Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
09-25 August 2021
28 February-11 March 2022
21-24 March 2022

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

Name of registrant:	Michael Christopher South
NMC PIN:	98C1260E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nurse – 17 March 2001
Area of registered address:	Exeter
Type of case:	Misconduct and Lack of competence
Panel members:	Anthony Griffin (Chair, Lay member) Laura Wallbank (Registrant member) Donna Green (Registrant member)
Legal Assessor:	Tracy Ayling QC (09-25 August 2021) John Donnelly (28 February 2022-24 March 2022)
Panel Secretary:	Roshani Wanigasinghe Holly Girven (22 and 23 March 2022)
Nursing and Midwifery Council:	Represented by Victoria Shehadeh, Case Presenter
Mr South:	Present and represented by Wafa Shah instructed by the Royal College of Nursing (09-18 August 2021) Ms Ylenia Rosso (19 August 2021) Unrepresented (20 August 2021 onwards)
Facts proved by admission:	Charges 5b, 13a, 14a, 14c, 14d, 14e, 16, 17, 19g, 19h, 20, 21 and 23.

Facts proved:	Charge 1, 2, 3 in its entirety, Charge 4 in respect of 3a- d and f in respect of HCA 1, 6, 7, 8, 9a, 9b, 10, 11a, 11b, 11c, 14b, 15, 19e, 19f and 22
Facts not proved:	Charge 4e and charge 4f in respect of Patient 1 only, 5a, 12, 13b, 13c, 18, 19a, 19b, 19c and 19d
Fitness to practise:	Impaired
Sanction:	Suspension order (9 months) with a review
Interim order:	Interim suspension order (18 months)

Details of charge (as amended)

That you a registered nurse while working at Northamptonshire Healthcare NHS Foundation Trust between 20 August 2015 and 28 February 2017:

1. On 26 August 2016 did not conduct a search of Patient 1 and/or Patient 1's property on her return to the ward after authorised leave. **[Charge found proved]**

2. Your inaction at Charge 1 contributed to a loss of opportunity to identify that Patient 1 was bringing one or more paracetamol on to the unit or had consumed one or more paracetamol while on authorised leave. **[Charge found proved]**

3. In your statement to your employer dated 29 August 2016, and/or your statement to your employer dated 22 September 2016 and/or your interview on 22 September 2016 and 05 October 2016, about the incident at Charge 1, you made one or more of the following representations which were not true.
   a) That you had been on a break when Patient 1 entered **[Charge found proved]**
   b) That you had not let Patient 1 into the Ward **[Charge found proved]**
   c) That HCA 1 had told you they let Patient into the Ward **[Charge found proved]**
   d) That HCA 1 had told you they had conducted a bag search on the return of Patient 1 to the Ward **[Charge found proved]**
   e) That you had subsequently searched Patient 1's wheelchair and/or bag **[Charge found proved]**
   f) That you had carried out the search at e) above in the presence of HCA 1 and/or Patient 1. **[Charge found proved]**

4. Your representations at one or more of 3 a)-f) above were dishonest in that you were making a representation which you knew was not true. **[Charge found proved in respect of charges 3a – d and 3f in respect of HCA 1. Charge 4 not proved in respect of charge 3e and 3f in respect of Patient 1.]**

5. On 18 November 2015

   a) did not respond promptly and/or follow procedure when Patient 2 absconded from the ward. **[Charge found NOT proved]**

   b) Identified to Nurse 3 the wrong patient when alerting him of the absconding at charge 5a). **[Proved by admission]**

6. On or around 20 October 2015, having been requested to do so by Nurse 3, did not inform colleagues that a Patient was being transferred from Harbour Ward to Bay Ward, and/or did not provide colleagues with any or adequate information about that Patient in preparation for the transfer. **[Charge found proved]**

7. In relation to Patient 2, did not formulate a person-centred care plan. **[Charge found proved]**

8. In relation to Patient 6, did not produce a Physical Health Care Plan for them, prior to 25 January 2016 **[Charge found proved]**

9. In relation to Patient 7:

   a) Did not evaluate their care plan between 20 December 2015 & 15 January 2016 **[Charge found proved]**

   b) Did not document in their clinical record that their rights had been read to them during the admission. **[Charge found proved]**

10. In relation to Patient 11, did not put in place a care plan to support staff in dealing with occasions when that Patient placed themselves on the floor. **[Charge found proved]**

11. In relation to Patient 11, on 23 December 2016:

    a) Did not seek advice and/or assistance promptly in relation to their continued presentation on the floor. **[Charge found proved]**

b) Did not escalate the concerns about Patient 11 to the Ward Matron. **[Charge found proved]**

c) Did not carry out NEWS/physical observations on Patient 11 or instruct another member of staff to do so. **[Charge found proved]**

12. On 28 October 2015 administered Ramipril despite being made aware there was an error with the prescription. **[Charge found NOT proved]**

13. On 28 October 2015

a) Administered Insulin to a patient at 14:00 when it should have been administered at 12:00 **[Proved by admission]**

b) Did not document the time the patient was administered the dose at 13 a) above **[Charge found NOT proved]**

c) Did not document why the patient was administered the dose at 13 a) above late **[Charge found NOT proved]**

14. On 26 December 2015

a) Gave Patient 3 their medication Depakote at approximately 12:30 when it was not prescribed until 17:00/18:00. **[Proved by admission]**

b) Did not document the medication error at 14 a) above in Patient 3's records. **[Charge found proved]**

c) Asked Nurse 1 not to include the medication error at 14 a) above in her handover notes. **[Proved by admission]**

d) When asked by Nurse 2 to report the medication error and/or document the error at 14 a) above replied with words to the effect of 'It doesn't matter. It's only Depakote, it should not be a problem' **[Proved by admission]**

e) Did not complete an incident form via DATIX for the medication error at 14 a) above. **[Proved by admission]**

15. Your actions at Charges one or more of 14 b) to 14 e) above demonstrated a lack of integrity in that you sought to avoid there being a record and/or report of the error

at 14 a) above, when you knew there should have been. **[Charge found proved in its entirety]**

16. On 4 August 2016 and/or 5 August 2016 administered CETRIZINE 10mg to Patient 9 when this medication had been cancelled on 3 August 2016. **[Proved by admission]**

17. On 17 August 2016 administered olanzapine to Patient 10 at the wrong time. **[Proved by admission]**

18. On or around 17 December 2015 did not plan the shift effectively in that you designated HCA 2 to complete most of the contact notes in the patient's clinical records. **[Charge found NOT proved]**

19. On one or more occasion between 20 August 2015 and 22 July 2016 did not effectively run the ward and/or support staff when acting as the Nurse in Charge in that you:

    a) Did not allocate observations and/or safety checks as part of a shift plan. **[Charge found NOT proved]**

    b) Amended parts of a shift plan without informing staff affected by the change at all/or in good time **[Charge found NOT proved]**

    c) (On one occasion) missed a member of staff off the shift plan **[Charge found NOT proved]**

    d) Left the ward for breaks during unsettled periods **[Charge found NOT proved]**

    e) Did not allocate breaks fairly **[Charge found proved]**

    f) When asked questions or otherwise asked for assistance by staff, did not attempt to answer queries or otherwise assist. **[Charge found proved]**

    g) (On One occasion) asked a physical health nurse to undertake mental health duties. **[Proved by admission]**

    h) On 22 July 2016 rotated staff to the section 136 suite for more than one hour. **[Proved by admission]**

20. On 26 June 2016 did not follow the fire policy procedure. **[Proved by admission in that you accept that you did not dial 5555 but dialled 0]**

21. Did not pass the Immediate Life Support Course between 20 August 2015 and 28 February 2017. **[Proved by admission]**

22. On one or more occasions when a patient raised a query or concern with you, you, did not prioritise a patient's needs. **[Charge found proved]**

23. Did not complete the capability plan put in place. **[Proved by admission]**

And, in light of the above, your fitness to practise is impaired by reason of you misconduct in respect of charges 1-17, and by reason of your lack of competence in respect charges 18-23.

Decision and reasons on application to amend the charges 2 and 3

The panel heard an application made by Ms Shehadeh on behalf of the Nursing and Midwifery Council (NMC) to amend charge 2 and the stem of charge 3.

Ms Shehadeh submitted that the amendment to charge 2 refers to the joining the stem of charge 2 to both 2a and 2b. She submitted that doing so would assist you in understanding the charge and provide further clarity. She further submitted that in respect of charge 3, the amendment is to add a further date of "05/10/2016" to the stem of the charge.

Current charge 2 and stem of charge 3:

"2. Your inaction at Charge 1 contributed to a loss of opportunity to identify:

a) That Patient 1 was bringing one or more paracetamol on to the unit

b) That Patient 1 had consumed one or more paracetamol while on authorised leave.

3. In your statement to your employer dated 29 August 2016, and/or your statement to your employer dated 22 September 2016 and/or your interview on 22 September 2016, about the incident at Charge 1, you made one or more of the following representations which were not true."

Proposed amendment to charge 2 and stem of charge 3:

"2. Your inaction at Charge 1 contributed to a loss of opportunity to identify that Patient 1 was bringing one or more paracetamol on to the unit or had consumed one or more paracetamol while on authorised leave.

3. In your statement to your employer dated 29 August 2016, and/or your statement to your employer dated 22 September 2016 and/or your interview on 22 September 2016

and 05 October 2016, about the incident at Charge 1, you made one or more of the following representations which were not true."

Ms Shehadeh submitted that the proposed amendments would not cause any unfairness or injustice to you. She stated that the amendments would provide clarity and better encapsulate the mischief that is alleged in this case.

Ms Shah on your behalf submitted that there were no objections to the proposed amendments. She agreed that the amendments to charges 2 and 3 do not cause any injustice to you.

The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

> 28 — (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—
>
> (a) the charge set out in the notice of hearing; or
>
> (b) the facts set out in the charge, on which the allegation is based,
>
> unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.
>
> (2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.

The panel considered the merits of the case and whether any unfairness would result if the amendments to the charges were made. The panel kept in mind that no injustice should flow from any amendment to the charges.

The panel noted that the proposed amendment to charge 2 was to join the contents of the sub charges to make one charge. It noted that the amendment was solely for the purpose of clarity and ease of understanding. The panel therefore accepted the amendment to charge 2. The panel then considered the proposed amendment to the stem of charge 3. It noted that you had not objected to the addition of a further date to the stem of this charge. The panel was of the view that the addition of the further date encapsulated the mischief that is alleged in this case. It was satisfied in allowing the amendment to this charge. The panel therefore accepted the two amendments, it being fair to make them and there being no injustice to either party as a result.

Background

The NMC received a referral from Northamptonshire Healthcare NHS Foundation Trust ("the Trust") in relation to concerns arising from your work as a mental health nurse on Bay Ward at the Trust between 20 August 2015 and 28 February 2017.

Bay Ward was a 17-bedded acute mental health ward for female patients aged between 18-65 years. Some of the patients were detained on the ward under the Mental Health Act.

You were employed to work as a Band 5 Mental Health Nurse on 20 August 2015. Within a few days of commencing work, it is alleged that concerns about your practise had begun to emerge.

The concerns are grouped into two categories; misconduct and lack of competence.

Misconduct

1. It is alleged that you allowed Patient 1 to return to Bay Ward from unescorted leave without searching her person or property. The patient was found to have overdosed on paracetamol. When questioned, at first you had stated that a colleague had let Patient 1 back onto the ward, and that you had later in the day searched the

patient's belongings and found no tablets or packaging. When confronted with contradictory evidence, you had stated that you must have been confused about the date. It is alleged that you were dishonest in your accounts of your actions regarding Patient 1.

2. It is also alleged that you did not act promptly when a patient absconded from the ward, that you did not communicate vital information on to your team, that you did not formulate appropriate care plans as required, that you did not manage an incident during which a patient was on the floor for a number of hours, appropriately, that you made a number of medication errors, and in relation to one of these, that you exhibited a lack of integrity.

3. A number of these incidents were investigated at local level and discussed with you in supervision sessions.

Lack of competence

4. The remaining charges are alleged to have shown a lack of competence to fulfil the role of a Band 5 Mental Health Nurse. These relate to not running shifts properly when acting as the Nurse in Charge, not adhering to fire safety policy, not completing a mandatory course in Intensive Life Support, and failing to complete an employee capability programme that was put in place.

5. This formal process began on 9 March 2016. You had been given support and supervision by Mr 5, Ms 3, Ms 14, Ms 8 and others. It is alleged that a number of concerns covered by the other charges had come to light while this process was in place.

6. The employee capability programme had not been satisfactorily completed by the time you left the Trust.

Decision and reasons on application pursuant to Rule 31 in respect of admissibility of evidence in relation to paragraph 9 of Ms 3's witness statement

The panel heard an application made by Ms Shehadeh under Rule 31 of the Rules for the evidence contained in paragraph 9 of Ms 3's witness to be admitted into evidence.

Ms Shehadeh submitted that Ms 3 states 'I was observing student nurse [Ms 13] [you were] also supporting [Ms 13] at the time.' This is an incident that Ms 3 observed herself. Ms Shehadeh submitted that Ms 3 says the student nurse flagged that Ramipiril should only be given at night. Ms 3 had further stated 'I confirmed that [Ms 13] was correct and commended her, but [you] still gave the medication regardless.' Ms Shehadeh submitted that Ms 3 had discussed this incident with you in a supervision, and explained to you why it had to be given at night.

Ms Shehadeh submitted that paragraph 9 of Ms 3's witness statement is not hearsay evidence and invited the panel to admit it. She submitted in that regard, that the words spoken by Ms 13 were spoken in your presence and the NMC did not rely on the truth of its contents, but only that those words were said. She submitted that this is direct evidence from Ms 3 and is relevant to the charge, relevant to whether you knew the prescription was wrong and relevant to Ms 3's involvement. She submitted that to strike out paragraph 9 out of Ms 3's witness statement would render what she states throughout her statement difficult to understand.

In the alternative, Ms Shehadeh submitted that if the panel determines that paragraph 9 is hearsay, it is nevertheless admissible for the following reasons:

(i) Hearsay evidence is not prima facie inadmissible in these proceedings. It must be shown that the evidence does not satisfy Rule 31 (relevance and fairness).
(ii) The evidence is plainly relevant. It goes to Charge 12, which alleges that you gave Rampiril at the wrong time, despite having been made aware of the prescription error.
(iii) It is not the sole evidence of this charge; Ms 3 gives evidence about the fact that Rampiril should be given at night. She gives evidence about what was on the prescription chart. She gives evidence that she commended the student nurse.

She gives evidence that you later asked the doctor to amend the medication chart. She submitted that this goes to the issue of whether you were aware that there was a prescription error, and sought to alter it after the fact. Ms Shehadeh submitted that Ms 3 gives evidence that she provided a supervision session to you regarding this drug thereafter.

(iv) For the same reasons above, the purported hearsay is demonstrably reliable; the Registrant appears to have accepted an error because he sought the correction of the prescription.

For all of the reasons above Ms Shehadeh urged the panel to admit paragraph 9 of Ms 3's witness statement submitting that that requirements of relevance and fairness are met. However, if the panel were of the view that Ms 13's flagging up of the error is not admissible, then Ms Shehadeh invited the panel to only redact the sentences within para 9 that are attributable to Ms 13. She applied for the same redactions for in respect of exhibit VB/01.

