# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Meeting**
**Wednesday, 24 January 2024 – Friday, 26 January 2024**

Virtual Meeting

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|---|---|
| **Name of Registrant:** | **David Hamilton** |
| **NMC PIN** | 10F1490E |
| **Part(s) of the register:** | Registered Nurse – Sub part 1<br>Adult Nursing – 12 November 2010 |
| **Relevant Location:** | Newcastle Upon Tyne |
| **Type of case:** | Misconduct and Conviction |
| **Panel members:** | Adrian Blomefield (Chair, Lay member)<br>Shorai Dzirambe (Registrant member)<br>Stacey Patel (Lay member) |
| **Legal Assessor:** | John Bassett |
| **Hearings Coordinator:** | Stanley Udealor |
| **Facts proved:** | Charges 1, 2, 3a, 3b, 4, 5, 6a, 6b, 7, 8, 9, 10, 11a and 11b (Misconduct)<br><br>Charge 1 (Conviction) |
| **Facts not proved:** | N/A |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Striking-off order** |
| **Interim order:** | **Interim suspension order (18 months)** |

## Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mr Hamilton's registered email address by secure email on 6 December 2023.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, and that the meeting was to be held virtually. It informed Mr Hamilton that he had until 5 January 2024 to supply any additional evidence or information and that a meeting would be held on or after 10 January 2024.

The panel noted that on 15 November 2023, a Fitness to Practise Committee determined that this case should be dealt with at a meeting rather than at a hearing as it was satisfied that Mr Hamilton did not want to further engage with the Nursing and Midwifery Council (NMC), did not wish to attend any case conference and the disputed allegations would not have a material impact on the outcome of this case.

In the light of all of the information available, the panel was satisfied that Mr Hamilton has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). It noted that Mr Hamilton has not forwarded to the NMC any response to the allegations since his last email dated 6 November 2023 and did not complete the Case Management Form.

## Details of charge

That you a registered nurse;

1. On 7 March 2021 incorrectly administered Morphine 10mg/ml to Resident A instead of the prescribed medication of Hyoscine Hydrobromide 400mcg/ml.

2. On 7 March 2021 incorrectly documented in Resident A’s MAR chart indicating that Hyoscine Hydrobromide 400mcg/ml had been administered to them when it had not.

3. On or around 14 March 2021, having been notified of Resident A’s death and/or there being a medication error in respect of Resident A;

    a. Altered Resident A’s MAR chart by changing the medication batch number to reflect that Hyoscine Hydrobromide 400mcg/ml had been administered to Resident A on 7 March 2021 when it had not.
    b. Altered the handover note for Resident A by adding information suggesting that Hyoscine Hydrobromide had been administered to Resident A on 7 March 2021 when it had not.

4. You actions in charge 3 were dishonest in that you was attempting to mislead others into believing that you had administered the correct medication to Resident A when you knew that you had not.

5. On or around 14 March 2021 breached Resident A’s confidentiality by removing a copy of Resident A’s MAR chart from Kenton Hall care home.

6. On or around 14 March 2021, at the point of having discovered that you had incorrectly administered Morphine 10mg/ml to Resident A on 7 March 2021, failed to;

    a. Report the medication error to the manager.
    b. Complete an incident report form detailing the incident.

7. On or before 21 June 2021 made an incorrect declaration to Kenton Hall care home maintaining that you had administered Hyoscine Hydrobromide 400mcg/ml to Resident A on 7 March 2021 when you knew that this was untrue.

8. Your declaration in charge 7 was dishonest in that you was attempting to mislead Kenton Hall care home that you had not made a medication error on 7 March 2021 when you knew that you had.

9. On 22 March 2021 and/or 23 March 2021, when interviewed by the police, maintained that you had not altered the medication batch number on Resident A's MAR chart relating to the medication error that occurred on 7 March 2021 when you knew that you had.

10. Your actions in charge 9 were dishonest in that you were attempting to mislead the police into believing that someone other than you had altered the medication batch number on Resident A's MAR chart when you knew at the time of being interviewed by the police that you had altered the MAR chart.

11. Your actions in charge 3 and/or charge 5 and/or charge 6 and/or charge 7 and/or charge 9 lacked integrity in that you sought to hide the medication error that occurred on 7 March 2021 for your own benefit to;

    a. Retain employment at Kenton Hall care home, and/or
    b. Avoid the possibility of a criminal prosecution.

