Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
13 – 20 February 2023

Virtual Hearing

Name of registrant:	**Emanuele Natale**
NMC PIN:	14G0241C
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing: Level 1 – 4 July 2014
Relevant Location:	Salford & Stockport Metropolitan
Type of case:	Misconduct
Panel members:	Des McMorrow (Chair, Registrant member) Tracey Chamberlain (Registrant member) Richard Bayly (Lay member)
Legal Assessor:	James Holdsworth
Hearings Coordinator:	Jumu Ahmed
Nursing and Midwifery Council:	Represented by Dominic Bardill, Case Presenter
Mr Natale:	Present and represented by Justin Yang (Crucible Law)
Facts proved by admission:	Charges 1(a)(i), 1(a)(ii), 1(b), 1(c), 1(d), 1(e), 2(a), 3(a)(i), 3(a)(ii), 3(a)(iii), 3(b), 3(c), 4(a)(i), 4(a)(ii), 4(a)(iii), 4(b), 4(c), 5(a)(i), 5(a)(ii), 5(a)(iii), 5(a)(iv), 5(b), 5(c), 6(a), 6(b), 6(c), 7(a), 8(a), 8(b), 8(c), 9, 10(a)(i), 10(a)(ii), 10(a)(iii), 10(b), 10(c), 10(d), 10(e), 10(f), 11(a), 11(b), 11(c), 11(d), 12(a), 12(b), 12(c), 12(d), 12(e), 13(a), 13(b), 13(c), 13(d), 13(e), 13(f), 13(g), 13(h), 13(i), 14(a), 14(b), 14(c), 14(d), 14(e), 15(a), 15(b), 15(c), 15(d), 15(e), 15(f), 16(a), 16(b), 16(c), 16(d),

	17(a), 17(b), 17(c), 18, 19(a), 19(b), 19(c), 19(d), 19(e), 20, 21(a), 21(b), 22, 23(a), 23(b), 23(c), 23(d), 23(e), 23(f), 24(a), 24(b), 24(c), 24(d), 24(e), 24(f), 24(g), 25(a), 25(b), 25(c) 25(d)
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

On 20 July 2019;

1. In respect of Patients A-H;

    a. Failed to complete accurate nursing evaluations, in that you;
        i. Did not record patient-specific evaluations;
        ii. Entered the same evaluations for all patients under your care on 20 July 2019;
    b. Your conduct at charge 1a was dishonest in that you intended for anyone reading the patients' nursing evaluations to believe that you had carried out accurate nursing evaluations;
    c. Failed to carry out intentional roundings at 16:00;
    d. Recorded that you had carried out intentional roundings at 16:00 when you had not;
    e. Your conduct at charge 1d was dishonest in that you intended for anyone reading the patient's roundings chart to believe that you had carried out the intentional roundings;

2. In respect of Patient A;

    a. Failed to check the effectiveness of pain relief that had been administered to the patient;

3. In respect of Patient B;

    a. Failed to administer;
        i. Gabapentin;

ii. Tinzarapin;
iii. Paracetamol;

b. Signed the patient's MAR chart to indicate that you had administered the medication at charge 3a;
c. Your conduct at charge 3b was dishonest in that you intended for anyone reading the patient's MAR chart to believe that you had administered the medication at charge 3a;

4. In respect of Patient C;

a. Failed to administer;
i. Metformin;
ii. Tinzarapin;
iii. Paracetamol;
b. Signed the patient's MAR chart to indicate that you had administered the medication at charge 4a;
c. Your conduct at charge 4b was dishonest in that you intended for anyone reading the patient's MAR chart to believe that you had administered the medication at charge 4a;

5. In respect of Patient D;

a. Failed to administer;
i. Oramorph;
ii. Tinzarapin;
iii. Gabapentin;
iv. Glicazide;
b. Signed the patient's MAR chart to indicate that you had administered the medication at charge 5a;

c. Your conduct at charge 5b was dishonest in that you intended for anyone reading the patient's MAR chart to believe that you had administered the medication at charge 5a;

6. In respect of Patient E;

a. Failed to carry out observations when the patient returned from surgery;
b. Recorded that you had carried out observations at 14:54, when the patient was undergoing surgery;
c. Your conduct at 6b was dishonest in that you intended for anyone reading the patient's records to believe that you had carried out observations;

7. In respect of Patient F;

a. Failed to administer or record the administration of 'Ensure' (a build-up drink);

8. In respect of Patient H;

a. Failed to administer Oxycodone;
b. Signed the patient's MAR chart to indicate that you had administered the Oxycodone;
c. Your conduct at charge 8b was dishonest in that you intended for anyone reading the patient's MAR chart to believe that you had administered the Oxycodone;

On or around 18 July 2019;

9. Left Tramadol, a controlled drug, unattended;

On 3 August 2019;

10. In respect of Patient I;

    a. Failed to complete;
        i. observations;
        ii. Intentional roundings at 08:00;
        iii. Patient-specific nursing evaluations;
    b. Your conduct at charge 10aiii was dishonest in that you intended for anyone reading the patient's nursing evaluations to believe that you had carried out accurate nursing evaluations;
    c. At 10:57, recorded in the nursing evaluation that you had completed intentional roundings when you had not;
    d. Your conduct at charge 10c was dishonest in that you intended for anyone reading the nursing evaluation to believe that you had carried out the intentional roundings;
    e. Told Colleague 1 that you had completed the patient's observations when you had not;
    f. Your conduct at charge 10e was dishonest in that you intended for Colleague 1 to believe you had completed the patient's observations when you had not;