Ms Shah on your behalf referred to the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) amongst others and submitted that hearsay evidence is not automatically inadmissible but is inadmissible when it breaches the principles of fairness.
Ms Shah submitted that the evidence of Ms 13 as related by Ms 3 in her statement in paragraph 9, and VB/01 is being relied upon to establish there was some error/fault in the prescription such that you ought not to have administered Ramipril. She submitted that is hearsay as it is evidence not given in the hearing being relied upon for the truth of its contents.

Ms Shah submitted that the evidence is sole and decisive as there is no prescription provided for this incident, it is for the panel to make its own assessment of whether something was wrong with Ms 3's statement. She further submitted that it is far from demonstrably reliable as it is contradicted by other evidence such as the evidence of Mr 4.

Ms Shah further submitted that there are no means of challenging what was said or even

clarifying it as Ms 3 states that she did not even hear what Ms 13 had said to you. She further submitted that there was no recording of this conversation and this was an “off the cuff” conversation without context in a non-formal setting.

Ms Shah submitted that even if the panel is of the view that paragraph 9 in Ms 3’s witness statement it is not hearsay, it would still be unfair to admit it without the accompanying prescription and an account from Ms 13. She submitted that this is because paragraph 9 is inherently unreliable and there is no way to challenge the assertion within the hearsay account of Ms 13’s exchange with you. She therefore invited the panel not to admit paragraph 9 of Ms 3’s witness statement into 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 of the Rules 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 legal assessor also referred the panel to the relevant considerations as set out in the cases of, NMC v Ogbonna [2010] EWCA 1216, R v Bonhoeffer and GMC [2011] EWHC 1585 (Admin), R v Horncastle and Others, both in the Court of Appeal [2009] EWCA Crim 964 and in the Supreme Court [2009] UKSC 14, R v Riat and Others [2012] All ER (D) 231 (Jul) and Thorneycroft v NMC [2014] EWHC 1565 (Admin).

The panel considered the submissions by both Ms Shehadeh and Ms Shah. It accepted the advice of the legal assessor and took into consideration the various principles derived from the cases cited to it.

The panel considered whether it would be fair and relevant to admit this material into evidence. The panel bore in mind that you had been present when the conversation between Ms 3 and Ms 13 had taken place. The panel noted the email dated 4 November 2015 in which Ms 3 describes to Mr 4 what she had observed. The panel was therefore of the view that it was fair to admit this evidence as this was not hearsay evidence but direct evidence as Ms 3 had had the conversation with Ms 13 in your presence. It was also

evidence of what Ms 3 had directly observed. The panel was also of the view that this evidence is relevant as there is a charge that directly applies to this evidence. The panel noted that Ms 3 refers to the contents of the evidence within paragraph 9 in her supervision sessions with you. The panel was also satisfied that as Ms 3 will attend and give evidence at this hearing; she can be examined as to what she actually saw and heard during the conversation between Ms 13 and yourself and therefore any ambiguity can be resolved. As you were also present Ms 3 may also be cross examined on any version of events you wish to challenge.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence paragraph 9 of Ms 3's witness statement, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on the NMC's application to admit Mr 4's evidence by video link

Ms Shehadeh made an application for Mr 4's evidence to be admitted by video link. She drew the panel's attention to Rule 31 of the Rules which she submitted allows the panel to admit video link evidence subject to satisfying the requirements of relevance and fairness. She told the panel that Mr 4 was warned to give evidence on day 4 of the hearing. She reminded the panel that Ms Shah is unable to attend the hearing in the morning of day 4 due to a prior professional commitment which the NMC is aware of. She also reminded the panel that the nature and effect of this commitment is such that there is a likelihood that Ms Shah may be unavailable in the afternoon as well and therefore Mr 4's live evidence is unlikely to be heard. Ms Shehadeh submitted that Mr 4's evidence could fairly be heard be heard virtually. She submitted that Mr 4's evidence relates to a specific issue and therefore is not likely to take too much time.

Ms Shah did not object to this. She agreed with the NMC that Mr 4's evidence is such that it could be fairly heard virtually.

The panel heard and accepted the advice of the legal assessor. She referred the panel to Rules 22 and 31 of the Rules.

The panel firstly considered whether Mr 4's evidence is relevant and determined that it is clearly relevant to the charges and provides potentially important background information. The panel next considered whether it would be fair to admit Mr 4's evidence by video link.

The panel noted that Mr 4 has been warned to attend on day 4 of this hearing. It noted that due to Ms Shah's unavailability on the morning of day 4 and possibly her unavailability in the afternoon, it could not be certain that Mr 4's evidence would be heard on day 4. The panel considered the parties' submissions regarding the nature and extent of Mr 4's evidence. The panel bore in mind the information it had received regarding Mr 4's professional commitments and the fact that he is currently working at the hospital. It took into account the difficulties of re-scheduling witnesses in order to provide live evidence. The panel also bore in mind that this application was not opposed by you.

The panel acknowledged that there is the need for the expeditious disposal of a case. It also bore in mind that Mr 4 would be heard and seen through video link and his demeanour could be satisfactorily assessed. In the circumstances, the panel determined to allow the video link application.

Decision and reasons on application pursuant to Rule 31 in respect of admissibility of Patient 8's evidence in Ms 7's witness statement

Ms Shehadeh made an application to admit Patient 8's hearsay evidence in Ms 7's witness statement. She submitted that Patient 8's complaint about you is important evidence in respect of charge 22 as it is one of the key examples that illustrates your behaviour towards patients whose concerns needed addressing. She submitted that not admitting the evidence of Patient 8 renders your confession to Ms 7 meaningless. She informed the panel that it would be depriving itself of key evidence in relation to the most

serious charge in the case if this evidence was not admitted into evidence.

Ms Shehadeh told the panel that Patient 8 is not relied upon as a live witness in these proceedings by reason of her vulnerability as a patient on a mental health ward. She submitted that it is not appropriate to subject her to the rigours of a hearing, and the attendant stress. Nevertheless, she submitted that it would be fair to admit her evidence, and that this evidence is relevant to the panel's determination of charge 22.

Further, Ms Shehadeh submitted that you had admitted the incident to Ms 7 as stated in her witness statement. She reminded the panel that Ms 7 is attending as a live witness and therefore she can be cross-examined. Ms Shehadeh further reminded the panel that if the real objection is that you do not accept admitting to Patient 8's accusation, then that is a matter of cross-examination and factual dispute with Ms 7, rather than a question of hearsay.

Ms Shehadeh also reminded the panel that there is a relatively contemporaneous account in e-mail form by Ms 7 in respect of this incident involving Patient 8. She also submitted that this was not the sole and decisive evidence as Ms 6 also produces evidence in respect of charge 22. Ms Shehadeh submitted that the evidence from Ms 7 is not an "off the cuff remark" but is reliable as it was recorded in a clinical and professional setting in a professional capacity.

Ms Shehadeh further submitted that you were given multiple opportunities to deny Patient 8's allegation, but had not done so. She submitted that the matter was discussed with Mr 5 on 5 August 2016, and again in an interview as part of the capability programme. She reminded the panel that during this interview, you had again not denied the truth of Patient 8's complaint, but stated that Patient 8 had become very angry in the nurses' office, that she had raised her voice and used abusive language, and that you were protecting your colleagues.

In light of the above, Ms Shehadeh submitted that this evidence was fair to admit evidence

and invited the panel to do so.

Ms Shah opposed the application. She submitted that the evidence in relation to Patient 8's complaint to Ms 7 is contested. She submitted that you do not accept that there was an exchange between yourself and Patient 8, whereby the patient had stated her leave was rubbish or words to that effect and you had simply walked away.

Ms Shah submitted that the hearsay evidence contained within Ms 7's statement should not be admitted as not only is it vague and poorly particularised, lacking both a date or any reference to a particular patient, but also, not relevant as the incident regarding Patient 8 does not amount to the patient raising a 'query'. She further invited the panel to bear in mind how Patient 8's evidence had been put before the panel. She told the panel that Patient 8's statement was served very shortly before the hearing, and the RCN had objected instantaneously. She submitted that an evidence matrix had been served on you on 13 July 2021. She said that this matter has been investigated for a long period of time by the NMC and throughout this time the RCN had stated that the charges were not clear and therefore you could not respond to these unclear charges. She told the panel that this case was listed three times and it was only on the fourth occasion that you were served with Ms 7's statement.

Ms Shah submitted that the hearsay account of Patient 8's complaint is the only evidence of what Patient 8 said and what you replied in return. There are no other direct witnesses to the incident, nor any patient records. It is therefore the sole evidence of the incident regarding Patient 8. She submitted that there is no one else who can be challenged about what was or was not said to you by the patient or how you responded to the queries by the patient. She submitted that although the NMC argue that Ms 7 can be challenged during her evidence about the complaint, there is no way to challenge Patient 8's statement. Ms Shah submitted that Ms 7's note is not a full verbatim note of any conversation with Patient 8; it is a summary and not any form of a contemporaneous note taken at the time. She reminded the panel that the conversation had taken place in a non-formal setting nor had patient 8 ever been asked if she wanted this to be pursued in regulatory sphere.

Further, she submitted that there is not even a witness statement from Patient 8 nor an explanation as to why this had not been taken. She further went on to say that the Trust had not produced a formal signed complaint. In these circumstances, Ms Shah submitted that the evidence is not only unreliable but is also hearsay that cannot be properly be tested.

Ms Shah therefore invited the panel to not admit Patient 8's evidence in Ms 7's witness statement into evidence.

The panel accepted the advice of the legal assessor.

The panel considered whether it would be fair and relevant to admit this material into evidence. The panel bore in mind that Ms 7 had had a direct conversation with Patient 8. She had immediately followed this with a conversation with you about what was said by Patient 8. It accepted that the evidence was not the "sole and decisive" evidence of the charge as there was evidence from Ms 6 which it was yet to hear. It therefore determined that her evidence was relevant. The panel also bore in mind that Ms 7 is due to attend and give evidence at this hearing and therefore she can be examined as to what she was told by Patient 8 and in turn what conversation took place between herself and you.

The panel bore in mind the submissions by Ms Shah on your behalf that the allegation in relation to Patient 8 was only made available to you in July 2021. However the panel was of the view that the bundle of documents before it contained an email dated 20 August 2016 in which there is a reference to the allegation in relation to Patient 8. In these circumstances, the panel was of the view that you had been aware of the concerns regarding Patient 8 in advance and as such it would be fair to admit Ms 7's evidence.

Decision and reasons on application pursuant to Rule 31 in respect of admissibility of Patient 8's evidence in Ms 6's witness statement

Ms Shehadeh made a further application to admit Patient 8's evidence in Ms 6's witness

statement. She invited the panel to have sight of paragraphs 12-15 of Ms 6's statement. She told the panel that the contents of the paragraphs simply indicate that patients had been asking for help, assistance and attention from you and that these were examples of some of her experiences she had whilst working with you. Ms Shehadeh submitted that although Ms 6 in her statement does not specify who the patients are, she has indicated that she remembers the incidents. Ms Shehadeh reminded the panel that Ms 6 is attending as a witness and therefore she can be cross-examined. She submitted that to admit her statement into evidence would be fair and relevant to this case.

Ms Shah opposed the application. She submitted that Ms 6's evidence is vague and that there were no identifiable features within her statement, excluding information such as dates and patient names. She submitted that it would be unfair to admit accounts of undated incidents where the patients are also not identified as it is impossible for you to respond to unspecific assertions or to mount a defence. In this regard, Ms Shah invited the panel not to admit any of the anonymous hearsay in Ms 6's statement.

The panel accepted the advice of the legal assessor.

The panel considered whether it would be fair and relevant to admit this material into evidence. The panel bore in mind that Ms 6 is due to attend and give evidence at this hearing and therefore she can be questioned about the incidents she speaks to in her witness statement. It further bore in mind that her evidence was relevant as it contained information regarding your alleged attitude towards patients in your care and therefore may assist with charge 22. The panel determined that it would give what weight was appropriate to it once it had heard and evaluated the evidence before it and any submissions and advice, which it might be given. In these circumstances, the panel was of the view that it would be fair and relevant to admit Ms 6's evidence.

Decision and reasons on the NMC application to amend charge 22

The panel heard a second application made by Ms Shehadeh to amend the wording of

charge 22.

Ms Shehadeh submitted that the amendment was to add ‘or concern’ to the charge. She submitted that the mischief of charge 22 is that you did not put patients first. She submitted that making this amendment would better particularise the charge and would encompass the incident in relation to Patient 8. Ms Shehadeh submitted that your representatives at the RCN had been given notice of such an application a few weeks in advance of the hearing. She accepted that although not lengthy notice, you had been informed of such an application in advance.

Current charge 22:

> “22. On one or more occasions when a patient raised a query with you, you, did not prioritise a patient’s needs.”

Proposed amendment to charge 22:

> “22. On one or more occasions when a patient raised a query or concern with you, you, did not prioritise a patient’s needs.”

Ms Shehadeh submitted that the proposed amendment would not cause any unfairness or injustice to you.

Ms Shah opposed this application. She submitted that it would be unfair to amend this charge at this stage. She submitted that injustice would be caused due to the lateness of this application and the delay that such an application causes.

Ms Shah submitted that the NMC had only made your representatives aware of such an application less than two weeks before the hearing. She submitted that if the NMC wanted to charge you with being dismissive towards Patient 8 that ought to have been included as a charge in advance of the hearing over the many years that the NMC has been

investigating this case so that you would have had an opportunity to prepare your defence to the charge and seek appropriate disclosure of relevant matters.

Further, Ms Shah submitted that the new wording of the charge is to include Patient 8. She submitted that you deny the evidence in relation to Patient 8. She submitted that Patient 8 had multiple personality related issues and it is your position that Patient 8, at the time, was engaging in one such personality. Ms Shah submitted that to amend the wording of charge 22 at this stage would be unfair and unjust to you.

The panel accepted the advice of the legal assessor in relation to Rule 28 of the Rules.

The panel again considered the merits of the case and whether any unfairness would result if the amendment to the charge was made.

The panel noted that the proposed amendments was to add “or concern” to the charge. It bore in mind that the amendment was to better particularise the charge, broaden the context of the wording of the charge and provide further clarity. The panel determined that you were aware of the incident in which charge 22 related to and that the evidence for this charge is not new as there is other witness evidence related to this charge. The panel therefore accepted the amendment, it being fair to make it and there being no injustice to either party as a result.

Decision and reasons on the NMC’s application to admit Ms 11’s evidence by video link

Ms Shehadeh made an application for Ms 11’s evidence to be admitted by video link. She submitted that Ms 11 had previously attended the hearing centre, however due to lack of time, her evidence was not heard and she was rescheduled. Ms Shehadeh submitted that you have confirmed that you are content to hear her evidence by video link. She submitted that Ms 11 has indicated that she will be available to give evidence to the panel by video on the morning of day 7. Ms Shehadeh submitted that Ms 11’s evidence could fairly be

heard be heard virtually.

Ms Shah confirmed that you did not object to this application.

The panel heard and accepted the advice of the legal assessor.

The panel acknowledged that there is the need for the expeditious disposal of a case. It also bore in mind that Ms 11 had attended the hearing centre in person previously but was not able to give evidence due to lack of time and therefore needed to be rescheduled. The panel noted that this application has not been opposed by you. It was satisfied that Ms 11's evidence could be fairly seen, heard and her demeanour satisfactorily assessed. In the circumstances, the panel determined to allow the video link application.