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

**Background**

The charges arose whilst Mr Hamilton was employed as a staff nurse at Kenton Hall Nursing Home ('the Home'). On 29 March 2021, Mr Hamilton was referred to the NMC by the Northumbria Police. The NMC also received a referral from the Manager of the Home on 2 August 2021.

The referrals relate to an incident that allegedly occurred on 7 March 2021, where it was alleged that Mr Hamilton had administered Morphine to Resident A, a resident on end-of-life care rather than Hyoscine Hydrobromide, and subsequently failed to report it. After he

learnt of Resident A's death on 11 March 2021, Mr Hamilton allegedly changed the batch number for the medication on the Medication Administration Record (MAR) chart relating to the Morphine administered on 7 March 2021 and amended the handover sheet relating to Resident A for that shift and copied both documents for himself.

Following the death of Resident A, there was both an internal investigation undertaken by the Home and a Police investigation. As part of the Home's investigation, a copy of Resident A's MAR chart had been provided to Witness 1 by Colleagues 1 and 2 before Mr Hamilton had allegedly altered and copied it. During the Home's investigatory meeting on 15 June 2021, Mr Hamilton denied administering Morphine to Resident A. He stated that he documented the wrong batch number and he also denied removing Resident A's patient records from the Home, stating that he had only taken a photocopy of the MAR chart home for his own evidence. Mr Hamilton further denied altering Resident A's MAR chart.

At the Police interview on 22 and 23 March 2021, Mr Hamilton admitted to administering morphine to Resident A instead of Hyoscine Hydrobromide. Mr Hamilton further stated that this was a mistake and that he was unaware that he had done it at the time.

During the Police interview on 22 March 2021, Mr Hamilton also admitted to photocopying Resident A's notes and taking them home, stating that he did so to confirm what he had written and prove his innocence, after he found out that Resident A had died, but before he was told that the discrepancy in medication stocks that had been discovered, would be looked into. In both Police interviews, Mr Hamilton denied changing the batch number written on the original MAR chart for Resident A.

However, in the Police interview dated 4 August 2021, Mr Hamilton admitted to changing the batch number on Resident A's MAR chart from the batch number relating to a vial of morphine to that relating to a vial of Hyoscine Hydrobromide.

Mr Hamilton resigned on 6 July 2021 and did not attend the disciplinary hearing held at the Home on 9 July 2021, where he was dismissed from the Home for gross negligence. Since his resignation from the Home, Mr Hamilton has not practised as a nurse and is currently employed within the railway industry.

## Decision and reasons on facts

Due to Mr Hamilton's failure to engage with these proceedings, there was no information before the panel to indicate whether he admits or denies any of the charges against him. In these circumstances, the panel decided to approach the charges on the basis that all charges against Mr Hamilton were denied/disputed and the burden of proof lies on the NMC to prove the charges on the balance of probabilities. The panel did not regard Mr Hamilton's non-engagement as an implied admission.

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the written representations made by the NMC.

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 had regard to the written statement of the following witness on behalf of the NMC:

- Witness 1: Manager of the Home at the time of the incidents.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

**Charge 1**

1. On 7 March 2021 incorrectly administered Morphine 10mg/ml to Resident A instead of the prescribed medication of Hyoscine Hydrobromide 400mcg/ml.

**This charge is found proved.**

In reaching this decision, the panel took account of the witness statement of Witness 1 dated 14 March 2023 in which he stated:

> *'….On 13 March 2021, we completed a stock check of controlled medication and identified that one 10mg/1ml vial of morphine which had been prescribed to this resident on 19 February 2021 was missing, with no record of it having been administered.'*
>
> *'We further identified records on the resident's medication administration record (MAR) chart that the patient had been administered Hyoscine Hydrobromide on three separate occasions (7, 8, and 11 March), when only two vials of Hyoscine had been removed from her prescription box, presumably pointing to morphine having been administered in the place of hyoscine in one instance.'*

The panel had sight of the copies of Resident A's controlled drugs book pages showing that a vial of Morphine was missing. The panel also had sight of Resident A's unaltered MAR chart showing the Morphine batch number written against the Hyoscine Hydrobromide entry for 7 March 2021. It noted that although that Mr Hamilton had signed to confirm the administration of Hyoscine Hydrobromide, he had recorded the Morphine batch number.