11. In respect of Patient J;

    a. Failed to complete the patient's intentional roundings;
    b. At 10:58, recorded in the nursing evaluation that you had completed intentional roundings when you had not;
    c. Your conduct at charge 11b was dishonest in that you intended for anyone reading the nursing evaluation to believe that you had carried out the intentional roundings;
    d. Failed to check the patient's discharge summary and 'to take out' medication when discharging them;

12. In respect of Patient K;

    a. Failed to complete patient-specific nursing evaluations, in that you recorded the patient, who was immobile, was;
        i. Independently mobile;
        ii. Maintaining their own pressure sores;
        iii. Passing urine in the toilet;
    b. Your conduct at charge 12a was dishonest in that you intended for anyone reading the patient's nursing evaluations to believe that you had carried out accurate nursing evaluations;
    c. Failed to carry out observations;
    d. Recorded that you had carried out the patient's observations;
    e. Your conduct at charge 12d was dishonest in that you intended for anyone reading the patient's observations to believe that you had carried out the observations;

13. In respect of Patient L;

    a. Failed to carry out observations;
    b. Recorded that you had carried out the patient's observations;
    c. Your conduct at charge 13b was dishonest in that you intended for anyone reading the patient's observations to believe that you had carried out the observations;
    d. Failed to record that the patient was being looked after by a different ward;
    e. Failed to complete patient-specific nursing evaluations, in that you failed to document the patient's;
        i. Stoma;
        ii. High heartrate;

f. Your conduct at charge 13e was dishonest in that you intended for anyone reading the patient's nursing evaluations to believe that you had carried out accurate nursing evaluations;
g. Failed to carry out intentional roundings at 08:00 and/or 12:00;
h. Recorded in the nursing evaluations that you had carried out the intentional roundings;
i. Your conduct at charge 13h was dishonest in that you intended for anyone reading the nursing evaluation to believe that you had carried out the intentional roundings;

14. In respect of Patient M;

a. Failed to complete patient-specific nursing evaluations, in that you recorded that the patient was eating and drinking well when they were on IV fluids and IV nutrition feeding;
b. Your conduct at charge 14a was dishonest in that you intended for anyone reading the patient's nursing evaluations to believe that you had carried out accurate nursing evaluations;
c. Failed to carry out intentional roundings at 12:00;
d. Recorded in the nursing evaluations that you had carried out the intentional roundings;
e. Your conduct at charge 14e was dishonest in that you intended for anyone reading the nursing evaluation to believe that you had carried out the intentional roundings;

15. In respect of Patient N;

a. Failed to carry out observations;
b. Recorded that you had carried out the patient's observations;

c. Your conduct at charge 15b was dishonest in that you intended for anyone reading the patient's observations to believe that you had carried out the observations;
d. Failed to carry out intentional roundings at 08:00 and/or 12:00;
e. Recorded in the nursing evaluations that you had carried out the intentional roundings;
f. Your conduct at charge 15e was dishonest in that you intended for anyone reading the nursing evaluation to believe that you had carried out the intentional roundings;

16. In respect of Patient O;

a. Failed to carry out observations;
b. Recorded that you had carried out the patient's observations;
c. Your conduct at charge 16b was dishonest in that you intended for anyone reading the patient's observations to believe that you had carried out the observations;
d. Failed to document that the patient was reacting negatively to antibiotics;

17. Attempted to spike a bottle of paracetamol in an unsafe manner, in that you;

a. Had not washed your hands;
b. Were not wearing gloves;
c. Were not wearing an apron;

18. At approximately 17:00, asked Colleague 1 to co-check the administration of Methadone to a patient that had received Methadone at 15:20 when Methadone can only be administered every 3 hours at most;

On 21 July 2020;

19. In respect of Patient P;

    a. Failed to carry out observations;
    b. Recorded that you had carried out at 17:00 when you had not;
    c. Your conduct at charge 19b was dishonest in that you intended for anyone reading the patient's records to believe you had carried out observations at 17:00 when you had not;
    d. Failed to record the patient's urine output at 19:00 and/or 20:00;
    e. Failed to record the patient's blood pressure at 16:00 and/or 19:00 and/or 20:00;

On 25 August 2020;

20. Mistakenly recorded in the controlled drugs book that you administered 10mg of Tramadol when you administered 50mg of Tramadol;

On 8 September 2020;

21. Asked Colleague 2 if you could administer codeine to an unknown patient;

    a. When said unknown patient was not on codeine;
    b. Whilst referring to the wrong patient's drug chart;

On or around 9 September 2020;

22. Failed to turn off an unknown patient's pacing box despite having been told to do so by the Cardiac Resident Medical Officer;

On 9 September 2020;

23. In respect of Patient Q;

a. Failed to put an identifying sticker and/or write identifying details on the patient's NEWS chart;
b. Failed to tidy away a finished syringe driver infusion;
c. Failed to carry out observations;
d. Gave a handover stating that you had completed the patient's observations;
e. Recorded the patient's blood pressure observations on their NEWS chart;
f. Your conduct at charges 23d and/or 23e was dishonest in that you intended for others to believe that you had carried out observations on the patient when you had not;

On 15 September 2020;

24. In respect of Patient R;

a. Failed to carry out observations;
b. Recorded that you had completed the patient's observations on their NEWS chart;
c. Your conduct at charge 24b was dishonest in that you intended for anyone reading the patient's NEWS chart to believe that you had carried out the observations when you had not;
d. Failed to monitor the patient's urine;
e. Failed to measure the amount of fluid in the patient's drain;
f. Recorded that you gave the patient medication at 18:00 when it was given by Colleague 3;
g. Your conduct at charge 24f was dishonest in that you intended for anyone reading the patient's notes to believe you had administered their medication at 18:00 when you had not;

25. In respect of Patient S;

a. Failed to connect the patient to the telemetry box despite having been told to do so by Colleague 3;
b. Failed to carry out observations at 11:00;
c. Recorded on the patient's NEWS chart that you had carried out observations at 11:00;
d. Your conduct at charge 25c was dishonest in that you intended for anyone reading the patient's NEWS chart to believe that you had carried out observations when you had not;

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

Background

You were referred to the NMC on 19 November 2019 by the Assistant Director of Nursing for Surgery and Orthopaedics, at Salford Royal Hospitals NHS Foundation Trust ('the Trust') where you commenced employment in January 2019.

