Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 7 June 2023 – Tuesday, 27 June 2023
Tuesday, 14 November 2023 – Friday, 17 November 2023
Thursday, 7 December 2023 – Friday, 8 December 2023

Virtual Hearing

Name of Registrant:	**Gavin Paul Sandy**
NMC PIN	17A0111E
Part(s) of the register:	Registered Nurse – Sub part 1 Children's Nursing – 21 March 2017
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Avril O'Meara (Chair, lay member) Michael Duque (Registrant member) Jan Bilton (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Clara Federizo (7-27 June 2023) Max Buadi (14-17 November 2023 and 7-8 December 2023)
Nursing and Midwifery Council:	Represented by Laura Paisley, Case Presenter
Mr Sandy:	Not present and unrepresented
No case to answer:	Charges 2a, 2b, 2c, 5a and 7a(ii)
Facts proved:	Charges 1a, 1b, 3a, 3b, 3c(i), 3c(ii), 3c(iii), 4a, 6a, 6b, 7b(i), 7b(ii), 8a, 8b, 9a, 9b, 9c, 10a, 10b, 10c, 11b, 13b(i), 13b(ii), 14a, 14b, 15a and 15d
Facts not proved:	Charges 4b, 4c, 5b, 7a(i), 11a, 12a, 12b, 13a, 14c, 15b(i), 15b(ii), 15c and 15e(i)-15e(iv)
Fitness to practise:	Impaired

Sanction:	**Suspension order with a review (6 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Sandy was not in attendance and that the Notice of Hearing letter had been sent to Mr Sandy's registered email address by secure email on 9 May 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Sandy's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Sandy

The panel next considered whether it should proceed in the absence of Mr Sandy. It had regard to Rule 21 and heard the submissions of Ms Paisley who invited the panel to continue in the absence of Mr Sandy. She submitted that Mr Sandy had voluntarily absented himself. She referred the panel to an email from Mr Sandy, dated 13 December 2022, which states:

> *"I'm no longer a nurse and have withdrawn from the register. I've not worked as a nurse since April 2020. I currently have no plans to return to nurse…"*

Ms Paisley submitted that there had been limited engagement by Mr Sandy with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Mr Sandy;
- Mr Sandy informed the NMC in December 2022, that he is no longer a nurse. The panel noted that Mr Sandy had time to seek legal advice and no application for adjournment was made;
- Mr Sandy has not engaged with the NMC since December 2022 and has not responded to any of the letters sent to him about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A number of witnesses are scheduled to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and

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

There is some disadvantage to Mr Sandy in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Sandy's decision to absent himself from the hearing, waive his right to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

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

At the outset of the hearing, Ms Paisley made a request that this case be held partly in private. [PRIVATE] The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel accepted the application and determined to go into private session [PRIVATE] in order to protect his privacy and confidentiality in these proceedings.

Details of charge

That you, a registered nurse:

1) On 1 December 2018 in relation to Patient C:

a) Failed to Ensure there was a prescription signed by a doctor;
b) Wrote or completed a prescription without authority;

2) On 23 to 24 May 2019, in relation to Patient O behaved inappropriately in that;

a) You informed the parent of Patient O that she was not to stay on the ward or words to that affect.
b) You informed the parent of Patient O that she should stop breast feeding due to the age of her infant or words to that affect.
c) Made a hand gesture in or to the face of parent of Patient O.

3) On 15 August 2019 in relation to Patient F:

a) Failed to any action to de-escalate Patient F's concerns regarding a blood test;
b) Grabbed and/or held Patient F's arm;
c) Behaved inappropriately towards Patient F in that you:

i. Raised your voice and/or shouted at Patient F;
ii. Told patient F to "get on with it" or used a gist of words that were similar in relation to a blood test;
iii. Informed patient F that Patient F's behaviour was unacceptable.

4) On 22 or 23 September 2019 in relation to Patient G behaved inappropriately towards Patient G in that you:

a) Spoke in an abrupt manner:
b) Pointed a finger towards Patient G;
c) Held Patient G's head when administering an inhaler.

5) On 22 or 23 September 2019 in relation to Patient H behaved inappropriately in that you:

a) Stated that Patient H's scar looked like a cigarette burn.
b) That "if patient H kicked you, you could always kick them back" or used a gist of words that were similar.

6) On 25 October 2019, in relation to Patient J, failed to administer medications, namely:

a) Clonazepam at 16:00hrs;
b) Phenobarbital at 18:00hrs.

7) In the alterative to charge (6) above, in relation to Patient J, on 25 October 2019, failed to record and/or sign:

a) The Controlled Drug Book in regard to:
i. Phenobarbital;
ii. Clonazepam.

b) Patient J's prescription chart namely for:
i. Phenobarbital;
ii. Clonazepam.

8) On 25 October 2019 and/or 29 October 2019, in relation to Patient J, purported to have administered the medications, namely, a dose of:

a) Clonazepam at 16:00 hrs;
b) Phenobarbital at 18:00 hrs.

9) On 29 October 2019, in relation to Patient J, purported to have entered the wrong times in records on 25 October 2019, namely:

a) Clonazepam;
b) Phenobarbital.

10) On 29/30 October 2019, in relation to Patient I, failed to:

a) Provide the correct feed, namely Infatrini Peptisorb;
b) Take any or any adequate action when Patient I's relative queried the type of feed provided.
c) Sign Patient I's prescription chart.

11) On an unknown date in relation to Patient I purported that:

a) Infatrini Peptisorb had been crossed out on Patients I's prescription chart;
b) A pharmacist had stated that "Infatrini was the same as Infatrini Peptisorb" or words to that affect.

12) Failed to set the oxygen rate in relation to Patient I, at the correct level, namely at 0.2 L per minute on:

a) 13 November 2019;
b) 16 November 2019.

13) On 13/14 November 2019 in relation to Patient K:

a) Failed to provide any or any adequate pain relief for Patient K;
b) Stated that:
i. “he wouldn’t be walking like that if he was in pain” or used similar words;
ii. “you just aren’t getting it are you” or used similar words.

14) On or around 14 November 2019 in relation to Patient P failed to:

a) Notice Patient P’s condition had deteriorated;
b) Take any or any adequate action in response to Patient P’s monitor alarm being activated;
c) Escalate Patient P’s condition to a doctor.

15) On 24 May 2020 in relation to Patient M:

a) Failed to adhere to the supportive plan, namely not to care for mental health patients;

b) Behaved inappropriately in that you:

i. Placed your hands across a doorway and/or prevented Patient M from leaving a room;
ii. Placed your hand on Patient M’s shoulder;

c) Refused to administer pain relief;

d) Became confrontational, namely by raising your voice;

e) In relation to Patient M said the following words or a gist of words that were similar:

i. Patient M “wouldn’t be walking like that if he was in pain”;
ii. You “wouldn’t be giving Oramorph because he can’t go home if he’d had that”;
iii. Patient M “couldn’t have appendicitis…..he would be doubled up in pain if it was his appendix.”
iv. In relation to Patient M’s relative “you’re just not getting it are you.”

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Paisley, on behalf of the NMC, to amend the wording of Charges 2a, 2b, 3a, 5b, 7, 8, 11 and 15a.

Ms Paisley submitted that the proposed amendments are required to correct grammatical errors and would provide clarity and more accurately reflect the evidence.

The panel also invited Ms Paisley to amend Charge 9 for the same reasons.

The charges with the proposed amendments read as follows:

"That you, a registered nurse:

1) On 1 December 2018 in relation to Patient C:

a) Failed to Ensure there was a prescription signed by a doctor;
b) Wrote or completed a prescription without authority;

2) On 23 to 24 May 2019, in relation to Patient O behaved inappropriately in that;

a) You informed the parent of Patient O that she was not to stay on the ward or words to that ~~affect~~ ***effect****.*
b) You informed the parent of Patient O that she should stop breast feeding due to the age of her infant or words to that ~~affect~~ ***effect****.*
c) Made a hand gesture in or to the face of parent of Patient O.

3) On 15 August 2019 in relation to Patient F:

a) Failed to ***take*** *any action to de-escalate Patient F's concerns regarding a blood test;*
b) Grabbed and/or held Patient F's arm;
c) Behaved inappropriately towards Patient F in that you:

i. Raised your voice and/or shouted at Patient F;
ii. Told patient F to "get on with it" or used a gist of words that were similar in relation to a blood test;
iii. Informed patient F that Patient F's behaviour was unacceptable.

4) *On 22 or 23 September 2019 in relation to Patient G behaved inappropriately towards Patient G in that you:*

a) Spoke in an abrupt manner:
b) Pointed a finger towards Patient G;
c) Held Patient G's head when administering an inhaler.

5) *On 22 or 23 September 2019 in relation to Patient H behaved inappropriately in that you:*

a) Stated that Patient H's scar looked like a cigarette burn.
*b) **Stated** that "if patient H kicked you, you could always kick them back" or used a gist of words that were similar.*

6) *On 25 October 2019, in relation to Patient J, failed to administer medications, namely:*

a) Clonazepam at 16:00hrs;
b) Phenobarbital at 18:00hrs.

7) ~~*In the alterative to charge (6) above,*~~ *In relation to Patient J, on 25 October 2019, failed to record and/or sign:*

a) The Controlled Drug Book in regard to:
i. Phenobarbital;
ii. Clonazepam.

b) Patient J's prescription chart namely for:
i. Phenobarbital;
ii. Clonazepam.

8) *On 25 October 2019 and/or 29 October 2019, in relation to Patient J, purported to have administered the medications, namely, a dose of:*

a) Clonazepam at 16:00 hrs;
b) Phenobarbital at 18:00 hrs;

…when you had not.

9) ~~*On 29 October 2019, in relation to Patient J, purported to have entered the wrong times in records on 25 October 2019, namely:*~~

~~*a) Clonazepam;*~~
~~*b) Phenobarbital.*~~

On or around 29 October 2019 in relation to Patient J:

a) Stated that you had signed in cannabidiol at 18:00 hrs when you had in fact done this at 16:00 hrs
b) Stated that you had incorrectly written 16:00 hrs in respect of signing in cannabidiol when 16:00 hrs was in fact the correct time
c) Incorrectly stated that you had been completing three other actions simultaneously with Witness 7 at 18:00 hrs, when this was not the case.

10) On 29/30 October 2019, in relation to Patient I, failed to:

a) Provide the correct feed, namely Infatrini Peptisorb;
b) Take any or any adequate action when Patient I's relative queried the type of feed provided.
c) Sign Patient I's prescription chart.

11) On an unknown date in relation to Patient I purported that:

a) Infatrini Peptisorb had been crossed out on Patients I's prescription chart;
b) A pharmacist had stated that "Infatrini was the same as Infatrini Peptisorb" or words to that affect.

…when this was not the case.

12) Failed to set the oxygen rate in relation to Patient I, at the correct level, namely at 0.2 L per minute on:

a) 13 November 2019;
b) 16 November 2019.

13) On 13/14 November 2019 in relation to Patient K:

a) Failed to provide any or any adequate pain relief for Patient K;
b) Stated that:
i. "he wouldn't be walking like that if he was in pain" or used similar words;
ii. "you just aren't getting it are you" or used similar words.

14) On or around 14 November 2019 in relation to Patient P failed to:

a) Notice Patient P's condition had deteriorated;
b) Take any or any adequate action in response to Patient P's monitor alarm being activated;

c) Escalate Patient P's condition to a doctor.

15) On 24 May 2020 in relation to Patient M:

*a) Failed to adhere to **your** supportive plan, namely not to care for mental health patients;*

b) Behaved inappropriately in that you:

i. Placed your hands across a doorway and/or prevented Patient M from leaving a room;
ii. Placed your hand on Patient M's shoulder;

c) Refused to administer pain relief;

d) Became confrontational, namely by raising your voice;

e) In relation to Patient M said the following words or a gist of words that were similar:

i. Patient M "wouldn't be walking like that if he was in pain";
ii. You "wouldn't be giving Oramorph because he can't go home if he'd had that";
iii. Patient M "couldn't have appendicitis…..he would be doubled up in pain if it was his appendix."
iv. In relation to Patient M's relative "you're just not getting it are you."

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel considered that the amendments are largely grammatical in nature. The panel was mindful that although the wording of Charge 9 was changed significantly, this was necessary to reflect the nature of the alleged misconduct. It noted that no new misconduct was alleged. The panel was satisfied that the proposed amendments better reflect the charges.

The panel was of the view that such amendments, as applied for, were in the interests of justice. The panel could see there would be no prejudice to Mr Sandy and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to adduce hearsay evidence

The panel heard an application made by Ms Paisley under Rule 31 to allow certain paragraphs from the written statements of Witness 5, Witness 6, Witness 8, Witness 9 and Witness 11 into evidence, and also certain exhibits relevant to their respective statements. Ms Paisley made the following written submissions to the panel:

*"**Submissions***

Charge 2

1. The evidence for Charge 2 comes from the witness statement of Witness 6 at paragraphs 26 – 32.

2. This allegation relates to comments made by the Registrant to the parent of Patient O. The parent of Patient O has not provided a statement and therefore the charge arises from conversations that Witness 6 had with the parent of Patient O. It is not disputed therefore that this charge is founded upon hearsay.

3. It is submitted that the evidence is plainly relevant to the charges.

4. It is submitted that it is fair to adduce this evidence, and thus it is admissible, for the following reasons:

a. Despite this evidence being 'sole and decisive' in respect of this charge, Witness 6 is being called to give evidence to the Panel and can be challenged about the conversation she had and what the parent of Patient O told her;

b. *Witness 6 spoke with the parent immediately upon the allegation being reported to her the following morning, and therefore it is submitted there was little time for this to have been fabricated and indeed the allegation was maintained by the parent of Patient O a day later, which in the NMC's submission adds weight to the truth of the accusation;*
c. *There is nothing to suggest that the parent of Patient O had any reason to make up an allegation against the Registrant;*
d. *The Panel can, upon deciding admissibility in the first instance, attribute appropriate weight to the remarks upon hearing the evidence of Witness 6.*

Charge 4

5. This allegation relates to the Registrant's behaviour towards Patient G as witnessed by Patient G's parent. Patient G's parent has not provided a statement and therefore it is not disputed that this charge is founded upon hearsay. The hearsay evidence in respect of this charge comes from:

a. *The statement of Witness 6 paragraphs 37 – 39*
b. *The statement of Witness 5 paragraphs 30 – 31*
c. *The statement of Witness 9 paragraphs 9 – 14*
d. *Exhibit CM/11A*
e. *Exhibit FJ/01*

6. It is submitted that the evidence is plainly relevant to the charges.

7. It is submitted that it is fair to adduce this evidence, and this is it admissible, for the following reasons:

a. *Both Witness 6 and Witness 9 spoke to the parent of Patient G and both witnesses are being called to give evidence and can be challenged about the conversation they had with the parent of Patient G;*
b. *The parent of Patient G discussed the allegations with more than one Registered Nurse which the NMC submit adds weight to the truth of the allegation;*
c. *The parent of Patient G approached Witness 5 of her own volition to make a complaint against the Registrant;*

d. *There is nothing to suggest the parent of Patient G had any reason to make up an allegation against the Registrant;*
e. *Both Witness 6 and Witness 9 had a conversation with the parent at Patient G at the time or very soon after the time the complaint was made;*
f. *Witness 9 raised her concerns very shortly after the allegations were made;*
g. *The Panel can, upon deciding admissibility in the first instance, attribute appropriate weight to the remarks upon hearing the evidence of Witness 6.*

Charge 5

8. This allegation relates to the Registrant's behaviour towards Patient H's parent. Patient H's parent has not provided a statement and therefore it is not disputed that this charge is founded upon hearsay. The hearsay evidence in respect of this charge comes from:

a. *Statement of Witness 6 paragraphs 37 to 39*
b. *Statement of Witness 9 paragraphs 16 – 18*
c. *FJ/01*
d. *CM/11A*

9. It is submitted that the evidence is plainly relevant to the charges.

10. It is submitted that it is fair to adduce this evidence, and that is it admissible, for the following reasons:

a. *Both Witness 6 and Witness 9 spoke to the parent of Patient H and both witnesses are being called to give evidence and can be challenged about the conversation they had with the parent of Patient H;*
b. *The parent of Patient H discussed the allegations with more than one Registered Nurse which the NMC submit adds weight to the truth of the allegation;*
c. *There is nothing to suggest the parent of Patient H had any reason to make up an allegation against the Registrant;*

d. *Both Witness 6 and Witness 9 had a conversation with the parent at Patient H at the time or very soon after the time the complaint was made;*
e. *Witness 9 raised her concerns very shortly after the allegations were made;*
f. *The Panel can, upon deciding admissibility in the first instance, attribute appropriate weight to the remarks upon hearing the evidence.*

Charge 10b

11. Charge 10b relates to the Registrant failing to take any or any adequate action when the parent of Patient I queried the feed provided to Patient I. The parent of Patient I has not provided a statement and therefore it is not disputed that this charge is founded on hearsay. The evidence in support of this charge is:

a. *CM/15C*
b. *Statement of Witness 6 paragraphs 77 – 90*
c. *Statement of Witness 11 paragraph 68 – 69*
d. *CM/15B*

12. It is submitted that the evidence is plainly relevant to the charges.

13. It is submitted that it is fair to adduce this evidence, and that it is admissible, for the following reasons:

a. *A Datix of the incident was filled in at or around the time of the incident;*
b. *Witness 6 is being called to give evidence and can be challenged about the conversation she had with the family of Patient I;*
c. *Witness 11 is being called to give evidence and can be challenged about the conversation she had the family of Patient I;*
d. *The incident is documented in the contemporaneous care notes of Patient I which the NMC submit adds weight to the truth of the allegation;*
e. *There is nothing to suggest the parents of Patient I had any reason to make up the allegation against the Registrant;*
f. *The Panel can, upon deciding admissibility in the first instance, attribute appropriate weight to the remarks upon hearing the evidence.*

Charge 11b

14. Charge 11b relates to the Registrant stating that "A pharmacist had stated that "Infatrini was the same as Infatrini Peptisorb" or words to that effect, when this was not the case. The evidence for this charge comes from the witness statement of Witness 6 at paragraph 86. She details that she spoke with Ms 1 who confirmed she had not said this to the Registrant. Ms 1 has not provided a witness statement. It is submitted that the evidence Witness 6 gives about this is admissible:

a. *Witness 6 is being called to give evidence to the Panel and can be challenged about the conversation she had with Ms 1;*
b. *There is nothing to suggest that Ms 1 is lying;*
c. *The Registrant spoke to Ms 1 at or close to the time;*
d. *The Panel can, upon deciding admissibility in the first instance, attribute appropriate weight to the remarks upon hearing the evidence.*

Charge 13

15. This allegation relates to the Registrant's behaviour towards Patient K as witnessed by Patient K's parent. Patient K's parent has not provided a statement and therefore it is not disputed that this charge is founded upon hearsay. The hearsay evidence in respect of this charge comes from:

a. *Statement of Witness 2 paragraphs 8 – 13;*
b. *CM/17;*
c. *Statement of Witness 8.*

16. It is submitted that the evidence is plainly relevant to the charges.

17. It is submitted that it is fair to adduce this evidence, and that is it admissible, for the following reasons:

a. *Both Witness 2 and Witness 8 spoke to the parent of Patient K and both witnesses are being called to give evidence and can be challenged about the conversation they had with the parent of Patient K;*

b. *The parent of Patient K discussed the allegations with more than one Registered Nurse which the NMC submit adds weight to the truth of the allegation;*
c. *There is nothing to suggest the parent of Patient K had any reason to make up an allegation against the Registrant;*
d. *Both Witness 2 and Witness 8 had a conversation with the parent of Patient K at the time or very soon after the time the complaint was made;*
e. *The Panel can, upon deciding admissibility in the first instance, attribute appropriate weight to the remarks upon hearing the evidence.*

Charge 15 (b) – (e)

18. This allegation relates to the Registrant's behaviour towards Patient M. Patient M has not provided a statement and therefore it is not disputed that this charge is founded upon hearsay. The hearsay evidence in respect of this charge comes from:

a. *JB/12*
b. *JB/13*
c. *JB/14*
d. *Statement of Witness 2 paragraphs 91 – 103*

19. It is submitted that it is fair to adduce this evidence, and that is it admissible, for the following reasons:

a. *Witness 2 is being called to give evidence and can be challenged about the conversations she had with Ms 4 and Ms 3;*
b. *A Datix was submitted at or close to the time;*
c. *Both Ms 3 and Ms 4 raised the issues in written correspondence at or close to the time which the NMC submit adds weight to the truth of the allegations;*
d. *There is nothing to suggest that Ms 3 and Ms 4 had any reason to make up an accusation against the Registrant;*
e. *The Panel can, upon deciding admissibility in the first instance, attribute appropriate weight to the remarks upon hearing the evidence.*

20. It should also be noted that the statements of Witness 11 and/or Witness 6 at various stages makes references to allegations that they have been notified of or otherwise made aware of. To save the Panel having to deal with those statements line by line, this application has focused on the underlying evidence in support of the charges. If the panel find that the underlying evidence is inadmissible, it will also find that the evidence given by Witness 11 and/or Witness 6 about those incidents is inadmissible, and this can be identified before the Panel decides upon any of the charges.