Application by you for an adjournment

The panel heard submissions on Thursday 19 August 2021 made by Ms Rosso on your behalf for an adjournment until the morning of Monday 23 August 2021. Ms Russo told the panel that as your previous counsel has returned her instructions, she had stepped in to make the application on your behalf. She submitted that the RCN are still on record and are yet to decide if they will continue to be instructed in your case. She submitted that the RCN will be able to give their decision by close of business today (day 9). She submitted that in any event, time until Monday would be fair for either new counsel to be instructed or for you to prepare in order to represent yourself going forward.

Ms Shehadeh submitted that it is in the public interest that there is an expeditious disposal of this case. However, she submitted that the NMC does not oppose an adjournment until Monday morning. She submitted that in fairness to you an adjournment should, in all the circumstances of this case, be granted.

The panel accepted the advice of the legal assessor who referred to Rule 32 of the Rules.

The panel gave careful consideration to Rule 32 (4) of the Rules which states:

(4) in considering whether or not to grant a request for postponement or adjournment, the Chair or Practice Committee shall, amongst other matters, have regard to –

(a) the public interest in the expeditious disposal of the case;

(b) the potential inconvenience cause to a party or any witnesses to be called by that party; and

(c) fairness to the registrant.

The panel firstly had regard to the public interest in the expeditious disposal of your case. The adjournment applied for by you is for approximately a day and a half which the panel regard, in all the circumstances of your case, as a necessary adjournment for either new counsel to be instructed or for you to properly prepare your defence. Those circumstances included the fact that you face 23 charges, some with numerous sub-allegations and the case is complex.

The panel acknowledged that witnesses have already been rescheduled although they have not yet been heard. It further noted that no witnesses had been scheduled for the day and a half the adjournment has been requested for.

The panel lastly considered fairness to you. Given that your counsel returned her instructions yesterday (day 8) and the RCN not having confirmed their position in relation to either to continue to be on record or not, the panel found that it would be manifestly unfair to reject your application for an adjournment. In this regard, the panel determined that you must be afforded time to either instruct new counsel or to properly consider and prepare your defence, if you were to represent yourself.

In light of the above reasons, the panel granted an adjournment to Monday 23 August

2021 at 09:00.

Change of admission to charges

On 10 August 2021, day 2 of this hearing, Ms Shah on your behalf made admissions to charges 5b, 13a, 14a, 14c, 14d, 14e, 16, 17, 19g, 19h, 20, 21 and 23. She submitted that the rest of the charges were denied. The panel therefore accepted that charges 5b, 13a, 14a, 14c, 14d, 14e, 16, 17, 19g, 19h, 20, 21 and 23 were admitted and found proved.

On 17 August 2021, through Ms Shah you admitted charges 1 and 2 and 3 a to d. Ms Shah clarified to the panel that you did not admit 3 e and f. Nor did you admit charge 4. The panel therefore accepted that charges 1 and 2 and 3 a to d were admitted and found proved.

On 23 August 2021, you told the panel that you were now representing yourself. In order to clarify the exact position in relation to the charges (given that your counsel had withdrawn from the case) the panel asked that all the charges were put to you again. You told the panel that although your previous counsel Ms Shah admitted charges 1, 2 and 3 a-d on your behalf, you now do not admit charges 1 and 2 and 3 in its entirety.

In response to the changes to the admissions on 17 August 2021, Ms Shehadeh applied to the panel to seek an explanation from you as to why you had now changed your position in relation to charges 1, 2 and 3.

The panel heard and accepted the advice of the legal assessor.

The panel determined that it would not seek an explanation from you at this stage as you were not providing evidence on oath. It noted that your previous counsel is no longer representing you and a waiver of privilege is not required at this stage. The panel therefore struck your previous admissions to charges 1, 2 and 3 a-d off the record and

noted that you maintained your denial of these charges.

Decision and reasons on the NMC's application to admit Mr 5's evidence by video link

Ms Shehadeh made an application for Mr 5's evidence to be admitted by video link. She submitted that Mr 5 had previously attended the hearing centre on one day and had taken leave on another day to provide evidence, however due to lack of time, his evidence was not heard. Ms Shehadeh submitted that the Trust Mr 5 works for is understaffed at the moment due to a major Covid-19 outbreak in which 17 staff members have been confirmed as Covid-19 positive. She further submitted that a number of patients in the hospital are severely ill with aggressive behavioural tendencies and require close clinical supervision. She submitted that Mr 5 has indicated that he will be available to give evidence to the panel by video on the afternoon of day 11 in two parts, from 13:00-14:00 and 15:00-16:30 to fit around his prior professional responsibilities. Ms Shehadeh submitted that Mr 5 had indicated that he will only be available to travel to London to give evidence in person again on Friday 26 August 2021 (the last day of this hearing, day 15.) She reminded the panel that Thursday 25 August 2021 and Friday 26 August 2021 were extra dates added to this hearing. Ms Shehadeh further reminded the panel that she will not be available on 26 August 2021 and that to have a new lawyer on behalf of the NMC to hear Mr 5's evidence would be wholly unworkable. She invited the panel to consider that the alternatives were either hearing Mr 5's evidence virtually or to go part-heard before finishing the NMC's case. Ms Shehadeh reminded the panel of the need for the expeditious disposal of a case and submitted that Mr 5's evidence could fairly be heard virtually.

You told the panel that you would have liked to hear Mr 5's evidence in person, however, given that Mr 5 had attended the hearing centre previously without his evidence being heard, his evidence being subsequently rescheduled without again being heard and given the circumstances at the Trust, you are content to hear Ms 5's evidence by video link.

The panel heard and accepted the advice of the legal assessor.

The panel bore in mind the need for the expeditious disposal of a case. It also bore in mind that Mr 5 had attended the hearing centre in person previously and had been rescheduled to give evidence again in person on a different day, but was not able to give evidence due to lack of time on both occasions. It bore in mind the professional difficulties Mr 5 was facing at the Trust. The panel also noted that this application has not been opposed by you. It was satisfied that Mr 5's evidence could be fairly seen, heard and his demeanour satisfactorily assessed. In the circumstances, the panel determined to allow the video link application.

Application by the NMC for an adjournment on 25 August 2021

Ms Shehadeh made an application to adjourn this hearing. She told the panel that Mr 5 has indicated, whilst attempting to action the panel's request for further documents, that he has identified there may be a concern about the patient anonymity key which the NMC have relied upon when formulating its charges. She submitted that this is vital information which needs to be further explored not only in fairness to you but also fairness in the presentation of the NMC's case. She invited the panel to release Mr 5 from his oath so that he will be able to provide a further witness statement to clarify this position. She reminded the panel that Mr 5 will no longer be available to give evidence to the panel this week. He has used the limited time available today to gather documents requested of him. She submitted that this case was inevitably going to be adjourned part-heard, however, due to the lack of witness availability, this case will need to be adjourned today, 25 August 2021, before the close of the NMC's case. Ms Shehadeh submitted that due to NMC's listings availability this case is unlikely to resume until March 2022 and during that time the NMC will be able to gather all relevant documents leading up to the resuming dates.

You did not oppose this application. You were concerned that this case had been hanging over you for some considerable time. You had found the information in the documents

confusing because of the passage of time and welcomed any efforts made to clarify the identification of the patients said to be involved.

The panel accepted the advice of the legal assessor who referred to Rule 32 of the Rules.

The panel had regard to the public interest in the expeditious disposal of your case. It noted that due to witness availability the NMC will not be able to close its case at this stage. It bore in mind the contents of the concerns raised by Mr 5 regarding the further documentation and the anonymity key. It was of the view that this is vital information for the progress of this case and in fairness to you. The panel also noted that you do not oppose this application. The panel therefore determined to grant this application.

Having discussed availability between parties, panel and the NMC, it granted an adjournment to 28 February 2022.

Decision and reasons on facts

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 Ms Shehadeh 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.

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

- Ms 1: Band 5 nurse at the Trust at the time of the events;

- Ms 2 — Mental Health nurse on Bay ward at the time of the events;
- Ms 3 — Band 6 nurse and physical healthcare lead at the Trust at the time of the events;
- Mr 4/HCA 2 — Healthcare assistant at the Trust;
- Mr 5 — Service Manager at the Trust;
- Ms 6 — Charge nurse at the Trust;
- Ms 7 — Clinical team leader at the Trust at the time of the events;
- Ms 8 — Charge nurse at Bay Ward at the time of the events;
- Ms 9 — Senior Support Worker at the Trust;
- Ms 10 — Staff nurse on Bay Ward at the time of the events;
- Ms 11 — Ward Manager at the Trust;
- Mr 12 — Ward Manager at Harbour Ward and Manager of the Health based Place of Safety South at the Trust.

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor who referred to the following cases: *Dutta v GMC* 2020 EWHC 1974 (Admin), *Dr Raisi Sawati v GMC* 2022 EWHC 283(Admin), *Re H* 1996 AC 563, *Ivey v Genting Casinos (UK)Ltd* 2017 UKSC 67, *Enemuwe v NMC* 2015 EWHC 2081 (Admin) and *Wingate v SRA* 2018 EWHC Civ 366.

The panel noted these events took place over 5 years ago. The panel noted the inherent risks of recollection over such a long period of time but noted the numerous inconsistencies in your account at various stages; from statements to your internal investigations, your questions put to witnesses and your oral evidence including your formal admissions. The panel found these inconsistencies to be significant, frequent and fundamental.

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

Did you let Patient 1 back onto the Ward

Firstly, in order to consider charges 1, 2, 3 and 4 the panel must establish whether you did or did not let Patient 1 into the Ward. In considering this, the panel had regard to the document entitled 'Bay Ward Main door activity' on 26 August 2016. The panel noted that there is definitive data to indicate that the doorbell to the entrance was pressed at 14:40:04 and the next entry in the data was when your key fob was permitted access at 14:40:11. The panel also had sight of two CCTV images from outside of Bay Ward 26 August 2016. The first image shows Patient 1 in her wheelchair. The panel noted the top of the image, the bottom half of an individual's body in which the individual is holding a piece of paper in their left hand, is shown. The panel then had sight of a second image in which it shows you walking towards the Bay Ward entrance with a piece of paper on your left hand.

The panel also bore in mind that according to the evidence provided throughout the case which was not contested by you, there was a 4 ½ minute difference between the fob

system and the CCTV system. It was accepted that the fob ran on real time and the CCTV was 4 ½ minutes behind.

The panel determined that it not likely than not that the entrance data in conjunction with the CCTV images demonstrates that you let Patient 1 into the Ward.

The panel therefore concluded that o the balance of probabilities that you let Patient 1 into the Ward.

Charge 1

1. On 26 August 2016 did not conduct a search of Patient 1 and/or Patient 1's property on her return to the ward after authorised leave.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 1, Mr 5, Mr 12, the key fob data on 26 August 2016, the CCTV images from 26 August 2016, the Disciplinary Sanction letter dated 2 November 2016, the interview notes from your meeting dated 7 October 2016 and your evidence. The panel excluded the findings of the internal investigation form its decision making process.

Firstly, the panel noted the Disciplinary Sanction letter dated 2 November 2016 in which it states:

> *"On 26 August 2016, you placed Patient 1's health at risk by allowing her on to the ward following a period of unescorted leave without searching her belongings; by doing so you did not adhere to CP057 (Policy for searching of the Inpatients, Visitors and Rooms) Patient 1 subsequently took an overdose of medication… resulting in her admission to Northampton Gen Hospital for her to undergo treatment.*

…

The meeting was to discuss the next steps in the formal process. At the meeting you admitted the misconduct in relation to the above-mentioned allegation…

With this in mind it was discussed at the meeting that the potential appropriate level of sanction of this misconduct should be a Final Written Warning. You agreed verbally to accept this sanction…"

The panel also noted Ms 1's witness statement dated 30 June 2019 which was consistent with her oral evidence, in which she stated:

"I did not think about whether anyone had a search on Patient 1 when she returned to the ward as this was expected, it is standard procedure to conduct a search of a patient when they return from unescorted leave from the ward"

The panel also bore in mind your evidence in which you too said that whoever lets a patient into the ward has the responsibility of checking the patient; however it was your position that you did not let Patient 1 into the ward.

The panel also had sight of the interview notes from your meeting on 7 October 2016. It noted that you said:

"There are times when you would just let her in and sometimes we would check her bag. By the door fob it looks like I have let her in. If the doorbell was rung then I assume someone would respond. She was due to see the psychologist in Daventry that day. Maybe I thought she had gone there."

The panel noted that throughout your evidence in relation to this charge, you changed your position more than once. The panel was of the view that at this stage, you had viewed the CCTV footage and admitted that you let the patient in.

The panel also had sight of the Northamptonshire Healthcare Searching of In-patients, Visitors and Rooms Policy. The panel had particular regard to the section under the subheading Nurse in Charge, which states:

> *"The nurse in charge has authority to conduct a personal search controlled by law and will be aware of the legal parameters within which they must operate through attending training and this policy. The nurse in charge of the ward is responsible for obtaining consent for a search to be undertaken and recording this within the clinical record. They are responsible for initiating the search process, documenting the reasons for initiating the search and recording steps taken, informing on call/senior staff and RMO. The nurse in charge must also ensure that any contraband items found as a result of a search are stored safely or disposed of appropriately."*

The panel considered that the policy states that the nurse in charge is responsible for any checks. However, the panel bore in mind that the practise on the ward did not apply such a rigid process. The panel noted that the evidence from various witnesses was that the practise on the ward was that staff letting patients back into the ward were responsible for searching the patient. The panel also bore in mind your evidence in which you accepted that this was the working practice of the ward: *"whoever lets the patient into the ward is to search the patient".*

The panel further noted that Mr 5 in his statement dated 17 July 2019 stated that:

> *"Mike should have searched her property on return to the ward; he should have summoned the assistance of a female member of staff if there were concerns in relation to maintaining Patient 1's dignity."*

The panel further noted that Ms 1 explained that the expected procedure was for a patient to be searched by whomever allowed them back onto the ward. She said:

'*The searches were conducted by whichever member of staff opened the door because it's a locked ward so the door is opened using a security access system so when the patients get to the door they normally buzz and whichever member of staff gives them access on to the wards then has to take them to a side room to search mainly their belongings before they can walk back on to the ward. My clarification would be the nurse in charge's responsibility would come about if a patient refuses to be searched and the staff are concerned then they will bring it up to the nurse in charge to say "Patient X has just walked in and refused for me to search them" and then the nurse in charge would talk to the patient and then escalate it accordingly.*

The panel noted that Ms 1's evidence regarding who was responsible for searching a returning patient was confirmed by Mr 12, both in his witness statement dated 27 September 2018 and during his oral evidence.

In determining this charge, the panel also took into account your position in relation to this charge at various stages of the proceedings. The panel noted that in your first internal investigation statement you wrote:

"Around 15:00 hours I commenced the general ward observations to check the whereabouts of all the patients. At that time, I had checked Patient 1's room and found that she was not in there. I returned to the nurses office and noted that Patient 1 was recorded as off the ward… I did not let Patient 1 back onto the ward. [HCA 1] had informed me that she had let Patient 1 back into the ward and had checked Patient 1 bag. [sic]"

The panel had sight of the key fob data on the day of the incident which showed that HCA1 was off the ward at that time, indicating that she went out of the bay entrance at 14:27:05 and did not enter back into the ward until 15:35:42.