20 July 2019

On 20 July 2019, you were working in a shift at the Trust and in the afternoon you were moved to work on Ward H4, a mixed-sex, post-surgical and short-stay ward in the Trust. You were responsible to care for eight patients in Bay 16 and in Side Rooms 1-4. During your shift, the following concerns were raised in relation to your clinical practice:

- You failed to check the effectiveness of previously administered pain relief for Patient A.
- You did not administer Gabapentin, a Controlled Drug ('CD'), Paracetamol and Tinzarapin to Patient B.
- All of the patients whom you were responsible for had the same evaluations.

recorded.

- You did not make any entries in the CD log book to indicate that Gabapentin was not given to Patient B. However, in Patient B's Medication Administration Record ('MAR') chart, you had signed all their medication as being administered, which was dishonest.
- Patient C did not receive Tinzarapin, Paracetamol and Metformin. You also informed a colleague that everything was in place for Patient C's discharge at the handover. However, TTOs require pharmacist to prepare, and discharge also requires the doctor's discharge summary. This was not done, and the medications had not been sent to the pharmacy for checking. Patient C had to pass urine naturally before discharge, trial without catheter (TWOC). You reported this to a colleague during your verbal handover, but did not record it in the nursing evaluation.
- You failed to administer Oramorph, Gabapentin, Glicazide and Tinzarapin to Patient D. You did not make any entries in the CD log book regarding the administration of Gabapentin. However, in Patient D's MAR chart, you recorded that you had administered all their medication, which was dishonest. You recorded that Patient D was comfortable, did not request pain relief and did not identify further issues, but the Patient D scored 3 on pain score, meaning "severe pain", which would necessitate pain relief.
- You did not carry out observations for Patient E in Side Room 1, post-surgery. You recorded observations at 14.54 when the patient was undergoing surgery.
- Patient F in Side Room 2 received Tinzaparin, but you failed to sign to say whether or not they administered "Ensure" (a build-up drink). You also suggested that the patient was eating and drinking well, when they were receiving IV fluids and had an NG tube. You also recorded the patient was comfortable, when they were actually upset due to bad news, which should have been recorded.
- Patient H in Side Room 4 did not receive their prescribed CD Oxycodone, but you

recorded this drug as administered in their MAR chart.

You also falsely recorded observations (routine observations, nursing evaluations and “intentional roundings”) for a number of patients that were under your care during the shift. Patients A, B, C, D, E, F and H at 16:00 signed but not taken. All of these observations, except Patient D and Patient E, were recorded within 6 minutes of each other.

Patient B told staff within the Trust investigation that she had not been given Tinzaparin, which was signed for by you.

Following this shift, you were placed on supervised practice, as an alternative to suspension, whilst under an internal investigation.

3 August 2019

On 3 August 2019, you worked a shift on Ward B2 at the Trust.

You were not seen by the staff nurse or any other colleague completing your observations. However, you had put entries of the observations on the system. The staff nurse and a colleague checked with patients who all said they had not had their observations taken. The staff nurse and colleague took the observations again, some of which were significantly different to those recorded by you. When you were confronted about this, you could not provide a clear answer.

In relation to Patient I and Patient J, you had signed to say that you had completed the roundings, when you had not. You also discharged Patient J without checking their

discharge summary and TTO medications. Subsequently, Patient J was given another patient's CD medication.

For Patient K, you recorded in the nursing evaluations that this patient was independently mobile, maintaining own pressure sores, and passing urine in the toilet. Patient K was immobile with a catheter, and so all three evaluations were falsely recorded.

For Patient L, the recording of the observations which were taken by you were different to another colleague's observations. You failed to document that Patient L was being looked after by a different ward and failed to document the patient's stoma or high heart rate in the nursing evaluation.

For Patient M, you had entered the incorrect nursing evaluations in which you suggested that the patient was eating and drinking well, despite notes saying that they were on IV fluids and taking a 'sloppy diet' along with IV nutrition feeding.

For Patient N, you failed to carry out observations and the records you entered were significantly different to your colleagues. You recorded in the nursing evaluations that you had carried out intentional roundings when you had not.

For Patient O, you failed to document the patient's negative reaction to antibiotics and notify the doctors of this. You also failed to carry out any observations on Patient O but intended for other people to believe that you had carried them out.

You also took a bottle of paracetamol and attempted to spike it without wearing gloves and an apron or having first washed your hands. This was a breach of the Trust's medication policy and placed the patient at risk of infection.

As the concerns were similar in nature to those already being investigated by the Trust, a decision was made to suspend you, pending an internal investigation. The disciplinary

hearing was due to take place on 31 October 2019. However, on 16 October 2019, you resigned from the Trust with immediate effect.

BMI Healthcare Concerns (The Alexandra Hospital)

On 11 November 2019, you started working for BMI Healthcare, Alexandra Hospital ('BMI Hospital'). A number of concerns were raised.

The Sisters at the BMI Hospital were aware that you were under investigation and gave you local support, supervision and training. It was deemed necessary for you to have "continuous proactive training" and "needed close observation".