The Registrant's position

21. At page 243 of the exhibits bundle is an email from the Registrant to the NMC dated 14 September 2020. On page 244 he writes "it has been since this incident that the management team have questioned my every move on hear say and 3rd party information often not questioning me until weeks after an event had taken place." In fairness to the Registrant, the Panel should consider that the applications for hearsay would be opposed by the Registrant were he in attendance at the hearing.

Conclusion

22. It is submitted in all of the circumstances, that the evidence relied upon by the NMC should be admitted into evidence."

In the preparation of this hearing, the NMC had indicated to Mr Sandy in the Case Management Form (CMF) that it was the NMC's intention for witnesses to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by witnesses, Mr Sandy made the decision not to attend this hearing. On this basis Ms Paisley advanced the argument that there was no lack of fairness to Mr Sandy in allowing the relevant paragraphs from the witness statements into evidence. Ms Paisley also stated that as she believes Witness 8 is likely to attend to give live evidence, she is not now applying to have Witness 8's witness statement adduced as hearsay evidence.

The panel accepted the written legal advice of the legal assessor. It also took into account relevant case law: *Bonhoeffer v GMC* [2011] EWHC 1585 (Admin), *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), *Horncastle v United Kingdom* [2015] 60 E.H.R.R 31 and *Ogbonna v Nursing and Midwifery Council* [2010] EWHC 272 (Admin).

The panel had regard to the submissions made by Ms Paisley and considered the proposed hearsay evidence in relation to the charges each relate to.

Charge 2

a. The statement of Witness 6 at paragraphs 26 – 32

The panel determined that this evidence is inadmissible and refused the application to adduce it as hearsay evidence.

The panel determined that this evidence is relevant to Charge 2. It next considered whether it would be fair to admit this evidence. The panel determined that it is the 'sole and decisive' evidence in respect of this charge. The panel noted that it has not been provided with contemporaneous evidence such as a Datix or any documented complaint from the parents, nor was it specifically addressed in the Hearing Report dated 28 January 2019. The panel noted that the first account of the incident was provided by Witness 6 on 13 July 2021 in her witness statement.

The panel noted that although there is no information to suggest that the parents had any reason to make up the allegations, it is unable to properly test the evidence. Therefore, the panel was not satisfied that it would be fair to admit paragraphs 26 – 32 of Witness 6's witness statement into evidence and refused the application.

Charge 4

b. The statement of Witness 6 paragraphs 37 – 39
c. The statement of Witness 5 paragraphs 30 – 31
d. The statement of Witness 9 paragraphs 9 – 14

e. Exhibit CM/11A
f. Exhibit FJ/01

The panel was satisfied that the evidence outlined above is relevant to Charge 4. The panel noted that there were other witnesses who spoke to the parents around the time of alleged incident. It also noted that the matter was internally investigated, and Mr Sandy was asked to respond. Further relevant information is included in the 'Outcome of Formal Meeting – Staff Discipline Policy – Informal Warning' letter dated 21 October 2019 and was also documented by Witness 9 on 4 October 2019. Therefore, there is contemporaneous evidence relating to this charge.

The panel was satisfied that the hearsay evidence is not the 'sole and decisive' evidence in respect of this charge, and that the evidence can be tested when the witnesses give oral evidence. Therefore, it determined that the hearsay evidence is admissible and admitting it would not cause unfairness to Mr Sandy. The panel accepted the application to adduce the hearsay evidence outlined above.

Charge 5

g. Statement of Witness 6 paragraphs 37 to 39
h. Statement of Witness 9 paragraphs 16 – 18
i. FJ/01

The panel noted its earlier decision in respect of Charge 4 to admit paragraphs 37-39 of Witness 6's statement and Exhibit FJ/01.

In relation to paragraphs 16-18 of the statement of Witness 9, the panel was of the view that the information is relevant to Charge 5 as it alleges that Witness 9 had a conversation with Mr Sandy directly after the event. The panel was satisfied that this is not the 'sole and decisive' evidence in respect of this charge and that the evidence can be tested when Witness 9 gives oral evidence. Therefore, it determined that it would not be unfair to admit this into evidence. The panel accepted the application to adduce the hearsay evidence outlined above.

Charge 10b

j. CM/15C
k. Statement of Witness 6 paragraphs 77 – 90
l. Statement of Witness 11 paragraph 68 – 69
m. CM/15B

The panel determined that this hearsay evidence is relevant to the charge.

The panel determined that the hearsay evidence was not the 'sole and decisive' evidence in relation to Charge 5. The panel noted Exhibit CM/19, Mr Sandy's grievance documents dated December 2019, and his reflective account dated 14 September 2020 which contains his response to this incident. Further, the panel noted Exhibit JH/06, in which Witness 6 provides an account of her meeting with Mr Sandy on 26 November 2019 where this incident was discussed. The panel considered that the hearsay evidence can be tested when the witnesses give oral evidence. The panel was satisfied that it would not be unfair to admit the above hearsay evidence. Therefore, the panel accepted the application to adduce hearsay evidence outlined above.

For the avoidance of any doubt, the panel noted that CM/15A is also relevant to Charge 10b and is fair to admit into evidence.

Charge 11b

n. Statement of Witness 6 at paragraph 86.

The panel referred to its previous decision, in relation to Charge 10b, that this evidence is admissible. It also considered this information relevant to Charge 11b and Patient I's prescription chart as outlined in Exhibit CM/15A. Therefore, the panel accepted the application to adduce the hearsay evidence outlined above and considered that it was fair to do so.

Charge 13

o. Statement of Witness 2 paragraphs 8 – 13;
p. Exhibit CM/17
q. Statement of Witness 8

The panel noted Ms Paisley's oral submissions that she was not now seeking to adduce the statement of Witness 8. The panel therefore did not consider this.

The panel was satisfied that paragraphs 8-13 of Witness 2's statement and Exhibit CM/17 are relevant to the charge. It also determined that this evidence was not the 'sole and decisive' evidence. The panel considered that there is contemporaneous evidence, including an email at the time of the alleged incident which documents what the parents told Witness 2. The panel was satisfied that this evidence is admissible and can be tested when Witness 2 gives oral evidence. The panel was satisfied that it would not be unfair to admit Witness 2's evidence and Exhibit CM/17. The panel accepted the application to adduce this hearsay evidence.

Charges 15 (b) – (e)

r. JB/12
s. JB/13
t. JB/14
u. Statement of Witness 2 paragraphs 91 – 103

The panel was satisfied that the above evidence is relevant to the charge.

The panel was satisfied that the evidence of Witness 2 is not the 'sole and decisive' evidence in respect of Charges 15 (b)-(e). The panel considered that the exhibits outlined above were contemporaneous documents and was satisfied that this evidence is admissible and can be tested. It noted that there are different accounts in relation to this incident, including the accounts set out in Witness 2's meeting notes dated 8 June 2020 and Mr Sandy's email dated 10 June 2020. The panel was satisfied that the evidence outlined above can be tested and it would not be unfair to

admit it into evidence. The panel therefore accepted the application to adduce the hearsay evidence outlined above.

In all the circumstances, the panel noted that it would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Clarification on the panel's earlier hearsay decision

After the Panel had handed down its decision on the hearsay application, Ms Paisley raised a query in relation to its finding on the application of the hearsay evidence in respect of Charge 13. Ms Paisley confirmed that Witness 8 is attending to give oral evidence, however, much of the evidence she gives in her witness statement is hearsay evidence. Ms Paisley confirmed that she is seeking to have paragraphs 7 to 15 of Witness 8's statement adduced as hearsay evidence and asked the panel to confirm if it satisfied that it is fair and relevant to admit this evidence.

The panel clarified that it was satisfied that it was both fair and relevant to admit paragraphs 7 to 15 of Witness 8's statement. It referred to its decision in relation to Charge 13. It noted that it was not the sole and decisive evidence in relation to Charge 13 and considered that it was fair to admit it for the same reasons as earlier rehearsed in this determination, in relation to this charge.

Decision and reasons on considering no case to answer

Having noted that Ms Paisley made reference to the panel's powers to consider evidence of their own volition, the panel considered whether there is no case to answer in respect of Charges 2a, 2b, 2c, 5a and 7a(ii). It noted that Mr Sandy is not present and is not represented at this hearing and cannot make an application in this regard. Therefore, in considering fairness to Mr Sandy, the panel invited Ms Paisley to make submissions.

In relation to this, Ms Paisley accepted in her submission that there is no evidence in relation to Charge 2.

Ms Paisley further accepted in her submission that there is witness evidence in relation to Charge 5a, however, it is unclear as to whether the alleged comment was made by Mr Sandy.

Ms Paisley accepted in her submission that in relation to Charge 7a (ii), there would be no duty upon Mr Sandy to sign the controlled drugs book as Clonazepam is not a controlled drug.

The panel took account of the submissions made. It also accepted the oral and written advice of the legal assessor, which included reference to Rule 24(7), the NMC guidance (DMA-5) in respect of judging 'No Case to Answer' submissions and the test set out in the case of *Galbraith* [1981] 1WLR 1039.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether Mr Sandy had a case to answer in respect of the charges outlined above.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of Charges 2a, 2b, 2c, 5a and 7a(ii) proved, for the reasons outlined below:

Charges 2a, 2b and 2c

The panel referred to its earlier decision that it had not admitted the hearsay evidence initially provided by the NMC in support of this charge. It determined that there is no evidence that would realistically lead to finding these charges proved. Therefore, it found no case to answer in relation to Charge 2.

Charge 5a

The panel noted that while there was some evidence in relation to this charge, however, the evidence was vague, tenuous and inconsistent. It noted that Witness 6

and Witness 9, who spoke to the parent involved, gave evidence that this conversation was likely to have taken place on a previous occasion. The panel also considered that it was not clear from the evidence of Witness 6 and Witness 9 whether it was the mother that had made the statement or Mr Sandy. Therefore, it found there was not a realistic prospect that it would find the facts of Charge 5a proved.

Charge 7a (ii)

The panel noted the written submissions by Ms Paisley in relation to this charge:

> *"82. In her evidence, Witness 6 stated that in respect of clonzepam [sic]:*
>
> a. *"Because it is not a controlled drug, there wasn't any corroborating evidence in the controlled drug book, unclear if it had been given and just not signed for. My assumption is that it hadn't been given – it hadn't been signed for, and I would have expected to see a record."*

The panel also considered the oral evidence of Witness 6, who told the panel that Clonazepam was not a controlled drug. The panel found that there was no duty on Mr Sandy to sign the controlled drugs book. Therefore, the panel determined there is no case to answer in respect of this charge.

Background

The NMC received a referral on 9 September 2020 from Western Sussex Hospitals NHS Foundation Trust ('the Trust'). The charges arose whilst Mr Sandy was employed as a registered Band 5 paediatric nurse on Howard ward ('the Ward') at St Richard's Hospital ('the Hospital').

The Ward is a 19 bedded general paediatric ward, which includes a high dependency bed and a children's assessment unit. The Ward sees a wide range of patients which includes high dependency and critical care patients.

Between 1 December 2018 and 24 May 2020, a number of concerns were raised about Mr Sandy's nursing practice. The alleged regulatory concerns identified and investigated by the NMC are:

- Errors in medication management/administration and clinical decision making
- Poor record keeping
- Inappropriate attitude towards patients, their families and colleagues
- Failing to act with appropriate candour in relation to errors made
- Acting contrary to reasonable instructions and/or without appropriate permission

The alleged concerns led to Mr Sandy being subject to the Trust's disciplinary process on two separate occasions. He was allegedly placed on a performance improvement plan in January 2019, made supernumerary in September 2019, and again placed on a performance improvement plan in November 2019.

Mr Sandy resigned from his position on 14 May 2020 and worked his final shift on the Ward on 20 June 2020.

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 by Ms Paisley.

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

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:

- Witness 1: At the time of allegations, was employed at the Hospital as a Band 6 Deputy Sister and Mr Sandy's line manager between February 2018 and 2019

- Witness 2: At the time of allegations, was employed at the Hospital as the ward manager on another ward and from February 2020 the ward manager on the Ward and Mr Sandy's line manager

- Witness 3: At the time of allegations, was employed at the Hospital as a Deputy Sister on the Ward

- Witness 4: At the time of allegations, was employed at the Hospital as a Paediatric Respiratory Nurse Specialist

- Witness 5: At the time of allegations, was employed at the Hospital as a Band 5 Paediatric Nurse

- Witness 6: At the time of allegations, was the ward manager on the Ward and between February 2018 and 2019 was the Paediatric Matron

- Witness 7: At the time of allegations, was retired and employed by the Hospital as a Bank Nurse, usually on the Ward and in children’s accident and emergency

- Witness 8: At the time of allegations, was retired and employed as a Bank Nurse on the Ward

- Witness 9: At the time of allegations, was employed as a Paediatric Deputy Sister on the Ward

- Witness 10: At the time of allegations, was employed at the Hospital as a Band 6 Deputy Sister on the children's assessment unit

- Witness 11: At the time of allegations, was employed by the Hospital as the Paediatric Matron except between February 2018 and February 2019 (when she was on leave)

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

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

Charge 1a

"That you, a registered nurse:

1) On 1 December 2018 in relation to Patient C:

a) Failed to Ensure there was a prescription signed by a doctor;"

This sub-charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 1, Witness 3 and Witness 11 as well as the documentary evidence relevant to this charge.

The panel considered the Blood Transfusion Policy, the relevant section reads as follows:

> *"**Transfusion Process***
> ***Consent and Prescribing***
> *…*
> *The prescription of blood components is the written authorisation to administer a transfusion. The prescriber should have made the decision to transfuse and this must be based on clinical need and documented in the patient's medical notes."*

The panel noted that Witness 3 was the nurse in charge on the shift of 1 December 2018. Witness 3 told panel that she allocated the Patient C to Mr Sandy. She referred the panel to the patient's prescription charts. In her witness statement, dated 13 July 2021, she states:

“When the Registrant gave me Patient C's blood prescription chart so that I could cross check this with the blood, I immediately noticed that it was a different prescription. I knew this as I had obtained the prescription for the transfusion from a doctor on the previous day. I noticed that the prescription that the Registrant had shown me had not been signed by a doctor, and so I queried who had written it. From memory the Registrant told me that he had written it, and that he was planning to have the doctors sign it later.

The process for a blood transfusion is very rigorous, and one of the first requirements is for us to have a valid prescription. A prescription can only be valid if written and signed by a doctor or qualified prescriber. The Registrant was not qualified to make the prescription and should not have written it onto Patient C's blood prescription chart. I told the Registrant that the prescription was not valid and I immediately crossed it out on the prescription chart.
…
However, I told him that I had gotten a prescription from the doctor yesterday and I located this on the prescription chart and showed it to him. The prescription that I obtained from the doctor on 30 November was not on the same sheet that the Registrant wrote on for 1 December 2018.

I recall that when I showed the Registrant the correct and valid prescription, he told me that we could not use this prescription as it was the incorrect date. This was not the case, and I told him that this was the appropriate prescription to use.

Following this, we cross checked the blood with the correct prescription to ensure that it was the correct blood, and then cross referenced the blood with the patient's name band to ensure that it was the correct patient. The transfusion was then set up and completed and both the Registrant and I signed the prescription chart next to the correct prescription.”

The panel also considered the statement of Witness 11, dated 13 July 2021:

"The blood needs to be prescribed by a doctor on the patient's blood prescription chart. The prescription of blood components is required as this is the written authorisation to administer a transfusion, and the prescriber should have made the decision to transfuse and this must be based on clinical need and documented in the patient's medical notes"

The panel also considered the statement of Witness 1, dated 19 July 2021:

"Regarding the first incident with the blood prescription, the Registrant explained that he felt anxious as he had already requested the blood to be delivered to the ward and that the porters had delivered this. As a result, the Registrant said he was keen to get the transfusion up and running. I discussed with him that he should not have requested the blood until he had a valid prescription and Patient C had been prepared for the transfusion. This is because there is a time factor involved in completing the transfusion once the blood is delivered to the ward."

The panel also noted the letter Witness 1 (Mr Sandy's line manager at the time) sent to Mr Sandy, dated 2 January 2019, following this incident, which states:

"I highlighted all of these issues as concerns and reiterated the level of concern due to the lack of judgement when administering the blood transfusion which could have resulted in a very serious incident or NEVER event..

I asked you whether there were any factors or underlying issues, which you felt had affected your performance and achieving the required standards in your role. [PRIVATE]. I think you now appreciate that all these things have impacted your work. Your Bradford score is… and you have attended work consistently and punctually.

[PRIVATE].

We discussed whether you felt that there was any further training or retraining that could be put in place in order to help you to achieve the required standards of performance. [PRIVATE].

We talked through the Performance Improvement Plan and the objectives which you will need to achieve in order to meet the required standards. You had the opportunity to comment on the Performance Improvement Plan and the objectives and you were happy with agreed objectives. I have enclosed a copy of the agreed Performance Improvement Plan."

The panel also heard live evidence from Witness 1, Witness 3 and Witness 11 and found that all three witnesses gave clear and consistent evidence. Their evidence was consistent with their witness statements, the Blood Transfusion Policy and the contemporaneous documents which included Patient C's blood prescription chart, the DATIX dated 1 December 2018 as well as the letter dated 2 January 2019. Therefore, the panel found the evidence of Witness 1, Witness 3 and Witness 11 to be credible. The panel was satisfied that there was a duty for Mr Sandy to ensure that there was a prescription signed by a doctor before transfusing any blood to Patient C.

The panel determined that there was sufficient evidence to support that on 1 December 2018, in relation to Patient C, Mr Sandy failed to ensure there was a prescription signed by a doctor.

The panel therefore finds Charge 1a proved.

Charge 1b

"That you, a registered nurse:

1) On 1 December 2018 in relation to Patient C:

b) Wrote or completed a prescription without authority;"

This sub-charge is found proved.

The panel considered the oral evidence and witness statements of Witness 1, Witness 3 and Witness 11. It also took into account the contemporaneous evidence placed before it, including Patient C's blood prescription charts, the DATIX dated 1 December 2018 and the Blood Transfusion Policy, as well as the letter dated 2 January 2019.

