this, you responded that you felt it would be unfair to call the daughter of Patient A to these proceedings. Mr Brown did not dispute that the daughter discussed the TEP with the GP, but referred the panel to the concern which is that you should have conducted CPR in the absence of the TEP.

Mr Brown referred to your written statement which states that you were told by Doctor A not to attempt CPR. He submitted that your statement creates the impression that you were told not to attempt CPR and the NMC's position is that the purpose of this statement was to mislead. Mr Brown submitted that it is for the panel to determine what your subjective knowledge was and whether your actions were dishonest.

[PRIVATE].

The panel accepted the advice of the legal assessor. He reminded the panel that you had made formal admissions to charges 1a, 1c, 1d, 1e and 3 at the outset of the hearing. He advised the panel that it should approach all the disputed facts in light of the evidence available to it as well as the position of both parties.

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you made full admissions to charges 1a, 1c, 1d, 1e and 3.

The panel therefore finds charges 1a, 1c, 1d, 1e and 3 proved, by way of your admissions.

The panel noted that you made admissions to charges 1a, 1c, 1d, 1e and charge 3 and it is satisfied that the admissions are sufficient and on the basis of your admissions and based on the evidence before it, the panel concluded that on the balance of probabilities these charges are found proved. The panel was invited to consider the validity of your admissions and it considered the evidence before it at length and together with your admissions found these charges proved.

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

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

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 both the NMC and you.

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

Charge 1b

1) Failed to commence / administer CPR to Patient A when it was clinically appropriate / justifiable for you to do so:

    b) due to the absence of a completed Treatment Escalation Plan ('TEP') providing instructions to the contrary;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, the notes of the interview with you during the Home's internal investigation, the transcript of the telephone conversation between you and Doctor A and the written statement provided by you.

The panel noted that during your oral evidence you stated that you had been told at handover that a TEP had been agreed with the family of Patient A. You acknowledged you did not check the patient records to confirm this at the time but realised at 03:00am there was no written TEP in place. The panel had regard to transcripts of a telephone conversation that took place on the night of the incident between yourself and the out of hours GP during which you stated: *"We're on the cusp of a TEP as well, but the GP was consulted on this only yesterday, but he feels he needs to have some more conversation with family".*

The panel also noted that during your internal interview which was carried out at the Home following the incident, you stated the documents to reflect the DNAR status were not physically in the building at the time but further stated "*The out of hours GP told me not to resuscitate and the GP spoke to the ambulance crew and there[sic] were not to commence CPR".*

The panel considered the evidence of Witness 1 during which she informed the panel that the Home's policy indicates that if there is an absence of a TEP, the nurse should attempt CPR.

Following your application to make further submissions under rule 24, you submitted that you accept that CPR should have been performed in the absence of a written TEP in the patients notes at the time.

The panel found that there are discrepancies between what has been reported by you during the internal investigation and what you have said during your evidence. The panel determined that there were internal inconsistencies in the evidence which you gave to it and that your evidence to the panel in relation to this charge was inconsistent with the documentation before it. The panel determined the evidence of the witnesses for the NMC was consistent with the documentation before it and credible and reliable. The documentary evidence before it is clear and cogent and the panel therefore concluded that this charge is found proved.

Charge 2

2) On one, or more, occasion, stated / maintained that Doctor A advised / instructed you not to do CPR on Patient A;

This charge is found proved,

In reaching its decision, the panel took into account the documentary evidence which included notes of the interview carried out by the Home, your written statement dated 23 October 2018, your letter to the Home of 15 December 2018 and the oral evidence put forward by you.

During the interview which was carried out by the Home, the panel noted that you stated "*The out of hours GP told me not to resuscitate and the GP spoke to the ambulance crew and they were not to commence CPR".* The panel further noted that in your statement dated 23 October 2018 you stated *"During the phone call with the GP he advised that CPR should not be attempted".*

The panel also had regard to the letter from you dated 15 December 2018 in which you maintained that "*The Out of Hours GP instructed both myself and the Paramedics that no attempt at resuscitation was to be made & stating that as a GP he could override any previous instruction."*

During cross examination, you stated you accept that the out of hours GP did not tell you that you should not do CPR. You also acknowledged that the transcript evidence is consistent with this. You stated that during the time of the incident this is what you believed you heard. You also referred to a comment that the GP made about being able to overrule a TEP.

You made further submissions in relation to this charge and you challenged the credibility of the notes from the interview held at the Home and described them as 'suspicious'. You submitted that your comments during the interview were not that you were instructed not to attempt CPR but that the GP advised you that he could overrule a TEP.

The panel found that there are discrepancies between what has been reported by you during the internal investigation and what you have said during your evidence. The panel determined that there were internal inconsistencies in the evidence which you gave to it and that your evidence to the panel in relation to this charge was inconsistent with the

documentation before it. The panel determined the evidence of the witnesses for the NMC was consistent with the documentation before it and credible and reliable. The documentary evidence before it is clear and cogent and the panel therefore concluded that this charge is found proved.

Charge 4a)

4) Your conduct at any, or all, of charges 2 and / or 3 above was dishonest in that you:
    a) you knew that Doctor A did not advise / instruct you not to do CPR on Patient A;

This charge is found proved.

In considering all the limbs of charge 4, the panel applied the test for dishonesty as set out in Ivey v Gentings Casino (UK) Ltd [2017] UKSC 67 which states that Lord Hughes, giving the judgment of a unanimous Supreme Court said:

> "48. Where it applies as an element of a criminal charge, dishonesty is by no means a defined concept. On the contrary, like the elephant, it is characterised more by recognition when encountered than by definition. Dishonesty is not a matter of law, but a jury question of fact and standards. Except to the limited extent that section 2 of the Theft Act 1968 requires otherwise, judges do not, and must not, attempt to define it: *R v Feely* [1973] QB 530. (…)"

> "74. (…) When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is

> whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."

In coming to its decision, the panel considered the transcripts of the telephone conversation between yourself and Doctor A. The panel has reviewed this at length and determined that during this conversation there is no suggestion or indication by Doctor A that CPR should not be carried out. The panel found that the transcripts of this call are very clear and there is nothing that was said by Doctor A during this conversation that was open to misinterpretation. In addition Doctor A arranged an ambulance to be sent which would not be consistent if treatment were not to be escalated for Patient A.

During your further submissions you stated that the patient would not have benefited from CPR and that you were not the cause of the patients death. You stated that the out of hours GP stated that CPR would not produce a suitable outcome for this patient. The panel found no evidence within the telephone transcript of Doctor A supporting this.

[PRIVATE].

[PRIVATE].

[PRIVATE].

The panel therefore concluded that you were aware that Doctor A had not advised or instructed you not to attempt CPR on Patient A. The panel concluded that in stating that Doctor A had advised you not to attempt CPR on Patient A or record Doctor A's advice your intention was to mislead.

The panel further determined that this conduct would be viewed as dishonest by the standards of ordinary decent people.

Charge 4b and 4c)

4) Your conduct at any, or all, of charges 2 and / or 3 above was dishonest in that you:
    b) intended to create a misleading account of the advice / instructions that Doctor A provided to you;
    c) intended to give a misleading account of / conceal the reasons for, your failure to commence CPR on Patient A;

These charges are found proved.

In coming to its decision, the panel took into account the transcripts of the telephone conversation between you and Doctor A, your evidence and [PRIVATE].