The panel noted that again during your internal meeting on 7 October 2016, the notes indicate that you accept that you let Patient 1 in by stating *"By the door fob it looks like I have let her in."*

The panel further bore in mind that during the course of this hearing, in relation to charge 1, through your then representative Ms Shah, you initially denied the charge, however on 17 August 2021, she stated:

> *"Charge 1 is admitted. Just so the panel are aware the registrant's position is that there was a limited search on Patient 1 upon arrival that acknowledged that was not sufficient and thus admits the charge". He accepts that the patient 1 in. I make those clarifications just so the panel know that when [Mr B12] come what the issues are." It is not an issue whether he let patient 1 in."*

The panel found this to be admissible evidence with the benefit of legal representations, which it found to be full and frank. However, again on Monday 23 August, when you said you would be representing yourself, you went onto say that you denied charge 1. The panel noted that whilst you abandoned the initial admissions, the panel was still able to take account of those positions.

The panel determined that it had sufficient evidence to satisfy it that although the policy states that the nurse in charge must search the returning patient, according to the evidence it had heard including your own, the working practise in the ward was that the nurse who lets the patient into the ward must check the patient. Accordingly, the panel having determined that you let the patient into the ward was satisfied that on 26 August 2016, you did not conduct a search of Patient 1 and/or Patient 1's property on her return to the ward after authorised leave.

The panel therefore found charge 1 proved.

Charge 2

2. Your inaction at Charge 1 contributed to a loss of opportunity to identify that Patient 1 was bringing one or more paracetamol on to the unit or had consumed one or more paracetamol while on authorised leave.

This charge is found proved.

In reaching this decision, the panel took into account a copy of the incident description from Datix Incident form for Patient 1 dated 27 August 2016, your initial local written statement, Interview notes from your meeting on 5 October 2016 and your evidence.

The panel reminded itself that on Tuesday 17 August 2021, Ms Shah, your then representative stated:

> *"The registrant accepts charge 2. The panel will recall that that was amended to "either/or" and he accepts it in those terms."*

On Monday 23 August 2021 you said you would be representing yourself and told the panel that you denied charge 2.

The panel had sight of a copy of the incident description from Datix Incident form for Patient 1 dated 27 August 2016. It stated:

> *"Patient asked me for a 1:1. Sat and spoke with patient. Patient said whilst out on leave this afternoon she took an overdose of 32 Paracetamol. Physical observation completed, NEWS score 1. Called duty doctor who contacted Accident and Emergency who advised the need to go straight down there…"*

The panel further noted that Ms 2 stated in her local statement which was consistent with her NMC witness statement that:

"I conducted a search of her bag. The ambulance crew had taken Patient 1 on a stretcher so her wheelchair was left behind in the interview room. On the back of the wheelchair Patient 1 rucksack [sic] was hanging. I searched Patient 1's rucksack and found 2 empty packets of paracetamol. I also found an empty strip of paracetamol in the zipped compartment in her purse."

The panel bore in mind that in your initial handwritten statement you provided to Mr 12, you stated that HCA 1 had conducted the search and following your viewing of the key fob data and CCTV footage you said that your initial representations might have been confused as you may have been thinking of another time.

The panel noted that within this statement you also wrote:

"I asked her for permission to search her wheelchair and room of which she agreed I checked the back of her wheelchair and the side of her seating area cushion, her bedside table, bed, curtains, chest of draws, desk, cupboard, and her toilet, shower area, No tablets or packaging was found."

The panel further bore in mind your Interview notes from your meeting on 5 October 2016 in which you said:

…I don't normally check her drawer but I checked the wheelchair, drawer, bathroom, behind curtain… I know she won't put things in her bag as it's checked. Even her mum has said that. I didn't see any packaging when I did the search. She could have eaten them beforehand."

Considering all the evidence above, the panel determined that although you may have conducted a superficial check later in the day, it was inadequate as you failed to find the paracetamol packets which was subsequently found that evening by Ms 2 in the patient's property. This reaffirmed your original position when your then representative stated on your behalf that you *"did not conduct an adequate enough check."*

The panel acknowledged that it was not known precisely when Patient 1 overdosed on paracetamol. However, had you thoroughly searched the patient upon her return to the ward you would have either identified that she was bringing paracetamol onto the ward, or you would have noticed the empty packets of paracetamol in her bag. The panel was of the view that this would have alerted you to the fact that the patient had consumed paracetamol whilst on leave from the ward. The panel bore in mind that Ms 2 had found empty paracetamol packaging in two separate places. This reaffirmed to the panel that your inaction to search Patient 1 and/or Patient 1's property on her return to the ward after authorised leave, contributed to a loss of opportunity to identify that Patient 1 was bringing one or more paracetamol on to the unit or had consumed one or more paracetamol while on authorised leave.

The panel therefore found charge 2 proved.

Charge 3a

3. **In your statement to your employer dated 29 August 2016, and/or your statement to your employer dated 22 September 2016 and/or your interview on 22 September 2016 and 05 October 2016, about the incident at Charge 1, you made one or more of the following representations which were not true.**

    a) That you had been on a break when Patient 1 entered

This charge is found proved.

In reaching this decision, the panel took into account your email dated 29 August 2016, your handwritten statement received on 22 September 2016, meeting notes both on 22 September 2016 and 5 October 2016, Bay Ward Main Door Activity document and your Key Fob data for 26 August 2016.

The panel noted your email to Mr 5 dated 29 August 2016 in which you stated:

> *"I do not know who let Patient 1 back onto the ward. I will usually check her backpack when she returns, and am aware that Patient 1 has a habit of hiding things in her wheelchair which is difficult to search for. I will also ask her if she has anything that she feels needs handing in. On the Friday, I did the 15:00 hour ward checks and noted that she had already returned back to the ward. I had returned from my break and Patient 1 was on the ward prior to me leaving and believe she had returned before my return. I observed Patient 1 in her room at 15:00 hours."*

The panel bore in mind that you said in your initial email that you believed Patient 1 had returned to the ward before you had returned from your break. Furthermore, it noted that in your written statement to Mr 12 dated 22 September 2016, you deny this position and state that you were on lunch break and that you were unsure whether Patient 1 had returned whilst you were on break; and you also state that the patient was let into the ward by HCA 1.

The panel also had sight of the Interview notes from your meeting on 22 September 2016 in which it states:

> *"You: I wasn't on the ward. I came back, did the check and couldn't find her.*
> *Mr 12: " Your break was 13:50- 14:50?*
> *You: Yes. The form said she was due back at quarter to.*
> *You: I didn't let her on the ward, [HCA 1] let her on the ward. [HCA 1] searched her bag. She returned a bit before me.*
> *Mr 12: Where did you take your break?*
> *You: The library. I read. I went to the gents on the way back.*
> *Mr 12: You didn't see her return to the ward?*
> *You: I don't recall seeing her return to the ward. [HCA 1] told me she let her on the ward."*

The panel also had sight of the Interview notes from your meeting on 5 October 2016 in which it states:

> *"Mr 12: Last time you mentioned that you went to the library on your break. We believe that the patient returned to the ward between 14:30 and 14:45. Another witness says she saw her around 14:45. In terms of the time you went on your break you believed it was around 13:50 and returned approximately an hour later at 14:50. The security system in place uses of fob data would shows on the central system. This assures that you will return to Bay 14:40. We have been led to believe that you were present when the patient returned?*
> *You: I didn't see her come in. When I did the obs board was the first chance I had to know she was on the ward. I checked with someone."*

The panel then had regard to the Bay Ward Main Door Activity document and your Fob data for 26 August 2016 in which it identifies that you left the ward at 13:49:04 and came back at 14:40:11. The document also indicated that the doorbell for the entrance was pressed at 14:40:04.

The panel was satisfied from the evidence before it that you returned from your break, using your key fob to enter the ward at 14:40:11, seconds apart from Patient 1 in the corridor and therefore let the patient in. The panel found this evidence reaffirmed it's earlier position that you let the patient in. The panel therefore determined that you made the representation that you had been on a break when Patient 1 entered, which was not true.

The panel therefore found charge 3a proved.

Charge 3b

3. **In your statement to your employer dated 29 August 2016, and/or your statement to your employer dated 22 September 2016 and/or your interview**

on 22 September 2016 and 05 October 2016, about the incident at Charge 1, you made one or more of the following representations which were not true.
b) That you had not let Patient 1 into the Ward

This charge is found proved.

In reaching this decision, the panel took into account the document entitled 'Bay Ward Main door activity' on 26 August 2016 and the CCTV images from outside of Bay Ward on 26 August 2016.

The panel had regard to the document entitled 'Bay Ward Main door activity' on 26 August 2016. The panel noted that there is definitive data to indicate that the doorbell to the entrance was pressed at 14:40:04 and your key fob was permitted access, seven seconds later at 14:40:11.

The panel also had sight of the CCTV images from outside of Bay Ward 26 August 2016. The first image shows Patient 1 in her wheelchair. The panel noted that at the top of the image, the bottom half of an individual's body in which the individual is holding a piece of paper in their left hand, is shown. The panel then had sight of a second image in which it shows you walking towards the Bay Ward entrance with a piece of paper in your left hand.

The panel also bore in mind that according to the evidence provided throughout the case which was not contested by you, there was a 4 ½ minutes difference between the fob system and the CCTV system. It was accepted that the fob ran on real time and the CCTV was 4 ½ minutes behind.

The panel was satisfied that the entrance data in conjunction with the CCTV images demonstrates that you let Patient 1 into the Ward. It therefore determined that you made the representation that you had not let Patient 1 into the Ward, which was not true.

The panel therefore found charge 3b proved.

Charge 3c and 3d

3. **In your statement to your employer dated 29 August 2016, and/or your statement to your employer dated 22 September 2016 and/or your interview on 22 September 2016 and 05 October 2016, about the incident at Charge 1, you made one or more of the following representations which were not true.**
   c) That HCA 1 had told you they let Patient into the Ward
   d) That HCA 1 had told you they had conducted a bag search on the return of Patient 1 to the Ward

These charges are found proved.

In reaching this decision, the panel took into account HCA 1's Manual Fob data on 26 August 2016, your meeting notes dated 22 September 2016 and on 5 October 2016.

The panel noted that on your hand written statement dated 22 September 2016, you state:

> *"[HCA 1] had informed me that she had let Patient 1 back onto the ward and had checked Patient 1 bag. I did not see this, I relied on HCA 1's assertion."*

The panel had sight of the Interview notes from your meeting on 22 September 2016 in which it states:

> *"You: I didn't let her on the ward. [HCA 1] let her on the ward, [HCA 1] searched her bag. She returned a bit before me."*

The panel also had sight of the Interview notes from your meeting on 5 October 2016 in which it states:

"Mr 12: The HCA on duty was [HCA 1] and you said that she had searched her bag? let her on the ward, [HCA 1] searched her bag.
You: That's what she told me."

The panel noted that on HCA 1's Manual Fob data on 26 August 2016, she was not in the ward from 14:27:05 to 15:35:42. Therefore the panel determined as HCA 1 was not in the ward at the time of Patient 1's return, she would not have had the opportunity to let Patient 1 into the ward nor checked her. The panel therefore concluded that you made the representation that HCA 1 had told you they let Patient 1 into the Ward, which was not true and made the representation that HCA 1 had told you they had conducted a bag search on the return of Patient 1 to the Ward, which was also not true.

The panel therefore found charges 3c and 3d proved.

Charge 3e and 3f

3. **In your statement to your employer dated 29 August 2016, and/or your statement to your employer dated 22 September 2016 and/or your interview on 22 September 2016 and 05 October 2016, about the incident at Charge 1, you made one or more of the following representations which were not true.**
   e) That you had subsequently searched Patient 1's wheelchair and/or bag
   f) That you had carried out the search at e) above in the presence of HCA 1 and/or Patient 1.

These charges are found proved.

In reaching this decision, the panel took into account you handwritten statement received on 22 September 2016, your meeting notes dated 22 September 2016 and on 5 October 2016 and HCA 1's Manual Fob data on 26 August 2016.

The panel noted that you said in you handwritten statement received on 22 September 2016 that:

> *"…I then asked [HCA 1] if she would come with me to find Patient 1. Patient 1 was found sitting upright on her bed. I asked her for permission to search her wheelchair and room of which she agreed I checked the back of her wheelchair and the side of her seating area cushion, her bedside table, bed, curtains, chest of draws, desk, cupboard, and the toilet, shower area, No tablets or packaging was found."*

The panel also bore in mind your Interview notes from your meeting on dated 22 September 2016 stated:

> *"You: Doing the obs I needed to see her on the ward. I checked with [HCA 1] and when I saw her changed the OP to an A.*
> *Mr 12: Then you conducted a search?*
> *You: I asked her to come to her room. [HCA 1] came too as a witness."*

The panel also bore in mind your Interview notes from your meeting on 5 October 2016 which state:

> *"Mr 12: What time did you do the room search?*
> *You: Around 15:00.*
> *…*
> *Mr 12: The fob data shows [HCA 1] was not on the ward 14:40-15:30*
> *You: She couldn't. I wasn't back until 14:40*
> *Mr 12: [HCA 1's] fob information does not correlate with what has been said. She went off the ward at 14:28 and came back at 15:34.*
> *You: I asked her to witness the search.*
> *You: I am certain it was [HCA 1]. I wouldn't have put O/P if I had seen her."*

The panel further had regard to your Interview notes from your meeting on 7 October 2016 which stated:

"You: So the facts are that she came in at 14:40 and I did the 15:00 check."

The panel reminded itself of the evidence it relied on at charges 1 and 2 where it determined that had you searched the patient upon her return to the ward you would have either identified that she was bringing paracetamol onto the ward, or you would have noticed the empty packets of paracetamol in her bag which would have alerted you to the fact that the patient had consumed paracetamol whilst on leave from the ward. The panel also bore in mind that Ms 2 had found empty paracetamol packaging in two separate places. This reaffirmed to the panel that you made representations that you had subsequently searched Patient 1's wheelchair and/or bag which was not true. It reminded itself of your earlier position that the search you had conducted was inadequate.

The panel also noted that HCA 1 was not in the ward during this search that you said took place as according to HCA 1's key fob data on 26 August 2016, she was not in the ward from 14:27:05 to 15:35:42. The panel therefore concluded that you made the representation that you carried out the searches on Patient 1's wheelchair and/or bag in the presence of HCA 1 and/or Patient 1, which was not true.

The panel therefore found charge 3e and 3f proved.

Charge 4

4. **Your representations at one or more of 3 a)-f) above were dishonest in that you were making a representation which you knew was not true.**

Charge 4 is proved in respect of 3a, 3b, 3c 3d and 3f (in relation to HCA1)
Charge 4 is NOT proved in respect of 3e, 3f

The panel took into account the NMC guidance on dishonesty and applied the case of *Ivy v Genting Casinos* [2017] UKSC 67.

In reaching this decision, the panel took into account its decisions in relation to charges 3 a)-f) above. The panel also took account of your evidence.

Charge 4 in respect of 3a

In respect of charge 4 in relation to charge 3a, the panel bore in mind the multiple inconsistencies in relation to this charge. The panel noted that your inconsistencies demonstrated that you attempted to deflect from the truth.