The panel referred to the contemporaneous evidence it outlined in Charge 1a and determined that Mr Sandy is not a prescriber and was not authorised to write a blood prescription for Patient C.

The panel determined that the 'Informal Capability meeting' letter from Witness 1, dated 2 January 2019 was consistent with and supported the oral evidence provided by Witness 1, Witness 3 and Witness 11 in relation to this charge. The panel found these witnesses to be credible and was satisfied that it was more likely than not that on 1 December 2018, Mr Sandy wrote or completed a prescription without authority for Patient C's blood transfusion.

The panel therefore finds sub-charge 1b proved.

Charge 3a

"That you, a registered nurse:

3) On 15 August 2019 in relation to Patient F:

a) Failed to take any action to de-escalate Patient F's concerns regarding a blood test;"

This sub-charge is found proved.

The panel took into account the oral evidence and witness statements of Witness 4 and Witness 11. It also took into account Patient F's care notes for 15 August 2019

and a written statement made by Witness 4 on 7 October 2019, following her report of the incident.

Witness 4 told the panel that she was a Paediatric Respiratory Nurse Specialist and Patient F was a long-term patient with Cystic Fibrosis, who she looked after for many years. She set out for the panel what the expectations would be of a registered nurse when trying to take blood from a paediatric patient with a needle phobia, who was distressed and refusing to have a blood test.

The panel considered the witness statement of Witness 4, who was caring for Patient F with Mr Sandy on 15 August 2019. Witness 4 stated:

> *"I was very surprised by the Registrant's conduct, it was as though the more upset Patient F became, the louder and more frustrated the Registrant got. The Registrant's conduct was just escalating the situation when really I would have expected the Registrant to be calm and encouraging with Patient F.*
>
> *When carrying out procedures with patients, particularly paediatric patients, it is a process of negotiation. The nurse is expected to remain calm, encourage the patient and find ways to distract them. Becoming angry and shouting at the patient is not the appropriate way to deal with these situations."*

In her oral evidence, Witness 4 told the panel that she could *"clearly recall his manner that day, it was a difficult procedure and it stays with me…it upset me the way it was handled. The longer it took, the louder his voice became…".* The panel found Witness 4's evidence to be clear, credible and consistent with her written statement of the incident dated 7 October 2019.

The panel also noted the care notes for Patient F, dated 15 August 2019, which stated:

> *"very needle phobic and became very upset eventually bloods taken with the aid of Entonox which was very affective [sic] in calming him down"*

The panel also considered the witness statement of Witness 11, who outlined the expectations of a registered nurse and the relevant policies of the Trust. Witness 11 stated:

> *"On 15 August 2019 Witness 4, the paediatric respiratory nurse specialist reported concerns about the Registrant's interactions with a patient ('Patient F'). It was reported that Patient F suffered with a chronic health condition, and was known to make self-derogatory comments, was very self- critical and expressed feelings of sadness. Patient F also had a needle phobia. My understanding from the records is that when attempting to carry out a blood test, Patient F became distressed and was refusing to have the blood test and was using self-derogatory language. The Registrant was reported to have raised his voice at Patient F and told him that his behaviour was not acceptable, and that he needed to stop mucking about and just get on with it. It was reported by Witness 4 that the Registrant shouted at Patient F at this time.*
>
> *In all three of the above incidents, the Registrant demonstrated inappropriate behaviour towards patients and colleagues which is not in line with the standards expected of a Registered nurse. The NMC Code of Conduct contains the professional standards that registered nurses, midwives and nursing associates must uphold. The Trust also has policies which specify the behaviours and conduct expected of staff including the Dignity at Work Policy and the Staff Discipline policy. These outline the expected behaviours of staff that will support the creation of a positive working environment. All staff are responsible for ensuring their behaviours meets the expected standards in all their interactions with patients, visitors and colleagues. The Trust expected behaviours are: to be Kind Friendly Respectful Compassionate Professional and working as a team.*
>
> *The Trust's "above and below the line" policy which is in line with our Trust values speaks to the expected standards of behaviours and specifies which behaviours would fall below the line, for example:*

a. Lack professional communication including aggressive behaviour;

b. Failing to acknowledge the concerns and/or difficulties of others;

c. Show frustration or intolerance to others"

The panel was mindful that Witness 11 had no direct knowledge of what happened as she was not present. However, as the Paediatric Matron, Witness 11 set out for the panel the Trust's relevant policies and expectations of a registered nurse. The panel has had sight of these policies.

The panel was satisfied that Patient F was upset and distressed on 15 August 2019 when Mr Sandy and Witness 4 were trying to take blood from him. The panel was also satisfied that Mr Sandy had shown frustration and intolerance toward Patient F. The panel determined that on 15 August 2019, it was more likely than not, that Mr Sandy failed to take any action to de-escalate Patient F's concerns regarding a blood test.

The panel therefore finds sub-charge 3a proved.

Charge 3b

"That you, a registered nurse:

3) On 15 August 2019 in relation to Patient F:

b) Grabbed and/or held Patient F's arm;"

This sub-charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 4 and her written statement dated 7 October 2019. Witness 4 stated as follows:

“I went to Patient F and started to discuss the procedure with him. I believe the Registrant was also present at this time. Patient F had a needle phobia and as a result, he became very distressed when I started to discuss the blood test with him. Patient F also tended to use self-derogatory language and would say things such as he was useless and a coward. He would express feelings of sadness and be very self-critical. We were also working with Patient F and his family to support them and to help Patient F be more positive. A psychologist was involved in this process.

I spent some time trying to calm Patient F down and tried to encourage him to extend his arm to allow the blood test to be completed. Patient F's mum was also trying to work with Patient F and distract him. However, I recall that Patient F was quite distressed and he would start to put his arm out for me to do the blood test and then would quickly pull it back. This process went on for some time, and in accordance with my written statement for around 30 minutes.

At this point, the Registrant became frustrated with Patient F. He spoke to Patient F in a way that was very matter of fact. I don’t recall exactly what was said, but it was things like, enough is enough you need to have the blood test done and you just need to get on with it.

I recall finding that the Registrant was getting louder and louder when speaking to Patient F and his tone was almost aggressive. He was telling Patient F to stop mucking about and put his arm out.

I recall that I tried to intervene by asking the Registrant to stop and explaining that we needed to calm things down and take some more time to discuss the process with Patient F and try to distract him.

Patient F started to settle down and was nearly at the point of extending his arm to have the blood test conducted. However, unfortunately, the fear stepped in again and Patient F refused.

I believe that it was at this point that the Registrant grabbed Patient F's arm and held it out so that the blood test could be taken. I recall that he was holding Patient F's arm firmly and again was speaking to Patient F in a raised voice. Patient F was frightened and upset at this point.

One of the other ward staff came in to assist due to being able to hear what was being said. I believe that this was an experienced healthcare assistant, Healthcare Assistant 1, and that she was completing some nursing training at the time that the incident happened.

When Healthcare Assistant 1 came in I asked the Registrant to leave the room. His conduct towards Patient F was not appropriate and it was not helping the situation. I felt that we needed to stop the process completely and find another way to settle Patient F and assist him to have his blood test. I recall that when the Registrant left, Patient F's mum said to me that the Registrant had no compassion at all."

The panel noted that Witness 4's oral evidence was consistent with her witness statement and her written statement, dated 7 October 2019. The panel heard from Witness 4 that Patient F had a needle phobia. It noted that in response to questions from the panel, Witness 4 said that this incident stood out in her mind for the following reasons. She stated:

"This is a mum we had been working on to give positive feed back to her child because she was quite negative and not very compassionate. So, it was more poignant for her to recognise that Mr Sandy lacked compassion. I don't very often have to speak to a member of staff in this way, but because of his manner and tone, etc, I felt I had to give him another chance to explain. I followed him to speak again, he said "I disagree with you", and walked off. I found this surprising"

The panel was satisfied Witness 4's oral evidence was clear and consistent with her witness statement, dated 14 July 2021, and her written statement, dated 7 October

2019. The panel therefore determined that it was more likely than not that on 15 August 2019, Mr Sandy grabbed and/or held Patient F's arm.

The panel therefore found sub-charge 3b proved.

Charge 3c (i) (ii) (iii)

"That you, a registered nurse:

3) On 15 August 2019 in relation to Patient F:

c) Behaved inappropriately towards Patient F in that you:

i. Raised your voice and/or shouted at Patient F;

ii. Told patient F to "get on with it" or used a gist of words that were similar in relation to a blood test;

iii. Informed Patient F that Patient F's behaviour was unacceptable."

These sub-charges are found proved.

The panel referred to its decision in relation to Charges 3a and 3b, where it found Witness 4's evidence to be credible and reliable. In relation to Charge 3c, the panel noted that Witness 4 stated that Mr Sandy had made comments to Patient F, such as *"enough is enough, you need to have the blood test done"* and that *"he got louder and louder".* The panel noted that this was consistent with her witness statement, where she stated:

> *"At this point, the Registrant became frustrated with Patient F. He spoke to Patient F in a way that was very matter of fact. I don't recall exactly what was said, but it was things like, enough is enough you need to have the blood test done and you just need to get on with it.*

I recall finding that the Registrant was getting louder and louder when speaking to Patient F and his tone was almost aggressive. He was telling Patient F to stop mucking about and put his arm out."

The panel noted that Witness 4's evidence was that Mr Sandy repeatedly spoke in a *"loud"* manner that was *"almost aggressive"* to Patient F. The panel determined that when considering the circumstances, it was satisfied that it was more likely that out of frustration Mr Sandy raised his voice and/or shouted at Patient F, told patient F to *"get on with it"* (or used a gist of words that were similar in relation to a blood test) and informed Patient F that his behaviour was unacceptable.

The panel therefore finds Charges 3c proved in its entirety.

Charge 4a

"That you, a registered nurse:

4) On 22 or 23 September 2019 in relation to Patient G behaved inappropriately towards Patient G in that you:

a. Spoke in an abrupt manner:"

This sub-charge is found proved.

In reaching this decision, the panel took into account the oral evidence and witness statements of Witness 5, Witness 6, Witness 9 and Witness 11.

The panel carefully considered the email from Witness 9 to Witness 6, dated 4 October 2019, following the incident:

"BED 7

- *Mum very upset about the way her son had been spoken to and held by nursing staff member while having observations taken and inhalers being administered, reported it was very abrupt and stern with the nursing staff*

member pointer their finger at her son and holding her sons head down to give inhalers

- *Reported to myself that nursing staff member had turned her son over to place oxygen saturation probe on her sons toe which woke him up and he became distressed, mum felt that previous staff who had cared for her son had been gentle but that this member of staff had not and the nursing staff member was upsetting her son more*

- *Mum very upset that nursing staff member had asked her to take her son to the playroom as he was making too much noise in the bay and was waking the other children*

- *Mum angry and requesting that she did not want the nursing staff member to come near her not even to apologise, she had contacted dad and was wanted to take discharge her son as did not want the nursing staff member to look after her son anymore. As discussed I spoke to the nursing staff member to explain the situation and reallocated patient workload to other members of staff."*

The panel considered this evidence to be contemporaneous as Witness 9 was the nurse in charge of the shift on 22-23 September 2019 on the Ward. She also spoke directly to the parent of Patient J. In her witness statement, Witness 9 stated:

"…She reported that the Registrant was very abrupt and stern, and that he had pointed his finger at her son and had also held his head down when giving the child his inhaler.

I was not present and did not witness the interactions that the Registrant had with Patient G, but I got the impression from the mum that he was quite overpowering. As nurses, it can be a fine line between giving nursing guidance to a child (in explaining why certain things need to be done) and disciplining the child. The impression that I got from the patient's mum was

that the Registrant had overstepped in the way that he spoke Patient G and that he had been very abrupt in handling Patient G.

With regards to the allegation that the Registrant held down Patient G's head to give the inhaler. The inhaler is given using a spacer and a face mask. The mask is placed over the patient's nose and mouth and the inhaler is pumped into the spacer for the patient to breathe in. Where a child is moving around a lot, a nurse may gently hold the child's head to try to still them so that the inhaler can be taken properly. The mum was quite upset in manner that the Registrant did this, but as I was not present, I cannot comment on the appropriateness of what he did.

In addition, the mum reported that the Registrant had turned Patient G over when placing the oxygen saturation probe, and that this woke him up and caused him to become distressed. To explain, the oxygen saturation probe is attached to the patient's finger or toe to measure oxygen saturation levels. There really isn't a right or wrong way to do this. While we would aim to avoid disturbing the child to do this, it is not uncommon for us to need to turn over or reposition a child to place this probe and sometimes they can become upset. However, the mum felt that other staff had been gentler in carrying this out previously."

Witness 9 told the panel that she spoke with Mr Sandy on the night of incident. The panel noted that Witness 9's record of her conversation with Mr Sandy (in her email dated 4 October 2019) stated:

"I spoke to Staff Nurse Gavin Sandy who was looking after the patients and explained that Bed 7's mum was upset about the way he had spoken to and treated her son, Gavin explained that he felt he had not held the patient down as mum had reported and he had told the child to stop shouting as was going to wake other children in the bay, Gavin did ask mum to leave the room as was concerned he would disturb the other children, Gavin left mum to settle the patient in the bay when she said she did want to leave the room. Gavin appeared shocked to hear that mum felt this way and wanted to apologise to

her. I explained to Gavin that mum was very upset at that moment in time and had requested she did not want to speak to Gavin not even for him to apologise. Gavin did say to me and felt strongly that he had to go and apologise if mum was so upset about this, I reiterated that now was not the best time for this to be done and once the patient and mum had managed to get some sleep it may be appropriate to go with myself in the morning for him to apologise to mum. Gavin did appear to accept this and just said ok to me... Gavin appeared to not understand exactly what he had done wrong and appeared to be confused why parents had raised these concerns when he gets so much good feedback and compliments. Gavin did not question about me reallocating his workload and went on to provide nursing care to new admissions that came onto the ward through the rest of the shift."

The panel also heard from Witness 6. It noted that the incident was reported to her by Witness 9, when she came on duty the following morning. Witness 6 stated that she also spoke with the parent of Patient G. Witness 6 stated:

"…My understanding is that the Registrant just went to Patient G and woke him up, causing Patient G to be startled and become distressed. Following this Patient G's mum reported that the Registrant pinned Patient G down in order to give him his inhaler. Patient G's also reported that the Registrant had been very abrupt when speaking with and giving care to Patient G. I recall that Patient G's was upset and tearful when I spoke with her about this."

The panel also had sight of the 'Disciplinary Meeting Outcome Letter' dated 21 October 2019, from Witness 6 to Mr Sandy, outlining the concerns raised regarding Patient G. This letter also set out Witness 6's summary of his response to the concerns:

"We discussed the concerns that the mum of a patient on the ward was very upset at the manner in which her son had been spoken to and held by yourself whilst you were undertaking observation and administrating inhalers. I raised with you that it was felt that your manner was abrupt and overly stern and that you pointed your finger at the child. We discussed that the mum was

upset that she had been asked to take her son into the playroom because he was making too much noise. It was explained that the mum was angry and disappointed in the nursing care that she was given and had requested that you did not look after her son. It was explained that as a result the patient was reallocated to another member of staff on that night shift.

You explained that you felt that you were guilty of being task focused and it was never your intention to sound or act in an aggressive manner. You explained that you were also conscious that you did not want the child in the opposite bed to be disturbed as they were sleeping. You discussed that had been trying to move the child physiologically to administer medication. You agreed that upon reflection it may have come across as abrupt and have been perceived in a negative manner. I explained the correct way to deal with this situation in the future.

You felt that you felt the night before you had had a good rapport with the family and that you personally felt disappointed that they felt this way, however upon reflection you could see how they had come to this outcome."

Further, the panel had sight of the 'Record of Informal Meeting' by Witness 11, who spoke with Mr Sandy on 26 September 2019, in relation to this incident:

"I explained that the purpose of the meeting was not to go over the events again unless he wanted to but to ensure he was ok and inform him of our next steps. He said he didn't want to talk about it again but he felt that had he been given the opportunity to speak with the family after the incident to apologise none of this would be happening. He said he was prevented from doing so and he was sure that the families had misread the situation and he could have explained and none of this would be happening. He said there hasn't been a formal complaint so I don't know why I had to meet with Witness 6 and then you. I explained that yes thankfully there hasn't been a formal complaint but he should understand that it is our duty to look into any incident that occurs on the Ward whether we hear about it in a complaint, datix, word of mouth or notes audit and regardless of how we hear about it the actions and process

are the same. He said he had reflected on the conversation with Witness 6 and felt that maybe he had taken over the parenting role in the manner of instructing the child not to pull Mum's hair."

…Gavin then stated that he felt he quite often was given the 'difficult' patients or families. I felt that it was his responsibility to speak up if he felt he needed support with his workload and I felt it would be suitable for him only to have a 'light' case load for the next couple of days to try and not induce further stress. He then made a comment that he felt the mothers of the patients involved were quite stressed and probably sleep deprived so that may have been why they were so stressed that night. I explained that it was even more important to be supportive of their needs"

The panel carefully considered that Witness 9 and Witness 6 did not directly witness the incident. However, it noted that they spoke with Patient G's parent shortly after the incident, as she had reported to them the way that Mr Sandy had behaved with her child. Their evidence was clear and consistent with the contemporaneous email records and correspondence relating to this incident, and they corroborated one another.

The panel particularly noted that, in discussion with Witness 6 following the incident, Mr Sandy appears to have accepted that he may have come across as *"abrupt"* when caring for the patient.

The panel determined that there is sufficient and credible evidence to satisfy it that, on 22 or 23 September 2019, it was likely that Mr Sandy behaved inappropriately towards Patient G, in that, he spoke in an abrupt manner.

The panel therefore finds sub-charge 4a proved.

Charge 4b

"That you, a registered nurse:

4) On 22 or 23 September 2019 in relation to Patient G behaved inappropriately towards Patient G in that you:

b. Pointed a finger towards Patient G;"

This sub-charge is found NOT proved.

The panel took into account the evidence of Witness 9, including her email dated 4 October 2019. It was mindful that Witness 9 did not directly witness the incident and that Patient G's parent reported her concerns to Witness 9.

Further, the panel considered the evidence of Witness 6 and the letter 21 October 2019, in which she stated:

> *"I raised with you that it was felt that your manner was abrupt and overly stern and that you pointed your finger at the child"*

However, the panel noted that in her oral evidence, Witness 6 could not recall whether the parent complained to her about Mr Sandy pointing his finger at her son.

The panel also considered Witness 11's evidence regarding her conversation with Mr Sandy on 26 September 2019, which referred to Mr Sandy finger pointing towards her:

> *"I asked Gavin to stop raising his voice and pointing at me and he didn't"*

> *"He again stated 'you can't speak to me like this' (in a raised voice and pointing) and I stated I was not going to continue the conversation and he needed to step in the staff room"*

The panel also noted that in her oral evidence, Witness 6 said *"my personal reflection was that he had used a pointing finger gesture or hand gesture during our discussions".* However, Witness 6 could not recall whether Patient G's parent and Witness 9 had reported to her that Mr Sandy had pointed his finger at Patient G.

Furthermore, she could not recall whether, in her discussions with him following the incident, Mr Sandy accepted that he had pointed his finger at Patient G.

The panel noted that in the discussion recorded in the outcome letter, dated 21 October 2019, there is no record of Mr Sandy admitting or commenting on this allegation that he had pointed his finger at Patient G. The panel also noted there was no formal written complaint from Patient G's parent.

The panel was not satisfied that there was sufficient evidence to find this charge proved.

The panel therefore finds sub-charge 4b not proved.