On 21 July 2020, you failed to conduct observations for Patient P (your only patient that day). No blood pressure recordings had been made between 3pm and 5pm. However, you suggested you had taken observations and recorded them on a piece of paper. A band 7 Sister put her observations on the chart at 17:40. After this, you went back and retrospectively recorded observations for blood pressure, heart rate, O2 saturation, and respiration rate for 17:00.

These were very similar to those that the band 7 Sister entered at 17:40, which suggests that you had falsified the results.

You failed to record the Patient P's urine output at 19:00 and 20:00, or blood pressure at 16:00, 19:00 and 20:00. When confronted, you first denied this was your patient, then admitted the patient was in your care once shown the patient's documentation. You did

not confirm or deny if you had taken the observations. You had a duty to record all fluids, as the patient was on IV fluids.

On 12 August 2020, you were placed on a Performance Improvement Plan ('PIP'). A "rolling report" was established to serve as a register, where Sisters and Charge Nurses, could record their concerns regarding your practice.

On 25 August 2020, you incorrectly recorded the administration of 50mg Tramadol in the CD book as 10mg.

On 8 September 2020, you asked the Senior Sister if you could administer codeine to a patient. The Senior Sister had to point out to you that this was the wrong patient's chart, and that the patient should not receive codeine.

On or around 9 September 2020, the Cardiac Resident Medical Officer (RMO) told you to turn off one of your patient's pacing box (for heartrate after a heart operation). The Cardiac Consultant attended later and found the pacing box still on. You did not have an answer as to why you had not done this.

On 9 September 2020, concerns were raised that you had falsified Patient Q's clinical records. When a Sister was taking over from you, she found that the NEWS did not have a sticker or patient details, and there was no identifying entry on the chart, so nothing to show who the chart belonged to. Further, Patient Q's room was untidy, with an empty / finished syringe driver infusion. Patient Q also had a face mask which was left on the floor along with their dressing gown. The mask should have been attached to a hook and covered to keep clean. You gave a handover saying all observations had been completed, but the monitor showed no blood pressure recordings or any other observations for Patient Q. Despite this, you recorded blood pressure on NEWS at 11:00, 13:30, 17:30, and 19:00.

On 15 September 2020, further concerns were raised regarding the falsification of Patient R and Patient S's clinical records. Patient R was feeling dizzy. You said that the

observations were complete and normal as recorded on NEWS at 11:00. The Sister checked the monitor, and no blood pressure had been taken since 08:01. She asked Patient R and their father, who both said the last observations were taken early in the morning by a colleague. You also failed to check and record Patient R's urine and measure the amount of fluid in the drain.

With regard to Patient S, the Sister had told you to connect Patient S to the telemetry box around 12:00. The Sister noticed at 13:15 that it was not connected to the central monitor. You also recorded observations on NEWS at 08:00 and 11:00. There was nothing on the monitor to suggest blood pressure readings for Patient S had been taken since 08:30.

On the same day, you were suspended from your role.

On 19 November 2020, following a disciplinary hearing, you were dismissed from BMI Hospital. An interim conditions of practice order was imposed on you by the NMC on 30 December 2020. Since December 2021, you have worked as a staff nurse in four care home's under this interim order. Following a reshuffle in your current care home on 22 September 2022, following one unit being shut down and a reduction in the need for qualified nurses, your role was changed to that of a care assistant and you continue to work in this role.

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

Mr Bardill, on behalf of the Nursing and Midwifery Council (NMC), made a request that this case be held partly in private on the basis that the proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Yang did not oppose the application.

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

Having heard that there will be reference to [PRIVATE], the panel determined to go into private session as and when such issues are raised.

Decision and reasons on facts

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

At the outset of the hearing, the panel heard from Mr Yang, on your behalf, who informed the panel that you have now made full admissions to all of the charges.

The panel therefore finds all of the charges proved in their entirety, by way of your admissions.

Mr Bardill informed the panel that you qualified as a registered nurse in in April 2013 in Rome. [PRIVATE]. You were employed at the Trust from January 2019 until you resigned on 16 October 2019, which was prior to a disciplinary hearing which was listed to be heard on 31 October 2019. You started work at BMI Hospital on 11 November 2019 and on 15 September 2020 you were suspended following concerns about your practice. You were dismissed from BMI Hospital on 19 November 2020.

Mr Bardill told the panel that you had denied all of the charges from the outset. He informed the panel that you had also said that you were not familiar with the iPads that were used within the Hospital to input entries of observations. [PRIVATE]. He told the

panel that you had told BMI Hospital that you would have nothing to gain from falsifying any records as you were under supervision and on an improvement plan.

Mr Bardill also informed the panel that your position has changed and you have now admitted to the charges in full.

Fitness to practise

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

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

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

Submissions on misconduct

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

Mr Bardill provided written submissions dated 13 February 2023 for the panel. In relation to misconduct, he submitted:

'INTRODUCTION

1. *…*

2. *It is submitted on behalf of the NMC that the actions of R, in the context of the charges found proved, amount to misconduct.*

3. *It is further submitted that R's fitness to practice is currently impaired by reason of that misconduct.*

Seriousness

12. *In relation to the charges found proved by admission, it is submitted that these actions do amount to 'sufficient serious misconduct'. It is submitted that this is the case whether taken together or separately. In particular, in this case, the concerns relate to dishonesty; consequently, R's actions do amount to sufficient serious misconduct in that the consequences of staff falsifying records or results or not carrying out tasks they are supposed to whilst recording that they had, is that the dishonesty or lack of candour renders the individual untrustworthy or unreliable and places patients at risk of harm and staff at risk of unwittingly inflicting or causing harm.*