[PRIVATE].

[PRIVATE].

The panel considered that during cross examination you stated "*I'm a big-headed guy and I don't like to admit that I've failed in any way, shape, or form, which is partly one of the reasons why all these questions are coming at me".*

You further submitted that you were not dishonest and referred to Witness 1's evidence as 'indulgent'.

The panel considered the evidence put forward by you and it noted that you said your intentions were not to create a misleading account but that you were stating what you believed to be true at the time. The panel was not satisfied by your version of events as it was not supported by or consistent with the factual evidence before it.

[PRIVATE].

The panel concluded that in stating that Doctor A had advised you not to attempt CPR on Patient A your intention was to mislead. The panel concluded that in stating that Doctor A had advised you not to attempt CPR on Patient A or record Doctor A's advice your intention was to mislead.

The panel further determined that this conduct would be viewed as dishonest by the standards of ordinary decent people. The panel therefore concluded that based on the evidence before it, both charges 4b and 4c are found proved.

Charge 4d)

4) Your conduct at any, or all, of charges 2 and / or 3 above was dishonest in that you:
    d) knew that you were required to carry out CPR on Patient A, but failed to do so;

This charge is found proved.

The panel took into account that the transcript of the telephone call and it determined that the instructions provided by Doctor A were clear. The panel noted that there was nothing that was said by the doctor during this conversation that was open for misinterpretation. The panel also considered that if you believed that you were instructed not to perform CPR if the situation arose, you did not document the instruction being given, have it clarified by Doctor A. The panel is therefore of the view that you did not misinterpret the instructions provided by Doctor A and that you knew you were required to carry out CPR but failed to do so.

The panel considered the evidence of Witness 1 and that she stated "*I would feel that - without the hard evidence in front of me, without the facts, without having that form*

actually telling me that person's not for resuscitation - I would feel nervous about following any other instruction without having that actual legal document in front of me". During her evidence, Witness 1 went on to state " *I think my thoughts would have been that's such a major piece of information or instruction to be given verbally over a telephone. I think I would have very, very, clearly documented the time, the date, doctor's name. I would have been very careful that I had all the information there, if you were going to act on that instruction from the GP. I would expect it to be very, very clearly documented".*

The panel was of the view that the standard expected of a registered nurse in this situation would be to clearly document the doctors instructions in the patient notes. Particularly, as in such cases, these instructions directly impact on patient outcomes.

When given the opportunity to make further submissions, you stated that the out of hours GP suggested that CPR would not produce a suitable outcome for this patient. However, the panel noted that this was not articulated in the telephone transcripts and therefore the documentary evidence before it was not consistent with this. The panel is of the view that whilst none of the documentary evidence indicates that this patient was not suitable for CPR, you failed to attempt CPR when it was required.

The panel determined that you knew that you were required to carry out CPR on Patient A but failed to do so. The panel concluded that in stating or maintaining that Doctor A advised or instructed you not to attempt CPR on Patient A or record the advice or instructions provided to you by Doctor A, your intention was to mislead.

The panel further determined that this conduct would be viewed as dishonest by the standards of ordinary decent people. On the basis of all the evidence before it, the panel determined that this charge is found proved.

Charge 5a

5) Failed to undertake and / or record adequate observations, including:

a) “Neuro Obs” in accordance with the Home’s “Service User Fall” policy and “Post Fall Injury Assessment and Management” policy;

This charge is found proved.

The panel took into account the written statement of Witness 2 and your oral evidence.

The panel noted that you stated in your evidence that you did not undertake observations on the patient every 15 minutes in line with the Home’s policy during the time. However, you stated that you did take some observations and that you documented the findings of these observations in your own black note book. You were specifically given the opportunity to present this evidence to the panel but you did not do so. You stated that the reason you did not present this is because it was circumstantial and that the observation notes could have been written at any time. You further stated that you offered this into evidence when the Home carried out its internal investigation but that it was refused by those carrying out the investigation.

The panel noted that you stated you were unable to take the patient’s blood pressure due to the machine being broken. The panel heard from Witness 1 that there were two blood pressure machines at the Home. One was an electronic machine and the other a manual machine. It was not clear to the panel which one was faulty. However, you did not use either machine to record the patient’s blood pressure, nor did you report the issue with the equipment to the on call manager at the home. The panel had regard to the written statement of Witness 2 it is documented that you stated “*it is not recommended to even do a BP for a head injury’.*

The panel did not have any information documenting any neurological observations being undertaken and therefore could not be satisfied that they were adequately carried out in line with the Home’s policies. The panel therefore determined that this charge is found proved.

Charge 5b and 5c

5) Failed to undertake and / or record adequate observations, including:
    b) a “24 Hours Post Fall Observation Log”;
    c) a “Care Plan”

These charges are found proved.

In relation to charge 5b, the panel took into consideration that you stated you recorded all your observations in your black note book and that you did not record any information in the “24 Hours Post Fall Observation Log” as you could not find this.

The panel noted that during the cross examination of Witness 1, she stated that the observations that should have been undertaken every 15 minutes should have been recorded by the nurse performing these observations as they went along. This is also documented in the Home’s post falls policy. You stated during your evidence that you undertook observations on Patient A however, it was not in line with the Home’s policies, specifically in respect of timings.

In relation to charge 5c, the panel considered that you stated that you had been noting your findings of observations undertaken by you in your black note book but that you stated that you failed to transfer notes you had made from your black note book into the patients care plan before going off duty. The panel further noted that you stated that you were in a hurry to go home as you were tired following a very stressful night shift.

On the basis of the evidence put forward by you, the panel concluded that charges 5b and 5c are found proved.

Charge 5d

5) Failed to undertake and / or record adequate observations, including:

d) in line with Patient A's clinical presentation;

These charges are found proved.

The panel considered that the evidence before it demonstrates that only the patients temperature and pulse were recorded intermittently between 21:30 and 04:15. The panel noted that the patient's blood pressure was not recorded and that you have previously stated that it is not 'recommended' to take the patient's blood pressure. The panel therefore determined that inadequate observations were undertaken in response to patient A's clinical presentations.

The panel noted that it was reported by a healthcare assistant that patient A had vomited a small amount of liquid and that you stated that the patient had not vomited and had only spat out some bile coloured liquid. The panel noted that around 03:00am you became more concerned and noted that the patient was becoming drowsy and his speech was slurred and it was at this point that you informed the out of hours GP, however the panel had no documentary evidence to show that you had carried out any baseline observations.

The panel also considered that during your evidence you stated that you were aware of the typical behaviours of this patient and that he wasn't presenting as his usual self and therefore this should have been a red flag to you. The panel determined that you did not adequately undertake or record observations or respond to the patients clinical presentations. The panel therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your 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, your fitness to practise is currently impaired as a result of that misconduct.

NMC 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.'*

Mr Brown 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.

Mr Brown provided written submissions on misconduct which stated:

1. "At this stage of the process, two questions should be asked separately (Cohen v GMC [2008] EWHC 581 (admin); Cheatle v GMC [2009] EWHC 645 (admin)):

- *(a) whether on the basis of the facts admitted or proved, the conduct in question amounts to one of the statutory ground (misconduct, lack of competence, criminal conviction, etc…)?*
- *(b) If so, whether the registrant's current fitness to practise is impaired.?*

2. The panel have found the facts in relation to all charges (1, 2, 3, 4 and 5) proved. I invite the panel to have regard to its reasoning and the contextual elements which are included in its factual findings when considering the questions of misconduct and impairment.