Charge 4c

"That you, a registered nurse:

4) On 22 or 23 September 2019 in relation to Patient G behaved inappropriately towards Patient G in that you:

c. Held Patient G's head when administering an inhaler."

This sub-charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 9. The relevant sections in her witness statement, dated 1 July 2021, read as follows:

"With regards to the allegation that the Registrant held down Patient G's head to · give the inhaler. The inhaler is given using a spacer and a face mask. The mask is placed over the patient's nose and mouth and the inhaler is pumped into the spacer for the patient to breathe in. Where a child is moving around a lot, a nurse may gently hold the child's head to try to still them so that the inhaler can be taken properly. The mum was quite upset in manner that the

Registrant did this, but as I was not present, I cannot comment on the appropriateness of what he did.

…

However, the mum felt that other staff had been gentler in carrying this out previously."

The panel also considered the witness statement of Witness 6, dated 13 July 2021, which stated:

"…Following this Patient G's mum reported that the Registrant pinned Patient G down in order to give him his inhaler. Patient G's also reported that the Registrant had been very abrupt when speaking with and giving care to Patient G. I recall that Patient G's was upset and tearful when I spoke with her about this.

…

The expectation in both cases would be that the Registrant would have gone to the bedside and discussed with the mum the care he needed to carry out, and addressed that he needed to give the children their inhalers. This would have allowed him to discuss the treatment with the parent and discuss how this would need to be carried out. Further, when giving the inhalers, it would not be appropriate for him to pin the patient down (as was stated by Bed 7's mum). When giving inhalers to children, sometimes some form of restraint is required, but this should always be done in collaboration with the resident parent. It is the parent who will usually step in and give the child a tight cuddle, or something of the sort, as a means of restraint so that the inhaler can be given by the nurse."

The panel considered the standard of care expected of a registered nurse when administering an inhaler to an incompliant child, as set out by Witness 6 above. The panel noted that Witness 6 stated that "*sometimes some form of restraint is required, but this should always be done in collaboration with the resident parent".* During her oral evidence, Witness 6 also told the panel that *"as I was not present, I cannot comment on the appropriateness of what he* [Mr Sandy] *did"* in relation to this incident.

The panel also noted that in her email, dated 4 October 2019, Witness 9 described the complaint by the parent as follows:

> *"…Held by nursing staff member while having observations taken and inhalers being administered"*
>
> *"…Holding her sons head down to give inhalers"*

The panel determined that the language and tone of the description of the incident by Witness 9 does not suggest that the holding of the head was done with force or in an inappropriate manner.

Further, the panel considered Mr Sandy's response, as recorded by Witness 6 shortly after the incident, and it noted that while he appears to accept that he may have come across as abrupt and his behaviour may have been perceived as negative, he does not appear to expressly accept that his behaviour in holding Patient G's head was inappropriate.

The panel accepts that it was likely that Mr Sandy did hold Patient G's head when administering an inhaler. However, the panel acknowledged the evidence it heard from Witness 6 that "*sometimes some form of restraint is required"* when a nurse administers an inhaler to an incompliant child.

The panel was not satisfied that there was sufficient evidence to find that Mr Sandy had behaved inappropriately when administering an inhaler to Patient G. The panel noted that "*the mum felt that other staff had been gentler*" but concluded that this was more likely to be a comment about the general approach taken by Mr Sandy in caring for Patient G, rather than him inappropriately holding Patient G's head when administering an inhaler.

The panel determined that the NMC has not discharged its burden of proof on the balance of probabilities in relation to this charge.

The panel therefore finds sub-charge 4c not proved.

Charge 5b

"That you, a registered nurse:

5) On 22 or 23 September 2019 in relation to Patient H behaved inappropriately in that you:

b) Stated that "if patient H kicked you, you could always kick them back" or used a gist of words that were similar."

This sub-charge is found NOT proved.

The panel had regard to the witness statements and oral evidence of Witness 6, Witness 9 and Witness 11, as well as the email from Witness 9 dated 4 October 2019 and Witness 6's record of discussions held between her and Mr Sandy in relation to the incident.

In her email dated 4 October 2019, Witness 9 stated:

> *"Mum openly admitted she struggled to get along with nursing staff member, tried to make light of this by joking about her son having long legs and he may kick them while he received inhaler treatment, again mum admitted nursing staff member likely to be joking as well but felt to be unprofessional when nursing staff reply that if he does kick he can always kick them back."*

The panel took into account that *'joking'* was also reflected in Witness 9's witness statement, which stated:

> *"The mum said that the registrant replied saying that if the patient kicked, that he could always kick them back. The mum said that she thought the Registrant to be joking, but found it a little unprofessional. I am not sure whether this situation had happened during this shift or whether it was an example of the care from the patient's previous admission."*

The panel also acknowledged Mr Sandy's response, as recorded in his discussion with Witness 9, in the letter dated 21 October 2019:

> *"…you felt the night before you had had a good rapport with the family and that you personally felt disappointed that they felt this way, however upon reflection you could see how they had come to this outcome.*
>
> *I read through the Summary of Concerns of the second parent in the bay that night which focused around the way in which you restrained and spoke to the child and his family. I asked if you would like to respond or reflect on that incident. You explained that you remembered caring for this particular child last winter and communicating effectively was quite a challenge at that time, especially at night. You explained that you had made a joke about the child's long legs but you appreciated that retrospectively it might not have been taken as a joke and would have seemed unprofessional."*

The panel noted that Mr Sandy appears to accept that he *"made a joke about the child's long legs".*

The panel further noted that Witness 6 and Witness 9 did not directly witness this incident.

The panel bore in mind that context is important when you are dealing with children and that both Mr Sandy and the parent of Patient H were consistent in stating that they made comments about the child's legs in a *'joking'* manner. Without any further evidence from those involved in the conversation (Patient H's parent or Mr Sandy), it is difficult for the panel to determine exactly what was said and whether Mr Sandy behaved inappropriately.

Furthermore, the panel was not satisfied that this comment was made on the 22 or 23 September 2019, as some of Patient H's parent's concerns related to a previous occasion when Patient H had been cared for by Mr Sandy. The panel also noted that

Witness 6 and Witness 9 were unable to say whether the parent's complaint related to the care provided on 22 or 23 September 2019 or on a previous occasion.

The panel determined that the NMC has not discharged its burden of proof on the balance of probabilities in relation to this charge.

The panel therefore finds sub-charge 5b not proved.

Charge 6a

"That you, a registered nurse:

6) On 25 October 2019, in relation to Patient J, failed to administer medications, namely:

a) *Clonazepam at 16:00hrs;*

This sub-charge is found proved.

In reaching this decision, the panel took into account the witness statements and oral evidence of Witness 6, Witness 7 and Witness 10. The panel also took into account Patient J's prescription charts, a Datix of the incident and emails from Witness 7 dated 24 November 2019.

The panel noted that Patient J had a complex condition which caused him to have seizures. In Witness 6's record of conversation with Mr Sandy, she stated that he confirmed to her that he had administered the medication but failed to record this.

Witness 6 confirmed in oral evidence that the night nurse phoned Mr Sandy at home to check if the Clonazepam had been administered to Patient J as there was no record of it in Patient J's chart. In her witness statement, Witness 6 stated:

"My understanding is that the night nurse…who took over the care of Patient ('Patient J') on 25 October 2019 noted that the 16:00hrs dose of clonazepam

and the 18:00hrs dose of phenobarbital had not been signed for in Patient J's chart. Phenobarbital is a controlled drug ('CD') and it was noted that it had not been signed for in the CD book either. Phenobarbital is an opiate drug which is used to control seizure activity. Patient J had a complex condition which caused him to have seizures and this drug was being used to assist with controlling this. If a dose of this drug is missed, it compromises the seizure control.

The Registrant was the nurse allocated to Patient J in the day shift (07:30 - 20:00hrs) of 25 October 2019. As a result, the Registrant was contacted at home to confirm whether the doses had been given, and he confirmed that they had been given but that he had omitted to sign for them. This is reflected in the DATIX under "immediate action taken".

Initially my concern was one of record keeping, in that the Registrant had failed to sign the prescription chart and CD book, and this is against Trust Policy. Particularly, section 8.7 of the Medication Management Policy and 13.3 of the Controlled Drug Policy.
…
I spoke with the Registrant about this incident on 29 October 2019. This meeting focused on the CD error (phenobarbital). During this meeting, the Registrant confirmed that he had administered the dose to Patient J but that he and Witness 7 had been completing three other actions simultaneously, which related to the signing in and administration of another controlled drug, cannabidoil. The Registrant stated that both he and Witness 7 omitted to sign the CD book for phenobarbital.

During this meeting, the Registrant told me that these actions took place around 18:00hrs and that as it was nearing the end of Witness 7's shift, he was in a hurry to leave.

I also spoke to Witness 7 on or around 29 October 2019. Although Witness 7 did not have a recollection of checking the phenobarbital with the Registrant, he did not dispute it, and commented he may just not remember that detail.

Following my discussions with the Registrant and Witness 7, I checked the CD book just to confirm the Registrant's account. In accordance with my timeline of events, this was on or around 31 October 2019. When I looked at this, the timings that the Registrant gave to me did not seem to be correct, as the CD book for cannabidoil showed that the Registrant and Witness 7 signed in cannabidoil, and then signed out a dose to be administered to Patient J at 16:00hrs, and not 18:00hrs as the Registrant had said.

I also looked at Patient J's prescription chart, and this reflect that the cannabidoil was due at 16:00hrs, and the Registrant has signed for this drug in the prescription chart to indicate administration at 16:00hrs.

On 1 November 2019 I had another meeting with the Registrant. However, prior to this meeting (but on the same date) I spoke with Witness 7 again to cross reference the timings recorded in the CD book relating to the cannabidoil. Witness 7's account did not change, and he told me that he did not have a clear recollection of checking phenobarbital with the Registrant, but he could not say with certainty that it did not happen when he checked drugs with the Registrant at 16:00hrs. Witness 7 recalled that he checked the medications with the Registrant 16:00hrs and not at 18:00hrs, and he had a clear recollection of carrying out the actions relating to cannabidoil at 16:00hrs.

During my meeting with the Registrant on 1 November 2019, I raised my concern about the discrepancy between his account on 29 October 2019, and the record in the CD book. The Registrant's response was that the entries for cannabidoil timestamped 16:00hrs, actually took place at 18:00hrs and that both he and Witness 7 had entered the incorrect time in the CD book. I queried the likelihood that two nurses would have erroneously signed the incorrect time by two hours, and the Registrant insisted that this is what had happened.

Based on what was recorded in the CD book and Patient J's prescription chart, and considering the account by Witness 7, the Registrant's account did not make sense. It seemed unlikely that the events would have occurred in the way that the Registrant described. I remember that at this stage I was very concerned about his honesty and integrity, as I felt that he was not being honest about what had occurred. During the meeting I discussed these concerns but the Registrant maintained his account of what happened.

Therefore, in conclusion, it is unclear whether this is a record keeping error, or a medication error as a result of the dose being missed. However, the Registrant's account is that it was a record keeping error."

The panel determined that Witness 6's oral evidence was clear and consistent with her witness statement dated 13 July 2021. In follow-up questions by the panel, Witness 6 stated that her ability to investigate whether Clonazepam had been administered to Patient J was limited because it was not a controlled drug. Witness 6 said that she was *"not certain"* whether the Clonazepam had been administered because *"I didn't have any corroborating evidence on the controlled drugs log, as it's not a controlled drug. My assumption is that it hadn't been given… I had no certainty, it hadn't been signed for"*.

Further, the panel considered the evidence of Witness 7, who stated in his witness statement dated 3 June 2021:

"Incident on 25 October 2019

I remember the shift on 25 October 2019 as it was a rare occasion that I worked a day shift. On this shift, I worked on Howard Ward, and the Registrant was also on this shift. I also remember this shift because I had arranged to finish the shift early (at 18:00hrs) as I had prior commitments, and I had arranged this with the matron ahead of time.

On this shift the Registrant and I were each allocated our own sets of patients which we were responsible for. However, around 16:00hrs I recall that I

checked some controlled drugs ('CD') with the Registrant. The reason for this is that controlled drugs are required to be checked by two registered nurses, and I was available at the time that he needed assistance with this.

I remember that it was 16:00hrs because following this shift I was questioned on the events by Witness 6, the Ward Manager. l was also asked to give Witness 6 a written account of the events Which I did via email dated 24 November 2019 arid 26 November 2019. I have a copy of these emails and the email on 26 November 2019 states that I checked the drugs with the Registrant at 16:00hrs.

I recall that the medications that I checked with the Registrant were for Patient J. I recall that I checked cannabidiol and this was memorable because we were disposing of expired stock and checking in new stock, and I recall that we discussed how best to enter this into the CD book. I also recall that we checked gabapentin which was being prepared to be administered to Patient J.

I recall that both the Registrant and I signed the CD book for both the cannabidoil and the gabapentin at the time that we completed the check.

Following my shift, I recall that I was questioned about having checked drugs with Witness 6. I recall being asked if I checked a CD called phenobarbital with the Registrant. However, I have no recollection of checking this drug with him and I believe that this drug was due to be given at a later time. I only checked medications with the Registrant on one occasion on this shift, which was 16:00hrs, and at this time, as stated above, I only recaII checking cannabidoil and gabapentin for Patient J.

As a part of making this statement, I have been show a copy of the CD book and confirm that my signature appears as follows:

a. On the Cannabidoil CD Book I signed twice on 25 October 2019 at 16:00hrs in the "witnessed by" column. On signature related to the

expired bottle of cannabidiol, the second related to an opened/valid bottle;

b. *On the Gabapentin CD book I signed once on 25 October 2019 at 16:00hrs. I note that there are two entries in the CD book for this time, with the second one witnessed by a different signatory. I don't know why this was, but my signature is the first entry for 16:00hrs on this date.*

I have also reviewed the CD book for Phenobarbital, and I note that I did not sign for this medication with the Registrant on 25 October 2019. However, I note that there is a retrospective entry that appears to be signed by myself for 18:00hrs on 25 October 2019. I am not able to recall signing this entry, and it appears strange that I would have signed this to indicate the medication was given at 18:00hrs as explained above I was finishing my shift at this time."

The panel determined that Witness 7's oral evidence was clear and consistent with his witness statement and his emails of 24 and 26 November 2019, giving his account of events. It noted that this shift was particularly memorable for him for a number of reasons, including that he usually worked nightshifts, that he had to finish early on this occasion and because this was a memorable client, who was a regular patient on the Ward.

Further, the panel took into account the statement of Witness 10, dated 30 May 2021, who had signed the Controlled Drugs book to confirm that she second checked a drug for Patient J with Mr Sandy at 18:00hrs on 25 October 2019. Witness 10 stated:

"I recall that the drugs were for Patient ('Patient J'), but I am not able to recall the drug that I checked with the Registrant, and nor do I recall the time that I checked this. However, I have been provided with a copy of Patient J's Controlled Drug Books, and I note that on 25 October 2019 signed the CD book in the "witnessed by" column for Cannabinol at 6:00pm (18:00hrs). This must have been the drug that I checked with the Registrant.

I recall quite clearly that it was only the one drug that I checked with the Registrant, and that we both signed for this at the time that we checked the medication.

On my next shift, I recall that Witness 6 asked me some questions about the check that I did with the Registrant. It is because of this that I remember the details so well. I believe she had some questions for me because it was noted that one of Patient J's medications had not been given and/or signed for on 25 October 2019 so she wanted to check with me what drugs I checked with the Registrant on that date."

The panel also heard evidence from Witness 11 and noted that her account of events was based on the investigation conducted by Witness 6. It recognised that although she had no direct involvement, her evidence assisted in that she clearly stated what the Trust's policy was on the administration of controlled drugs. Witness 11 stated:

"We have a very clear policy on the administration of controlled drugs ('CD') which states the controlled drugs must be second checked by a registered nurse/nursing associate/midwife/ODP or by a doctor or pharmacist. The policy also states that both the person administering the drug, and the person second checking must record and sign the entry in the CD book.
…
As a result of this incident, the Registrant's medication management practice was restricted, and he was no longer allowed to single check medications."

The panel also carefully considered Patient J's prescription charts, the controlled drug book entries for 25 October 2019 and the Datix completed in respect of this incident. It also considered the Disciplinary Hearing outcome letter, dated 10 February 2020, which set out a summary of Mr Sandy's response to the incident:

"Firstly you were involved in a medication error involving a controlled drug that was not signed for on both the prescription chart and the controlled drug record book. You confirmed that you had administered the medication but had

not recorded this on either the controlled drug book or the prescription chart. It has not been possible to clarify who double checked the medication with you at this time.

You explained that it had been very difficult to get a second checker. You advised the panel that you had noticed that the Cannabidiol wasn't being treated as a controlled drug on the ward and you want to ensure that it was added into the Controlled Drug book once this has been confirmed by the pharmacists as the correct action to take. Due to this you explained that you had tried to do too much at the same time but could not defend the error that had been made. You went on to say that you were fully aware of when and where mistakes had been made and would welcome any re-training on medication administration. You explained that you appreciated that you did not have a systematic approach to drug administration that day."

The panel also noted Witness 6's record of her discussion with Mr Sandy on 29 November 2019, which stated:

*"**29.10.19 Discussion regarding Controlled Drug error***

Gavin said he had administered the dose to the patient but he and Witness 7 were undertaking three other actions simultaneously (signing in and administering another controlled drug cannabidoil) and that both nurses had omitted to sign out the phenobarbitone in the CD record book or to document the administration on the patient prescription chart.

Gavin explained these events took place at approximately 18:00 and as this was at the end of Witness 7's shift and he was in a hurry to leave. Gavin described the process as being chaotic and although they had checked the drug correctly together, this had led to them not signing the prescription chart or CD book. He agreed the process had not been followed carefully or systematically.

Gavin and Witness 7 engaged in a reflective discussion with me that day and were both given a MEAT tool to complete and return and were asked to complete a clear retrospective entry in the CD record book which they did."

In considering the documentary evidence before it, the panel noted that Mr Sandy had signed Patient J's prescription chart at 16:00hrs to confirm that he had given Gabapentin. However, it noted that Mr Sandy failed to sign or record that he had given Patient J Clonazepam which was also due at the same time. Therefore, the panel determined that having failed to sign for Clonazepam at 16:00hrs, when he had signed for Gabapentin at 16:00hrs, it was more likely than not that Mr Sandy had failed to administer the Clonazepam medication to Patient J.

Therefore, the panel finds sub-charge 6a proved.

Charge 6b

"That you, a registered nurse:

6) On 25 October 2019, in relation to Patient J, failed to administer medications, namely:

b) *Phenobarbital at 18:00hrs."*

This sub-charge is found proved.

In reaching this decision, the panel had regard to the witness statements and oral evidence of Witness 6, Witness 7 and Witness 10. The panel also carefully considered Patient J's prescription charts, the controlled drugs book for 25 October 2019 and the Datix of the incident.

The panel noted that there was no entry in the controlled drugs book that would serve as evidence that Phenobarbital was signed for in Patient J's prescription chart.

The panel was persuaded by the account of Witness 7, who stated that he had not second checked the administration of Phenobarbital to Patient J at 18:00hrs.

Witness 7's oral and written evidence was clear and consistent with the report that he gave to Witness 6 at the time, and with the documentary evidence (i.e. the prescription charts and controlled drug entry for Phenobarbital on 25 October 2019, and his emails dated November 2019).

The panel noted that Witness 7 admitted that he had agreed to sign retrospectively on 29 October 2019 to record that he had second checked the administration of Phenobarbital to Patient J. However, he stated that this was because he had been told to do so by Witness 6 and he did not question this at the time, but that on reflection and further investigation by Witness 6, he was in fact clear about the timings and the drugs he had second checked with Mr Sandy on 25 October 2019. The panel was satisfied that Witness 7 had signed for Gabapentin and Cannabidiol at 16:00hrs, as this was clearly recorded in the controlled drugs book and Patient J's prescription chart.