13. *It is submitted that an additional consequence of the dishonesty element is that it places fellow staff members in difficult positions insofar as they cannot trust or rely on the candour or honesty of their colleagues. There is a risk that this would impact the care they deliver. This could be in the form of reading inaccurate patient notes and providing the wrong treatment or not rendering treatment at all under the belief that it has already been done.*

14. *It is submitted, therefore, that in addition to patients coming to actual harm due to not receiving the required care, dishonesty also affects other staff members and places them at risk. It is submitted that the impact on other staff members of dishonesty from colleagues, in turn, risks impacting the safety of their respective patients.*

15. *It is submitted, therefore, that owing to the dishonesty element and the risk arising from this particular case, the registrant's actions did amount to 'sufficiently serious misconduct' for the purposes of these proceedings.'*

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

Mr Bardill identified the specific, relevant standards where your actions amounted to misconduct. He submitted that you were in breach of the Code's: 1, 1.1, 1.2, 1.3, 1.5, 2, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 3, 3.1, 3.2, 3.3, 8, 8.2, 8.3, 8.5, 8.6, 10, 10.1, 10.2, 10.3, 14, 14.1, 14.2, 14.3, 18, 18.1, 18.3, 18.4, 19, 19.1, 19.2, 19.3, 19.4, 20, 20.1, 20.2, and 20.5.

Mr Bardill in this written submission dated 13 February 2023:

'CONCLUSION

32. *It is submitted that R's actions and omissions were in breach of the above parts of the NMC Code.*

33. *It is submitted that those breaches amount to misconduct because they fell short of what was proper in the circumstances.*

34. *It is submitted that this misconduct is sufficiently serious, pursuant to the case law and NMC guidance on seriousness.*

35. *The panel are invited to consider the case law, NMC guidance (in particular relating to dishonesty) and all the circumstances, balancing fairness between the parties and having regard, in particular, for the impact of any findings on R, with proportionality in mind.'*

Mr Yang informed the panel that there are many charges, but that this is because there is one charge for each drug. He told the panel that the charges fall into three categories: failing to make observations, failing to administer medication and dishonesty as you signed off the medications as being administered when they had not been.

Mr Yang submitted that you initially denied the charges as you were naïve and you were fearful. However, since then you have taken responsibility and he informed the panel that you are willing to face 'anything from this hearing'.

Mr Yang accepted that the facts found proved do amount to serious misconduct.

Submissions on impairment

Mr Bardill moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Bardill provided written submissions for the panel. In relation to impairment, he submitted:

'THE PRESENT CASE

1. *In the present case, it is submitted that R's actions consisted of both actions and omissions.*

2. *The NMC say that R's actions or act(s) were the inaccurate information dishonestly recorded in the patient notes, which resulted in patients being placed at a real risk of harm.*

3. *The NMC says that alongside the dishonest acts, there were omissions in the giving of care, keeping of records, administration of medication and being candid with fellow colleagues regarding the bad practice. It is submitted that the omissions and actions in this case are inextricably linked and reliant on each other.*

4. *It is submitted that as part of R's response, R demonstrated limited to no insight initially. He denied the allegations and provided excuses or reasons for his conduct which amounted to placing the blame elsewhere. This has since changed, and whilst the subsequent admission and reflections can be taken to reflect insight and remorse, it is submitted that the initial response was not that and that it has taken longer into the proceedings than necessary for the Registrant to reach these otherwise, it is submitted, obvious conclusions. The panel are invited to take account of this.*

5. *The panel may think that without remediation, there remains a real risk to patient safety and of repetition, in particular in a dishonesty case. Indeed in this instance, the same pattern of behaviour has been repeated at more than one place of employment, justifying the point regarding repetition. Therefore the risk to patient safety would be clear and ongoing.*

6. *The NMC say that dishonesty is extremely difficult to remedy.*

7. *The panel may also consider that R has no previous findings against him and has practised as a Nurse since the alleged incident under a Conditions of Practice*

Order. Nevertheless, it is a matter for the panel whether they feel sufficient insight has been demonstrated and sufficient steps taken to eliminate any risk. It is submitted that there appears to be no real evidence of remediation in this sense.

8. *In addition, the panel may think that there is a public interest in a finding of impairment, in particular where patients have been placed at risk of harm or staff put in difficult or risky situations pertaining to their own practice. It is submitted that in this case, whilst the other submissions still stand, impairment may be found in any event, owing to the public interest arising out of the dishonesty and the risk.*

9. *More specifically, impairment can be found in order to maintain public trust and confidence in the profession and to fulfil one of the panel's duties of declaring and upholding proper standards of professional conduct. If the panel are of the view that a finding of impairment is in the public interest for them to fulfil this duty, then they ought to find impairment on this ground*.

…

36. *The NMC submit that it is a matter for the panel as to whether there remains a real risk of repetition, a risk of harm to patients or public safety, or whether there is a public interest basis for finding impairment. The panel may think that because of R's misconduct, there remains a risk of repetition and of a real risk of harm to patient and public safety and/or a public interest reason to find impairment.*

37. *It is the NMC's submission that all three grounds apply, and the panel are therefore invited to find misconduct and that R is currently impaired by reason of that misconduct.'*

[PRIVATE].

Mr Yang submitted that the key dates are 20 July, 3 August and 15 September. [PRIVATE]. He submitted that in between these dates and the days following, there were no issues.

Mr Yang told the panel that you were working under an interim conditions of practice order without any issues. He submitted that what is clear is that no issues were raised when you were working in a better work environment. Mr Yang, therefore, accepted that you were impaired at the time of the incidents.