The panel considered the Police statements of Colleague 1 and Colleague 2 both dated 17 March 2021. It noted that their accounts of the discrepancies in the stocks for Hyoscine Hydrobromide and Morphine, supports the account of Witness 1.

The panel had sight of the unaltered MAR chart for Resident A. The unaltered MAR chart was a copy made by Colleague 1 on 13 March 2021 after she and Colleague 2 had discovered the discrepancies in the medication stocks. The panel noted that although it was recorded that Hyoscine Hydrobromide had been administered to Resident A, the batch number of the Morphine was recorded in the Running Balance section for Hyoscine Hydrobromide.

The panel also took into account that although Mr Hamilton had denied the allegation during the Home's local investigation, he later admitted to administering Morphine to Resident A instead of Hyoscine Hydrobromide during his Police interviews on 22 and 23 March 2021.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that Mr Hamilton had incorrectly administered Morphine 10mg/ml to Resident A instead of the prescribed medication of Hyoscine Hydrobromide 400mcg/ml on 7 March 2021. Accordingly, charge 1 is found proved.

**Charge 2**

2. On 7 March 2021 incorrectly documented in Resident A's MAR chart indicating that Hyoscine Hydrobromide 400mcg/ml had been administered to them when it had not.

**This charge is found proved.**

The panel took account of the witness statement of Witness 1 dated 14 March 2023 in which he stated:

> *'….On 13 March 2021, we completed a stock check of controlled medication and identified that one 10mg/1ml vial of morphine which had been prescribed to this resident on 19 February 2021 was missing, with no record of it having been administered.'*
>
> *'We further identified records on the resident's medication administration record (MAR) chart that the patient had been administered Hyoscine Hydrobromide on three separate occasions (7, 8, and 11 March), when only two vials of Hyoscine had been removed from her prescription box, presumably pointing to morphine having been administered in the place of hyoscine in one instance.'*

The panel had regard to Resident A's unaltered MAR chart for Hyoscine Hydrobromide and Morphine respectively. This showed the incorrect information recorded on Resident

A’s MAR chart about the administration of Hyoscine Hydrobromide and the actual stock of the medication. It also noted that the Controlled Drug book shows that a vial of Morphine was missing from the stock.

The panel had sight of the unaltered MAR chart for Resident A and noted that although it was recorded that Hyoscine Hydrobromide had been administered to Resident A, the batch number of the Morphine was recorded in the Running Balance section for Hyoscine Hydrobromide.

The panel also took into account that although Mr Hamilton had denied the allegation during the Home’s local investigation, he later admitted to incorrectly documenting that he had administered Hyoscine Hydrobromide to Resident A in the MAR chart, when he had not, during his Police interviews on 22 and 23 March 2021.

Based on the evidence before it, the panel was satisfied that, it was more likely than not, that on 7 March 2021, Mr Hamilton had incorrectly documented in Resident A’s MAR chart indicating that Hyoscine Hydrobromide 400mcg/ml had been administered to them when it had not. Accordingly, charge 2 is found proved.

**Charge 3a**

3. On or around 14 March 2021, having been notified of Resident A’s death and/or there being a medication error in respect of Resident A;

    a. Altered Resident A’s MAR chart by changing the medication batch number to reflect that Hyoscine Hydrobromide 400mcg/ml had been administered to Resident A on 7 March 2021 when it had not.

**This charge is found proved.**

The panel took account of the supplementary witness statement of Witness 1 dated 22 May 2023 in which he stated:

*'….on the discovery of potential medication administration errors, staff at Kenton Hall take photocopies of all MAR charts and CD books for the patient concerned . On the night of 7 March 2021, Mr Hamilton entered the batch number of a vial of Morphine in Resident A MAR chart. I present a copy taken of the original MAR chart of Resident A when the discovery was discovered as Exhibit SR/03.'*

*'When the original version of Resident A MAR chart was given to Northumbria Police on 19 March 2021, the batch number for a vial of Hyoscine Hydrobromide had been written in over the top of the original batch number. A photocopy of this version was also found by Northumbria Police at Mr Hamilton's home. I present the altered MAR chart of Resident A as Exhibit SR/04.'*

The panel considered the unaltered MAR chart for Resident A and the altered version of the MAR chart. The unaltered MAR chart was a copy made by Colleague 1 on 13 March 2021 after she and Colleague 2 had discovered the discrepancy in the medication stocks while the altered version of the MAR chart aligned with the copy found by the Police in Mr Hamilton's house. The panel noted that on the unaltered MAR chart, the batch number of the Morphine was recorded in the Running Balance section for Hyoscine Hydrobromide, however, on the altered MAR chart, the batch number for a vial of Hyoscine Hydrobromide had been written in over the top of the batch number relating to the Morphine.