The panel also noted that this was a memorable shift for Witness 7 as he did not usually work day shifts and he had to finish early that evening at 18:00hrs.

The panel also noted the evidence of Witness 10 who had only signed as second checker with Mr Sandy for the administration of Cannabidiol to Patient J at 18:00hrs. The panel was satisfied that Witness 10's account was clear and consistent with the documentary evidence (i.e. the controlled drugs book entry for Cannabidiol and Patient J's prescription chart on 25 October 2019). The panel was satisfied that Witness 7 did not second check any drugs for Patient J, at 18:00hrs with Mr Sandy. Taking into account all the evidence, the panel determined that it was more likely than not that Mr Sandy had failed to administer Phenobarbital to Patient J at 18:00hrs.

Therefore, the panel finds sub-charge 6b proved.

Charge 7a (i)

"That you, a registered nurse:

7) In relation to Patient J, on 25 October 2019, failed to record and/or sign:

a) The Controlled Drug Book in regard to:

i. Phenobarbital;"

This sub-charge is found NOT proved.

In reaching this decision, the panel took into account the witness statements and oral evidence of Witness 6, Witness 7 and Witness 11. The panel also took into account the controlled drugs book entry for Phenobarbital on 25 October 2019 and the Datix for this incident.

The panel noted that Phenobarbital is a controlled drug as confirmed by all three witnesses when questioned during each of their oral evidence. Witness 6 and Witness 11 informed the panel that according to the Trust's Controlled Drugs Policy, the controlled drugs book must be signed when a controlled drug is administered. The panel has had sight of this policy and determined that the witnesses gave clear and consistent evidence regarding the procedure to be followed when administering controlled drugs.

The panel referred to its earlier decision that Mr Sandy had failed to administer Phenobarbital on 25 October 2019 at 18:00hrs. The panel noted that there is only a duty on a registered nurse to sign the controlled drugs book where a controlled drug has been administered by them. It follows that there was no duty on Mr Sandy to record or sign the controlled drugs book for Phenobarbital as he had not administered it.

Therefore, the panel finds sub-charge 7a not proved.

Charge 7b(i) and 7b(ii)

"That you, a registered nurse:

7) In relation to Patient J, on 25 October 2019, failed to record and/or sign:

b) Patient J's prescription chart namely for:
i. Phenobarbital;
ii. Clonazepam."

These sub-charges are found proved.

In reaching this decision, the panel took into account the witness statements and oral evidence of Witness 6, Witness 7 and Witness 11. It found the witness evidence of all three witnesses to be clear and consistent.

It also considered the relevant Trust policies and Patient J's prescription chart. The panel determined that there was duty on Mr Sandy to record, sign or write a note on Patient J's prescription chart regardless of whether he administered the medications or not. The panel determined that the instructions on the prescription chart are clear:

> *"If a dose is omitted for any reason, the nurse should enter one of the following codes on the administration record and document reason in nursing notes"*

The panel noted that Mr Sandy had failed to record or sign Patient J's prescription chart on 25 October 2019, in relation to Phenobarbital and Clonazepam.

Therefore, the panel finds sub-charges 7b(i) and 7b(ii) proved.

Charge 8a and 8b

"That you, a registered nurse:

8) On 25 October 2019 and/or 29 October 2019, in relation to Patient J, purported to have administered the medications, namely, a dose of:

a) Clonazepam at 16:00 hrs;
b) Phenobarbital at 18:00 hrs;

…when you had not."

These sub-charges are found proved.

The panel had regard to the evidence and its findings as set out in Charges 6a and 6b above.

In considering whether Mr Sandy had purported to have administered the medications when he had not. The panel took into account in particular, the evidence of Witness 6, who investigated this incident. The panel found the evidence of Witness 6 to be clear and consistent and credible.

The panel accepted Witness 6's evidence that Mr Sandy had initially maintained that he had administered both medications. The panel noted that when Witness 6 investigated this incident, the night nurse who contacted Mr Sandy at home, confirmed that he had told her that he had administered the Clonazepam and Phenobarbital to Patient J but not signed for them. In the meeting on 29 October 2019 between Witness 6 and Mr Sandy, he told Witness 6 that he had given the Phenobarbital to Patient J at 16:00hrs. In response to the Panel's questions during her oral evidence, Witness 6 said:

> *"what became apparent was that his account was inconsistent and wasn't corroborated by others. My suspicion is that he had found himself caught in a lie."*

The panel determined that there were some inconsistencies in Mr Sandy's account in relation to the timings of when he said that he administered the Clonazepam and Phenobarbital to Patient J.

The panel referred to its earlier findings, in Charges 6a and 6b, that Mr Sandy did not administer the medications. The panel determined that on 25 and 29 October 2019, Mr Sandy purported to have administered Clonazepam at 16:00hrs when he had not.

Notwithstanding inconsistencies in Mr Sandy's account regarding when he had administered Phenobarbital, the panel was also satisfied that on 25 October 2019 Mr Sandy purported to have administered Phenobarbital at 18:00hrs when he had not.

Therefore, the panel finds sub-charges 8a and 8b proved.

Charge 9a

"That you, a registered nurse:

9) On or around 29 October 2019 in relation to Patient J:

a) Stated that you had signed in cannabidiol at 18:00 hrs when you had in fact done this at 16:00 hrs"

This sub-charge is found proved.

In reaching this decision, the panel took into account the witness evidence from Witness 6 and Witness 7, Patient J's prescription chart and the controlled drug book entry for Cannabidiol on 25 October 2019.

The panel referred to the evidence and its findings set out in Charges 6 and 7 above. It was satisfied Mr Sandy had signed the controlled drugs book for Cannabidiol on two occasions at 16:00hrs.

The panel found Witness 6's oral evidence was clear and consistent with her witness statement and the record of her discussions with Mr Sandy:

*"**01.11.2019 Discussion regarding three clinical incidences***

Discussion regarding Controlled Drug error
When I then reviewed the records, I found the CD record book showed the signing in of the cannabidiol and signing out a 16:00 dose documented by both Gavin and Witness 7 in the CD record book at 16:00 not at 18:00 as Gavin had recalled.

I explained to Gavin that Witness 7 had stated he did not recollect checking the dose of phenobarbitone. Witness 7 did recall checking and documenting 'the other actions in regard to cannabidiol at 16:00.

When I raised this concern with Gavin regarding this discrepancy, Gavin stated that the 16:00 cannabidiol entries actually took place at 18:00 and both nurses entered the wrong time in error. The cannabidiol dose was due and signed for at 16:00 on the prescription chart. I queried that both Staff nurses could have entered and signed the wrong time by two hours erroneously, and Gavin was insistent this is what had happened. I pointed out that a different set of actions were documented at 18:00 in the CD record by him and Witness 10, this would have been the same time he said he had been checking drugs with Witness 7. Gavin continued to assert his recollection of events were correct."

The panel also heard from Witness 7, who told the panel that he had signed the controlled drugs book and prescription chart for Cannabidiol with Mr Sandy at 16:00hrs and that he had left his shift at 18:00hrs. The panel found that his oral evidence was consistent with his witness statement and the contemporaneous emails he sent to Witness 6 on 24 and 26 November 2019:

"In addition to my previous statement regarding medication checking on the 25/10/19 the timing of the memorable checks of Gabapentin and Cannabidoil where around 16:00 hours and I recall no further medication checks and my shift finished at 18:00."

The panel therefore determined that it was more likely than not, that Mr Sandy had signed in Cannabidiol at 16:00hrs as the controlled drugs book and Patient J's prescription chart were both signed by Mr Sandy and Witness 7 with a recorded time of 16:00hrs.

Witness 6 was clear, consistent and credible and supported by her record of discussion with Mr Sandy on 1 November 2019. Therefore, the panel determined that Mr Sandy had stated on or around 29 October 2019, in relation to Patient J, that he had signed in Cannabidiol at 18:00hrs when in fact he had done this at 16:00hrs.

The panel therefore finds sub-charge 9a proved.

Charge 9b

"That you, a registered nurse:

9) On or around 29 October 2019 in relation to Patient J:

b) Stated that you had incorrectly written 16:00 hrs in respect of signing in cannabidiol when 16:00 hrs was in fact the correct time"

This sub-charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 6, Witness 7 and Witness 10, as well as the controlled drugs book and prescription chart for Patient J.

The panel noted that on 29 October 2019 Mr Sandy and Witness 7 both signed the controlled drugs book entry for Cannabidiol at 16:00hrs and recorded *"received from patient"*.

The panel referred to its earlier finding that Witness 7 provided clear, consistent and credible evidence, that he did not usually work dayshifts and that he finished his shift that day at 18:00hrs as he had an appointment. Witness 7 stated that he would not have signed the controlled drugs book at 18:00hrs as he had already left work at that time. Witness 7 stated that he had signed at 16:00hrs as recorded in the controlled drugs book.

The panel noted that Mr Sandy explained to Witness 6 that he incorrectly wrote 16:00hrs on 29 October 2019:

"Gavin explained these events took place at approximately at 18:00 and as this was at the end of Witness 7's shift and he was in a hurry to leave."

"Gavin stated that the 16:00 cannabidiol entries actually took place at 18:00 and both nurses entered the wrong time in error…I pointed out that a different

set of actions were documented at 18:00 in the CD record by him and [Witness 10]. this would have been the same time he said he had been checking drugs with [Witness 7]. Gavin continued to assert his recollection of events were correct."

The panel reflected its earlier finding at charge 9a above that cannabidiol was more likely than not administered at 16:00hrs as the controlled drugs book and Patient J's prescription chart were both signed by Mr Sandy and Witness 7 with a recorded time of 16:00hrs.

Having carefully considered all of the evidence, in particular the evidence of Witness 6 and the records of discussions with Mr Sandy following the incident, the panel determined that Mr Sandy stated that he had incorrectly written 16:00 hrs in respect of signing in Cannabidiol when 16:00 hrs was the correct time.

The panel therefore finds sub-charge 9b proved.

Charge 9c

"That you, a registered nurse:

9) On or around 29 October 2019 in relation to Patient J:

c) Incorrectly stated that you had been completing three other actions simultaneously with Witness 7 at 18:00 hrs, when this was not the case."

This sub-charge is found proved.

In reaching this decision, the panel took into account the witness evidence provided by Witness 6 and her record of the meeting she had with Mr Sandy. The panel also referred to the evidence and findings it had made in Charges 9a and 9b above.

In the record summary of Witness 6's meeting with Mr Sandy, she states:

"Gavin said he had administered the dose to the patient but he and [Witness 7] were undertaking three other actions simultaneously (signing in and administering another controlled drug cannabidiol) and that both nurses had omitted to sign out the phenobarbitone in the CD record book or to document the administration on the patient prescription chart.

Gavin explained these events took place at approximately at 18:00 and as this was at the end of [Witness 7]'s shift and he was in a hurry to leave."

The panel was satisfied that Witness 6's summary of her meeting with Mr Sandy is an accurate record of the conversation that took place, and this was consistent with her witness statement and oral evidence.

The panel determined, on the balance of probabilities, it was more likely that on 29 October 2019 Mr Sandy incorrectly stated that he had been completing three other actions simultaneously with Witness 7 at 18:00 hrs when this was not the case.

The panel therefore finds sub-charge 9c proved.

Charge 10a

"That you, a registered nurse:

10) On 29/30 October 2019, in relation to Patient I, failed to:

a. Provide the correct feed, namely Infatrini Peptisorb;
b. Take any or any adequate action when Patient I's relative queried the type of feed provided;
c. Sign Patient I's prescription chart."

These sub-charges are found proved.

In reaching this decision, the panel took into account that there is no written record of the complaint from Patient I's parents in relation to this incident, no record of

conversation with the pharmacist and no response from Mr Sandy apart from Witness 6's summary of the discussions between them at the time and his grievance documents. The panel took into account the witness evidence of Witness 6 and Witness 11 and also the DATIX for the incident, Patient I's notes dated 29 and 30 October 2019, Patient I's prescription charts and feeding regime chart.

In her witness statement, Witness 6 outlined the following:

> *"Incident on 29/30 October 2019*
> *I believe that I was informed of this incident by receiving the DATIX and I also recall discussing it with [Witness 11] (Paediatric Matron)…I think I was notified of the incident around 29 October 2019.*
>
> *This incident also involved Patient I, and my understanding was that the Registrant was the nurse allocated to her care for the shift on 29 October 2019. Patient I had a volatile clinical condition and she suffered from profound desaturations (low oxygen saturation levels) when she had an episode of gastroesophageal reflux. The episodes of reflux caused life threatening events for Patient I, and as a result of her condition, Patient I was prescribed a specific feed, which was Infatrini Pebisorb.*
>
> *The Registrant had provided the evening feed for Patient I, and the DATIX states that Patient I's father queried whether the feed was correct. The Registrant assured Patient I's father that it was 100% the correct feed. Patient I's father administered this feed at 18:00hrs and 22:00hrs.*
>
> *Following this, Patient I had a life threatening reflux episode during the night which caused her to stop breathing. After the episode, the family raised concerns about the feed that was administered to Patient I and stated that they believed that the episode was caused by the incorrect milk being given. Unfortunately at this time it was discovered that the Registrant had provided the incorrect feed for Patient I, in that he had provided Infatrini rather than Infatrini Peptisorb. I believe this was confirmed as the feed bottles used were still identifiable.*

There is no way of saying with certainty what caused Patient I's episode or if the incorrect feed contributed to this. However, Patient I's family requested that the Registrant did not look after Patient I again.

After I was informed, I spoke to the Registrant about the incident. I don't remember when this was, but it was the next time I saw him and I recall that it was on the ward and first thing in the morning on that day. I also spoke with him about the incident more formally on 1 November 2019.

The Registrant's initial response when I first spoke with him was that the word "Pebtisorb" had been crossed off the drug chart so that the drug chart just said "Infatrini". At the time I accepted his explanation.

I then reviewed Patient I's drug chart and this stated "Infatrini Peptisorb" and the word "Peptisorb" had not been crossed off.

I spoke to the Registrant again and told him that the word "Peptisorb" had not been crossed off. His response was then that he had actually spoken to Ms 1 (pharmacist) and she had told him that "Infatrini" and "Infatrini Peptisorb" were the same milk, and she told him that the word "Peptisorb" had been crossed off the drug chart.

As a result, I spoke with [Ms 1] to check if this was correct. I do not recall the date of this, and I do not have a record of the conversation, other than that stated in the record of my conversation with the Registrant on 1 November 2019. [Ms 1] told me that she did recall speaking with the Registrant, but that this conversation was regarding milk stock on the ward and whether there was enough milk.

I went back to the Registrant and explained what [Ms 1] had told me. At this point he told me that he had not actually checked or seen the milk himself, and that Patient I's parents had been fetching their own milk independently. While this is not unusual, as parents do have access to the milk kitchen, this

contradicted the account of Patient I's parents. As above, Patient I's parents stated that the Registrant had brought them the milk and that they had queried whether the milk was correct, and the Registrant had reassured them that it was "100%" the correct milk. When I told the Registrant this, he denied ever having that conversation with the family and maintained that Patient I's parents obtained the milk from the milk kitchen independently.

However, even where feeds/medications are being self-administered by parents, the Registrant as Patient I's allocated nurse has the overarching responsibility to ensure all medications and feeds are correct, and the Registrant must still sign the medication chart to indicate that the medication/feed has been administered. We also have a code, which is a "5" which can be used to sign the prescription chart where medications/feeds have been self-administered by a patient/parent. This is in line with the Medication Management Policy.

On reviewing Patient I's drug chart, it was noted that the Registrant had failed to sign the drug chart for that day to indicate when the feed had been administered throughout the day. When I spoke with the Registrant regarding the lack of documentation on the prescription chart when the feed was administered, the Registrant admitted that he did not do this.

With this incident, I also had concerns about the Registrant's honesty and integrity. As seen in the above paragraphs, the Registrant's account changed when challenged, and was in conflict with the accounts of others, in this case Patient I's parents."

The panel also took into account the witness statement of Witness 11:

"Patient I was a long term patient with very complex needs. I knew Patient I and her family well. I am aware of the incident as I was informed by [Witness 6].

Patient I suffered with severe gastroesophageal reflux and as a result was prescribed a special feed called infantrini peptisorb. This is a specialised infant formula specifically designed for infants with malabsorption problems.

On the evening of 29 October 2019, the Registrant was caring for Patient I and provided Patient I with the incorrect feed, being infatrini feed rather than Infatrini Peptisorb. Following this, during the early hours of 30 October 2019, Patient I suffered a severe gastroesophageal reflux episode causing her to have profound desaturations, being low levels of oxygen saturation in the blood, and apnoea, meaning she stopped breathing.

Patient I required manual ventilation through a bag-valve-mask for a period of time, an once she commenced a normal breathing pattern she required increased oxygen requirements over the following 12 hours before she could be weaned back to her normal requirement.

Following being informed of the incident, I spoke with Patient I's parents on the 30 October 2019. During this conversation, Patient I's parents told me that they wondered whether Patient I's reflux episode was caused as a result of her being given the wrong milk. I asked what made them think that, and they told me that when the Registrant brought in the feed for Patient I, it was in a different packaging. As a result, Patient I's Dad questioned the Registrant on whether it was the correct feed, and Patient I's Dad said that the Registrant told him that it was 100% the correct feed."

The panel also had sight of the Datix for the incident dated 30 October 2019:

"Patient required NJ feed Infatrini peptisorb, reported from family nurse gave patients father a bottle of Infatrini. When the father questioned that this milk was incorrect the nurse assured the father that this was exactly the same milk. Father used the milk for 18:00 and 22:00 feed continuous feeds."

The panel also considered Mr Sandy's grievance documents, which stated:

"During November it was alleged that the wrong milk was hung for a patient who experienced desaturations 6 hours post my shift. The family are being nurtured to go home and at this time the milk was not prescribed but ordered by the dietitian for the pharmacy to send to the ward. The father hung the milk and started the feed as he has done numerous times. I did not sign for the milk and treated the patient no differently to my colleagues and yet my conduct is being questioned. I feel that this is totally unacceptable and singling me out for something that categorially could not have been my fault"

The panel was of the view that Witness 6's and Witness 11's oral evidence was clear and consistent with their witness statements, the patient's records and documentation surrounding the incident. The panel determined from a review of the information that "Peptisorb" was not crossed off Patient I's chart and it was clear from the feeding regime that Patient I was prescribed "Infatrini Peptisorb". The panel also heard evidence that "Infatrini Peptisorb" and "Infatrini" came in different packaging and were different products and it considered that it was unlikely that the pharmacist had told Mr Sandy that it was the same milk. The panel also determined that given the packaging was different it was likely that the parents would have checked with Mr Sandy before administering the feed of "Infatrini" to Patient I. The panel noted that Patient I's notes recorded that the parents spoke to Witness 6 and Witness 11 on 30 October 2019, the day after they had administered the incorrect feed and they recalled that Mr Sandy had told them it was the right feed for their child.

Further, the panel had regard to Mr Sandy's responses to Witness 6 during their discussion on 1 November 2019. The panel noted that in her oral evidence, Witness 6 told the panel that feedback had to be provided to the wider nursing team as a number of staff had not completed Patient I's prescription chart as required. Following this feedback, the panel noted that from 30 October 2019, Patient I's feeds were recorded four hourly. The panel accepted Witness 6's evidence that, when addressing the issue of poor recording, she had dealt with this across the wider nursing team and had not singled out Mr Sandy. The panel was satisfied based on its review of Patient I's prescription chart and Mr Sandy's admission to Witness 6

that he did not sign the chart, that Mr Sandy had failed to sign Patient I's prescription chart on 29 and 30 October 2019.