The panel bore in mind that you said in your initial email that you believed Patient 1 had returned to the ward before you had returned from your break. Furthermore, it noted that in your written statement to Mr 12 dated 22 September 2016, you denied this position and stated that you were on lunch break and that you were unsure whether Patient 1 had returned whilst you were on break; and you also stated that the patient was let into the ward by HCA 1.

The panel then had regard to the Bay Ward Main Door Activity document and your Fob data for 26 August 2016 in which it identified that you left the ward at 13:49:04 and came back at 14:40:11. The document also indicated that the doorbell for the entrance was pressed at 14:40:04, some seven seconds before your entrance.

The panel bore in mind its determination at charge 3a above that it was satisfied from the evidence before it that you returned from your break, using your key fob to enter the ward at 14:40:11, seven seconds apart from Patient 1 in the corridor and therefore let the patient in. The panel found this evidence reaffirms its earlier position that you let the patient in. The panel therefore determined that your representation that you had been on a break when Patient 1 entered was dishonest in that you knew it was not true.

The panel therefore found charge 4 in respect of 3a proved.

Charge 4 in respect of 3b

In respect of charge 4 in relation to charge 3b, the panel bore in mind its determination at charge 3b above.

The panel also had sight of the CCTV images from outside of Bay Ward 26 August 2016. The first image shows Patient 1 in her wheelchair. The panel noted that at the top of the image, the bottom half of an individual's body in which the individual is holding a piece of paper in their left hand, is shown. The panel then had sight of a second image in which it shows you walking towards the Bay Ward entrance with a piece of paper in your left hand.

The panel also bore in mind that according to the evidence provided throughout the case which was not contested by you, there was a 4 ½ minutes difference between the fob system and the CCTV system. It was accepted that the fob ran on real time and the CCTV was 4 ½ minutes behind.

The panel was satisfied that the key fob entrance data in conjunction with the CCTV images demonstrates that you let Patient 1 into the Ward. It therefore determined that you made the representation that you had not let Patient 1 into the Ward, which was not true.

The panel reminded itself of the different inconsistent evidence you produced in relation to this charge at various stages of this hearing. The panel noted that you had changed your position in the local investigation following viewing the CCTV footage. The panel determined that your representation that you had not let Patient 1 into the Ward was dishonest in that you knew it was not true.

The panel therefore found charge 4 in respect of 3b proved.

Charge 4 in respect of 3c and 3d

In respect of charge 4 in relation to charge 3c, the panel bore in mind its determination at charge 3c above.

The panel reminded itself of your statements and meetings notes in which you stated that HCA 1 had let the patient into the ward and had told you that they had conducted a bag search on return of Patient 1 to the ward.

The panel also bore in mind that on HCA 1's Manual Fob data on 26 August 2016, she was not in the ward from 14:27:05 to 15:35:42. Therefore the panel determined as HCA 1 was not in the ward at the time of Patient 1's return, she would not have let Patient 1 into the ward nor searched her or her bag. The panel therefore concluded that you made the representation that HCA 1 had told you they let Patient 1 into the Ward, which was not true and that HCA 1 had told you they had conducted a bag search on the return of Patient 1 to the Ward, which was not true.

In respect of charge 4, the panel determined that your representations both that HCA 1 had told you they let Patient into the ward and that HCA 1 had told you they had conducted a bag search on return of Patient 1 to the ward, were dishonest in that you knew it was not true.

The panel therefore found charges 4 in respect of charges 3c and 3d proved.

Charge 4 in respect of 3e

In respect of charge 4 in relation to charge 3e, the panel reminded itself of your earlier evidence that you had conducted an inadequate check.

The panel noted that you said in you handwritten statement dated 22 September 2016 that:

> *"…I then asked [HCA 1] if she would come with me to find Patient 1. Patient 1 was found sitting upright on her bed. I asked her for permission to search her wheelchair*

and room of which she agreed I checked the back of her wheelchair and the side of her seating area cushion, her bedside table, bed, curtains, chest of draws, desk, cupboard, and the toilet, shower area, No tablets or packaging was found."

The panel noted that you had consistently stated in your evidence that you conducted a check on Patient 1. The panel was of the view that although it found charge 3e proved in that you had made representations that you had subsequently searched Patient 1's wheelchair and/or bag, the panel bore in mind its determinations that it was an inadequate check conducted by you as you had not been able to successfully find the empty paracetamol packets.

The panel was of the view that you had reasonably believed that you searched Patient 1's wheelchair and/or bag. The panel determined that this was an honest view on your part.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and the evidence in relation to this charge is weak, therefore, on the balance of probabilities, the panel found charge 4 in relation to charge 3e not proved.

Charge 4 in respect of 3f in relation to HCA 1

In respect of charge 4 in relation to charge 3f with regard to HCA 1, the panel was of the view that you knew that HCA 1 had not been in present when you had conducted a check on Patient 1.

The panel bore in mind its earlier determination at charge 3f above where it noted that HCA 1's key fob data on 26 August 2016 indicated that she was not in the ward from 14:27:05 to 15:35:42.

The panel therefore determined that your representation that you carried out the search on Patient 1's wheelchair and/or bag in the presence of HCA 1 was dishonest in that you knew it was not true.

The panel therefore found charges 4 in respect of charges 3f in relation to HCA 1 proved.

Charge 4 in respect of 3f in relation to Patient 1

In respect of charge 4 in relation to charge 3f with regard to Patient 1, the panel was of the view that you had purportedly carried out a search in the presence of Patient 1. The panel found your evidence to be consistent in that you said you said you had searched Patient 1 albeit late, at around 15:00.

The panel reminded itself of its determination on charge 3e and charge 4 in respect of 3e above. The panel bore in mind that you had reasonably believed that you searched Patient 1's wheelchair in the presence of Patient 1. The panel determined that this was an honest view on your part.

The panel did not have any information before it whether or not the patient was present.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and the evidence in relation to this charge is weak, therefore, on the balance of probabilities, the panel found charge 4 in relation to charge 3f with regard to Patient 1 not proved.

Charge 5a

5. **On 18 November 2015**
   a) did not respond promptly and/or follow procedure when Patient 2 absconded from the ward.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Mr 5.

The panel noted that Mr 5 provided oral evidence of how you should have acted when Patient 2 absconded from the ward. However, the panel bore in mind that it was not provided with any policy stating what a 'prompt' response constitutes, nor what procedure you should have followed in such an event.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and the evidence in relation to this charge is weak, therefore, on the balance of probabilities, the panel found charge 5a not proved.

Charge 6

6. **On or around 20 October 2015, having been requested to do so by Nurse 3, did not inform colleagues that a Patient was being transferred from Harbour Ward to Bay Ward, and/or did not provide colleagues with any or adequate information about that Patient in preparation for the transfer.**

This charge is found proved

In reaching this decision, the panel took into account the evidence of Mr 5, Meeting notes between Nurse 3 and yourself dated 1 December 2015 and your evidence.

The panel noted Mr 5's oral evidence in which he stated that he asked you to inform the rest of the team about an incoming patient that was expected at Bay Ward. He explained that you did not pass on this information to the team, and as a consequence, the patient could not be accepted. The panel had sight of Mr 5's witness statement dated 17 July 2019 in which he confirmed this:

> *"In addition to this, Mike did not pass information to the team regarding a patient who was being transferred to Bay Ward. I told Mike that the patient would be*

transferred to Bay Ward at 13:00; I asked him to inform the rest of the team about this patient. The patient arrived on the ward at 13:00."

The panel also bore in mind that this position was noted in the meeting notes between Nurse 3 and yourself on 1 December 2015. It stated:

"Failure to handover information relating to bed management. Whilst [Mr 5] was bed managing, he contacted Michael to state that he was transferring a patient from Habour to Bay Ward. [Mr 5] asked Michael to let [Nurse 3] know that the patient was been transferred at 1 pm; [Nurse 3] contacted Harbour Ward in Michael's presence to state that she had not been aware of the transfer and that the ward was not ready to accept a transfer. Michael continued not to let [Nurse 3] know that he had been aware of the transfer."

The panel noted that it was your evidence that you wrote it on the board and the shift planner. However, the panel bore in mind Mr 5's evidence in which he confirmed that it was appropriate to note down on the shift planner and diary as long as the verbal handover took place.

The panel also reminded itself that during your cross-examination, you provided inconsistent evidence in that you said you told Nurse 3 and a few HCAs' as well as writing on the board although you did not receive all the information about the patient. The panel also recalled your evidence in which you said that it was Mr 5's job to provide that information to others. It noted that your position initially was that Mr 5 told Nurse 3 about the patient and their arrival. However, when challenged during cross-examination, you said, *"I am not sure"* and stated that you should not get involved in transfers.

The panel found your evidence to be inconsistent in relation to this charge.

The panel determined that it had satisfactory evidence before it to determine that on or around 20 October 2015, having been requested to do so by Nurse 3, did not inform

colleagues that a patient was being transferred from Harbour Ward to Bay Ward, and/or did not provide colleagues with any or adequate information about that Patient in preparation for the transfer.

The panel therefore, on the balance of probabilities, found charge 6 proved

Charge 7

7. **In relation to Patient 2, did not formulate a person-centred care plan.**

This charge is found proved

In reaching this decision, the panel took into account the evidence of Mr 5, the Care Plan for Patient 2 and your evidence.

The panel had satisfactory evidence to show that you were the key worker for Patient 2.

Mr 5 told the panel that you were the key worker for Patient 2 and that the responsibility to create a person-cantered care plan lies with the keyworker. He also provided detailed oral evidence about what a person-centred care plan should contain. He told the panel that Patient 2's care plan does not address the patient's needs such as suicidal thoughts, illicit drug use and stockpiling of medication, but addresses only the patient's housing issues. He submitted that to that extent, the care plan was not 'patient-centred'.

It was your evidence that you do not recognise this care plan as one written by you. You said that this was an 'admission care plan' which was not accepted by Mr 5. You also stated that a nurse might wish to address one thing at a time in the care plan.

The panel had sight of Patient 2's care plan. It considered the details within the care plan was limited and that the plan did not entail the detail necessary to be person centred.

The panel therefore was of the view that as Patient 2's key worker you had failed to formulate a person-centred care plan.

The panel therefore found charge 7 proved.

Charge 8

8. **In relation to Patient 6, did not produce a Physical Health Care Plan for them, prior to 25 January 2016**

This charge is found proved

In reaching this decision, the panel took into account the evidence of Mr 5, the Care Plan for Patient 2 and your oral evidence.

The panel noted that Mr 5 in his witness statement dated 24 February 2022 stated:

> *"I have been asked if I am able [sic] provide a Physical Healthcare Plan for Patient 6 dated 25 January 2016 produced by Mike. There is no record on SystmOne of Mike completing a Physical Healthcare Plan and I am unable to produce such a document. "*

The panel noted that Mr 5 produced screenshots showing the date on which Patient 6 was admitted. However it bore in mind that it was not possible to say who admitted Patient 6 to the ward. The screenshots indicated that the transfer took place on 13 October 2015. The panel noted that Mr 5 also made clear in oral evidence that it was the key worker's responsibility to prepare such a care plan, not that of the person receiving the patient to the ward.

It was your evidence that physical care plans were the responsibility of the physical health nurse, Ms 3. The panel noted that Mr 5 firmly disagreed with this, stating that the

responsibility lies with the key worker, who can ask for help from the physical health nurse.

It noted your general observations that you have in the past undertaken MUST scores which is a type of physical assessment and care plan related to malnutrition.

In considering this charge, the panel also considered the transcript of your cross examination of Mr 5 during his oral evidence. It noted the following:

"THE REGISTRANT: No, I do not recall the patient.

THE LEGAL ASSESSOR: The point about this, Mr. South, is that you denied this allegation, which is "in relation to Patient 6 did not produce a physical health care plan on or prior to 25th January". So your case is that you did produce a physical health care plan, yes, before that date?

THE REGISTRANT: I do not know if I produced it or there was one produced that I made reference to. I cannot remember, sorry.

MS. SHEHADEH: Perhaps the witness could be asked if there was any physical health care plan in existence at the time (unclear). I wonder if that would capture it.

THE CHAIR: Mr. South, would you like to ask the witness?

THE LEGAL ASSESSOR: Shall I do it? I wonder if you can help with this, [Mr 5]. There might, mightn't there, have been a physical health care plan produced either by Mr. South or by somebody else, is that possible?

[Mr 5]: There was no physical health care plan on the system. That is why this issue was raised in an (unclear). I would have expected a physical health care plan inserted not long after admission because the individual care plan highlighted

that the patient's left kidney was not working due to a cancerous blockage, the patient was obese, they were smoking, they had low back pain and they had toothache. There are a number of physical health concerns there, therefore I would have expected a plan of care to be put in place in relation no some of these quite complex concerns. That care plan was not -- there was no physical health care plan until towards the end of January. I think it was 25th January.

THE LEGAL ASSESSOR: Yes, that is the date.

THE REGISTRANT: Where was the patient admitted to?

[Mr 5]: They were transferred to -- likely the patient would have been admitted to our triage ward, which was Harbour Ward, where patients go for the first few days. At the time, patients were admitted to an admission ward and transferred through to Bay Ward.

THE REGISTRANT: There would have been an admission nurse and doctor when the patient was accepted for an admission?

[Mr 5]: Yes. The nursing staff that work on Harbour Ward and the patient would have been what we call clerked in by a junior doctor.

THE REGISTRANT: A nurse on Harbour Ward would have done the physical health care plan?

[Mr 5]: Not necessarily, no. They would have addressed any immediate physical health needs. However, given that the patient had a protracted stay on Bay Ward I would have expected longer continuing care needs to be addressed in a physical health care plan on Bay Ward rather than Harbour Ward. Harbour

Ward was there to address immediate needs, in essence to keep the patient safe."

The panel then reminded itself of your evidence during cross-examination. It had particular regard to the following:

"Ms Shehadeh- Do you accept you were the key worker?
You- I don't know I don't recognise
Ms Shehadeh- Accept that the key worker is responsible for psychical health plan?
You- [Mr 5] told me on several occasions it was a new role and it was the physical health care nurses' responsibility to do the physical health care plans.
Ms Shehadeh – [Mr 5] said that [Ms 3] was there to support you…do you accept this?
You- No not at the time. It was made clear that it was her responsibility that [Ms 3] was to do all the physical health care plans. It was an experiment and it was made clear that she was to do it. I did not have access to systems the only physical health care we would do is weights."

The panel was satisfied from the evidence before it that you did not produce a Physical Health Care Plan for Patient 6, prior to 25 January 2016.

The panel therefore found charge 8 proved.

Charge 9a

9. **In relation to Patient 7:**
   a) **Did not evaluate their care plan between 20 December 2015 & 15 January 2016**

This charge is found proved

In reaching this decision, the panel took into account the evidence of Mr 5 and your evidence.

The panel noted that you have been identified as the keyworker for Patient 7. The panel had sight of Mr 5's witness statement dated 17 July 2019, which states:

> *"…When looking at patients' who had been assigned to Mike as the keyworker, I raised the following concerns:*
>
> *…*
> *III. Care plan for Patient 7 had not been evaluated recently..."*

The panel bore in mind your evidence during cross examination where you were asked if you accept whether the keyworker has an overall responsibility to review the care plans, to which you agreed that the keyworker should review the plans. However, it was your evidence that you could not remember if you were the keyworker for Patient 7.