The panel took into account that during his Police interview dated 4 August 2021, Mr Hamilton admitted that when Colleague 1 had notified him of the death of Resident A and the medication error, he obtained the MAR chart for Resident A and altered it by changing the medication batch number to reflect that Hyoscine Hydrobromide 400mcg/ml had been administered to Resident A on 7 March 2021 when it had not.

Having considered the evidence before it, the panel found, on the balance of probabilities, that charge 3a is proved.

**Charge 3b**

3. On or around 14 March 2021, having been notified of Resident A's death and/or there being a medication error in respect of Resident A;

b. Altered the handover note for Resident A by adding information suggesting that Hyoscine Hydrobromide had been administered to Resident A on 7 March 2021 when it had not.

**This charge is found proved.**

The panel considered the handover note for Resident A which covered the night shift on 7 March 2021. It took into account that although the relevant sections of the handover note had been completed, there was an entry made at the bottom of the handover note stating that at 3:45, Hyoscine Hydrobromide had been administered to Resident A. The panel noted that the batch number for Hyoscine Hydrobromide was included in this entry, however, this was in contrast to the batch number recorded on the unaltered MAR chart for Resident A (which was the batch number for Morphine).

The panel also took into account that during his Police interview dated 22 March 2021, he had admitted that he had administered Morphine to Resident A rather than Hyoscine Hydrobromide. He had seemingly admitted during his Police interview dated 4 August 2021, that he had altered the handover note for Resident A by adding information suggesting that Hyoscine Hydrobromide had been administered to Resident A on 7 March 2021 when it had not. In any event, the handover note purported to be a contemporaneous record of not only the batch number of the Hyoscine Hydrobromide from which the drug allegedly administered to Resident A had come but also of its expiry date. Given the panel was satisfied that the drug referred to in the handover note, had not been administered by Mr Hamilton to Resident A, the only proper inference that can be drawn is that Mr Hamilton altered the handover note after he had learnt of Resident A’s death.

Based on the evidence before it, the panel found, on the balance of probabilities, that charge 3b is proved.

**Charge 4**

4. You actions in charge 3 were dishonest in that you was attempting to mislead others into believing that you had administered the correct medication to Resident A when you knew that you had not.

**This charge is found proved.**

Having found charges 3a and 3b proved, the panel went on to consider whether Mr Hamilton's actions in charge 3 were dishonest. In considering whether Mr Hamilton's actions were dishonest, the panel had regard to the test laid down in the case of *Ivey v Genting Casinos UK Limited* [2017] UKSC 67 which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this case, the panel noted that Mr Hamilton admitted during his Police interview dated 4 August 2021, that when Colleague 1 had notified him of the death of Resident A and the medication error, he actively sought and obtained the MAR chart and handover note for Resident A in order to alter the records to reflect that Hyoscine Hydrobromide 400mcg/ml had been administered to Resident A on 7 March 2021 when it had not. The panel was of the view that it was reasonable to infer that by altering the MAR chart and handover note for Resident A respectively, there was a deliberate intention by Mr Hamilton's actions to mislead and conceal his medication error. Therefore, he was aware of the actual state of facts and sought to conceal it.

In applying the second limb of the test to this case, the panel was satisfied that Mr Hamilton's conduct in altering the MAR chart and handover note for Resident A respectively in order to conceal his medication error, would be considered dishonest by the ordinary decent people.

Accordingly, the panel determined that Mr Hamilton's conduct in charge 3 was dishonest, therefore, charge 4 is found proved.

**Charge 5**

5. On or around 14 March 2021 breached Resident A’s confidentiality by removing a copy of Resident A’s MAR chart from Kenton Hall care home.