Mr Yang told the panel that that you deny that you are currently impaired. He told the panel that you have been working since December 2020 without a single incident or dishonesty. He submitted that you are taking active steps such as attending and undertaking courses. He told the panel that you are not being watched and not being treated the way you were, and that where there is an issue, you actively take steps to seek help and guidance rather than dealing with it alone. Therefore, in light of the steps you have taken to strengthen your practice, you are not currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Cheatle v General Medical Council* [2009] EWHC 645 (Admin) and *Grant*.

Decision and reasons on misconduct

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

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

'1 - Treat people as individuals and uphold their dignity

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

…

1.5 respect and uphold people's human rights

2 - Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

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

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

To achieve this, you must:

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

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

8 - Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

8.6 share information to identify and reduce risk

10 - Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

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

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.

18 - Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures.

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It had regard to the case of *Roylance v General Medical Council* 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.'* It determined that your failings and dishonesty amounted to misconduct.

The panel noted that the failings include: medication administration, false and incorrect record keeping, failure to undertake observations and evaluations, not following instructions, infection control and dishonesty. The panel determined that your actions in each of the individual charges did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct. It noted that you were working on the morning shift on 20 July 2019 with no concerns. However, after you were moved to a different ward, which you admit you were reluctant to be moved to, concerns about your practice became evident. You had previously worked under the same systems in the same hospital but when moved to this ward you did not undertake your duties as a registered nurse and were observed by colleagues spending a large amount of time sitting at the nursing station rather than caring for your patients. This conduct caused the panel to be concerned regarding your attitude.

The panel noted from Patient B's written statement:

> *'11. In the evening, as he was leaving his shift (I cannot remember what time this was), the Registrant walked past the bay. He looked in, waved with a smirk on his face, and said something like "I'm going." I interpreted this to be a deliberate smirk and his mannerisms gave me the impression he was saying "tough." We had still not received any medications at this point. Nobody in the bay said anything in response. Once he had left, one of the girls on the bay looked at me and said 'what was that about?". This was very different to how the other Nurses say goodbye, who usually go around the bay saying goodbye to everybody before they leave.'*

The panel also noted from Patient C's written statement:

‘8. After teatime, before I tumed poorly again, I asked the Registrant if I could go home. I think he may have been in the bay at this time. He told me that I would need the discharge papers first and so I asked him for these. A little while later he came back and, while I was in the bed, he sort of threw the discharge papers at me. I remember he was near my bed, only a short distance away, and he flung them onto the bed. He was just a little bit away. He almost shoved them at me and told me something like "you can go". I found it very rude and he was looking down at me as he did so in a way I found demeaning. I asked him if he could have my catheter removed and he said that somebody would come back and do it. He then walked away.’ [sic]

Further, the panel was of the view that patients pre and post-surgery are vulnerable patients. The panel considered that the majority of the tasks you were expected to complete were basic nursing interventions and well within the scope of a registered nurse. The panel noted that junior staff within the ward were asking you, as the registered nurse, whether you had completed the tasks. The panel noted that no actual harm was caused however, it determined that your failings and dishonesty placed patients at a potential risk of significant harm. The panel determined that your conduct failed to prioritise people and the safety of patients, which is a requirement of you as a registered nurse.

The panel was of the view that your failings and dishonesty extended over a significant period of time, July 2019 to September 2020, and took place in two different hospitals. It also considered that your intention to mislead staff by falsifying records could be indicative of a deep seated attitudinal issue. Further, it determined that your dishonesty breached fundamental tenets of the Code. It was of the view that your conduct was very serious and would be considered as ‘*deplorable*’ by fellow practitioners.

The panel was in no doubt that your conduct and dishonest behaviour fell significantly short of the standards expected of a registered nurse and is sufficiently serious to amount to misconduct.

Decision and reasons on impairment

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

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

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

The panel concluded that all four limbs of this test were engaged.

Whilst there is no evidence of serious or long term harm caused to your patients, the panel determined that you failed to care for your patients, you falsified records, you failed to administer or dispense medication appropriately, and you failed to undertake observations and evaluations for patients pre and post-surgery. This meant that patients were put at significant risk of unwarranted harm as a result of your misconduct. Furthermore, having breached multiple provisions of the Code, the panel determined that your misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find your fitness to practise to be impaired. The panel found the charges relating to dishonesty to be extremely serious.

The panel noted that you initially denied the allegations and all of the charges entirely as you say you were scared. However, you have now much later have accepted the charges in its entirety at the outset of this hearing.

[PRIVATE]. It bore in mind that dishonesty is often more difficult to remediate than clinical concerns.

The panel was of the view that you were developing insight from your reflective piece, but it was also of the view that this needs to be developed further. It noted that you were able to reflect as to what you should have been doing during the time of the incidents and what could have gone wrong. It noted that that you were remorseful for what has happened. [PRIVATE]. The panel noted that your misconduct and dishonesty was a pattern of behaviour as similar concerns were raised in two different hospitals over a two year period. It also noted that you have failed to fully cooperate whereby before the disciplinary hearings were held by the Trust and BMI Hospital and before the internal investigations had concluded, you resigned with immediate effect. It was of the view that your conduct demonstrated a deep seated attitudinal concern.

In relation to the training courses and competency assessments you have undertaken, the panel noted that these are mandatory training and consist of standard competency assessments which did not focus on the incidents that were of concern. The panel was of the view that you had not taken additional steps to strengthen your practice by focusing on specific concerns such as record keeping, observations, and medication administration management. The panel also took into account the reference provided by your manager. It was of the view that it was not very detailed as to your practice, and noted that you are currently practising as a care assistant, and not as a registered nurse.