The panel noted that the only care plan the panel had before it was the MUST care plan. It did not have before it a mental health care plan. The panel noted that the MUST identified malnutrition risk.

The panel noted Mr 5's supplementary witness statement dated 18 June 2021, which stated:

> *"Patient 7 presented with a high risk of malnutrition. There was an expectation that Patient 7's care plan would be evaluated at least once per week. However, no evaluation is recorded as having been undertaken in Patient 7's care plan between 20 December 2015 and 15 January 2016. Mike worked 13 days during this timeframe and was the key worker for patient 7."*

Mr 5 confirmed during oral evidence that you had been working 13 days of that time.

The panel also had sight of Patient 7's care plan and noted that it has entries on 20 December and 15 January 2016. The panel further took into account that Patient 7's care plan has not been reviewed for 26 days. It noted that you had not reviewed or evaluated the patient's care plan between the dates specified in the charge.

The panel determined that you did not evaluate Patient 7's care plan between 20 December 2015 & 15 January 2016**.**

The panel therefore found charge 9a proved.

Charge 9b

9. In relation to Patient 7:

b) Did not document in their clinical record that their rights had been read to them during the admission.

This charge is found proved

In reaching this decision, the panel took into account the evidence of Mr 5, and your evidence.

The panel noted that you have been identified as the keyworker for Patient 7. The panel had sight of Mr 5's witness statement dated 17 July 2019, which states:

> *"…When looking at patients' who had been assigned to Mike as the keyworker, I raised the following concerns*
> *…*
> *III. Care plan for Patient 7 had not been evaluated recently. There was no evidence that Patient 7 had their rights read to them during the admission."*

The panel noted Mr 5's supplementary witness statement reaffirmed this on dated 18 June 2021, which stated:

> *"In relation to Patient 7 having their rights read to them during admission, at the time this would have been recorded on a separate form rather than in the care plan. However, this form was not present in Patient 7's clinical record and there is no evidence that this occurred…"*

The panel had sight of the Northamptonshire Healthcare NHS Trust record of information given to detained patients form for Patient 7. It noted that the form details that:

> *"The information should be given as soon as practical after the patient's detention and after the commencement of any subsequent detention or transfer to another unit, at renewal of section, when patient gives consent to treatment, at review of medication etc "*

The panel noted the following during Mr 5's oral evidence:

> *"Ms Shehadeh: Why do you say Mr. South should have done this recording as opposed to anybody else?*
> *[Mr 5]: I would have expected Mr. South to have read the patient's rights, what I would term regularly, not necessarily on that transfer to Bay Ward because I am not sure if Mr. South -- he may not have been working the shift. However, as the key worker I would have expected Mr. South to look at whether the patient's rights were last read. If the rights had not been read on transfer to Bay Ward and he was not present as the key worker, I would have expected him to pick that up as part of his key working duties."*

You accepted during your evidence that the keyworker is responsible for updating patient rights as part of the Mental Health Act requirements.

The panel found no evidence to demonstrate that the patient's rights had been read to them. It found that as you were the key worker for Patient 7, you had the responsibility to ensure that the patient's rights were read to them. The panel therefore determined that you did not document in Patient 7's clinical record that their rights had been read to them during the admission.

The panel therefore found charge 9b proved.

Charge 10

10. In relation to Patient 11, did not put in place a care plan to support staff in dealing with occasions when that Patient placed themselves on the floor.

This charge is found proved

In reaching this decision, the panel took into account the evidence of Mr 5, Patient 11's care plan and your evidence.

The panel noted that in oral evidence, you accepted that you were the keyworker for Patient 11, although you could not remember when you became Patient 11's keyworker. The panel bore in mind your oral evidence in which you said, *"this is something that has been happening for awhile"*

The panel noted that the 15 minutes observations form for Patient 11 where it had been recorded that Patient 11 had been sat on the floor for the most part of the day from 9.30 am until 20:00 hours when the ambulance was called.

The panel noted Mr 5's witness statement dated 17 July 2019, which stated:

> *"[Ms 10] was a newly qualified nurse which meant that Mike was acting as the NIC; although he was not meant to work as the NIC, I was present on the ward in my*

office during this time to support him in this role. [Ms 10] reported to me that she felt unsupported by Mike and received limited support from Mike to attempt to support Patient 11. [Ms 10] was also concerned about the length of time Patient 11 had been on the floor prior to her becoming involved.

…

Mike was the allocated keyworker for Patient 11. A review of her clinical record on SystmOne by myself and [Ms 11] revealed record keeping discrepancies. Patient 11 had a tendency of placing herself on the floor but Mike had not put in place a care plan to support staff to manage this behaviour and had not consulted with [Ms 3]. A patient presenting with such risk behaviours requires a care plan which staff can follow when this behaviour takes place so that the patient is safe. Patient 11 had been on Bay Ward for several months, the keyworker is responsible for formulating care plans."

The panel had sight of the care plan. It noted that there are records of observations within it, however it did not find any information in relation to the patient placing themselves on the floor. The panel found that there is no information in Patient 11's care plan to reflect this charge. It therefore found that you did not put in place a care plan to support staff in dealing with occasions when Patient 11 placed themselves on the floor.

The panel therefore found charge 10 proved.

Charge 11a

11. In relation to Patient 11, on 23 December 2016:

a) Did not seek advice and/or assistance promptly in relation to their continued presentation on the floor.

This charge is found proved

In reaching this decision, the panel took into account the evidence of Mr 5, Ms 10, Ms 11 and your evidence.

The panel noted that Mr 5 in his witness statement dated 17 July 2019 stated:

> *"On 23 of December 2016, the day before my annual leave, I arrived at work at approximately 07:30; my plan was to finish at lunch time. Before I left the ward I asked Mike whether there were any concerns, Mike confirmed that there were no concerns. I left the ward believing that there were no concerns but on my return to work following my annual leave I was told by Staff Nurse [Ms 10] that she was concerned about an incident where are Patient 11 had been found on the floor and she had concerns in relation to Mike's management of the incident.*
> *…*
> *Mike was the allocated keyworker for Patient 11. A review of her clinical record on SystmOne by myself and [Ms 11] revealed record keeping discrepancies. Patient 11 had a tendency of placing herself on the floor but Mike had not put in place a care plan to support staff to manage this behaviour and had not consulted with [Ms 3]. A patient presenting with such risk behaviours requires a care plan which staff can follow when this behaviour takes place so that the patient is safe. Patient 11 had been on Bay Ward for several months, the keyworker is responsible for formulating care plans."*

The panel noted that the 15 minutes observations form for Patient 11 where it had been recorded that Patient 11 had been sat on the floor for the most part of the day from 9.30 am until 20:00 hours when the ambulance was called. The panel bore in mind that the patient was on the floor for almost 12 hours.

The panel also reminded itself of Ms 11, the Occupational Therapist Ward Manager's oral evidence in which she confirmed that the *"patient was on the floor for a long time*" however she said that you did not take any action regarding this.

The panel also bore in mind Ms 10's witness statement dated 6 April 2020 in which she said:

> *"I took an hour's break around 3pm and upon my return, I asked one of the HCA's who I cannot recall, if Patient 11 was still on the floor and she confirmed that she was. I immediately went to see Patient 11 to try and help myself. Patient 11 did respond to my presence but her answers to my questions were incoherent other than to shake her head to indicate she did not want to get off the floor. I attempted to assist her to move but each time I tried she was moving away from me. Mike, other staff members and myself tried several times but she resisted and pushed us away. Each time I returned to her she was in a different position on the floor."*
>
> *At the point, Mike hadn't escalated this to anyone, despite managers being on the shift. I discussed with the team about using a hoist to aid Patient 11 off the floor. However, as it would have been the first time using a hoist with a patient, I felt that I required further support. Therefore, I called the Clinical Team Lead (CTL) on duty that day, who I cannot recall, to ask for advice. The CTL attended the ward, and after seeing decided a hoist would be not to be an appropriate way of getting the patient off the floor."*

The panel was of the view that Ms 10's evidence was contemporaneous and independent and supported the evidence of Ms 11 as she was present at the scene at the time.

The panel bore in mind your oral evidence in which you said that you contacted the CTL, however, the panel had no evidence to support this. You also said that you attempted to call the doctor but you were told that no one was available as they were all in a meeting. The panel reminded itself that both Ms 10 and Ms 11 did not recall this and Mr 5 denied this. Mr 5 explained that there was a very large number of doctors at the hospital overall so it would have been "*very unlikely and very concerning"* if no duty doctor had been available.

The panel preferred the evidence of the NMC witnesses to your evidence. The panel was satisfied from the information before it that on 23 December 2016, you did not seek advice and/or assistance promptly in relation to Patient 11's continued presentation on the floor.

The panel therefore found charge 11a proved.

Charge 11b

13. In relation to Patient 11, on 23 December 2016:

b) Did not escalate the concerns about Patient 11 to the Ward Matron.

This charge is found proved

In reaching this decision, the panel took into account the evidence of Mr 5 and your evidence.

The panel noted Mr 5's witness statement dated 17 July 2019, which stated:

> *"[Ms 10] was a newly qualified nurse which meant that Mike was acting as the NIC; although he was not meant to work as the NIC, I was present on the ward in my office during this time to support him in this role. [Ms 10] reported to me that she felt unsupported by Mike and received limited support from Mike to attempt to support Patient 11. [Ms 10] was also concerned about the length of time Patient 11 had been on the floor prior to her becoming involved.*
>
> *My concern was that Mike had not escalated this concern to me as i was still at work in my office on the ward when it happened. I was also concerned that Mike did not report this incident to me when I asked him if there were any concerns prior to my leaving the ward. If I had known about this incident, I would have attended to Patient 11 and supported Mike to formulate a safe management plan."*

The panel bore in mind Mr 5's oral evidence in which he was asked about this incident.

> *"THE LEGAL ASSESSOR: Pause there. Do you remember having that conversation, [Mr 5], with Mr. South, that that is what he told you?*
>
> *[Mr 5]: No, I was not aware that the patient was on the floor.*
>
> *THE REGISTRANT: I said to she was sitting on the floor, she was comfortable, everything is okay at the moment, we are weighing for a doctor, and then you said "I have to go on holiday now. I need to go fairly promptly".*
>
> *[Mr 5]: That is absolutely not true. I would not have left the ward if there was an incident ongoing at the time.*
>
> *[THE REGISTRANT]: But you agree you did ask Mr. South if there were any concerns?*
>
> *[Mr 5]: I asked Mr. South if there was any concerns before I left and I was given the response that there was no concern. I was satisfied that I was then able to leave the ward."*

The panel bore in my mind your questions to Mr 5 about you having said that you were waiting for a doctor and making the patient comfortable. However, the panel noted that during your oral evidence and in cross-examination, you disputed this. You said that you attempted to look for Mr 5 but could not find him in order to escalate and that you were "irritated" by this. The panel noted the inconsistencies in you evidence and that your earlier position, when you said you spoke to him, conflicts with your oral evidence.

The panel determined that it preferred the evidence of Mr 5 as it was consistent and more compelling than your evidence.

The panel was therefore satisfied that on 23 December 2016, you did not escalate the concerns about Patient 11 to the Ward Matron.

The panel therefore found charge 11b proved.

Charge 11c

11. In relation to Patient 11, on 23 December 2016:

c) Did not carry out NEWS/physical observations on Patient 11 or instruct another member of staff to do so.

This charge is found proved

In reaching this decision, the panel took into account the evidence of Mr 5, Ms 10 and your evidence.

The panel noted Mr 5's witness statement dated 17 July 2019, which stated:

> *"There is no record of Mike taking physical observations when Patient 11 was on the floor. Furthermore he documented that she had put herself on the floor despite there being no witnesses to this. There was a risk that she had fallen to the floor or was physically unwell. In order to rule out injury or illness, he should have taken Patient 11's physical observations and requested that she was reviewed by a doctor…*
>
> *When I spoke to Mike about the incident he was regretful for not taking Patient 11's observations whilst she was on the floor; he was also regretful for not informing me about the incident but could not identify why he did not inform me."*

The panel also borne in mind that at local level, you admitted to Mr 5 that you had not recorded the NEWS scores, and had expressed regret about it. The panel reminded itself that Mr 5 repeated this during his oral evidence:

> *"Q. You say at your paragraph 94 there is no record of Mike taking physical observations when Patient 11 was on the floor. How did you satisfy yourself that there were no records of physical observations?*
>
> *A. We record physical observations on a NEWS chart (National Early Warning Signs) where you detail the patient's blood pressure, pulse, oxygen saturations, their level of consciousness, and that is how we record the observations and by virtue of admission the observations have not been taken."*

The panel also recalled Ms 10's evidence on how she knew that no NEWs observations were recorded, she was clear; she had looked at the paperwork herself when she gave it to the duty doctor, and the duty doctor had also remarked upon it.

The panel had sight of Patient 11's care plan and noted that it only had general recording of observations. The panel did not find any NEWS/physical observations recorded.

The panel further had sight of an enhanced observations recording form, which could have been used by you in these circumstances to record the physical observations.

The panel noted that although you admitted initially at local level that you had not done the NEWS scores, during your oral evidence you said that you did a baseline NEWS and had documented this. You conceded that you did not do it on a standard form but had noted it on an A4 piece of paper. The panel was not presented with any such material.

In the absence of any such material to demonstrate that you had carried out NEWS/physical observations on Patient 11 or instructed another member of staff to do so,

the panel concluded that it had satisfactory evidence before it to determine that these observations had not been done.

The panel therefore found charge 11c proved.

Charge 12

12. On 28 October 2015 administered Ramipril despite being made aware there was an error with the prescription.

This charge is found NOT proved

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

The panel reminded itself of Ms 3's evidence in which she said that she was in the room when you administered the drug to the patient. She said she saw this happen. She said she knew what the drug was because she had checked the medication afterwards and that she spoke about what time Ramipiril should have been given with Ms 13 in your presence.

You maintained your position in relation to this charge. You said that you did not administer Ramipril. You said that you were training a student at the time.

The panel bore in mind the documents before it. It noted that there is no evidence before it in the form of medication charts or otherwise to indicate that Ramipiril had been administered.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and the

evidence in relation to this charge is weak, therefore, on the balance of probabilities, the panel found charge 12 not proved.

Charge 13b

13. On 28 October 2015

b) Did not document the time the patient was administered the dose at 13 a) above

This charge is found NOT proved.

In reaching this decision, the panel took into account of the patient's charts, Ms 3's evidence and your evidence.

The panel noted that Ms 3 states that you did not record what time the insulin was given; '*there was no documentation about the insulin*'. The panel noted that you deny this charge.

The panel was not presented with a MAR chart in order to confirm whether you had or had not administered insulin.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and the evidence in relation to this charge is weak, therefore, on the balance of probabilities, the panel found charge 13b not proved.

Charge 13c

13. On 28 October 2015

c) Did not document why the patient was administered the dose at 13 a) above late

This charge is found NOT proved.

In reaching this decision, the panel took account of the patient's charts, Ms 3's evidence and your evidence.

The panel noted that Ms 3 conceded in cross-examination that you had used a symbol/code to indicate on the MAR chart why the insulin was given late.