Having heard evidence from Witness 6 and Witness 11, the panel was satisfied that it was Mr Sandy's responsibility, as the nurse caring for Patient I, to ensure that the correct feed was provided to the parents to administer to Patient I.

The panel determined that it was more likely than not that on 29 or 30 October 2019, Mr Sandy failed to provide the correct feed namely "Infatrini Peptisorb", failed to take any or any adequate action when Patient I's relative queried the type of feed provided and failed to sign Patient I's prescription chart.

The panel therefore finds sub-charges 10a, 10b and 10c proved.

Charge 11a and 11b

"That you, a registered nurse:

11) On an unknown date, in relation to Patient I, purported that:

a. Infatrini Peptisorb had been crossed out on Patients I's prescription chart;

b. A pharmacist had stated that "Infatrini was the same as Infatrini Peptisorb" or words to that affect.

…when this was not the case."

Charge 11a is found not proved and Charge 11b is found proved.

The panel took into account the witness statement and oral evidence of Witness 6. It also had sight of Patient I's prescription chart.

In her witness statement dated 13 July 2021, Witness 6 stated:

“I spoke to the Registrant again and told him that the word "Peptisorb" had not been crossed off. His response was then that he had actually spoken to Ms 1 (pharmacist) and she had told him that "Infatrini" and "Infatrini Peptisorb" were the same milk, and she told him that the word "Peptisorb" had been crossed off the drug chart.”

The panel considered Mr Sandy’s account to Witness 6 as outlined in her record of the discussions on 1 November 2019:

“<u>Discussion regarding Enteral Feed error</u>
I explained the error to Gavin and he replied that Ms 1 (ward pharmacist) 'said it was the same milk and the word 'peptisorb' was crossed off the drug chart - it had then said 'Infatrini'

I then reviewed the prescription chart, patient documentation and spoke to Ms 1, I then sought further information from Gavin. I explained the Drug chart did not reflect the alterations Gavin had recollected. Gavin had not signed the prescription chart or document any feed type/name information on the patients feed chart and the dietetic feed plan did not reflect any change in milk. Both the Prescription chart and dietetic feed chart stated the feed required was lnfatrini Peptisorb. He then stated he had been told it had been crossed off the chart and that his conversation with [Ms 1] had been in regard to whether we had the correct milk in stock to which [Ms 1] had assured him there was stock on the ward. He admitted that he had not checked or seen the milk himself and that the patient's parents were fetching the milk independently from the milk kitchen. I explained that this contradicted the account of the parents which had been relayed directly to a Deputy Sister and to the Matron, where Gavin had reportedly confirmed to the patient's father it was '100% the same feed' despite the bottle appearing different to the father who queried it with Gavin. Gavin denied this conversation had taken place and said the patients father had fetched the feed independently. Gavin did acknowledge he had not maintained any documentation regarding administration of the feed and we discussed the overarching responsibility of

the nurse to ensure all medications or feeds administered by parents are correct, and the importance of not assuming any parent has a level of expert knowledge, and how this may lead to error."

The panel further considered Mr Sandy's account to Witness 6 as outlined in her record of the discussions on 26 November 2019:

"I asked him to recall why he had said initially to me that the peptisorb was crossed off the prescription chart and it just said 'infatrini'. He denied this, explaining he said to me that the whole drug prescription was crossed off the chart (the 'as required' page). I explained this was not my recollection and he again disputed that."

The panel noted that the records of discussions in November 2019 between Mr Sandy and Witness 6 show that there was a difference of opinion as to what Mr Sandy had initially told Witness 6. Mr Sandy denied telling Witness 6 that "Peptisorb" had been crossed off the prescription chart. Mr Sandy stated that he had relied on what he had been told by Ms 1. The panel noted in particular Witness 6's records of her meeting with Mr Sandy on 1 November 2019 in which Mr Sandy had said that Ms 1 *"said it was the same milk and peptisorb was crossed off the drug charts – it had then said "Infantrini"*. The panel was not satisfied that the NMC had provided sufficient evidence to support charge 11a. Therefore it did not find this charge proved.

In relation to charge 11b, the panel noted that it did not have a contemporaneous note of either a conversation between Mr Sandy and Ms 1 (the ward pharmacist) nor a record of a conversation between Witness 6 and Ms 1 regarding this incident. However, the panel took into account the evidence of Witness 6 regarding her conversation with Ms 1 about the incident. The panel considered Witness 6's evidence to be credible and reliable. The panel noted that the pharmacist denied telling Mr Sandy that *"Infatrini was the same as "Infatrini Peptisorb"*. The panel considered that it would be unlikely that a ward pharmacist would tell Mr Sandy that *"Infatrini was the same as "Infatrini Peptisorb"* when these were two different products.

Therefore, the panel finds sub-charge 11b proved.

Charge 12a and 12b

"That you, a registered nurse:

12) Failed to set the oxygen rate in relation to Patient I, at the correct level, namely at 0.2 L per minute on:

a. 13 November 2019;
b. 16 November 2019."

These sub-charges are found NOT proved.

In reaching this decision, the panel took into account Patient I's observation records, the witness statements and oral evidence of Witness 6 and Witness 11.

The panel noted Patient I's observation records. On 13 November 2019 at 20:25, the 'Receive O2' column shows the figure 0.02L with Mr Sandy's initials. The panel noted that the entries on the following day at 01:43 and 05:07 also recorded a figure of '0.02L' and were signed or initialled by Mr Sandy. The panel noted that all other entries on the observation records prior to these three times, were initialled by other nurses and recorded a figure of '0.20L'.

The panel heard from Witness 11, who told the panel that Mr Sandy would have entered the received oxygen flow level figure manually into the system using an iPad. In her witness statement, dated 13 July 2021, Witness 11 stated:

"<u>Incident on 13 November 2019 and 16 – 19 November 2019</u>
A further clinical incident was discovered on 19 November 2019. This involved Patient I.

Nurse 5 was the staff nurse on the nightshift of 19 November 2019 and noted that Patient I had been placed on the incorrect level of oxygen therapy, in that her flow rate was set to 0.02L per minute, rather than the required (higher) rate of 0.2L per minute.

The error appears to have started on the Registrant's Day shift on 16 November 2019 (started at 07:30hrs and ending at 20:00hrs) when the Registrant was allocated Patient I.

This error then was carried on by staff taking over Patient I's care until it was noted on 19 November 2019. This was noted because when [Nurse 5] was switching Patient I from the wall oxygen to the portable oxygen (on 19 November), she noted that the flow rate was at 0.02L rather than 0.2L. We believe that this error was carried on by staff from 16 November 2019, until it was noted on 19 November 2019. This is because when it was investigated by [Witness 6], none of the staff responsible for Patient I between 17 – 19 November recall adjusting Patient I's oxygen flow rate.

The staff who continued to care for Patient on the incorrect oxygen levels are:
a. [Nurse 6] Night shift 16.11.2019
b. [Nurse 7] Day shift 17.11.2019
c. [Nurse 5] Night shift 17.11.2019
d. [Nurse 8] Day Shift 18.11.2019
e. [Nurse 5] Night shift 18.11.2019
f. [Nurse 7] Day shift 19.11.2019

However, it is quite difficult to know what happened, as looking at Patient I's observation records, they reflect that between 17 – 19 November, the correct oxygen flow rate, being 0.2L was set. This is except for at the 03:34hrs check on 17 November where the rate is noted to be 0.02L. However, because on 19 November it was noted that the oxygen level was 0.02L, and no staff recalled adjusting this on their shifts, we believe that the oxygen rate remained at 0.02L until it was noted on 19 November, and that the incorrect flow rate was recorded by staff on Patient I's observation chart.

As a result of this error, it was also noted that the error also occurred on the Registrant's night shift on 13 November 2019 (starting at 19:30hrs and finishing at 08:00hrs), at which time he was also allocated to Patient I.

No harm came to Patient I as a result of these errors. The reason that Patient I was receiving oxygen therapy was not because she required oxygen to maintain her oxygen saturations continuously, but was due to her suffering from episodes of severe reflux (as explained in the above paragraphs). Patient I received continuous flow of oxygen to assist her in recovering more quickly from these episodes of reflux which caused desaturations and apnoea."

The panel also had regard to the record of discussion between Mr Sandy and Witness 6, dated 26 November 2019, in relation to the concerns regarding the oxygen flow rate errors for Patient I. The relevant section reads:

"Discussion continued – Oxygen flow rate error
Gavin conceded he may well have done this although he did suggest that it may have been the child's parents who placed the flow meter back in the wall and set the rate, he couldn't be sure, and that it was likely him as he has done the same thing on two separate occasions. I asked if there was anything he found difficult with visualising numbers, he said his vision was deteriorating with age but felt it was likely an oversight."

The panel noted that Mr Sandy could not be sure whether he had set the rate at the correct level, that he had suggested that it may have been Patient I's parents, but conceded it may well have been him. The panel carefully reviewed Patient I's observations charts for the period of 11 November 2019 to 20 November 2019, it noted that Mr Sandy had cared for this patient and the chart indicates that he had recorded oxygen flow levels of 0.02L per minute when it should have been 0.2L. However, the panel was not satisfied that there was sufficient evidence to show that it was Mr Sandy that had set the oxygen rate at an incorrect level.

Furthermore, the panel considered that given the process of recording the oxygen flow level required manual entry onto the system, it was possible that this was a recording failure rather than a failure to set the oxygen at the correct rate.

The panel was not satisfied that Mr Sandy had failed to set Patient I's oxygen rate at the correct level on 13 November 2019 and 16 November 2019.

Therefore, the panel finds charge 12a and 12b not proved.

Charge 13a

"That you, a registered nurse:

13) On 13/14 November 2019 in relation to Patient K:

a) Failed to provide any or any adequate pain relief for Patient K;"

This sub-charge is found NOT proved.

The panel had regard to the witness statement of Witness 8, dated 20 July 2021:

*"**Nightshift on 13 - 14 November 2019***

On 13 November 2019 I worked a nightshift with the Registrant. I was the nurse in charge of the shift.

During the shift, one of the paediatric nursery nurses came and told me that one of the parents was requesting to speak with me. I don't remember the name of the patient involved, but I recall that he was a teenage boy in Bed 16 and that his mum was the resident parent.

I went to Bed 16, and when I got there I recall that the patient was in tears. His mum told me that the Registrant had come to introduce himself around the beginning of the shift, and that at this time he had been very short and

condescending when speaking to the patient. I don't know the details, but I recall that the mum told me that the Registrant had said to the patient that he was not in any pain and that he needed to just go to sleep. I recall the patient telling me that he found the Registrant to be very unfriendly. They told me that she did not want the Registrant to come back and see them.

I did not witness the Registrant speaking with the patient/mum. However, based on what was reported, it does not seem like the Registrant spoke with them in an appropriate manner. Particularly, I would not expect a nurse to tell a patient that they were not in pain and refuse to provide pain relief. The expectation is that if a patient complains of pain, the nurse would assess the pain by asking the patient for their pain score and following this provide the appropriate pain relief.

While the above is true, it is also worth noting that every nurse will get on differently with every patient, and sometimes patients/families interpret interactions in the wrong way and make complaints. I know a lot of patients who have been very satisfied with the care provided by the Registrant.

In any event, I noted the patient's/mum's concerns and told them that I would sort it out. I am not able to recall if I provided the patient with pain relief after my conversation with them, and I no longer have access to the medical records.

After this, I spoke with the Registrant and told him that I would take over the patient's care, and I handled this by telling the Registrant that there was a new admission coming up to the ward, which there was, and that this patient would need more care, and as a result I needed to allocate the Registrant to this new admission. The Registrant was happy with this and agreed."

The panel found the oral evidence of Witness 8 to be consistent with her witness statement. She told the panel that this was a memorable shift for her as this was her last before she went on extended leave.

Witness 8 informed the panel that Patient K was admitted for abdominal pain. In her oral evidence, she stated that Patient K's mum told her that she asked for pain relief for her child, but Mr Sandy refused to provide any. In response to panel questions, Witness 8 could not recall whether pain relief was due to be administered to Patient K during the time Mr Sandy cared for Patient K or whether she had given pain relief to Patient K when she took over his care from Mr Sandy.

Further, the panel considered the witness evidence of Witness 2:

> *"Concerns regarding Conduct*
>
> *On the nightshift of 13 November 2019, the Registrant was the nurse allocated to Patient K. During the morning of 14 November 2019, I was informed that Patient K's mum had raised a complaint about the Registrant's conduct towards Patient K during the night. I dealt with the complaint and reported it to the Ward Manager, and the Paediatric Matron.*
>
> *From my recollection, when I arrived on the ward in the morning of 14 November 2019, the Deputy Sister informed me that one of the parents wanted to make a complaint and asked me if I could go and see them. Following the discussion with Deputy Sister which outlined what had occurred overnight she went to handover to the day staff. I received a brief handover of other patients on the ward and escalated concerns over the patient in the high dependency room. Following this I went to meet Patient K and spoke with his mum about her concerns.*
>
> *Patient K's mum told me that she had concerns about the Registrant's attitude and the way that the Registrant had been so dismissive of Patient K's pain during the night. I made notes of what Patient K's mum was telling me and then put this information into the email. Patient K's mum reported the following concerns regarding the Registrant:*
>
> a. *The Registrant failed to introduce himself or say hello when he came to see Patient K;*

b. *The first thing that the Registrant said when coming into see Patient K was that he "wouldn't be walking like that if he was in pain". The Registrant said this when he saw Patient K walking out of the bathroom;*

c. *Patient K/Patient K's mum had requested pain relief for Patient K. The Registrant stated that he would not provide oramorph (morphine) for Patient K as he would not be able to go home if he had this;*

d. *The Registrant was adamant that Patient K did not have appendicitis as if he did he would be doubled over in pain;*

e. *Patient K said that he did not like the Registrant and was not going to tell him if he needed anything; and*

f. *When discussing Patient K's pain, the Registrant told Patient K's mum "you just aren't getting it are you?'*

In essence, Patient K's mum's complaint related to the fact that the Registrant had not been friendly, empathetic or professional and they felt dismissed and like the Registrant did not take Patient K's pain seriously. This was reported to the nursing staff overnight, and Patient K was reallocated to another nurse.

I apologised to Patient K's mum for the Registrant's behaviour, and reassured her that the complaint would be dealt with by the senior nursing team. I asked whether the care for the remainder of the night had been satisfactory (following reallocation) or if she had any other concerns she wanted to raise. She responded positively and said that they had been well cared for during the remainder of the shift and was happy with the care they received. Patient K's mum said she did not want to make a formal complaint, but wanted to raise this as she felt unhappy with the way the Registrant handled Patient K's care."

Witness 2 told the panel that she investigated this incident, however, she could not recall the conversation she had with Mr Sandy "very well".

The panel also considered Witness 6's record of a discussion with Mr Sandy:

"I then shared the complaint from a parent of a patient from the night of 13.11.2019. He was understandably shocked to learn of it as it had not been fed back to him at the time, and this was now weeks ago, I explained it was because he had been on annual leave and so had I. We discussed and reflected at length in a calm manner, he did not feel that the parents perception was accurate and felt he had not communicated in a way which could have been perceived in this way. I explained that this was concerning to me and I had to take it seriously in light of the complaint about his professional behaviour at his formal disciplinary meeting. I acknowledged this was be concerning and distressing for him following that experience. I asked if there was anything which may have influenced his manner or interactions that particular night, he could only guess that because the patient was low care in comparison to his other patients, he had not spent as much time with them and he had not gone back to reassess the child's pain following analgesia, possibly giving the impression he wasn't interested. I said I would take on board how he described all of his interactions."

The panel also considered Mr Sandy's account of the events as set out in his grievance documents:

"Then following a weeks leave from work I was called into [Witness 6]'s office for a catch up where she proceeded to advise me that they would be seeking further formal investigation as a parent requested that I was not their nurse. I had no knowledge of this incident prior to being called into the office. I had no chance to defend myself but feel in the job I do, I am a very visible member of the ward; that parents end I are going to clash from time to time. I fully admit that I am not perfect but this particular parent and I had discussed pain relief and the ladder to follow. I do not believe that I was unprofessional in any way when I suggested that her child, who was walking around the room, may not need pain relief at this time. I believe that I was professional in my conduct but mother disagreed with my assessment as is sometimes the case. The nurse in charge did not discuss this with me and I had no opportunity to rectify this

with the mother. Had this been another member of staff I am in no doubt that the matter would have been dealt with differently."

The panel had regard to the outcome of formal disciplinary hearing letter, dated 10 February 2020:

"You explained that your recollection of events was that at handover it was discussed that the patient had been in the ward for 2 days and the surgical team had not diagnosed appendicitis. The handover specifically informed the nursing team to actively discourage using Oromorph on the patient and to try other simple analgesia first…

On discussing medications you recall explaining to the mother about the triangle of medication and that the Oromorph could affect the abdomen (i.e. constipation) if the patient took for a long period of time. You felt you hadn't been dismissive with the mother or rude to the child and was only trying to advise that the patient should be using other pain medications prescribed first to manage her child's pain.

…You reiterated said you were just trying to explain the path of medication that should be taken."

In her oral evidence, Witness 8 told the panel that she was not aware of whether the nursing staff were told during the handover to discourage Patient K from using Oramorph. Witness 8 also could not recall whether she looked at Patient K's chart and whether he was due any pain relief.

The panel noted that no notes or prescriptions for Patient K were provided to it to demonstrate whether there was any pain relief due to Patient K during Mr Sandy's shift on 13 or 14 November 2019. The panel determined that as there was no evidence of a prescription before it, then it could not conclude that there was a duty on Mr Sandy to provide any pain relief despite a complaint from the child's parent.

The panel could not be satisfied there was sufficient evidence to find that Mr Sandy failed to provide any or any adequate pain relief for Patient K. It determined that the NMC has not discharged its burden of proof on the balance of probabilities in relation to this charge.

Therefore, the panel finds Charge 13a not proved.

Charge 13b(i) and 13b(ii)

"That you, a registered nurse:

13) On 13/14 November 2019 in relation to Patient K:

b) Stated that:

i. "he wouldn't be walking like that if he was in pain" or used similar words;

ii. "you just aren't getting it are you" or used similar words."

These sub-charges are found proved.

The panel heard the oral evidence of Witness 2 in relation to this incident and considered it to be clear and consistent with her witness statement dated 23 July 2021. Further to this, the panel also considered her evidence to be consistent with the contemporaneous evidence before it. Namely, Witness 2's email dated 14 November 2019, which was a record of the parent's complaint to her the day after. In particular, the panel noted that the email recorded:

"The first thing that the Registrant said when coming into see Patient K was that he "wouldn't be walking like that if he was in pain". The Registrant said this when he saw Patient K walking out of the bathroom;

When discussing Patient K's pain, the Registrant told Patient K's mum "you just aren't getting it are you?'"

The panel had regard to Mr Sandy's account of events set out in the grievance documents as follows:

> *"I do not believe I was unprofessional in any way when I suggested that her child, who was walking around the room, may not need pain relief at this time."*

The panel also had sight of the records of Witness 6's discussion with Mr Sandy on 10 February 2020:

> *"On discussing medications you recall explaining to the mother about the triangle of medication and that the Oromorph could affect the abdomen (i.e. constipation) if the patient took for a long period of time. You felt you hadn't been dismissive with the mother or rude to the child and was only trying to advise that the patient should be using other pain medications prescribed first to manage her child's pain."*

The panel determined that on the evidence before it, it was more likely than not that on 13 or 14 November 2019, Mr Sandy stated that *"he wouldn't be walking like that if he was in pain"* and *"you just aren't getting it are you"* or used similar words.