Misconduct

3. NMC guidance sets out the meaning of misconduct (NMC Guidance FTP-2a). It is not a clearly defined legal standard to be proven, but rather a question of appreciation for the panel, whether the actions of the registrant amount to misconduct.

4. Misconduct generally means conduct which falls short of what would be proper in the circumstances. The guidance states that:

"The Code sets the professional standards of practice and behaviour for nurses, midwives and nursing associates, and the standards that patients and public tell us they expect from nurses, midwives and nursing associates. While the values and principles can be interpreted for particular practice settings, they are not negotiable.

If nurses, midwives or nursing associates fall short of the Code, what they did or failed to do may be serious professional misconduct. Certain kinds of clinical concerns we think are the most serious because they may lead to patients or members of the public suffering harm."

Relevant standards in the Code

5. *When considering misconduct the panel should refer to the 2015 version of the Code. It was updated on 10 October 2018, after the events. However, in relation to dishonesty, the most up to date code and requirements are arguably relevant.*

6. The following provisions of the code are most relevant to the charges.

- *1.2 make sure you deliver the fundamentals of care effectively*

7. This article is a fundamental tenet of the profession. Mr Morgan's conduct fell short of this expected standard in respect of Charges 1 and 5.

- ***"3 Make sure that people's physical, social and psychological needs are assessed and responded to***

3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life"

8. Mr Morgan's conduct fell short of the expected standards in respect of Charges 1 and 5.

- ***"8 Work co-operatively***

(…)

8.6 share information to identify and reduce risk"

9. Mr Morgan's conduct fell short of the expected standards in respect of charges 2, 3, 4 and 5.

- ***"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

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

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

10. Mr Morgan's conduct fell short of the expected standards in respect of charges 3, 4 and 5 in particular.

- ***"16 Act without delay if you believe that there is a risk to patient safety or public protection***

  To achieve this, you must:

  16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices."

11. Mr Morgan's conduct fell short of the expected standards in respect of charges 1 and 5 in particular.

- ***"20 Uphold the reputation of your profession at all times"***

12. Mr Morgan's conduct fell short of the expected standards in respect of charges 1, 4 and 5 in particular. Dishonest conduct is especially serious and likely to bring the profession into disrepute.

Conclusion on misconduct

13. Mr Morgan's conduct as found proved by the committee in relation to all of the charges fell short of the professional standards expected of a nurse.

14. Both individually, and in sum, the facts which have been found proven demonstrate misconduct."

NMC Submissions on impairment

Mr Brown 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. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Brown provided written submissions which stated:

*"**Legal framework***

15. Impairment is a present day test. The panel must consider whether the registrant "is impaired", not "was". It is therefore a forward-looking test (Meadow v GMC [2006] EWCA Civ 1390).

16. A number of factors have been set out in the case law. In Cohen v GMC [2008] EWHC 581, the approach was described as follows:

> *"[62] Any approach to the issue of whether a doctor's fitness to practise should be regarded as 'impaired' must take account of 'the need to protect the individual patient, and the collective need to maintain confidence [in the] profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the'(sic). In my view, at stage 2 when fitness to practise is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor's misconduct, his or her fitness to practise has been impaired. It must not be forgotten that a finding in respect of fitness to practise determines whether sanctions can be imposed: s 35D of the Act.*

[65] Indeed I am in respectful disagreement with the decision of the Panel which apparently concluded that it was not relevant at stage 2 to take into account the fact that the errors of the Appellant were 'easily remediable' . I concluded that they did not consider it relevant at [that] stage because they did not mention it in their findings at stage 2 but they did mention it at stage 3. That fact was only considered as significant by the Panel at a later stage when it was dealing with sanctions. It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated. These are matters which the Panel should have considered at stage 2 but it apparently did not do so."

17. Accordingly, the panel should consider impairment in light of the following three factors:

- *Is the conduct of the registrant remediable;*
- *Has it been remedied;*
- *Is it highly unlikely to reoccur.*
-

18. In Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council (Grant) [2011] EWHC 927 (Admin), the Court decided that the Committee had misinterpreted the decision in Cohen as establishing a three-fold test in relation to conduct, rather than identifying relevant factors to be considered, the weight of which would vary from case to case depending on the facts.

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"69. It is clear, notwithstanding the references in those passages to whether fitness to practise "has been" impaired, that the question is always whether it is impaired as at the date of the hearing, looking forward in the manner indicated by Silber J in his judgment. The question for this Committee as at 21 April 2010 was therefore "is this Registrant's current fitness to practise impaired?"

70. An assessment of current fitness to practise will nevertheless involve consideration of past misconduct and of any steps taken subsequently by the practitioner to remedy it. Silber J recognised this when referring, at paragraph 65, to

the necessity to determine whether the misconduct is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

71. However it is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations emphasised at the outset of this section of his judgment at paragraph 62, namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.

72. This need to have regard to the wider public interest in determining questions of impairment of fitness to practise was also referred to by Goldring J in R (on the Application of Harry) v. General Medical Council [2006] EWHC 3050 (Admin) and by Mitting J in Nicholas-Pillai , where he held that the Panel were entitled to take into account the fact that the practitioner had contested critical allegations of dishonest note-keeping, observing that:

"[19] In the ordinary case such as this, the attitude of the practitioner to the events which give rise to the specific allegations against him is, in principle, something which can be taken into account either in his favour or against him by the panel, both at the stage when it considers whether his fitness to practise is impaired, and at the stage of determining what sanction should be imposed upon him."

19. The court also went on to say:

74. (…) 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."

20. At paragraph 76, the Court incorporated further factors with reference to the Shipman report:

"Dame Janet Smith in her Fifth Report from Shipman , referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering

impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

Factors to consider, whether impaired the registrant:

(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."

Relevant factors for impairment

21. In the next section, I will go through each of the charges in turn. I will address the question of "remediation", i.e. how serious the charges are, and whether they are remediable. I will also address whether they have been remedied, with reference to Mr Morgan's insight, training, and activities since the events in question.

22. After that, I will address whether Mr Morgan is likely to repeat the concerns in the future.

23. The relevance of insight and strengthened practice is discussed in NMC Guidance FTP-13.[1] I invite the panel to have regard to that guidance as well as the relevant further guidance at FTP 13a, FTP 13b, and FTP 13c.

Remediation

Charge 1

24. The charge of failing to carry out CPR when clinically justifiable is a serious one. There is an abundance of policy and procedures which set out the appropriate ways to identify when and how to carry out CPR.

25. The panel should consider the full circumstances of the case when assessing whether the concerns can be addressed.

26. The NMC has not alleged that Mr Morgan caused the death of Patient A, the panel has heard no evidence on that, and has made no finding in that regard. However, no matter what the outcome, it is vitally important that proper procedures are followed in respect of resuscitation. If they are not, it evidently can put patients at serious risk of harm. Furthermore, failure to provide adequate care in line with professional standards also risks bringing the profession into disrepute.

27. NMC guidance highlights that "rather than focusing on whether the outcome can be put right, decision makers should assess the conduct that led to the outcome, and consider whether the conduct itself, and the risks it could pose, can be addressed by taking steps, such as completing training courses or supervised practice."

28. Arguably, clinical failings may be addressed and remedied, for example through a combination of training, supervision, and demonstration that the registrant has learned from their failings and no longer represents a risk to patients.