The panel further noted that in light of this evidence, the NMC did not seek to prove this charge.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and therefore, the panel found charge 13c not proved.

Charge 14b

14. On 26 December 2015

b) Did not document the medication error at 14 a) above in Patient 3's records.

This charge is found proved

In reaching this decision, the panel took into account the evidence of Ms 2, Mr 5 and your evidence.

The panel noted Ms 2's witness statement dated 27 February 2019 in which she said:

"I cannot confirm whether the incident was ever raised with the CTL by Mike, he made me believe that he was doing that but I never actually saw him do it. I am not sure who reported the medication error either. Mike should have done it as per policy but I am not sure it was done…"

The panel also noted Mr 5's evidence in which he addresses the lack of documentation in relation to this error. He states in his witness statement dated 17 July 2019:

"I met Mike in a disciplinary investigation meeting on 27 January 2016 along with Human Resource Business Partner… and Royal College of Nursing Representative ("RCN")…. Mike admitted to stating 'it is only Depakote, it should not be a problem.' He could not confirm why he had not documented the information on the patient's clinical record and stated he was not aware of how to complete a Datix incident form. He was unaware of the side effects of the error but admitted that his mistake did constitute a medication error."

The panel noted that Mr 5 interviewed you about this incident. It bore particular regard to the following:

"*why did you not document on the medication chart the time you administered the drug? I know I should have done this. I did put this on the PC system but nothing was said in handover by [Mr 6]. Why did you not document the error in the patient's SystmOne record? I am not sure why I did not document this on SystemOne.*"

The panel had sight of Patient 3's records on 26 December 2015 and noted that you had not recorded the error made by you.

The panel further took note of the interview notes with Ms 1 dated 2 February 2016. It noted she said the following:

"Question: What time did the medication error occur?

Answer: Michael started the medication round at 12:30 therefore it was at this approximate time that he came to tell me about he error.

Question: Did he document the incident?
Answer: No I checked- I had to document for him.

Question: Does NFT operate a similar reporting process to other Trusts and services?
Answer: Yes, there are standard procedures in healthcare for reporting medication incidents. You always contact a doctor and make sure that the patient is safe."

The panel determined that it had satisfactory evidence before it to conclude that on 26 December 2015, you did not document the medication error at 14 a) above in Patient 3's records.

The panel therefore found charge 14b proved.

Charge 15

15. **Your actions at Charges one or more of 14 b) to 14 e) above demonstrated a lack of integrity in that you sought to avoid there being a record and/or report of the error at 14 a) above, when you knew there should have been.**

This charge is found proved in its entirety

In considering this charge, the panel had regard to the case of Wingate v SRA 2018EWCA Civ 366. It bore in mind that *'Integrity'* expressed the higher standards society and professionals expected from professionals, it connoted adherence to the ethical standards of one's profession and it involved more than mere honesty.

The panel noted your admissions at charges 14a, 14c, 14d and 14e. The panel also bore in mind its determination at charge 14b.

The panel bore in mind that you were seeking to avoid there being a written record of your medication error by preventing it being in the typed handover notes, not raising a Datix and not recording it in the patient notes, and preventing a colleague from writing it down. The panel also noted that you had been aware that Mr 5 had concerns about your performance and work, and had already begun a capability process. The panel noted that you had been subject to various medical administration training during your time at the Trust and therefore you ought to have been familiar with the policies, however you departed from the professional way of working. It also noted that by preventing a colleague from writing your error down, you attempted to include a colleague in your error as well as breached the code of conduct. The panel noted that by stating, *"it is only Depakote"* you acted in an unprofessional manner and sought to diminish the error regardless of the risk level. It determined that the error should have been documented, not merely verbally communicated.

The panel determined that you failed to show transparency and integrity in your attempts to avoid recording this incident.

The panel determined that your actions at charges 14 b) to 14 e) above demonstrated a lack of integrity in that you sought to avoid there being a record and/or report of the error at 14 a) above, when you knew there should have been.

The panel therefore found charge 15 proved in its entirety.

Charge 18

18. On or around 17 December 2015 did not plan the shift effectively in that you designated HCA 2 to complete most of the contact notes in the patient's clinical records.

This charge found NOT proved

In reaching this decision, the panel took account of HCA 2's evidence, and your evidence.

It noted HCA 2's witness statement in which he stated:

> *"As part of my role, I fill in contact notes into patient's clinical records. Contact notes are a daily entry into the patient's clinical records detailing their mental state and presentation over the course of a shift. As a HCA, I am usually allocated contact notes of three of four patients at the start of a shift...*
>
> *Whilst working on Bay Ward when Mike was in charge, I felt that approximately 70% of the time, I filled in more contact notes than the usual amount (which would be 3-4 per shift). During shifts when Mike was the Nurse in Charge, I filled in approximately between 12-17 contact notes myself.*
>
> *I suffer from dyslexia and often had difficulties in making entries in the clinical records. Therefore, my notes were not as in-depth as it could be because of spelling errors or in case I made an error that led to further complications."*

The panel also noted that Mr 5 confirmed in oral evidence that around 3-4 patients would usually be allocated to an individual.

The panel noted that HCA 2 had raised this issue with Mr 5 as a concern as noted in the concerns log and action plan for 20 October 17 December 2015. The panel noted that within this log, it was recorded:

> *"HCA felt unsupported by Mike when he was left to do the majority of contact notes. HCA reported that he was dyslexic and finds it difficult to write contact notes. Mike*

went on to write 3 contact notes and prioritised the completion of the handover sheet over assisting with contact notes."

You accepted during your evidence that that the normal practice would be to allocate 3-4 patients; however you said that it was not true that you delegated 17 patients to HCA 2. The panel also bore in mind your evidence in which you said that HCA 2 has asked to do more contact notes on occasion. You further said that you had allocated contact notes to be completed by another member of staff too and therefore it is unlikely that HCA 2 would have had to complete 17 notes.

The panel bore in mind all the relevant evidence it was of the view that although there is evidence to demonstrate that the concerns were raised; however, there is no evidence before the panel that the notes were not completed on these specific dates as charged.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and the evidence in relation to this charge is weak, therefore, on the balance of probabilities, the panel found charge 18 not proved.

Charge 19a

19. On one or more occasion between 20 August 2015 and 22 July 2016 did not effectively run the ward and/or support staff when acting as the Nurse in Charge in that you:
a) Did not allocate observations and/or safety checks as part of a shift plan.

This charge found NOT proved

In reaching this decision, the panel took account of HCA 2's evidence and your evidence.

The panel had regard to the HCA 2‘s witness statement dated 28 March 2020, which stated:

> *“My general observation of Mikes shift planning was that it was very poorly handled. This shift planning did not outline what had to be done for the shift. A good plan would entail who does the observations and who goes around making sure the patients are safe, but this information was not always included in his plans.”*

The panel noted that HCA 2’s witness statement was signed in 2020, which it considered to be a significant time after the events in the charge. The panel considered that the evidence presented to it was not sufficiently reliable or cogent to find this charge proved.

The panel was of the view that it had before it an example of a shift planner. It demonstrated that observations had been allocated. However, the panel noted that there was no evidence regarding the allocation of safety checks. The panel also bore in mind that it was not clear to it from the information before it what the safety checks were supposed to encompass. Therefore the panel noted that there is no evidence to support the charge in relation to both the allocation of observations and safety checks part of the charge.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and the evidence in relation to this charge is weak, therefore the panel found charge 19a not proved.

Charge 19b

19. On one or more occasion between 20 August 2015 and 22 July 2016 did not effectively run the ward and/or support staff when acting as the Nurse in Charge in that you:

b) Amended parts of a shift plan without informing staff affected by the change at all/or in good time

This charge is found NOT proved

In reaching this decision, the panel took account of HCA 2's evidence and your evidence.

The panel noted that in HCA 2's witness statement dated 28 March 2020, he stated:

> *"My general observation of Mikes shift planning was that it was very poorly handled. This shift planning did not outline what had to be done for the shift. A good plan would entail who does the observations and who goes around making sure the patients are safe, but this information was not always included in his plans. It seemed like Mike did not put much care and attention into his shift planning and on a few occasions, he would change the plan without informing anyone. For example, he would change the time of my break without informing me or suddenly tell me I have to carry out the observations of a patient."*

You said during oral evidence that sometimes a shift planner does need to be amended, but that you always do try to speak to the staff members about it.

The panel could find no evidence of shift planners that might have been changed.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and the evidence in relation to this charge is weak, therefore the panel found charge 19b not proved.

Charge 19c

19. **On one or more occasion between 20 August 2015 and 22 July 2016 did not effectively run the ward and/or support staff when acting as the Nurse in Charge in that you:**
    c) (On one occasion) missed a member of staff off the shift plan

Charge found NOT proved

In reaching this decision, the panel took account of Ms 9's evidence and your evidence.

The panel noted that in Ms 9's witness statement dated 21 June 2019, she stated:

> *"The second concern I refer... is in regard to a person being missed of the shift planner, I cannot remember the person's name. This resulted in my workload increasing significantly. I had to take the initiative to allocate this person tasks on the shift planner. Although Mike had not put her down for tasks all day she did what she could."*

The panel also had regard to the document entitled 'Concerns raised by Ms 9 dated 29 July 2016, which stated the same as above. The panel also had sight of the meeting notes between Mr 5 and yourself in July/August 2016, which stated:

> *"Met with Michael and [Ms 8] on 27th July. Advised him that several concerns had been raised about his practice. Advised him that several staff from within the ward and external to the ward do not feel safe and that the ward is unsafe when he is on shift; advised him that a complaint had been lodged from a patient. Concerns raised at this point: poor shift leading, dis-organised, abrupt nature with patients. Advised him that I would seek advice from HR before putting together a management plan"*

The panel acknowledged the evidence above. However, it was not provided with specific dates or any shift planners to indicate that you missed a member of staff off the shift plan.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and the evidence in relation to this charge is weak and therefore the panel found charge 19c not proved.

Charge 19d

19. On one or more occasion between 20 August 2015 and 22 July 2016 did not effectively run the ward and/or support staff when acting as the Nurse in Charge in that you:

d) Left the ward for breaks during unsettled periods

Charge found NOT proved

In reaching this decision, the panel took account of Ms 8's evidence, the supervision recordings sheet dated 2 December 2016 and your evidence.

The panel noted that in Ms 8's witness statement dated 10 July 2019, she stated:

> *"The plan was for Mike to continue with the performance objectives and I highlighted that it was important for him to communicate with who he was working with."*

The panel also had sight of the copy of supervision recordings sheet dated 2 December 2016. It noted that the only evidence in respect of this charge is in relation to 2 December 2016, which is outside of the dates specified in the charge.

The panel reminded itself that the burden of proof at the fact-finding stage is upon the NMC. The panel determined that the NMC has not discharged its burden of proof and the evidence in relation to this charge is weak and therefore the panel found charge 19d not proved.

Charge 19e

19. **On one or more occasion between 20 August 2015 and 22 July 2016 did not effectively run the ward and/or support staff when acting as the Nurse in Charge in that you:**
    e) Did not allocate breaks fairly

This charge is found proved

In reaching this decision, the panel took account of Ms 9's evidence and your evidence.

The panel noted that in Ms 9's witness statement dated 10 July 2019, she stated:

> *"I had to tell Mike assertively that I was taking a break. The person who allocates the breaks and tasks is the NIC which was Mike on that day. Mike did not relieve me for the whole time I was down there. The only time I was called to come up was to get the diners for the patients, then I was sent back down. The shifts are supposed to be equal unless we are short staffed, there was a lack of good allocation and communication from Mike regarding this."*

The panel had regard to the shift planner dated 22 July 2016. It noted that you were the shift coordinator from 14:00 hours to 20:00 hours it also noted that there were seven members of staff listed on the shift planner but only three members were allocated breaks. It bore in mind that the shift planner recorded that Ms 9 and other staff members of staff were on duty, however there were no recorded breaks allocated to them. The panel noted that at least two other members of staff were not allocated breaks.

The panel was satisfied that Ms 9's witness statement was consistent with the details of the shift planner.

The panel determined that it had satisfactory evidence before it to determine that on one or more occasion between 20 August 2015 and 22 July 2016, you did not effectively run the ward and/or support staff when acting as the Nurse in Charge in that you did not allocate breaks fairly.

The panel therefore found charge 19e proved.

Charge 19f

19. On one or more occasion between 20 August 2015 and 22 July 2016 did not effectively run the ward and/or support staff when acting as the Nurse in Charge in that you:

f) When asked questions or otherwise asked for assistance by staff, did not attempt to answer queries or otherwise assist.

Charge found proved

In reaching this decision, the panel took account of Ms 5's evidence and your evidence.

The panel noted a letter dated 18 April 216 from Mr 5 to you in which it states:

> *"I write further to your meeting on 9th March 2016. The purpose of this meeting as to discuss your work performance in line with the Trust's Policy and procedure for Dealing with Employee Incapability- Unsatisfactory Work Performance..."*

The panel also had sight of the meeting notes between Mr 5 and yourself in July/August 2016.

> *"Met with Michael and [Ms 8] on 27th July. Advised him that several concerns had been raised about his practice. Advised him that several staff from within the ward and external to the ward do not feel safe and that the ward is unsafe when he is on*

shift; advised him that a complaint had been lodged from a patient. Concerns raised at this point: poor shift leading, dis-organised, abrupt nature with patients. Advised him that I would seek advice from HR before putting together a management plan"

The panel also had regard to a copy of concerns raised by Ms 9 dated 29 July 2016 in which she states:

"…Someone had to be referred to a private provider. Unfortunately the fax machine at reception was not working; I informed MA of this and he stated that it could wait until the following morning. I was aware that this was an urgent issues, [Ms 3] then took it from me and tried to fax it."

The panel further bore in mind the contents of the copy of concerns raised by Ms 6 dated 9 August 2016 in which she states:

" On most shifts, I observe Michael to ignore patients; he will not listen to what the patient is wanting to say; he will often state to them that he is busy or in the middle of doing something. Its difficult to prompt him as he will walk away and then other staff have to take over, deal with the patient query or de-escalate the patient as he has made them agitated. [sic]"

The panel determined that it had satisfactory evidence before it to determine that on one or more occasion between 20 August 2015 and 22 July 2016, you did not effectively run the ward and/or support staff when acting as the Nurse in Charge in that you did not attempt to answer queries or otherwise assist when asked questions or otherwise asked for assistance by staff.

The panel therefore found charge 19f proved.

Charge 20

20. On 26 June 2016 did not follow the fire policy procedure.

This charge is proved by admission in that you accept that you did not dial 5555 but dialled 0

The panel bore in mind that the NMC did not seek to pursue this charge any further. Charge 20 was admitted on a specific basis namely that you had dialled 0 instead of 5555.

At the close of the NMC case and upon review of the evidence counsel on behalf of NMC accepted that this basis was consistent with the evidence before panel and did not seek therefore to advance any alternative finding. (The basis of plea was therefore accepted).

The panel determined that this charge has been admitted on the basis that you did not dial 5555 on both occasions. It accepted Ms 8's oral evidence, that this is the extent of the deviation from the fire policy. It concluded that although you diverted from the policy, you did alert the alarm.

The panel therefore found this charge proved by your admission.

Charge 22

22. On one or more occasions when a patient raised a query or concern with you, you, did not prioritise a patient's needs.