[PRIVATE]. Nevertheless, the panel was of the view that you had not demonstrated sufficient insight into your misconduct. The panel could not be satisfied you fully understand and appreciate the seriousness of your failure to act appropriately and your dishonesty. Such insight as you have shown has come somewhat late in the day. The panel noted that your initial reaction to the local investigations and subsequently to the NMC investigation was a complete denial.

In having regard to the above, the panel considered that there is insufficient evidence to demonstrate that you have fully remediated your misconduct. The panel also did not have sufficient evidence to allay its concerns that you currently pose a risk to patient safety. The

panel considered there is a risk of repetition of your misconduct and dishonesty. Also, the panel considered there to be a risk of unwarranted harm to patients in your care, should adequate safeguards not be imposed on your nursing practice. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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 considered there to be a public interest in the circumstances of this case. The panel found that the charges found proved are serious. It was of the view that a fully informed member of the public would be appalled by your misconduct and dishonesty. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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

Mr Bardill provided the panel with written representation dated 17 February 2023:

'***INTRODUCTION***

1. *It was submitted on behalf of the NMC that there **is** a current and ongoing risk to patient and public safety if the Registrant ('R') is allowed to practice unrestricted because of his misconduct.*

2. *The panel have found misconduct and impairment on both public protection and public interest grounds by virtue of that misconduct.*

3. *The panel has also found dishonesty in the charges and serious misconduct arising out of that and other areas of concern.*

4. *The Registrant admitted the charges and misconduct at the outset. He did not accept that he was currently impaired, although he accepted dishonesty. The panel have made a note of these admissions.*

5. *The NMC submit that the overarching objective of the Panel is public protection, which is one of the grounds on which misconduct and impairment were found in addition to the public interest. In light of that, it is submitted that the only appropriate sanction for these charges is a Strike Off Order.*

…

THE PRESENT CASE

12. It is submitted that in the present case, the following aggravating features apply:

***i. THE FACT THAT THE ACT WAS DISHONEST** (Dishonesty)*

It is submitted that dishonesty, being heavily interlinked with attitude and insight, is extremely difficult to put right, and it is extremely difficult to be sure that it has been put right. With that in mind, the dishonesty of the charges found proved in itself is an aggravating feature.

ii. THE FACT THAT THE ACTS, OMISSIONS AND DISHONESTY WERE ONGOING AND MULTIFACETED

(A pattern of misconduct over time).

It is submitted that in the present case, the acts and omissions took multiple forms; failing to give medication and render care property, infection control, etc. [sic]

Consequently, not only was the misconduct ongoing and multifaceted, but the dishonesty in falsifying records and lying about care rendered was ongoing. It was made to numerous parties through numerous mediums and not only one occasion with one individual or act.

It is submitted that the multifaceted and ongoing nature of both the misconduct and the dishonesty suggests that if R had not been found out, it would have continued.

iii. THE REASON FOR THE DISHONESTY

In the present case, it is submitted that the dishonesty was used to try to cover up other serious misconduct in his practice. It is further submitted that these failings, omissions and actions alone would amount to serious misconduct going to impairment.

However, the dishonesty only aggravates it further. R initially denied all of the allegations and maintained that he had done nothing wrong. It was only later in proceedings that the charges were admitted, along with the dishonesty.

***iv. LACK OF INSIGHT** (Insight)*

Whilst R has shown clear insight into his failings and attempts to remedy them, it is submitted that this insight comes late in proceedings after initial attempts to deny outright any wrongdoing.

v. THE RISK POSED TO PATIENTS & PUBLIC

It is submitted that the multiple types of misconduct, in this case, are related to matters that, if not done properly, can have serious effects on patients, particularly vulnerable patients or patients who are recovering from serious illnesses and operations.

It is submitted that patients were placed at serious risk of harm, and had R not been found out; the conduct would have continued.

In addition, the dishonesty puts other members of staff at risk also. The job requires candour and trust, which is tainted by the dishonesty in these charges. In short, it is submitted that the dishonesty has put patients at risk, along with the other members of staff who are opened up to errors in their practice in acting on false or misleading information from R.

13. It is submitted that in the present case, the following mitigating features apply:

vi. *The Registrant has practised without issues since the imposition of his interim conditions of practice order.*

vii. *There are no previous Sanctions or NMC findings against R.*

viii. *R admitted all of the charges, and indeed the dishonesty, at the outset.*

ix. *Demonstration of some current competency and some limited insight or remorse.*

x. [PRIVATE].

14. *It is submitted that these are not exhaustive, and the Panel may find additional aggravating and mitigating features to which they will attach the appropriate weight accordingly.*

AVAILABLE SANCTIONS

Caution Order

15. *It is submitted that in the present case, a Caution Order would not be sufficient to reflect the seriousness of the case or protect the public.*

Conditions of Practice Order

16. *It is submitted that a Conditions of Practice Order would not be appropriate to address the ongoing and multifaceted dishonesty and, therefore, would not protect the public.*

Suspension Order

17. *It is submitted that a Suspension Order is not the appropriate sanction because it would not address insight or remediation. In short, for similar reasons as to why the Conditions of Practice Order is not appropriate, so too a Suspension Order is not.*

Strike Off

18. *It is submitted that in light of this matter relating to ongoing serious misconduct, coupled with continuing and multifaceted dishonesty, the only appropriate sanction to achieve the overarching objective of patient safety and public protection is a Strike Off Order.*

19. *It is submitted also that the Strike Off Order would preserve public confidence in the profession and the NMC as a regulator and provide deterrence for others.*

CONCLUSION

20. *The Registrant has admitted to misconduct and dishonesty, which on the facts, was continuous over a period of time and put numerous patients and staff at risk.*