29. The guidance also states:

> *"Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include:*
>
> - *medication administration errors*
> - *poor record keeping*
> - *failings in a discrete and easily identifiable area of clinical practice*
> - *concerns about incidents that took place a significant period of time in the past, especially if the nurse, midwife or nursing associate has practised safely since they occurred."*

30. Mr Morgan has undertaken extensive training, and some of it is relevant to charge 1. He has drawn your attention to his familiarity with the NEWS2 methodology and provided certificates of training, for example on provision of first aid, and also on "death, dying and bereavement". A further list of training is provided at page 325 of the exhibit bundle. He has informed the panel in a recent email that he has also carried out relevant training on the following:

- *Safeguarding Adults, Level 2.*

- *Safeguarding Children, Level 3.*
- *Attaining and maintaining safeguarding competencies.*

31. He has also shown insight and remorse in some of his letters and in his evidence. Some of his insight is equivocal, however. When asked what he would do differently, he stated that he would send the patient to hospital so he didn't have to worry about it.

Charge 2

32. With respect to the facts of Charge 2, the statement itself is evidence of a failure of communication, accuracy and candour in line with professional standards. This failing might be remedied, however, through training, experience and insight.

33. I also note that there are no other concerns with regard to communication and candour which have been notified to the NMC.

Charge 3

34. In relation to charge 3, the failure to record information is itself misconduct and it had a significant effect during the investigations. However, it can arguably be remedied by demonstration of training and good practice in record keeping. Mr Morgan has also shown insight, cooperation and candour by admitting this charge.

Charge 4

35. NMC guidance states that "because of the importance of honesty to a nurse, midwife or nursing associate's practice, dishonesty will always be serious."[2]

36. The panel have found that Mr Morgan intended to mislead by his acts and omissions. Honesty is one of the fundamental tenets of nursing care. A finding of dishonesty is also likely of itself to bring the profession into disrepute, and the panel must therefore consider the seriousness of this charge when deciding whether to make a finding of impairment, irrespective of whether the conduct itself can be or has been remedied.

37. NMC guidance highlights that, "in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice."

38. Mr Morgan has admitted that it was incorrect to state that the doctor informed him to do CPR. However, he has also variously claimed that he never did state it, despite evidence to the contrary. [PRIVATE]. He did not accept the charges of dishonesty which the panel have now found proved in relation to an intention to mislead by his actions. He has maintained his version of events over a period of several years.

39. In the CMF form, at page 329, he states that he has worked on his attitudinal problem. There is however, at the time of writing these submissions, no evidence of insight into that dishonest behaviour specifically.

Charge 5

40. In relation to charge 5, this charge includes serious and repeated failures to carry out adequate observations in respect of a patient, in line with the requirements of a clear policy. This exposed the patient to a risk of harm. Furthermore, falling below the expected standard of patient care gives rise to the possibility of bringing the profession into disrepute. It is also one of the fundamental tenets of the profession to provide care to patients when it is required.

41. Mr Morgan has carried out training on "falls response" and emergency first aid as indicated in the list on page 325.

Likelihood of repetition

42. The NMC guidance[3] states that: "When considering how likely it is that conduct will be repeated, decision makers will assess the extent of the nurse, midwife or nursing associate's insight into the concerns, and will also consider whether the steps taken to address concerns are sufficient."

43. The panel should have regard to the full circumstances of the concerns. The clinical failings all took place over one evening, and Mr Morgan has raised several potential mitigating factors [PRIVATE]. This is relevant to the likelihood of repetition.

44. In relation to all of those charges, it is also relevant for the panel to note that there have been no other incidents of alleged misconduct notified to the NMC.

45. The extent to which Mr Morgan has undergone training and demonstrated successful practice is also relevant. Mr Morgan did continue to practice as a nurse for a period following the referral to the NMC. The NMC received a positive reference from his employer at the time.

46. Mr Morgan then left work and has not practiced as a nurse consistently throughout the period. There is therefore limited evidence of long-term successful practice. He has now begun to practice again in the NHS, in a research-based role, and there are currently no concerns in relation to this employment.

47. He has written letters on 16 July 2021, and emails, which show insight into the failings. He also made certain admissions in his case management form. He has engaged with the NMC throughout the process, and expressed a desire for all the relevant information to be presented to the panel.

48. The panel should also take into account the fact that he did accept the majority of the charges in his evidence to the panel, although he maintained certain reasons for them which were inconsistent with a full admission.

49. With respect to the likelihood of repetition of dishonest behaviour, it is difficult to determine since it has arisen in particular circumstances. However, the maintaining of an inconstant and dishonest account over a period of time may be considered to demonstrate a fundamental attitude which is difficult to remedy.

Conclusion on impairment

50. The panel ought to make a finding of current impairment in the present case due to the seriousness of the charges, in particular charge 4 of dishonesty.

51. The cumulative concerns outlined in the findings of the panel also lead towards a finding of current impairment. The panel may consider that given the extent of clinical and administrative failings, there remains a risk of harm to patients if Mr Morgan is allowed to practice unrestricted.

52. Regardless of the steps that Mr Morgan has taken to demonstrate remediation, in particular his training records and his letters and evidence indicating insight, the charges and the circumstances are so serious that a finding of impairment is necessary. If the

panel does not find that Mr Morgan is impaired, there is a risk of bringing the profession, and the NMC as regulator, into disrepute.

53. In doing so, the panel should also bear in mind the fact that, absent a finding of impairment, it has no power to impose any sanction, including a warning."

Your submissions on misconduct and impairment

You provided written submission on misconduct and impairment which stated:

> *"During the hours of yesterday evening and into the night I have read and re-read the paper prepared on my accusations of misconduct and impairment. It is clear beyond doubt that based on the evidence that the NMC have presented that those allegations cannot, understandably, be challenged. I know and unreservedly admit, and not for the first time, that my actions of that night in 2018 most certainly fell far short of what should be expected of a trained professional nurse.*
>
> *As the panel knows there were some extenuating circumstances which may had a negative impact on my ability to provide a service of care that the public and the NMC would expect. [PRIVATE]. For that reason alone, for me to have worked that particular shift constituted misbehavior and impairment at that time. Because of this I have written to several case presenters stating my shame and profound regret for my failings during that night.*
>
> *Over the past four years I have spent many a sleepless night pondering on what I did and didn't do and what I fervently believed in my mind what had actually taken place that night. [PRIVATE]. I state this not to justify my failings at that time for which I will never forgive myself for.*
>
> *I have also given much thought as to whether my actions on that night and subsequently constituted dishonesty and/or impairment. Based on the evidence presented to the panel it would be logical to assume dishonesty and impairment leading to a belief that I had attempted to mislead or misdirect those people given the task of investigating my case. To prove to the satisfaction of the panel and my governing body that my subsequent statements to the investigation were not a*

fabrication designed to mislead is beyond my ability and therefore I fully understand the panels position. All that I can say in my defense is that I fervently believed that I had presented a true series of statements based on my understanding of the events of what was a hectic and confusing night. I swear to God and all that is holy, {and I am still under oath}, that in my mind I was always truthful but only succeeded in misleading myself in the end. I accept that the panel find it difficult to acknowledge this.