This charge is found proved

In reaching this decision, the panel took account of Ms 6's evidence and your evidence.

The panel noted Ms 6's witness statement dated 27 February 2020 states:

"I think Mike could understand patients' requests, but I don't think he realised the value of the information to the patient. For example, instead of saying 'is that what you need, don't worry I will get back to you' he'd say "I don't know, I can't find out now because the ward is busy"…

I've heard Mike give patients answers like 'I don't know followed by I'm really busy.' I've also heard him say ''I really need to go and get coffee' I recollect patients asking for answers and Mike would say he's typing or he needs to make coffee. He won't stop what he's doing (typing) to answer a patient.

There were two qualified nurses and our offices had two doors on each side. Patients can knock on either door if they need something of if they need to talk to someone regarding their medication. Mike would leave me to attend to everything, he would keep on typing instead of prioritising the patient.

I can't say I remember specific patients, but I can remember incidents. For example a patient said "the doctor promised to review my medication, I'm not sleeping do you know when I can see the doctor?" The client may not be sleeping and all they want is to see their doctor. Mike said "I'm sorry I can't give you that information, I'm busy" and the door closes and I think you can't do that and then I get up to go after the patients…

I've told Mike - we leave our work to go and answer them cause they rely on us and he replied when I'm busy I'm busy."

The panel also bore in mind Ms 6's oral evidence in which the following evidence was produced:

"Q: On an average shift, can you give us an idea of how frequently this would occur?
A. Maybe six to ten times.

Q. You have explained in your statement that – you say the question could have been as simple as when am I seeing my doctor, and you say it might be small, but it means a lot to the clients. Why did you feel it was important to respond?
A. Because people with mental illness, sometimes they are so distressed, and they need something to help them with their distress, so maybe that conversation with the consultant, they are clinging on it, thinking they will give the answer and get a solution to what is bothering them, so it means a lot to them. If we do not have a mental illness, we will be like it is not a big deal, but it is a big deal to them.
Q. At paragraph 12 you say, "I've heard Mike give patients answers like 'I don't know' followed by, 'I'm really busy'." You also say that you have heard him say, "I really need to go and get coffee". How frequently would you hear him saying this sort of thing when you were working on shift with him?
A. Maybe twice or three times.
Q. Is that per shift or are you saying two or three times in total?
A. Per shift."

The panel also bore in mind the witness statement of Ms 7 dated 15 July 2021 in which she wrote:

"On 22 July 2016, I was on duty as the on call clinical team leader for the Hospital. I received a call from a colleague asking me to attend the Acute Ward as Patient 8 was agitated and wanted to speak with a Senior Nurse. Patient 8 had explained to me that she wanted to speak with Michael about her concerns. She had experienced a difficult time whilst on leave and wanted to discuss this with Michael. He had asked Patient 8 if she was ok when answering the door and when had answers 'no' Michael walked away not showing any care or interest.

When I spoke with Michael about Patient 8's complaint he did not deny what she had discussed with me. Michael confirmed the incident between himself and Patient 8 to be true and was very dismissive about it"

The panel noted that Ms 7's witness statement was consistent with her oral evidence. It reminded itself that Ms 7 said:

> *"Q. You have told us in your statement that you spoke to Patient 8 about her concerns, "She had experienced a difficult time whilst on leave and wanted to discuss it with Michael. He had asked Patient 8 if she was okay when answering the door and when she had answered 'no' Michael had walked away not showing any care or interest". How clear are you that that is what the patient said to you?*
>
> *A. I can remember that being a conversation that I had, and I know that I emailed this very soon after, so I can rely on my email that I sent."*

The panel had sight of the email Ms 7 referred to above in which Ms 7 wrote to Ms 5 on 3 August 2016 that:

> *"[Mr 5] I would like to express my concern for a member of staff I met on your ward when I was CTL on-call 22/07/2016… When I saw Patient 8 she was very cross at Michael stating he had answered the door to her but when asked if she was okay and she said 'no' he turned and walked away When I spoke to him about this he did not deny it. I was shocked by his lack of compassion…"*

The panel also had sight of a log of concerns recorded by staff members with multiple concerns raised about your failure to prioritise patient needs.

You did not accept this charge. You highlighted in cross-examination that you had been encouraged to focus on your record keeping. The panel also bore in mind that you said you found it very difficult to work in the nursing office as you found working on the computer and securing a computer quite difficult, and that you found the constant interruptions very difficult. The panel noted that you said you prioritised emergencies by risk, but did not think checking information for patients was something you should be

asked about. You also did not accept the general suggestion that patients would become agitated if they didn't get the answers they needed.

The panel had regard to all the evidence in relation to this charge and determined that it had satisfactory evidence before it to determine that on one or more occasions you did not prioritise patient's needs when a patient raised a query or concern with you.

The panel therefore found charge 22 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 (in relation to the charges found proved of charges 1-17) or lack of competence (in relation to the charges found proved of charges 18-23) 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 for those charges found proved of charges 1-17 and lack of competence for those charges found proved of charges 18-23. Secondly, only if the facts found proved amount to misconduct or lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct or lack of competence.

Submissions on misconduct, lack of competence and impairment

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

Ms Shehadeh identified the specific, relevant standards where your actions amounted to misconduct. She submitted that the charges relating to dishonesty and a lack of integrity are particularly serious. She submitted that you put your own interests above those of patients, and were not transparent about errors. She submitted that charges 7-10 relate to charges regarding failures in completing care plans, which was a key part of your role as a Band 5 staff nurse.

Ms Shehadeh submitted that the charges found proved are not a mere technical breach of the Code, but are serious and amount to serious misconduct. She submitted that they relate to vulnerable patients, and include findings that you attempted to involve your colleagues in the misconduct. She submitted that your actions did fall far short of the standards expected of a registered nurse and amount to misconduct.

In relation to lack of competence, Ms Shehadeh invited the panel to measure your performance against the standard expected of someone working in that role. She reminded the panel of the evidence of your colleagues, and submitted that despite a capability plan being imposed, the errors continued. She submitted that you did not complete the capability plan before you left the Trust. She further reminded the panel of the evidence of Mr 5 that in hindsight he would have placed you under a preceptorship programme, although he stated this would not '*feel right'* for a nurse with your level and years of experience. She submitted that your difficulties in prioritising patients, and multi-tasking, were a key area of concern. She submitted that the facts found proved show that your competence at the time was below the standard expected of a band five registered nurse.

Ms Shehadeh 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) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Shehadeh invited the panel to find that your fitness to practise is impaired both on the grounds of public protection, and also in the public interest. She submitted that the reflective accounts and training certificate you have provided do not address the charges found proved. She submitted that you have shown minimal insight during the hearing, although acknowledged that you are entitled to put the NMC to proof in relation to the charges you denied.

Ms Shehadeh referred to the case of *Cohen*, and stated that whilst your conduct is capable of remediation, it has not yet been remediated. She submitted that dishonesty is difficult to remediate. She submitted that there is a risk of repetition, and a risk of harm to the public should you be permitted to practise unrestricted.

You stated that you accept that you made mistakes, and stated that you were sorry you got things wrong. You stated that you tried your best, but you accept this was not good enough. You informed the panel that you have not worked as a registered nurse recently, but have kept up to date with nursing practice by reading and completing some training. You informed the panel that the reflective statements you have provided were written around March 2021 and you intended to use them should you decide to revalidate with the NMC at the start of 2023. You stated that you are committed to continuous training and learning, as demonstrated by your CV and the training certificate provided.

You submitted that you did not reach your own high standards, and that it was a mistake to work at the Trust. You informed the panel that you currently plan to retire at the end of

this year, but are happy to do further training and work with a mentor. You submitted that you do not agree with some of the panel's findings, but you do accept them and that this does not demonstrate a lack of insight. You submitted that you recognise that there are areas of your practice that need improvement, such as working with computers, care planning and prioritising your time.

In relation to your future plans, you stated that you have considered working as a disability assessor for welfare benefits, which does require you to be a registered nurse but would not require the same clinical skills. You informed the panel that you have previously worked within the welfare system, and would like to use this knowledge before you retire.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Grant* and *Cohen.*

Decision and reasons on breaches of the Code

When determining whether the facts found proved amount to misconduct and a lack of competence, 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***
> *To achieve this, you must:*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

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

To achieve this, you must:

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

To achieve this, you must:

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

Decision and reasons 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.'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel considered that charges 1 and 2 did amount to misconduct as your failure to search Patient 1 put them at risk of harm and they were subsequently admitted to hospital, which the panel determined was a serious failure. The panel further considered that your actions outlined in charge 3 amounted to misconduct, and noted that it found several elements of charge 4, that you acted dishonestly in relation to charge 3, proved. The panel was satisfied that acting dishonestly is serious and falls below the standards expected of a registered nurse.

The panel considered whether your actions at charge 5b amounted to misconduct. The panel considered that Mr 5 had outlined the consequences of you identifying the incorrect patient. The panel determined that your action put a patient at risk of harm, and did amount to misconduct.

The panel determined that your failure at charge 6 was not, on its own, sufficiently serious as to amount to misconduct.

The panel considered whether charges 7, 8, 9 and 10 amounted to misconduct as a whole. The panel considered that these charges were similar in nature and related to care plans. The panel determined that due to the repetition of the failures, the charges did amount to serious misconduct. The panel further noted that charge 9b relates to a legal requirement to read someone their rights, and determined that failing to document that this was completed, was serious.

The panel considered whether your actions at charge 11 amounted to misconduct. The panel considered that Patient 11 was put at risk of harm as a result of your failures, and determined that the failures were serious.

The panel considered whether the medication errors found proved of charge 13a, 14, 16 and 17 amounted to misconduct when considered as a whole due to their similar nature. The panel noted that you had received additional training and assessment of your ability to administer medications on a number of occasions. The panel therefore determined that collectively the number of medication related errors did amount to serious misconduct.

In relation to charge 15, the panel noted that it has found it proved that you demonstrated a lack of integrity. The panel determined that such a finding was serious and fell below the standards of a registered nurse.

In conclusion, the panel found that your actions as a whole did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on lack of competence

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable band five registered nurse and not by any higher or more demanding standard. The panel considered whether charges 19e, f, g and h, 20, 21, 22 and 23 demonstrate a lack of competence. The panel noted that you left the Trust prior to completing your capability plan and failed to pass the required Immediate Life Support Course. The panel determined that your standard of work at the Trust was unacceptably

low, and you lacked the necessary knowledge and skills for the role of key worker Band 5 registered nurse on Bay Ward. The panel considered that you were offered additional training and support, but failed to consistently meet the required standard of your role over the period of your employment.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that your practice was below the standard that one would expect of a registered nurse acting in your role.

In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of your misconduct and lack of competence, 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 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 some patients were put at risk of harm as a result of your misconduct. Your misconduct and lack of competence breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Further, the panel noted it has found it proved that you acted dishonestly, although it determined that this was not at the highest end of seriousness as, whilst this was not a one-off incident there is no evidence your dishonesty was premeditated or for personal gain. The panel also noted that it found that you had acted with a lack of integrity in relation to charge 15.

Regarding insight, the panel acknowledged that you are entitled to deny the charges and it is difficult to demonstrate insight into charges that you deny. However, the panel considered that you have not yet demonstrated sufficient insight into the charges, particularly those you admitted. The panel noted that in your submissions you expressed some remorse and acknowledged that you made errors.

The panel was satisfied that the misconduct and lack of competence in this case is capable of being addressed. However, it determined that dishonesty and lack of integrity are harder to remediate due to the nature of the concerns. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account the training certificate provided, and your reflective accounts, and acknowledged that the training certificate includes reference to fire safety. However, the panel determined that the reflective accounts do not directly address the concerns identified, and that the training was over a year ago and does not address the majority of the concerns.

The panel is of the view that there is a potential risk of repetition should you be in a similar environment again. The panel considered that the charges relate to multiple errors over a prolonged period of time, and occurred despite you receiving support from the Trust. The panel considered that you have not yet provided sufficient evidence that you have strengthened your practice and you have demonstrated limited insight. 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 concluded that public confidence in the nursing profession and the NMC as its regulator would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of nine months with a 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.

Submissions on sanction

Ms Shehadeh invited the panel to impose a 12 months suspension order with a review. She submitted that, whilst the concerns found proved are remediable, the concerns in this case are serious. In particular, the concerns fall within the higher bracket of seriousness due to the misconduct and lack of competence identified and its related dishonesty. She reminded the panel that the issues identified included attitudinal concerns, misleading investigators and your tendency to blame others. Ms Shehadeh submitted that a conditions of practice order would be appropriate if the concerns were merely related to a lack of competence issue, however noted that the majority of the charges found proved related to matters of misconduct and therefore conditions of practice would not adequately protect the public. She told the panel that a 12 month suspension order would allow you time to reflect upon the matters found proved and to provide evidence to a reviewing panel that your insight has improved. She said that such an order was necessary to protect the

public and address the public interest concerns in your case. She submitted that a striking-off order would be disproportionate in your circumstances.

You invited the panel to impose a conditions of practice order. You told the panel that you initially wanted to return to nursing, however due to the length of time these NMC investigations and proceedings have taken, namely 5 years, you have not been successful in securing a role. You said that you have now acknowledged your mistakes. You told the panel that you were a good nurse, you have invested a lot in nursing and that prior to becoming a nurse you served the public in other ways.

You told the panel that in order to revalidate you are required to complete 450 practise hours. You said that if the panel were to impose a suspension order, you would not be able to complete these hours and thus not be able to work again. You told the panel that you have applied to be a disability assessor however “this application is on hold for the moment” due to these NMC proceedings. You said that although this role is very different from your mental health nurse role, there is some overlap and that your previous experiences as a mental health nurse would therefore assist you in your potential new role. You said that if conditions were to be imposed on your practice, any work that you would do would satisfy the conditions. You said you will ensure you would not put yourself in a positon which puts yourself or your colleagues at risk.

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 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:

- Multiple errors of a similar nature over a prolonged period of time which put patients at risk of suffering harm;
- Limited insight into failings;
- Inconsistent accounts of the events; and
- Lack of any recent and relevant training.

The panel also took into account the following mitigating features:

- Some admissions at the start of the hearing; and
- Personal mitigation around family issues and difficult working environment.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection and public interest concerns identified. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel 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, lack of competence and the dishonesty attached 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 noted that your failings relate to a lack of competence and misconduct in a number of areas, some of which relate to dishonesty. The panel decided that in light of this, your limited insight and the absence of remediation to date, sufficient conditions could not be formulated which would 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 some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. 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 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 nine 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. The panel noted that a future reviewing panel may consider imposing a striking-off order.

Any future panel reviewing this case would be assisted by:

- A reflective piece evidencing your understanding of your failings, particularly in relation to the dishonesty and integrity, the potential impact on patients and your work colleagues;
- Detailed evidence of any training you have undertaken during the period of your suspension which is relevant to the charges found proved;
- Up-to-date references or testimonials from voluntary positons or current employers detailing any work you have undertaken during the period of suspension; and
- Your continued engagement with the NMC and your attendance at a future review hearing.

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. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Shehadeh that an interim order should be made, to allow for the possibility of an appeal, on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

Decision and reasons on interim order

The panel was satisfied that an interim suspension 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. To do otherwise would be incompatible with its earlier findings.

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

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

That concludes this determination.