**This charge is found proved.**

The panel took account of  the supplementary witness statement of Witness 1 dated 22 May 2023 in which he stated:

> *‘As well as this chart, copies of Resident A handover documents were found at Mr Hamilton’s home. These are documents that the night nurse will complete to handover to day staff to document what care has been given to each patient to ensure it is continued properly. I present copies of these patient documents as Exhibit SR/05.’*
>
> *‘Nurses are not allowed to remove any original or copies of patient documents from the Home. This is detailed in the employee handbook, which I present as Exhibit SR/06.’*

The panel took into account that during the Police interview on 22 March 2021, Mr Hamilton admitted to photocopying Resident A’s MAR chart and handover notes and taking them home in order to assist him to prove his innocence. The panel noted that Mr Hamilton had stated in his written answers to the questions posed by the Home in their letter dated 15 June 2021, that he was aware that the removal of any confidential document from the Home, was a breach of General Data Protection Regulation (GDPR). Also, Mr Hamilton, as an employee of the Home, was expected to be aware of the provisions of the Home’s Employee Handbook which restricted nurses from removing any original or copies of patients’ records from the Home.

The panel bore in mind that a patient’s MAR chart constitute part of the confidential information/records protected by GDPR and registered nurses are obliged to protect the confidentiality of patients. Therefore, it was of the view that Mr Hamilton’s conduct in removing a copy of Resident A’s MAR chart from Kenton Hall care home, was a breach of Resident A's confidentiality.

Having considered the evidence before it, the panel determined that charge 5 is found proved.

**Charge 6**

6. On or around 14 March 2021, at the point of having discovered that you had incorrectly administered Morphine 10mg/ml to Resident A on 7 March 2021, failed to;

    a. Report the medication error to the manager.
    b. Complete an incident report form detailing the incident.

**This charge is found proved.**

The panel took account of the supplementary witness statement of Witness 1 dated 22 May 2023 in which he stated:

> *'….our Administration of Medicines Policy and Procedure details the actions that Mr Hamilton should have taken on discovering that he had administered the incorrect medication to Resident A. I present this document as Exhibit SR/07.'*
>
> *'….Mr Hamilton, and all of our staff, had previously received training on medication administration and the reporting of such errors. I present records of his training as Exhibit SR/08.'*

The panel took into consideration that Mr Hamilton had stated in his written answers to the questions posed by the Home in their letter dated 15 June 2021, that he was aware of the Home's policy on reporting and managing a medication error as well as the Home's policy for the administration of medication.

The panel noted that during his Police interview dated 4 August 2021, Mr Hamilton admitted that when Colleague 1 had notified him of the medication error, he obtained the MAR chart and handover note for Resident A and altered it to reflect that Hyoscine

Hydrobromide 400mcg/ml had been administered to Resident A on 7 March 2021 when it had not.

The panel further noted that there was no evidence to show that Mr Hamilton had reported the medication error to the manager or had completed an incident form detailing the incident. Instead, there was evidence that he sought to conceal the medication error and mislead others about the incident.

Having considered the evidence before it, the panel determined that charges 6a and 6b are found proved.

**Charge 7**

7. On or before 21 June 2021 made an incorrect declaration to Kenton Hall care home maintaining that you had administered Hyoscine Hydrobromide 400mcg/ml to Resident A on 7 March 2021 when you knew that this was untrue.

**This charge is found proved.**

The panel took account of the supplementary witness statement of Witness 1 dated 22 May 2023 in which he stated:

> *'….Mr Hamilton denied administering the incorrect medication to Resident A when I questioned him about it. I present the form Mr Hamilton returned to us on 21 June 2021 stating this as Exhibit SR/09.'*

The panel had sight of Mr Hamilton's written answers to the questions posed by the Home in their letter dated 15 June 2021 in which Mr Hamilton had declared to the Home that he had administered Hyoscine Hydrobromide 400mcg/ml to Resident A on 7 March 2021.

However, the panel noted that during his Police interview dated 22 March 2021, Mr Hamilton admitted that he had administered Morphine to Resident A rather than Hyoscine Hydrobromide.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that, on or before 21 June 2021, Mr Hamilton made an incorrect declaration to Kenton Hall care home maintaining that he had administered Hyoscine Hydrobromide 400mcg/ml to Resident A on 7 March 2021 when he knew that this was untrue. Accordingly, charge 7 is found proved.