In the years that have followed I have learned that as human beings we can and do make mistakes. It is how we react and respond to mistakes that brings about personal and professional growth. Where mistakes are made it is essential to acknowledge them, learn by them and to put in place corrective strategies to minimize the chances of it happening again. I have since the events of that night shift endeavored to address all and any shortcomings in my nursing practice. I have done this through formal and informal study and training, and I have amassed a formidable portfolio of certificates which evidence my professional development. Also, I have begun my training as a mentor and supervisor run by the University of Plymouth to enable me to support nursing students up to and including MSc level. My recent appointment as a Vaccination Clinical Supervisor has exposed me to a mass of new clinical subjects much of which I have already submitted to the NMC. I am going to attempt to attach my most recent training activity report. Not all the NHS training courses end up with a certificate of achievement, but I will send copies of those that do if required. The NHS only require sight of the activity report.

There are many issues that I would wish to address in order to give strong assurances that I have grown professionally because of my failings of four years ago. However, I think that I have referenced how I have addressed this in several documents that I have submitted. To refer to them again would, I suspect, be an unwelcome burden on the panels time and patience.

I will therefore just summarize my learning as follows: -

- *It is my understanding that the NMC accepts that mistakes can and do happen. It is how we respond that is important.*

- *We do not operate in an accusatory way in the nursing profession.*
- *When mistakes occur, I take ownership of them and learn by them.*
- *I am fastidious in recording all and every discussion and observation contemporaneously.*
- *I try to put personal and professional strategies in place to minimize any chance of recurrence for myself and others.*
- *I abide by always 'Being Open', { DUTY OF CANDOUR}.*
- *I have a strong commitment to an open and just culture for myself and others.*
- *The NHS Trust that employs me has in place an incident reporting data base called 'DATIX' which is open to all staff to report incidents. It is an intuitive system.*
- *When an incident occurs my Trusts culture is one of 'How and why did this happen, NOT one of 'Who can we blame'.*

It is pertinent to keep in mind the words of Robert Frances when he described candour as 'the volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested'. I fully support this description of candour and teach it to others as the only way to conduct themselves when an adverse incident occurs.
In summary, I have made great efforts to continually improve as a professional nurse and one who can be trusted to practice in a way that follows our Code of Practice. In doing so I pray that the NMC and the panel can be assured that my nursing practice is not impaired. Mr Brown wrote that this incident happened on one night several years ago and that I have cooperated and responded to all requests that were made of me. I hope that it can be seen that I do not present a risk to patients, their families and that I represent the nursing profession and the NMC honorably."

The panel accepted the advice of the legal assessor which included reference to the relevant judgments. This included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311.

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life*
>
> ***8 Work co-operatively***
> *8.2 maintain effective communication with colleagues*
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
>
> ***10 Keep clear and accurate records relevant to your practice***
> ***This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.***
> *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
10.5 take all steps to make sure that records are kept securely

13 Recognise and work within the limits of your competence
13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required

20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel took into consideration the evidence before it and in the circumstances determined that your actions did amount to misconduct.

The panel determined that your actions in charge 1 and limbs a to e of this charge seriously fell short of the standards expected of a registered nurse. The panel noted that you did not attempt CPR on a patient when it was clinically appropriate or justifiable to do so and that this demonstrated a failure to provide care and breached fundamental tenets of nursing practice. The panel noted the serious nature of your failures exacerbated the misconduct in this case.

The panel concluded that your actions in charge 2 amount to misconduct. The panel is of the view that in the circumstances, and based on the charges found proved, you were dishonest about the instructions and knowingly maintained that Doctor A advised you not to do CPR on Patient A. The panel concluded that in light of the charges found proved, charge 2 constitutes misconduct.

The panel next considered whether charge 3 amounts to misconduct. The panel considered the nature of the instructions that this charge relates to and noted the seriousness of it. The panel further noted that record keeping is a fundamental aspect of nursing and, in the circumstances of this case, it determined that this charge gives rise to misconduct.

The panel took into consideration charge 4 and limbs a to d of this charge. The panel determined that this charge constitutes misconduct and concluded that dishonesty is considered a serious departure from the standards expected of a registered nurse. The panel is of the view that in these circumstances that the intended outcome was to mislead and therefore concluded that charge 4 does amount to misconduct.

In relation to charge 5, the panel determined that your actions did amount to misconduct. The panel considered that limbs a to d of charge 5 relate to fundamental aspects of nursing care. The panel determined that your actions in this charge demonstrate a serious failure in what was expected of you. The panel noted that a registered nurse has a duty of care to their patients and that your actions in charge 5 demonstrates that you failed to recognise and respond to the needs of your patient.

In conclusion, the panel is of the view that individually and collectively your actions fell far short of the standards expected of a registered nurse. The misconduct is serious in that your actions in charges 1 to 5 breach a number of fundamental tenets of nursing practice. The panel determined that your actions demonstrate many acts and omissions which led to potential harm. The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your 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. 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 finds that a patient was put at unwarranted risk of harm as a result of your misconduct. It was of the view that in failing to undertake and record adequate observations, you failed to recognise and respond to the needs of the patient. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that you made admissions to the charges 1a, 1c, 1d, 1e and 3 at the outset of these proceedings and that you have demonstrated some insight. The panel took into account that you showed remorse for what had happened.

However, the panel noted that throughout the facts stage of this hearing you maintained that your actions were not dishonest. The panel is of the view that you did not fully accept the extent of your failures and that you have not taken full responsibility for your actions on the night in question. It noted that in relation to the charges, you blamed either the circumstances of you working on that date, the equipment failures at the Home, or your access to certain documents such as the required forms. The panel further noted that you have not demonstrated that you understand how your actions placed the patient at a risk of harm. You have also not demonstrated how your actions, omissions and dishonesty has impacted negatively on the reputation of the nursing profession.

The panel was satisfied that the misconduct in this case is capable of remediation. The panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel has had sight of a number of training certificates and documentation some of which predated this incident. The panel noted the letter you sent to your case coordinator dated 21 March 2022 which provides a list of training you have undertaken. This list does not provide completion certification or competency assessment of all the courses listed. For example, the panel noted that the Emergency First Aid at Work course certificate records that this training was undertaken at ‘Angling-School CIC’ and therefore appears not to relate to a healthcare setting. The panel therefore was not satisfied that the areas of concern have been addressed to the required standard.

The panel also took into account that you have provided lists of training that you have stated have been completed by you between 1 February 2022 to 3 June 2022. The panel noted that the lists provided did not reflect any identifiable factors relating back to you such as your name and NMC pin number. It further noted that these did not reflect that you were certified in these areas and assessed as competent in them. It also noted that these training modules do not address the concerns raised by the charges. The panel therefore determined that this has not sufficiently addressed the relevant areas of concern and did not demonstrate that you have taken significant steps to strengthen your practice.

The panel also noted that you did not provide any documentation to evidence any re-training that you have undertaken to address your record keeping failures.

In relation to the charges of dishonesty, you denied these charges and continue to assert that your intention was not to mislead. Therefore the panel is not satisfied that these concerns have been remediated. The panel is of the view that you have not satisfactorily taken accountability of your failures during the incident.

The panel is of the view that there is a risk of repetition based on the insufficient insight that you have demonstrated and that sufficient and relevant steps to strengthen your practice have not been taken. The panel noted that as you did not demonstrate an understanding of how your actions placed the patient in your care at a risk of harm and therefore could not be satisfied that the risk of repetition was low. The panel therefore 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; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because the public confidence in the profession would be undermined if a finding of impairment were not made in this case.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months with review. The effect of this order is that the NMC register will show that your 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.