21. *It is submitted, in particular in light of the panel's findings, that the Registrant's conduct is incompatible with continued registration. The dishonesty was committed to cover up for other serious, dangerous misconduct. The Registrant's actions not only put patients and the public in danger but also undermined the integrity of the register, engaging significant public protection and public interest issues.*

22. *Consequently, it is submitted that owing to the nature and reason for the misconduct, the aggravating features, and the lack of remediation, a Strike Off Order is the only appropriate sanction to protect the public and protect the reputation of the profession and NMC as a regulator.*

23. *The panel are therefore invited to make a Strike-Off Order in light of the above submissions.'*

Mr Yang referred the panel to the case of *Bolton v The Law Society* [1994] WLR 512. He told the panel that it should take into account whether you had repeated the misconduct

and dishonesty and whether you had maintained the reputation of the nursing profession. He told the panel that you had been under an interim conditions of practice order for three years and he submitted a further three years of the conditions of practice order would be appropriate. He submitted that this prolonged punishment would satisfy the public protection ground and would also otherwise be in the public interest. Mr Yang submitted that the issue of proportionality is paramount here, and there is no evidence of the failings and dishonesty being repeated. He submitted that due to the passage of time since the imposition of the interim order, it would be wholly disproportionate to remove you from the register as you had not been a risk since 2019.

Mr Yang submitted that where there are two possible sanctions available to the panel, it is critical that all mitigation is taken into account. He submitted that dishonesty was found and there was no excuse for it. [PRIVATE]. He submitted that the failures took place on specific dates, which meant that your case is not such that you were dishonest throughout. [PRIVATE].

Mr Yang submitted that it is difficult to face that many charges with particular dates and patients. He told the panel that it would be difficult to remember such information. However, once you were able to digest it, you did admit to the charges. He submitted that you are extremely remorseful, but that this may have come a little later but early enough to de-warn the witnesses from attending this hearing. He told the panel that you never thought you would be subject to these proceedings to potentially be suspended/struck-off. He told the panel that nursing was your passion in your life.

Mr Yang submitted that dishonesty does not mean it leads to a suspension order. He told the panel that it is open for the panel to find misconduct and to take no action even in dishonesty cases.

Mr Yang submitted that a three year conditions of practice order would be the most appropriate order. However, if the panel were not with him, his secondary submission was that the panel should impose a suspension order.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Conduct which put patients at risk of suffering harm
- A pattern of misconduct and dishonesty over an extended period of time
- Conduct and dishonesty which took place over two different hospitals
- Attempted to mislead colleagues
- Insufficient steps taken to strengthen your practice

The panel also took into account the following mitigating features:

- Admissions to the charges from the outset of this hearing
- Some insight into failings
- Some evidence of remorse

[PRIVATE].

The panel concluded that the aggravating features of this case far outweigh the mitigating features.

The panel had regard to the NMC guidance on *'Considering sanctions for serious cases'* (SAN-2) and considered that your dishonesty was towards the higher end of the spectrum.

In reaching this decision, the panel concluded that your dishonesty was a deliberate attempt to mislead your colleagues at both the Trust and BMI Hospital, over an extended period of time. Whilst there is no evidence of patient harm, there was a direct risk which could have potentially caused significant harm to patients. By providing false information on documentation and in oral hand overs, you also put your colleagues professional reputation at risk as they could not provide appropriate care to their patients.

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

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel acknowledged that you have been practising under an interim conditions of practice order for the past three years without any concerns. It also noted that you had not been practising under this interim order as a registered nurse since September 2022. The panel considered this misconduct and dishonesty spanned over two different work environments and was over an extended period of time. The panel considered this demonstrated deep seated attitudinal concerns and therefore determined that a conditions of practice order would not serve the public interest.

Furthermore, the panel determined that placing conditions of practice on your registration would not be sufficient or an appropriate response as your failings and dishonesty was at the high end of the spectrum of misconduct.

Therefore, panel was of the view that there are no practical or workable conditions that could be formulated, given the dishonesty charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel had regard to the SG which outlines the circumstances where a suspension order may be appropriate. The panel considered that you had demonstrated deep seated attitudinal issues as your failings and dishonesty took place over an extended period of time. You have not demonstrated a sufficient level of insight or have taken sufficient steps to strengthen your practice regarding your failings. The panel was of the view that your failings were not because of your lack of competency, but rather a choice you had made to not deliver patient care. The panel determined that your misconduct and failings were multifaceted.

The panel noted that since the imposition of the interim conditions of practice order, there had been no further concerns identified. However, you have not been practising as a registered nurse since September 2022 and have not taken further steps to strengthen your practice other than what was mandatory. Therefore, you have not taken addition steps to demonstrate to the panel that you are able to practise safely. Further, the panel determined that you had deep seated attitudinal issues. It was of the view that your conduct was a significant departure from the standards expected of a registered nurse. It noted that the serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register and as such, determined that a suspension order would not be a sufficient, appropriate or proportionate

sanction in that it would not protect patients or maintain confidence in the nursing profession.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel determined that your actions and your dishonesty was a significant departure from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your misconduct was serious, placed patients at risk of harm, and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. The panel recognised the adverse effect that a striking off order may have on you but was mindful of case law and of the NMC's own guidance that the reputation of the nursing profession is more important than the fortunes of an individual nurse.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the affect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was 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.

This will be confirmed to you in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interest until the striking-off 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 Mr Bardill. He submitted that an interim suspension order for a period of 18 months is necessary to protect the public and is otherwise in the public interest to allow sufficient time for any appeal to be heard.

Mr Yang did not oppose the application.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to allow sufficient time for any appeal to be heard. The panel is satisfied that this order and for this period is proportionate in the circumstances of this case.

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

That concludes this determination.