Therefore, the panel finds sub-charges 13b(i) and 13b(ii) proved.

Charge 14a

"That you, a registered nurse:

14) On or around 14 November 2019 in relation to Patient P failed to:

a) Notice Patient P's condition had deteriorated;"

This sub-charge is found proved.

The panel took into account Witness 2's oral evidence and witness statement. The panel also considered the email Witness 2 sent to Witness 6 on 14 November 2019, which outlined her concerns regarding to Patient P:

> *"I also had a concern regarding a patient in HDU Patient P that he was caring for. She was an asthmatic on optiflow 25l 60% on 2hrly nebs (previously had MGSO4). She was desaturating when I was at the desk and I had to increase the % to 70% to improve saturations, her chest had decreased air entry and some crackles, I advised him to give a further salbutamol and atrovent and [Dr 1] came to the ward and discussed and asked to review and said I was going to give further nebs and discussed my concerns re her chest sounds. As basically she had deteriorated overnight, he had said her chest was fine previously no wheeze. (No wheeze as so tight I feel with a 60% Oxygen requirement) anyway he reviewed decided she had got worse since he saw her and started her on burst and atrovent.*
>
> *I am just concerned that if I hadn't have been there reviewed her and escalated her care that he didn't realise she was as ill as she was and thought she was settled and scoring 1. …Maybe it was just a deterioration as I arrived but I don't think so really, she was under treated. I thought it should be raised in light of previous concerns re clinical decision making. I have documented in the nursing notes."*

The panel was of the view that this email was contemporaneous evidence as it was completed and sent shortly after the incident took place. The panel concluded that Witness 2's evidence was clear and consistent with the email sent on 14 November 2019. The panel found Witness 2 to be a credible witness.

The panel was satisfied that Mr Sandy was caring for Patient P on or around 14 November 2019. The panel determined that, on the balance of probabilities, it was more likely than not that on or around 14 November 2019, Mr Sandy failed to notice Patient P's condition had deteriorated.

Therefore, the panel finds Charge 14a proved.

Charge 14b

"That you, a registered nurse:

14) On or around 14 November 2019 in relation to Patient P failed to:

b) Take any or any adequate action in response to Patient P's monitor alarm being activated;"

This sub-charge is found proved.

The panel noted that Witness 2 was the nurse who attended to and took action in relation to Patient P when the monitor alarm repeatedly activated. It also referred to the evidence and its earlier findings in charge 14a above. Having found Charge 14a proved that Mr Sandy had failed to notice Patient P's condition had deteriorated, the panel was satisfied that it follows that Mr Sandy also failed to take action in response to Patient P's monitor alarm being activated.

The panel therefore finds sub-charge 14b proved.

Charge 14c

"That you, a registered nurse:

14) On or around 14 November 2019 in relation to Patient P failed to:

c) Escalate Patient P's condition to a doctor."

This sub-charge is found NOT proved.

The panel had regard to Witness 2's witness statement, in relation to this charge:

"…I also advised that we needed to discuss Patient P's condition with Dr 1.

Dr 1 came to the Ward and I explained my concerns about Patient P's chest sounds."

The panel noted that Witness 2 stated she advised Mr Sandy that Patient P's condition needed to be discussed with a doctor, and Dr 1 later came to the Ward. The panel carefully considered that Witness 2's evidence was not that Mr Sandy failed to escalate Patient P's condition to a doctor and she does not mention anything further in her evidence regarding a failure by him to escalate Patient P's condition to a doctor. On the contrary, Witness 2's evidence was that Patient P's condition was escalated to a doctor following the discovery that Patient P had deteriorated.

Therefore, the panel could not be satisfied there was sufficient evidence to find that Mr Sandy had failed to escalate Patient P's condition to a doctor. It determined that the NMC has not discharged its burden of proof on the balance of probabilities in relation to this charge.

Therefore, the panel finds sub-charge 14c not proved.

Charge 15a

"That you, a registered nurse:

15) On 24 May 2020 in relation to Patient M:

a) Failed to adhere to your supportive plan, namely not to care for mental health patients;"

This sub-charge is found proved.

The panel had regard to Witness 2's witness statement, where she outlined that Mr Sandy was put on a supportive plan when he returned to work and was working supernumerary around 17 February 2020:

"The Registrant returned to work on or around 17 February 2020, and I put in place a supportive plan for him to remain in place for four weeks from this date. This was designed to bring the Registrant back to clinical work gradually and to make sure that he was receiving the right amount of support from the nursing team. During this time, the Registrant worked shifts as a supernumerary.

As a part of this plan, the Registrant was told that he was not to look after mental health patients or patients in the HOU, and was also told that would not be supervising junior staff/student nurses. These restrictions were going to remain in place after the completion of the supportive plan and the Registrant was told they would be kept under review. The reason for this was that HOU and mental health patients can be quite complex, and we wanted the Registrant to be able to focus on improving his practice with patients with more simplistic needs first. The more complex patients would then be reintroduced into his workload as we thought he was ready to take these on.

On completion of the supportive period, I believe that the Registrant worked his first shift in a non-supernumerary role on 1 April 2020."

The panel had sight of the supportive plan put in place for Mr Sandy, which started on 17 February 2020 (Week 1) until 23 March 2020 (Week 4). It also stated that:

"Following supernumerary period Witness 2 advised both GS and B6 team not to allocate GS HDU/CAMHS (Mental Health) patients until reviewed and GS could not mentor/supervise Students/new starters."

The panel noted that Mr Sandy returned to working supernumerary in May 2020, as corroborated by the evidence of the nurse in charge, Ms 4, who stated:

"I did mention to the NIC that if GS wanted to look after the patient then he should have been allocated him, to which the NIC replied 'He isn't allowed to look after CAMHS patients'."

The panel noted that the incident in relation to Patient M happened on 24 May 2020, therefore Mr Sandy would have been working in a supernumerary role. In Witness 2's oral evidence, she told the panel that Mr Sandy never came off the supportive plan and that he would have been subject to it at the time of the incident. The panel was of the view that Witness 2's evidence was clear and consistent.

The panel considered Mr Sandy's response to a similar incident on 27 April 2020, as set out by Witness 6 in their record of discussions:

> *"I raised the point that you had been advised following a supernumerary period that you should not be caring for a patient requiring this type of care (mental health) you stated you were unaware of this. I advised that I had made this clear to you verbally on number of occasions and that the senior team were aware of this. You denied knowledge of this instruction and stated you were aware of this during your supernumerary period but indicated that you thought this was no longer the case following your return to usual practice."*

The panel found the evidence of Witness 2 and Witness 6 to be clear and consistent. It was satisfied that when this incident occurred on 24 May 2020, Mr Sandy would have been aware of the supportive plan and that he had to adhere to it, given that this was previously raised to him, including in April 2020. The panel determined that, on the balance of probabilities, it was more likely than not that on 24 May 2020, Mr Sandy failed to adhere to his supportive plan, namely not to care for mental health patients.

Therefore, the panel finds sub-charge 15a proved.

Charge 15b(i) and 15b(ii)

"That you, a registered nurse:

15) On 24 May 2020 in relation to Patient M:

b) Behaved inappropriately in that you:

i. Placed your hands across a doorway and/or prevented Patient M from leaving a room;
ii. Placed your hand on Patient M's shoulder;"

These sub-charges are found NOT proved.

The panel had regard to the witness statement and oral evidence of Witness 2 and Ms 2. It had sight of the email from Ms 2, where she stated her recollection of the events:

> *"On 24/05/2020 [Nurse 4] had a patient. [Nurse 4] was in the office typing up her notes for the patient. I was at the front desk when I heard raised voices from the bay containing beds 3-5. I went over to the bay entrance and saw [Mr Sandy]…standing in the door for the bathroom with his arm out stretched, blocking the doorway. was inside the bathroom and shouting that they wanted to see their mum. [Mr Sandy] was replying to in a raised voice. began to raise their voice even more so before punching a soap dispenser on the wall and attempting to leave the bathroom. [Mr Sandy] pushed back into the bathroom when they tried to leave, however I did not observe this to be done with force, it was just to guide back into the bathroom and to stop [Patient M] from leaving. I stopped observing [Mr Sandy] and went to speak to [Nurse 4], said that I did not think the way [Mr Sandy] was speaking to was appropriate and asked if she wanted me to swap positions with [Mr Sandy]. [Nurse 4] agreed so I went into the bay and said to shall we sit down and have a chat. agreed and was calm when talking to me. [Mr Sandy] came over and asked if hand was ok, said yes. [Mr Sandy] left the bay. Hand was red but no significant injury observed to the hand. I asked [Nurse 4] to come into the bay and check hand. When [Mr Sandy] left the bay told me that they did not like [Mr Sandy] as he had shouted at her and pushed her and made her angry."*

The panel also considered Mr Sandy's account of the incident as sent to Witness 2 by email dated 10 June 2020:

"All patient details have been removed to protect confidentiality.

I had very limited interaction with the patient in question. The student nurse and I witnessed destructive behaviour and the patient was expressing a wish to hurt himself.

As the patient was not to be left alone, myself and my colleague entered the room and followed him into the bathroom. He proceeded to punch a soap dispenser and was hitting his head off the walls. The patient was extremely loud, shouting and verbally aggressive. After he had hit the soap dispenser I asked to see his hand. I did raise my voice in response to his verbal aggression and advised the patient I would need to call security if his behaviour continued. Whilst looking at his hand I placed my hand on his shoulder to reassure him but this agitated him further. He liked and had a good rapport with the student nurse. He was calm enough to leave with her and so i removed myself from the situation.

About 30 mins later I went to check on the patient who was calm and he said he was in some pain. I administered paracetamol accordingly.

The shift ended with the patient and I on good terms. No mention of this incident was made by any of my colleagues and as such this is the first opportunity I have had to address any concerns that may have been raised."

The panel recognised that Mr Sandy admitted placing his hand on Patient M's shoulder. However, the panel also acknowledged that Mr Sandy says this was not confrontational nor done inappropriately.

The panel considered all the evidence placed before it but could not be satisfied there was sufficient evidence to find that Mr Sandy had behaved inappropriately by placing his hands on Patient M's shoulder or across a doorway and/or prevented Patient M from leaving a room. The panel was unable to test the hearsay evidence of Nurse 2 which was different in some material respects from Mr Sandy's account of the incident. The panel did not hear evidence from anyone who directly witnessed

the incident and as there was no other evidence that supported Nurse 2's account of events, it attached limited weight to her evidence. It determined that the NMC has not discharged its burden of proof on the balance of probabilities in relation to this charge.

Therefore, the panel finds sub-charges 15b(i) and 15b(ii) not proved.

Charge 15c

"That you, a registered nurse:

15) On 24 May 2020 in relation to Patient M:

c) Refused to administer pain relief;"

This sub-charge is found NOT proved.

The panel considered all the evidence placed before it. The panel concluded that there was no evidence before it to indicate that Mr Sandy, on 24 May 2020, refused to administer pain relief to Patient M. The evidence from Mr Sandy in his email dated 10 June 2020 is that he did administer paracetamol to Patient M about 30 minutes after the incident. The panel determined that the NMC has not discharged its burden of proof on the balance of probabilities in relation to this charge.

Therefore, the panel finds sub-charge 15c not proved.

Charge 15d)

"That you, a registered nurse:

15) On 24 May 2020 in relation to Patient M:

d) Became confrontational, namely by raising your voice;"

This sub-charge is found proved.

The panel referred to the evidence it considered in charges 15a and 15b. The panel particularly considered Mr Sandy's response to Witness 2 in the email dated 10 June 2020:

> "*The patient was extremely loud, shouting and verbally aggressive. After he had hit the soap dispenser I asked to see his hand. I did raise my voice in response to his verbal aggression and advised the patient I would need to call security if his behaviour continued. Whilst looking at his hand I placed my hand on his shoulder to reassure him but this agitated him further."*

The panel acknowledged that Mr Sandy admits to have *"raised his voice in response to [Patient M] verbal aggression".* The panel then considered whether this was confrontational and given the context that the patient was already agitated or shouting, a response of raising one's voice it considered this behaviour would be deemed confrontational. It considered that a nurse in this instance would be expected to aim to de-escalate the situation and attempt to calm the patient. The panel was of the view that a response of raising one's voice in this situation would be unlikely to achieve that and would be confrontational.

The panel determined that, on the balance of probabilities, it was more likely than not that on 24 May 2020, Mr Sandy became confrontational by raising his voice in response to Patient M.

Therefore, the panel finds sub-charge 15d proved.

Charge 15e

"That you, a registered nurse:

15) On 24 May 2020 in relation to Patient M:

e) In relation to Patient M said the following words or a gist of words that were similar:

i. *Patient M "wouldn't be walking like that if he was in pain";*
ii. *You "wouldn't be giving Oramorph because he can't go home if he'd had that";*
iii. *Patient M "couldn't have appendicitis…..he would be doubled up in pain if it was his appendix."*
iv. *In relation to Patient M's relative "you're just not getting it are you."*

These sub-charges are found NOT proved.

The panel considered all the evidence placed before it. The panel concluded that there was no evidence before it to indicate that Mr Sandy said the words listed on the charge above or words of similar effect to Patient M. It determined that the NMC has not discharged its burden of proof on the balance of probabilities in relation to this charge.

Therefore, the panel finds charge 15e not proved in its entirety.

The hearing resumed on 14 November 2023. The panel spent a day in camera concluding its decision on facts. The chair opened the hearing on 15 November 2023.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Sandy was not in attendance and that the Notice of Hearing letter had been sent to Mr Sandy's registered email address by secure email on 11 October 2023.

Ms Paisley, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor. He highlighted to the panel that the Notice of Hearing stated that Mr Sandy would be sent a link for him to join the hearing at least a day before the hearing was to resume on 14 November 2023.

However, this was not done until moments before the hearing actually resumed on 15 November 2023.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Sandy's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Sandy

The panel next considered whether it should proceed in the absence of Mr Sandy. It had regard to Rule 21 and heard the submissions of Ms Paisley. She informed the panel that the NMC had not received any correspondence from Mr Sandy since his email dated 22 December 2022. She reminded the panel that he stated that he had no plans to return as a nurse.

Ms Paisley also informed the panel that the NMC has telephoned Mr Sandy today and there has been no response. She submitted that Mr Sandy was aware of the hearing and there has been no correspondence from Mr Sandy requesting the link to join the hearing.

Ms Paisley submitted that Mr Sandy had chosen not to attend and invited the panel to continue in his absence.

The panel accepted the advice of the legal assessor.

The panel noted that it had a discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

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

The panel bore in mind that Mr Sandy has been served with notice of this hearing and that there has been no communication from him since December 2022 when he stated that he is no longer working as a nurse. There have been several attempts to contact him and the NMC has not received a response.

The panel noted that Mr Sandy has not asked for an adjournment of this hearing and there is no guarantee that adjourning would secure his attendance at a future date. It also bore in mind that there is a strong public interest in the expeditious disposal of the case.

The panel bore in mind that it finalised its decision on the facts today and resumed the virtual hearing in the afternoon. It was at this time the panel was informed that the Microsoft Teams link was not sent to Mr Sandy on Monday 13 November 2023 as per the Notice of Hearing.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Sandy today (Wednesday) for the limited purpose of handing down its decision on the facts. The panel will resume on Friday 17 November 2023 and directs that the Microsoft Teams link is sent to Mr Sandy, along with the determination on facts, before this date so that he has the opportunity to attend to make submissions on misconduct and impairment should he wish to do so.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so,

whether Mr Sandy's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

Submissions on misconduct

Ms Paisley referred the panel 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.'* She also referred the panel to the cases of *Calhaem v GMC [2007] EWHC 2006 (Admin)* and *Nandi v GMC [2004] EWHC 2317 (Admin)*

Ms Paisley invited the panel to take the view that the facts found proved amount to misconduct as Mr Sandy's actions fell below the standards expected of a registered nurse. She directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified where, in the NMC's view, Mr Sandy's actions amounted to misconduct.

With regard to charges 1a and 1b, Ms Paisely submitted the Mr Sandy's actions amounted to a serious failing, which other gave other registrants serious cause for concern.

With regard to charges 3a, 3b, 3c(i), 3c(ii) and 3c(iii), Ms Paisley submitted that Mr Sandy behaved in a manner that caused another registrant, Witness 4, serious concern and upset. She further submitted that the conduct fell far below that expected of a registered nurse and the way that patients should be treated with dignity and respect.

With regards to charge 4a, Ms Paisley submitted that the conduct found proved fell far short of what the parents of Patient G and fellow colleagues of Mr Sandy deemed to be appropriate and was not in line with proper standards. She submitted that the conduct caused the parent of Patient G to directly raise their concerns with senior staff on the ward.

With regard to charges 6a, 6b, 7b(i), 7b(ii), 8a, 8b, 9a, 9b and 9c Ms Paisley submitted that the charges found proved amount to a serious failing that caused real concern to a fellow registrant, Witness 11. She submitted that medication errors created the potential of risk of harm to patients, and documentation errors could mean that other registrants and practitioners providing care to a patient could miss information necessary to provide safe and effective care.

With regard to charges 10a, 10b, 10c and 11b, Ms Paisley submitted that Mr Sandy's actions amounted to serious failings which caused concern to his colleagues and also significantly undermined the trust of the parent of Patient I, and the parent's confidence to provide the correct feed to their child. She submitted that medication errors create the potential of risk to patients, and documentation errors could mean that other registrants and practitioners providing care to a patient could miss information necessary to provide safe and effective care.

With regard to charges 13b(i) and 13b(ii), Ms Paisley submitted that the conduct found proved fell far short of what the parents and fellow colleagues of the registrant deemed to be appropriate and in line with proper standards. She submitted that the conduct caused the parents of Patient K to directly raise their concerns with senior staff on the ward.

With regard to charges 14a and 14b, Ms Paisley submitted that Mr Sandy's actions amounted to serious failings which were observed by his colleague Witness 2 who expressed strong concerns about his care. She submitted that Mr Sandy's actions created the potential for risk of harm.

With regard to charges 15a and 15d, Ms Paisley submitted that Mr Sandy's actions amounted to a serious failure by operating outside of the restrictions put in place on

his practice, which were there for good reasons. She submitted that the aim was to bring him back to clinical work gradually and make sure he was getting the right support, and to assign him patients with more simplistic needs to improve his practice.

Submissions on impairment

Ms Paisley 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. She referred the panel to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) *and Cohen v GMC [2008] case of Cohen v General Medical Council [2008] EWHC 581 (Admin).*

Ms Paisley submitted that the first three limbs of *Grant* are engaged in this case.

Ms Paisley submitted that Mr Sandy has not engaged with the proceedings. She submitted that, as a result, there is a lack of insight, no evidence of remediation, and this means there is a risk of repetition. She submitted that the charges found proved occurred over a period of time, as opposed to one shift only and there were repeated failings on a number of different occasions.

Ms Paisley submitted that the panel should consider whether any of the actions of Mr Sandy are an attitudinal problem, and whether such problems are, in fact, capable of remediation.