The panel considered this case very carefully and took into account submissions from Mr Brown and from you on sanction.

Submissions on sanction from the NMC

Mr Brown informed the panel that in the Notice of Hearing, dated 23 February 2022, the NMC had advised you that it would seek the imposition of a 12 month suspension order, with a review before expiry or a striking off order if it found your fitness to practise currently impaired.

1. *"The Committee should consider whether to impose the following available sanctions:*

- *taking no further action*
- *a caution order of between one and five years*
- *a conditions of practice order of up to three years*
- *a suspension order of up to twelve months*
- *a striking-off order*

2. *Realistically, some form of substantive sanction must be imposed in this case, and the NMC suggests that a 12 month suspension order or strike-off are appropriate, for the reasons below.*
3. *For the benefit of the panel and Mr Morgan, I will set out parts of the relevant guidance which the panel should take account of when determining what sanction to impose.*

Proportionality

4. *A fundamental principle in assessing what sanction should be imposed where a registrant's practice is found to be impaired is proportionality. I refer the panel to the NMC's Guidance SAN-1 on this topic: https://www.nmc.org.uk/ftp-library/sanctions/decision-making-factors/.*
5. *The guidance sets out, inter alia, that:*

- *"Being proportionate means finding a fair balance between the nurse, midwife or nursing associate's rights and our overarching objective of public protection.4 We need to choose a sanction that doesn't go further than we need to meet this objective. This reflects the idea of right-touch regulation."*
- *"Any decisions to restrict a nurse, midwife or nursing associate's right to practise as a registered professional must be justified."*
- *"The panel should consider whether the sanction with the least impact on the nurse, midwife or nursing associate's practise would be enough to achieve public protection, looking at the reasons why the nurse, midwife or nursing associate isn't currently fit to practise and any aggravating or mitigating features."*
- *"If this sanction isn't enough to achieve public protection, they should consider the next most serious sanction. When the Committee finds the sanction that is enough to achieve public protection, then it has gone far enough."*
- *"They need to explain why the following most serious sanction is not necessary as it would be going further than is needed to achieve public protection."*

6. *Courts have also given relevant guidance on proportionality in the case of dishonesty, in the case of Brennan v Health Professions Council [2011] EWHC 41 (Admin), it was said at paragraph 47:*

- *"Where the purpose of sanction is to deal with issues other than the primary one of maintaining public safety, and is instead to provide deterrence to others, to maintain confidence in the profession's reputation and standards and in its regulatory*

process, the reasoning is particularly important in showing that the sanction is proportionate to the misconduct and for the individual."

Misconduct and Impairment

7. *The misconduct which has been proven includes dishonesty and several breaches of fundamental tenets of nursing practice. The panel summarised its reasons as follows:*

- *"In conclusion, the panel is of the view that individually and collectively your actions fell far short of the standards expected of a registered nurse. The misconduct is serious in that your actions in charges 1 to 5 breach a number of fundamental tenets of nursing practice. The panel determined that your actions demonstrate many acts and omissions which led to potential harm. The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct."*

8. *I remind the panel that it has found that Mr Morgan is currently impaired on the following grounds:*

- *"The panel finds that a patient was put at unwarranted risk of harm as a result of your misconduct. It was of the view that in failing to undertake and record adequate observations, you failed to recognise and respond to the needs of the patient. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious."*
- *"In relation to the charges of dishonesty, you denied these charges and continue to assert that your intention was not to mislead. Therefore the panel is not satisfied that these concerns have been remediated. The panel is of the view that you have not satisfactorily taken accountability of your failures during the incident.*
- *The panel is of the view that there is a risk of repetition based on the insufficient insight that you have demonstrated and that sufficient and relevant steps to strengthen your practice have not been taken. The panel noted that as you did not demonstrate an understanding of how your actions placed the patient in your care*

at a risk of harm and therefore could not be satisfied that the risk of repetition was low. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection."

- *"The panel determined that a finding of impairment on public interest grounds is required because the public confidence in the profession would be undermined if a finding of impairment were not made in this case."*

Seriousness

9. *The Guidance SAN-1 sets out that the panel should consider any aggravating and mitigating features. It also sets out some examples of each.*

Aggravating features

10. *In the present case, the NMC submits that the following are potentially aggravating features:*
    a. *Dishonesty is always treated seriously, particularly in the context of nursing.*
    b. *The panel found that Mr Morgan showed limited insight and remedial action in respect of his clinical failings.*
    c. *He showed a particular lack of insight into his failings in relation to dishonesty. He made continual denials in the local investigation and at the hearing.*
    d. *Mr Morgan failed to comply with basic nursing obligations and breached fundamental tenets of nursing; compliance with protocols and policies is a basic nursing obligation. Record keeping is also an important basic obligation.*
    e. *The level of potential risk of harm associated with the specific clinical failings in question under Charges 1 and 5 is high.*
    f. *Mr Morgan's misconduct is liable to cause damage to the reputation of the profession.*

Mitigating features

11. *The guidance sets out that Mitigation can be considered in three categories:*

- *Evidence of the nurse, midwife or nursing associate's insight and understanding of the problem, and their attempts to address it. This may include early admission of the facts, apologies to anyone affected, any efforts to prevent similar things happening again, or any efforts to put problems right.*
- *Evidence that the nurse, midwife or nursing associate has followed the principles of good practice. This may include them showing they have kept up to date with their area of practice.*
- *Personal mitigation, such as periods of stress or illness, personal and financial hardship, level of experience at the time in question, and the level of support in the workplace.*

12. *I would also draw the panel's attention to the guidance which specifically notes the following:*

"If a nurse, midwife or nursing associate's actions put people at risk of being harmed, this risk makes their case more serious. However, keeping patients safe also includes avoiding a culture of blame or cover up, so we do not want to punish nurses, midwives or nursing associates for making genuine clinical mistakes."

Insight and remedial action

13. *The panel noted in its reasons that "the panel was satisfied that the misconduct in this case is capable of remediation."*
14. *With regard to Mr Morgan's insight, he has admitted to some of the misconduct charges and shown remorse. I refer you back to my submissions on impairment in this regard.*
15. *In terms of remedial action, Mr Morgan has addressed some of the clinical concerns through further training. He has begun practice in a different area of nursing*

Good practice

16. *With respect to evidence of good practice, there are no other clinical concerns relating to Mr Morgan and he has a long history in nursing.*
17. *He states that he has kept up to date with required training and taken additional courses to increase knowledge in certain areas*

Personal mitigation

18. *Mr Morgan has also spoken about some of the personal difficulties which may have impacted on his conduct and which are relevant to considering the appropriate sanction, including:*
    a. *[PRIVATE].*
    b. *[PRIVATE].*
    c. *He had only recently returned to work.*
    d. *The expectations of the care home were too high in his view. However, they were described as normal and no staffing issues were identified by the care home manager at the time.*

Seriousness

19. *This is a serious case involving dishonesty, therefore the panel should also have regard to Guidance SAN-2 https://www.nmc.org.uk/ftp-library/sanctions/sanctions-serious-cases/.*
20. *That guidance states that "The most serious kind of dishonesty is when a nurse, midwife or nursing associate deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone's care."*

"Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*
- *direct risk to patients*
- *premeditated, systematic or longstanding deception*

Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*

- *no risk to patients*
- *incidents in private life of nurse, midwife or nursing associate"*

21. *In this case, the charge of intention to mislead has been proved and accordingly, the breach of the duty of candour must be considered deliberate. It was done in a context of covering up proven failures to provide an adequate standard of care. Although the event in question was a one-off, Mr Morgan maintained that he was not dishonest throughout the local and NMC investigations and at this hearing. This also indicates that it must be treated as serious.*
22. *In the case of Parkinson v NMC [2010] EWHC 1898 (Admin) . The court considered an appeal where the panel had ordered erasure (striking off). At paragraph 18 the court said:*

"On the information which it had, I cannot say that the decision of the Panel was wrong. It was stern certainly, but it was properly stern because, as the Panel noted, one of its tasks is to maintain public confidence in the professions. A nurse found to have acted dishonestly is always going to be at severe risk of having his or her name erased from the register. A nurse who has acted dishonestly, who does not appear before the Panel either personally or by solicitors or counsel to demonstrate remorse, a realisation that the conduct criticised was dishonest, and an undertaking that there will be no repetition, effectively forfeits the small chance of persuading the Panel to adopt a lenient or merciful outcome and to suspend for a period rather than to direct erasure." [my emphasis]

23. *However, the guidance states that "Nurses, midwives and nursing associates who behaved dishonestly can engage with the Fitness to Practise Committee to show that they feel remorse, that they realise they acted in a dishonest way, and tell the panel that it will not happen again…. If they do this, they may be able to reduce the risk that they will be removed from the register."*
24. *The panel can and should consider any representations Mr Morgan has made orally, in writing, and any other relevant documents before them.*

Correct sanction

25. *In light of the seriousness of findings of misconduct and the corresponding level of impairment, the NMC considers that a conditions of practice order would not be an adequate sanction to protect the public and the reputation of the profession.*
26. *The NMC invites the panel to impose a minimum sanction of a 12 month suspension or a striking-off order.*

Conditions of practice order

27. *The NMC submits that a Conditions of Practice Order is not sufficient.*
28. *Guidance SAN-3c https://www.nmc.org.uk/ftp-library/sanctions/the-sanctions/conditions-of-practice-order/ sets out the key considerations and a number of factors which indicate when conditions would be appropriate.*
29. *The key consideration for the panel, before making a conditions of practice order, is whether conditions can be put in place that will be sufficient to protect patients or service users, and if necessary, address any concerns about public confidence or proper professional standards and conduct.*
30. *In this case, the NMC submits that it is not, due to the seriousness of the misconduct. Mr Morgan's conduct led to grave potential harm. Charges 1 and 5 are both serious clinical failings. Charge 2-4 contain dishonesty which is especially serious for a nurse. Given the current level of insight and remediation, a conditions of practice order is not sufficient to protect the public.*
31. *To make sure conditions of practice achieve their aim of public protection, in a way that's fair to the nurse, midwife or nursing associate, they should be* ***relevant, proportionate, workable and measurable****. The NMC considers that that is not possible in this case due to the wide ranging and serious concerns.*

Suspension order

32. *I refer the panel to NMC Guidance SAN-3d https://www.nmc.org.uk/ftp-library/sanctions/the-sanctions/suspension-order/.*
33. *The guidance notes that a suspension order of up to a year may be appropriate in cases where:*
    a. *the misconduct isn't fundamentally incompatible with the nurse, midwife or nursing associate continuing to be a registered professional, and*

b. *the NMC's overarching objective may be satisfied by a less severe outcome than permanent removal from the register.*

34. *Key things to weigh up before imposing this order include:*
    - *Whether the seriousness of the case requires temporary removal from the register?*
    - *Will a period of suspension be sufficient to protect patients, public confidence in nurses, midwives or nursing associates, or professional standards?*
35. *In considering these questions, I invite the panel to have regard to its reasons, and to the aggravating and mitigating circumstances set out above. In the NMC's submission, the conduct is sufficiently serious in this case to justify at least a temporary removal from the register. Furthermore, any suspension order should be at the upper end of potential sanctions, i.e. 12 months.*
36. *A suspension order will be reviewed before expiry. If it makes a suspension order, the Panel may wish to explain clearly what expectations it has, or what actions Mr Morgan could take that would help a future Committee reviewing the order before it expires.*

Strike off

37. *Striking off orders are considered in Guidance SAN-3e: https://www.nmc.org.uk/ftp-library/sanctions/the-sanctions/striking-off-order/.*
38. *A striking-off order is the most serious sanction. This sanction is likely to be appropriate when what the nurse, midwife or nursing associate has done is fundamentally incompatible with being a registered professional.*
39. *Before imposing this sanction, key considerations the panel should take into account include:*
    - *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
    - *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

40. *In considering these questions, I invite the panel to have regard to its reasons, and to the aggravating and mitigating circumstances set out above. In the NMC's submission, there are fundamental questions of professionalism which must be considered.*

Conclusion

41. *The panel should consider the circumstances of the misconduct and the reasons for impairment, along with any aggravating and mitigating factors.*
42. *However, it must remember that the primary purpose of sanctions is to achieve the overarching objective to protect the public. The overarching objective requires the NMC to:*

· *protect, promote and maintain the health, safety and wellbeing of the public*

· *promote and maintain public confidence in the nursing and midwifery professions*

· *promote and maintain proper professional standards and conduct for members of the nursing and midwifery professions*

43. *Confidence in the profession is likely to be damaged by a perceived failure to impose a commensurate sanction where a registrant is found to be dishonest.*
44. *Accordingly, the NMC proposes that the panel should consider imposing a sanction of suspension for 12 months or strike off in this instance. The conduct is sufficiently serious in this case to justify at least a temporary removal from the register.*
45. *However, the panel must satisfy itself that the sanction it imposes is proportionate and does not go further than necessary to satisfy the overarching objective."*

Your submissions on sanction

The panel also bore in mind your written submissions that stated:

“Having read this document there are several observations that I would like to make. I have given the observations the same paragraph number to help the reader to view them in context.

7. I want to state that I have admitted misconduct even though it was not intentional. I also fully agree that dishonesty is a very serious charge in any situation but especially in the nursing profession. I agree that my claims of certain events of that night would be seen as dishonesty. However, I only had stated or commented on what I believed to be true at the time. It therefore follows that I did not seek to mislead, and my statements were in fact innocently made.

I have accepted accountability for my failings during that night shift. I am conscious of the importance that the code places on accountability. Surely, admitting, as I have, my poor care of the patient and my failings is seen as taking accountability for my actions.

It has been stated that the Committee believes that there is a risk of repetition based on my insufficient insight into the seriousness of my actions and that I have not demonstrated relevant steps to strengthen my practice and consequently I am currently impaired.

Until April 2022 I was 100% up to date with all mandatory training. I addition to this I had attended specific training courses in our local hospice. I took part in the early development and assessment of the NEWS 2 system of recognizing the deterioration patient and clear guidance on actions to be taken. I have reported that this year I have undertaken a significant amount of training modules all of which enhances my clinical and psychological skills. The NHS Activity of Training report which I submitted was apparently not believed to be genuine as my name and PIN number were not shown. I downloaded my specific training report from the NHS training site – e-LfH Hub for which I have my own access code and password. I can submit further copies of several certificates which show my name, the date and my PIN number as I do not want to be accused of dishonesty any more.