**Charge 8**

8. Your declaration in charge 7 was dishonest in that you was attempting to mislead Kenton Hall care home that you had not made a medication error on 7 March 2021 when you knew that you had

**This charge is found proved.**

Having found charge 7 proved, the panel went on to consider whether Mr Hamilton's conduct in charge 7 was dishonest. In considering whether Mr Hamilton's conduct was dishonest, the panel had regard to the test laid down in the case of *Ivey* which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this case, the panel noted that Mr Hamilton admitted during his Police interview dated 4 August 2021, that on or around 14 March 2021, when Colleague 1 had notified him of the death of Resident A and the medication error, he actively sought and obtained the MAR chart and handover note for Resident A respectively in order to alter the records to reflect that Hyoscine Hydrobromide 400mcg/ml had been administered to Resident A on 7 March 2021 when it had not. The panel was of the view that it was reasonable to infer that by altering the MAR chart and handover note for Resident A respectively, Mr Hamilton was fully aware of his medication error on or around 14 March 2021, and actively sought to conceal it. Thereafter, on or around 21 June 2021, Mr Hamilton knowingly made an incorrect declaration to the Home that he had administered Hyoscine Hydrobromide 400mcg/ml to Resident A on 7 March 2021. This

suggested a deliberate intention by Mr Hamilton to mislead the Home about his medication error. Therefore, he was aware of the actual state of facts and sought to conceal it.

In applying the second limb of the test to this case, the panel was satisfied that Mr Hamilton's conduct in which he made an incorrect declaration to the Home maintaining that he had administered Hyoscine Hydrobromide 400mcg/ml to Resident A on 7 March 2021 when he knew that this was untrue, would be considered dishonest by the ordinary decent people.

Accordingly, the panel determined that Mr Hamilton's conduct in charge 7 was dishonest, therefore, charge 8 is found proved.

**Charge 9**

9. On 22 March 2021 and/or 23 March 2021, when interviewed by the police, maintained that you had not altered the medication batch number on Resident A's MAR chart relating to the medication error that occurred on 7 March 2021 when you knew that you had.

**This charge is found proved.**

The panel considered the transcripts of Mr Hamilton's Police interviews dated 22 March 2021 and 23 March 2021 respectively. It noted that in both interviews, Mr Hamilton had maintained that he had not altered the medication batch number on Resident A's MAR chart relating to the medication error that occurred on 7 March 2021.

However, the panel had sight of the unaltered MAR chart for Resident A and the altered version of the MAR chart. The unaltered MAR chart was a copy made by Colleague 1 on 13 March 2021 after she and Colleague 2 had discovered the discrepancies in the medication stocks while the altered version of the MAR chart aligned with the copy found by the Police in Mr Hamilton's house. The panel noted that on the unaltered MAR chart, the batch number of the Morphine was recorded in the Running Balance section for Hyoscine Hydrobromide, however, on the altered MAR chart, the batch number for a vial

of Hyoscine Hydrobromide had been written in over the top of the batch number relating to Morphine.

The panel took into account that during his Police interview dated 4 August 2021, Mr Hamilton admitted that when Colleague 1 had notified him of the death of Resident A and the medication error, he obtained the MAR chart for Resident A and altered it by changing the medication batch number to reflect that Hyoscine Hydrobromide 400mcg/ml had been administered to Resident A on 7 March 2021 when it had not.

Having considered the evidence before it, the panel found, on the balance of probabilities, that charge 9 is proved.

**Charge 10**

10. Your actions in charge 9 were dishonest in that you were attempting to mislead the police into believing that someone other than you had altered the medication batch number on Resident A's MAR chart when you knew at the time of being interviewed by the police that you had altered the MAR chart.

**This charge is found proved.**

Having found charge 9 proved, the panel went on to consider whether Mr Hamilton's conduct in charge 9 was dishonest. In considering whether Mr Hamilton's conduct was dishonest, the panel had regard to the test laid down in the case of *Ivey* which provides:

- what was the defendant's actual state of knowledge or belief as to the facts; and
- was his conduct dishonest by the standards of ordinary decent people?