Ms Paisley submitted that the panel must consider both public protection and public interest. She submitted that the charges found proven are serious and invited the panel to find that Mr Sandy's current fitness to practice is impaired.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognise diversity and individual choice

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.3 encourage and empower people to share in decisions about their treatment and care

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5 respect, support and document a person's right to accept or refuse care and treatment

2.6 recognise when people are anxious or in distress and respond compassionately and politely

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues…

8.2 maintain effective communication with colleagues

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

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

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

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

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

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

To achieve this, you must:

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

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

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

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

With regards to charges 1a and 1b, the panel bore in mind that Witness 11 stated: *"Each stage of the blood transfusion process is associated with risks that can lead to patient morbidity or mortality, which is why there is a very rigorous policy and procedure in place for blood transfusions which sets out a systematic process on how these are carried out."*

The panel noted the standards expected which were set out in the Hospital's policy and heard from witnesses about the procedure that should have been followed. Mr Sandy as an experienced nurse would have undergone training on blood transfusion administration and should have been aware that a prescription for a blood transfusion was required to be signed by a doctor. Mr Sandy failed to follow the Hospital's policy, completed a prescription without authority and failed to clarify any concerns he had regarding the prescription with his colleagues.

The panel bore in mind that Witness 11 also stated:

> *"The further concern was the Registrant's response to the incident. From the information I was given by the Deputy Sister involved and by the Ward Manager at the time, the Registrant had initially dismissed the Witness 3's (as second checker) concerns, and hadn't appreciated the serious risk involved in the incident."*

Witness 3 in her oral evidence stated that she was shocked that this had happened as it had never happened before. The panel was of the view that Mr Sandy's actions were serious as he would have known that this was not in accordance with policy or good practice. Additionally, his actions could have caused serious harm to Patient C.

In light of the above, the panel considered Mr Sandy's actions fell significantly short of the conduct and standards expected of a registered nurse and were serious departures from the Code, amounting to serious misconduct.

With regards to charges 3a, 3b, 3c(i), 3c(ii) and 3c(iii), the panel was of the view that this amounted to serious misconduct. It considered how Mr Sandy's behaviour affected Patient F, Patient F's parent and Witness 4 another registered nurse caring for Patient F at the relevant time. The panel noted that Witness 4 expressed serious concern about Mr Sandy's conduct, lack of care and compassion regarding Patient F. Witness 4 stated that Mr Sandy's manner, tone and aggression had upset her, Patient F and his mother. The panel noted that when Witness 4 sought to discuss his behaviour, Mr Sandy was dismissive and failed to engage with her appropriately and disagreed that his behaviour was inappropriate.

The panel also bore in mind that Mr Sandy is a paediatric nurse and found that the conduct proved in charge 3 is particularly inappropriate considering he is treating children.

The panel noted that the Trust's expected behaviours of a registered nurse are to be kind, friendly, respectful, compassionate, professional and that they work as a team. Further, the Trust's "above and below the line" policy speaks to the expected standards of behaviours and specifies which behaviours would fall below the line. In the panel's view, Mr Sandy's inappropriate behaviour towards Patient F and his reaction to Witness 4 fell below that line.

In light of the above, the panel considered Mr Sandy's actions fell significantly short of the conduct and standards expected of a registered nurse and were serious departures from the Code, amounting to serious misconduct.

With regards to charge 4a, the panel was of the view this amounted to misconduct. It considered that nurses are expected to be compassionate, caring and understanding and Mr Sandy speaking to Patient G, a child, in an abrupt manner is not what is expected of a registered nurse.

The panel bore in mind that Mr Sandy's actions caused the parent of Patient G to directly raise their concerns with senior staff on the ward. It took account of Witness 6's witness statement which stated:

"*Both of these reports related to complaints of the Registrant overstepping the boundaries of his nursing role. In this case, he was being described as crossing the line between nursing and stepping into the role of parent. What was described to me was very much that the Registrant was chastising and disciplining [Patient G].*"

The panel was of the view that Mr Sandy's actions fell short of what the parent of Patient G and fellow colleagues deemed to be appropriate.

In light of the above, the panel considered Mr Sandy's actions fell significantly short of the conduct and standards expected of a registered nurse and were serious departures from the Code, amounting to serious misconduct.

With regard to charges 6a and 6b, the panel noted that Mr Sandy had failed to provide prescribed anti-seizure medication to Patient J who was a child. It also bore in mind that Witness 11 stated that Mr Sandy's failure to administer this medication could have increased the risk of seizures for Patient J. The panel noted that this was particularly serious because it is unlikely that a child would be able to tell a practitioner that they have not been administered their medication. Therefore, Patient J was particularly vulnerable.

With regards to charge 7b)i) and 7b)ii) the panel noted that after failing to administer the medications to Patient J, Mr Sandy also failed to document this so on Patient J's prescription chart which was contrary to the instructions on the prescription chart. The panel was of the view that this could have caused confusion for his colleagues.

With regards to charge 8a, 8b, 9a, 9b and 9c the panel found that Mr Sandy, rather than take responsibility for medication administration errors, he maintained that he had entered the incorrect times on Patient J's prescription chart which misrepresented what he had done. The panel was of the view that this created a false impression which could mean that other registered nurses and practitioners providing care to Patient J were missing necessary information to provide safe and effective care.

The panel considered that the charges found proved in relation to Patient J individually, and collectively, amounted to misconduct and were serious departures from the standards expected of a registered nurse. The panel considered that Mr Sandy had the opportunity to correct his medication administration and documentation errors, however, he did not do this and sought to implicate colleagues, in particular Witness 7 in covering up his errors.

With regard to charges 10a, 10b and 10c the panel was of the view that this amounted to serious misconduct. Mr Sandy failed to provide the father of Patient I, a very young child, with the correct feed of Infatrini Peptisorb. It also bore in mind that the father queried this in an attempt to ensure that the feed was correct. The panel noted that from the witness evidence that Mr Sandy should have taken further steps to ensure that the feed was correct. Instead, Mr Sandy did not take adequate action and, in addition, failed to sign Patient I's prescription chart. In the panel's view, Mr Sandy's failures undermined the trust and confidence the parents had in him when providing care to Patient I.

The panel also bore in mind that Witness 11 informed the panel that Patient I became ill. She stated:

> *"As a result of the Registrant's actions, Patient I's Dad administered the wrong feed to Patient I. I recall that Patient I's Dad was feeling really guilty over giving his baby the wrong feed, which led to a significant clinical deterioration."*

The panel considered the impact Mr Sandy's actions had on the parents and Patient I as providing the incorrect feed caused actual harm to Patient I.

With regards to charge 11b, the panel determined that this was serious misconduct. Mr Sandy failed to take full responsibility for his own actions by seeking to blame another healthcare practitioner.

The panel was of the view that medication errors create the potential of risk to patients, and documentation errors could mean that other registered nurses and practitioners providing care to Patient I would not have had the information necessary to provide safe and effective care.

The panel was satisfied that individually and collectively, in respect of charges 10 and 11, Mr Sandy's actions fell short of the conduct and standards expected of a registered nurse and were serious departures from the Code, amounting to misconduct.

With regards to charges 13b(i) and 13b(ii), the panel determined that this amounted to serious misconduct. It bore in mind that Witness 2 in oral evidence stated that the parent of Patient K was really upset about the care their child had received and also did not feel like they were being listened to. The panel determined that Mr Sandy did not provide care in a kind or compassionate way, rather he was inappropriate and insensitive by making the comments he did. The panel determined that Mr Sandy's conduct fell short of the conduct and standards expected of a registered nurse and were serious departures from the Code, amounting to misconduct.

The panel again had regard to the Trust's policy on expected behaviours. The panel was also of the view that Mr Sandy's conduct regarding Patient K breached the Trust's policy which included to be kind, friendly, respectful, compassionate and professional.

In light of the above, the panel considered Mr Sandy's actions fell significantly short of the conduct and standards expected of a registered nurse and were serious departures from the Code, amounting to serious misconduct.

With regard to charges 14a and 14b, the panel was not satisfied that this amounted to misconduct. It took account of the evidence of Witness 2 who stated:

> *"I considered whether Patient P had just deteriorated just as I arrived at the nurses' desk, but I do not feel that this was the case and felt that she was undertreated by [Mr Sandy] and medical team. The reason for this is that I*

listened to Patient P's chest, her chest was quite quiet and I could not hear the air going in and out. It is easy to mistake this to mean that everything is okay, but really what it means is that the patient's chest is so tight at the entry is significantly reduced."

The panel noted that Witness 2's opinion was that both Mr Sandy and the medical team had undertreated Patient P and that the presentation of symptoms had been missed.

The panel also bore in mind that Witness 2 acknowledged that Mr Sandy came from the other end of the ward and that he may have been caring for another patient at the time she noticed that Patient P's condition was deteriorating. She further stated that Mr Sandy may not have been experienced enough to recognise the symptoms of Patient P and that a nurse that was not experienced in this area of practice may not have identified that Patient P's condition was deteriorating.

In light of the above, the panel was not satisfied that Mr Sandy's conduct fell below the standards required of a registered nurse in the circumstances and therefore his conduct set out in charges 14a and 14b did not amount to misconduct.

With regards to charge 15a, the panel was satisfied that Mr Sandy's failure to adhere to the supportive plan amounted to serious misconduct. It was of the view that Mr Sandy would have been aware of the supportive plan which meant he was not supposed to care for a child who was receiving care from Child and Adolescent Mental Health Services (CAMHS). Additionally, Nurse 4 in her witness statement stated:

"I was increasing frustrated as [Mr Sandy] had tried to get involved with my patient care throughout the day, I hadn't asked for his help at all, and didn't require any assistance from him, as my senior was the NIC. I did mention to the NIC that if GS wanted to look after the patient then he should have been allocated him, to which the NIC replied 'He isn't allowed to look after CAMHS patients"

In the panel's view Mr Sandy had inappropriately stepped in to assist in caring for a "CAMHS" patient which was a departure from his support plan. This plan had been put in place to minimise risk and support Mr Sandy's return to full and unrestricted practice.

In light of the above, the panel considered Mr Sandy's actions fell significantly short of the conduct and standards expected of a registered nurse and were serious departures from the Code, amounting to serious misconduct.

With regards to charge 15d, the panel was satisfied that this amounted to serious misconduct. The panel was of the view that a standard of professionalism is expected of registered nurses. Nurses should remain calm and not become confrontational in challenging situation. Mr Sandy's behaviour did not adhere to that standard.

The panel again had regard to the Trust's policy on expected behaviours. The panel was also of the view that Mr Sandy's conduct regarding Patient M breached the Trust's policy which included to be kind, friendly, respectful, compassionate and professional.

In light of the above, the panel considered Mr Sandy's actions fell significantly short of the conduct and standards expected of a registered nurse and were serious departures from the Code, amounting to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

For reasons already set out above in relation to misconduct, the panel determined that limbs a, b and c were engaged by Mr Sandy's misconduct.

The panel considered that Patient C, Patient J and Patient M were all put at risk of harm as a result of Mr Sandy's misconduct.

The panel also considered that Patient I suffered actual harm as a result of Mr Sandy's misconduct. The panel noted that these patients were all children and were particularly vulnerable.

The panel determined that Mr Sandy's conduct breached multiple parts of the Code and also breached fundamental tenets of the nursing profession. In particular the panel considered that there were serious failures by Mr Sandy to treat people with kindness and compassion. Additionally, the panel considered Mr Sandy's unprofessional behaviour towards patients, their parents and colleagues brought the nursing profession's reputation into disrepute.

The panel recognised that it must make an assessment of Mr Sandy's fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether Mr Sandy would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether Mr Sandy had provided evidence of insight and remorse.

Regarding insight, the panel noted that there is some evidence of limited remorse and acceptance of responsibility by Mr Sandy for some of the concerns raised during the initial investigation at local level. However, the panel noted that since December 2022, Mr Sandy has not engaged with the NMC process or this hearing. And, he has

not provided any evidence of insight and remorse to this panel to address the misconduct found proved.

The panel considered that there was little recognition by Mr Sandy of the impact his misconduct had on patients, their families, colleagues and the nursing profession. Additionally, the panel had no reflective statement to demonstrate how he would approach similar circumstances in the future.

In light of the above, the panel determined that Mr Sandy had demonstrated minimal insight into his misconduct.

The panel considered whether the misconduct found in this case was capable of being addressed. It bore in mind that aspects of Mr Sandy's misconduct pertained to his behaviour towards patients, who were children, and their parents where he had not acted in a kind and compassionate manner. Further, there were concerns from his fellow registrant colleagues about how he had overstepped professional boundaries as well as falsifying patient records.

The panel considered that the misconduct was capable of being remediated and went on to consider whether in fact it had been.

The panel bore in mind that Mr Sandy had, at times, refused to take responsibility for his actions and on occasions had sought to deflect blame onto his colleagues. It noted that there were concerns regarding Mr Sandy's ability to work cooperatively with colleagues and accept and reflect on feedback provided by colleagues. It was therefore concerned that there were indications of underlying attitudinal concerns at the relevant time.

The panel noted that it had no evidence before it to demonstrate any steps Mr Sandy had taken to strengthen his practice and remediate the concerns identified.

The panel bore in mind that the misconduct took place over a significant period of time, namely from December 2018 and from August 2019 to May 2020. It noted that the misconduct found proved related to multiple incidents and patients. Mr Sandy's

misconduct as a paediatric nurse involved young, vulnerable patients, their parents and colleagues. Additionally, the panel was concerned that his misconduct demonstrates that he failed to be candid and transparent when things went wrong.

As a result of the number and nature of the concerns over a significant period of time and Mr Sandy's lack of insight and lack of evidence of strengthened practice, the panel was of the view that there remains a high risk of repetition of the misconduct found proved. The panel therefore determined 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 was satisfied that, having regard to the nature of the misconduct in this case, *"the need to uphold proper professional standards and public confidence in the profession would be undermined"* the public would be concerned if a finding of current impairment were not made. It was of the view that a reasonable and well informed member of the public would be very concerned if Mr Sandy's fitness to practise were not found to be impaired on public interest grounds.

In light of the above, the panel determined that a finding of impairment on public interest grounds is required. Having regard to all of the above, the panel was satisfied that Mr Sandy's 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 6 months with a review. The effect of this order is that the NMC register will show that Mr Sandy's registration has been suspended.

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

Submissions on sanction

Ms Paisley submitted that the appropriate sanction in this case is a conditions of practice order for a period of 12 months, with a review. She submitted that the case is too serious to take no further action or impose a caution order.

Ms Paisley submitted that there are workable conditions that would both protect the public and address the public interest concerns. She submitted that there remains a risk of repetition, which could be addressed by a conditions of practice order. She provided the panel with some conditions for its consideration.

Ms Paisley submitted that this case is not so serious as to warrant a suspension order.

In response to panel questions, Ms Paisly submitted that while Mr Sandy is not currently practising, he could choose to go back into practice. She submitted that conditions of practice would be workable should he choose return to practice.

Ms Paisley also provided the panel with the aggravating and mitigating factors which she said applied in this case.

Decision and reasons on sanction

Having found Mr Sandy's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Mr Sandy's misconduct was repeated over a period of time and involved multiple patients who were young and vulnerable;
- Mr Sandy demonstrated only minimal insight into failings at local level;
- Mr Sandy's conduct caused actual harm to one patient and placed other patients at risk of suffering harm;
- Mr Sandy failed to acknowledge his shortcomings.

The panel also took into account the following mitigating features:

- [PRIVATE];
- Positive feedback about Mr Sandy's practice as a registered nurse from witness evidence including from his line manager and ward manager;
- Mr Sandy accepted some responsibility at local level.

Before the panel considered what sanction to impose, it bore in mind evidence it heard from witnesses where they provided details of Mr Sandy's personal mitigation and provided positive feedback in relation to his practice as a nurse.

Witness 6, Mr Sandy's ward manager, stated that he did forge some really good relationships with patients, and children in his care. She stated that he was seen very positively by a lot of families, and for some families his approach was *"really good, positive, and therapeutic"*. However, she said that for other families it was not so positive.

Witness 1, Mr Sandy's line manager for some of the relevant period, stated that Mr Sandy *"[PRIVATE]"* She further stated that *"he sometimes came across frustrated and angry and sometimes brought that into work. He always turned up for shifts, never took any time off and was willing to swap shifts and help out. He was a very supportive colleague."*

The panel kept this at the forefront of its mind as it considered what sanction it should impose.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Sandy's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Sandy's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing a conditions of practice order on Mr Sandy's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel noted that it could identify areas of Mr Sandy's practice that could be addressed through retraining. It bore in mind that there were incidents in relation to medication administration management, record keeping and prescribing for a blood transfusion. It was of the view that workable conditions could be formulated to address these shortcomings.

However, the panel considered that a number of charges found proved relate to Mr Sandy's behaviour and how he had interacted with the patients, their relatives and colleagues. In the panel's view this was not evidence of a deep-seated attitudinal problem but did indicate poor practise by him. It bore in mind that when Mr Sandy was faced with challenging circumstances with young patients, his attitude had not always been kind, compassionate or caring. Additionally, the panel noted that there were occasions where Mr Sandy did not accept responsibility for his action and sought to deflect responsibility onto other colleagues.

The panel was of the view that it would be difficult to formulate conditions to address the behavioural concerns and his lack of kindness and unprofessionalism. Particularly without evidence or engagement from Mr Sandy to understand whether or to what extent any personal challenges he was experiencing at the relevant time played a part in his misconduct.

The panel considered that if Mr Sandy had engaged with the hearing, and provided evidence of insight, remorse, remediation, and demonstrated how he would act differently in the future, then a conditions of practice order may have been appropriate. However, without this, the panel is of the view that there are no practical or workable conditions that could be formulated to address all of the concerns identified by the panel that would protect patients.

The panel concluded that the placing of a conditions of practice order on Mr Sandy's registration would not therefore adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. It took account of the NMC guidance entitled "Suspension Order" and particularly noted the following:

> *"When considering seriousness, the Fitness to Practise Committee will look at how far the nurse, midwife or nursing associate fell short of the standards expected of them. It will consider the risks to patients and to the other factors above, and any other particular factors it considers relevant on each case."*

The panel also took account of the SG which states that a suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *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;*

The panel noted that the misconduct found in this case was not a single incident. It was repeated over a significant period of time. The panel also identified indications of underlying attitudinal concerns.

The panel also reminded itself that Mr Sandy had informed the NMC that he is no longer practising as a registered nurse. Therefore, it does not have any evidence of repetition of the behaviour since the incidents. However, it did find that Mr Sandy had minimal insight and as a result, the panel deemed the risk of repetition of his behaviour to be high.

The panel determined that a suspension order would be a sufficient, appropriate and proportionate sanction to mark the seriousness of Mr Sandy's misconduct.

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

The panel heard evidence from witnesses, namely his ward manager and line manager during the relevant period, stating that notwithstanding the incidents that led to the charges, Mr Sandy was a good, caring and compassionate nurse. The witnesses also stated that, during the relevant time, Mr Sandy [PRIVATE] did not always demonstrate the values and tenets of the nursing profession.

Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Sandy's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order is the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Mr Sandy. 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 6 months is appropriate in this case to mark the seriousness of the misconduct. The panel was of the view that this period would allow Mr Sandy the opportunity to address the concerns in this case and provide evidence of insight, remorse and strengthened practice.

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

Any future panel reviewing this case would be assisted by:

- Mr Sandy's engagement with NMC and his attendance at the review hearing;
- A comprehensive reflective piece addressing the impact his unprofessional behaviour had on patients, their families, colleagues and the nursing profession;
- References and testimonials from any work undertaken whether it be paid or voluntary;
- Evidence of Mr Sandy keeping his clinical knowledge up to date;
- Mr Sandy's stated intention regarding his future in the nursing profession.

This decision will be confirmed to Mr Sandy 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 Mr Sandy's own interests 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 Paisley. She submitted that an interim order should be made in order to allow for the possibility of an appeal to be made and determined. She submitted that an interim suspension order for a period of 18 months should be made 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 order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. Not to impose a suspension order would be inconsistent with the panel's decision in this matter. The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.