[Also in reference to the earlier document I received from the panel. The Emergency First Aid course delivered by an organization called Angling School CIC was organized by the nursing home. The course was very much health related and

adapted for real life scenarios that could occur in a nursing home environment. That same document suggested that I lied about my use of Tramadol. It is very important for the panel and the FtP committee to understand that whilst the prescription was for Tramadol 50mg 4 to 6 hourly I had been only taking one capsule on a prn basis when I experienced severe discomfort]. I am more than happy to be questioned on this again to assure myself that I have explained it clearly and that people have understood.

<u>Seriousness</u>

The panel wrote that I did not take remedial action in respect to my clinical failings and that I showed limited insight. [PRIVATE]. It has been a constant battle for me to fight these awful feelings.

The question of dishonesty continues to be at the forefront of the seriousness of this case. I have learned that there is nothing that I can say or do to convince people that my apparent dishonesty was unintentional and purely based on my understanding of the events of that night as they unfolded.

I would have thought that a nurse with 50 plus years of experience would deserve some measure of trust. I have been made to feel that those years of unblemished practice counts for something. Clearly it seems it does not.

I agree that my misconduct could damage the reputation of the profession. I must repeat that in the years since I have worked very hard remedy this but again, either my efforts are viewed as untruths or of no value, at least that is how it feels.

12. I have admitted my serious failings on the night shift in question and yet the NMC seeks to punish me contrary to their own guidance on the importance of openness.

20. I strongly state again that I did not breach my professional Duty of Candour. All my earlier statements were innocent and based on how I saw them at the time. This does not constitute dishonesty.

21. Please consider this:- Statements made by me were indeed dishonest or perhaps a gentler word would be false, but, they were made were made in all honesty and sincerity.

22. Surely, I have shown deep remorse and shame for my standard of work that night. I am by nature an emotional being which has been a predominant feature of my nursing care.

Yes, I have also admitted that my conduct at the time was by definition dishonest. I did not plan to be dishonest and I did not seek to hide the facts nor was my poor behavior deliberate.

23. I have demonstrated extreme remorse and regret for being a very poor clinician on that occasion. I can fully understand that on examination, several of my statements would be seen as dishonest. I my new role of Registered Vaccinator along with the extensive studies I have undertaken will minimize any chance of repetition.

<u>Sanctions.</u>

I have over the past four years undergone a profound strengthening of my nursing practice and given me significant improvements in my clinical skills.

I have to say that should a 12 month suspension be my punishment it will destroy all that I have achieved as a consequence of the learning curve I have travelled. Most certainly I would lose my new job. A job that I am so very proud to have been appointed to and my return to the NHS. I guess too that at my age, 75, such a sanction would make it almost impossible to find another job.

30. I have tried many times to address these issues but there is a reluctance on someone's part to accept my sincerity.

31. Fairness to me appears to be heavily weighted against me. It seems that there is nothing I can say or do is viewed with any measure of empathy but more od doubt and suspicion. You state that I am guilty of a wide range of serios[sic] concerns even though I have worked so hard to remedy them.

<u>In summary.</u>

I will in my new role should you allow me to proceed, I will have several layers of supervision. Mostly the people coming for vaccination will be fit. Any protracted period of suspension could be seen as a serious act of misjudgment and ignoring one of the NMC's basic values which is to support the nurse and help them to overcome a very bad experience.

If the FtP Committee course of action you will be removing a dedicated caring nurse who has followed the NMC guidance of learning from this dreadful event and done all he can to take extensive remedial action to ensure that it is not repeated.

I was informed over a year ago by one of the case examiners that my sanction would be a 12-month suspension. Thus, should I make an assumption that my punishment had already been decided prior to the continued investigations and my hearing.

I had fervently hoped that the FtP Committee would have recognized that I have learned from my mistakes and put in place strategies and actions designed to strengthen my practice. As a result, I had prayed that I would be given a strong and final written warning making it very clear that any misconduct would be met with profound sanctions.

I would plead with the Committee to give me a more lenient punishment given that I have made a serious mistake in one occasion in so many happy years nursing. My actions on the 4th/5th of October 2018 were very atypical of me."

Application to submit further evidence

After providing your written submission on sanction, you made an application to submit further evidence orally and in document form in relation to the training that you have undertaken. You submitted that you have never been good at presenting your evidence and forget to include parts of your evidence. You submitted that, based on the panel's findings in the previous stages of this hearing, you would like to provide certificates evidencing the training you have undertaken. [PRIVATE].

Mr Brown, in response to you, submitted that he supported your application to provide further evidence. He submitted that there are specific points raised by you in your application that indicate that they relate to mitigation.

The panel accepted the advice of the legal assessor.

The panel decided to accept your application to submit further evidence. The panel noted that this further evidence has been offered on the last scheduled day for this hearing but deemed that it would be fair to allow you the time and opportunity to provide these documents. The panel therefore invited to you submit the documents of your certificates into evidence.

The panel then heard evidence from you under oath in relation to sanction.

Decision and reasons on sanction

Having found your 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 (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Dishonesty is always treated seriously;
- Lack of sufficient insight into your failings and in relation to your dishonesty;
- Lack of remedial action in respect of the clinical failings;
- Failure to comply with basic nursing obligations and breached fundamental tenets of nursing;
- The level of potential risk of harm associated with the specific clinical failings is high; and

- The misconduct is liable to cause damage to the reputation of the profession.

The panel took into account the following mitigating features;

- [PRIVATE];
- [PRIVATE].

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 determined that there was a breach of the professional duty of candour, in that you were dishonest about when things went wrong. The panel is of the view that you maintained your dishonesty and that there was a continuing intention to mislead. The panel therefore 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 your 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 your 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*

- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining alone.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where there is a single instance of misconduct but where a lesser sanction is not sufficient.

It did go on to seriously consider whether a striking-off order would be proportionate but taking account of all the information before it and the NMC's guidance which states:

"The panel should consider whether the sanction with the least impact on the nurse, midwife or nursing associates practice would be enough to achieve public protection, looking at the reasons why the nurse, midwife or nursing associate isn't currently fit to practise and any aggravating or mitigating features."

The panel is of the view that a suspension order would be sufficient to achieve public protection and maintain public interest. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your 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. The panel had regard to the SG which notes

that a suspension order may be appropriate if the misconduct was not fundamentally incompatible with remaining on the register and the NMC's overarching objective may be satisfied by a less severe outcome than permanent removal from the register.

The panel noted the hardship such an order will inevitably cause you. 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.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

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:

- A reflective piece which demonstrates:
    - Your insight into your dishonest and misleading conduct and the negative impact this had on patient care, your colleagues and the profession;
    - Your understanding of the importance of contemporaneous record keeping;
- Demonstrate how you have kept up-to-date with the nursing profession; and
- Evidence of references or testimonials from colleagues in any employment you have undertaken in any capacity.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Brown. He submitted that an interim order was necessary on public protection and public interest grounds. Mr Brown submitted that an interim order should cover the appeal period until the substantive suspension order comes into effect. He further submitted that the interim order should be in place for a period of 12 months.

The panel also took into account the submissions made by you, You submitted that the suspension order should be imposed immediately as opposed to in 28 days. You stated that you believed your nursing career is effectively ‘over’.

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 to protect the public and uphold the public interest and uphold confidence in the profession and the NMC as a regulator. The interim order will cover the period that an appeal may be lodged and for any appeal to be heard.

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

That concludes this determination.