In applying the first limb of the test to this case, the panel noted that Mr Hamilton admitted during his Police interview dated 4 August 2021, that on or around 14 March 2021, when Colleague 1 had notified him of the death of Resident A and the medication error, he actively sought and obtained the MAR chart and handover note for Resident A respectively in order to alter the records to reflect that Hyoscine Hydrobromide 400mcg/ml had been

administered to Resident A on 7 March 2021 when it had not.  The panel was of the view that it was reasonable to infer that during his Police interviews on 22 March 2021 and 23 March 2021 respectively, Mr Hamilton was fully aware that he had altered the MAR chart to conceal his medication error. This suggested a deliberate intention by Mr Hamilton to mislead the Police about the alteration of the MAR chart. Therefore, he was aware of the actual state of facts and sought to conceal it.

In applying the second limb of the test to this case, the panel was satisfied that Mr Hamilton's conduct in which he attempted to mislead the Police into believing that someone other than him had altered the medication batch number on Resident A's MAR chart when he knew at the time of being interviewed by the police that he had altered the MAR chart, would be considered dishonest by the ordinary decent people.

Accordingly, the panel determined that Mr Hamilton's conduct in charge 9 was dishonest, therefore, charge 10 is found proved.

**Charge 11**

11. Your actions in charge 3 and/or charge 5 and/or charge 6 and/or charge 7 and/or charge 9 lacked integrity in that you sought to hide the medication error that occurred on 7 March 2021 for your own benefit to;

    a. Retain employment at Kenton Hall care home, and/or
    b. Avoid the possibility of a criminal prosecution.

**This charge is found proved.**

The panel carefully considered Mr Hamilton's actions in charges 3, 5, 6, 7 and 9. It was of the view that it was reasonable to infer that Mr Hamilton's actions in charges 3, 5, 6 and 7 were motivated by his desire to retain his employment at the Home for his own benefit as he sought to conceal his medication error from the Home even when questioned during the Home's local investigation.

The panel took into account that Mr Hamilton admitted during his Police interview dated 4 August 2021, that his attempts at concealing his medication error was borne out of fear and panic that he could be prosecuted for manslaughter. Therefore, the panel was satisfied that Mr Hamilton's actions in charges 3, 5, 6, 7 and 9 were intended to be for his own benefit namely trying to avoid the possibility of criminal prosecution.

The panel was of the view that by taking several steps to conceal his medication error for his own benefit, Mr Hamilton breached the duty of candour and lacked integrity.

Having considered the evidence before it, the panel determined that charge 11 is found proved.

**Fitness to practise**

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

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

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

**Representations on misconduct**

In its written representations, the NMC submitted that:

15. *‘It is submitted that the facts amount to misconduct.*

16. *The comments of **Lord Clyde in Roylance v General Medical Council [1999] UKPC 16** may provide some assistance when seeking to define misconduct:*

    *‘[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances.’*

17. *As may the comments of **Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin)** and **Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin)**, respectively*

    *‘[Misconduct] connotes a serious breach which indicates that the doctor’s (nurse’s) fitness to practise is impaired’.*

*And*

> *‘The adjective “serious” must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner’.*

18. *Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per **Roylance**) can be determined by having reference to the Nursing and Midwifery Council’s Code of Conduct 2015 (“**the Code**”).*

19. *At all relevant times, Mr Hamilton was subject to the provisions of the Code. The Code sets out the professional standards that nurses must uphold. These are the standards that patients and members of the public expect from health professionals.’*

The NMC submitted that Mr Hamilton had breached the following sections of the Code: 1.1, 1.2, 1.4, 1.5, 3.2, 5.1, 5.3, 10.3, 19.1, 20.1, 20.2, 20.3, 20.4, 20.5 and 20.8. The NMC further stated in its written representations that:

20. *'It is submitted that Mr Hamilton's conduct detailed in charges 1-11 fell far short of what would have been expected of a registered nurse. Mr Hamilton's significant departure from the principles of prioritizing people, promoting professionalism and trust could a) be seen to be putting patients at risk of harm if Mr Hamilton was to repeat the medication error and therefore not being able to deliver the fundamentals of care effectively and b) Mr Hamilton was dishonest and attempted to conceal the medication error by falsifying records and breaching patient confidentiality. Hence, lacking a duty of candour and not being open and honest about making the mistake. Either conduct would be seen as deplorable by fellow practitioners and would damage the trust that the public places in the profession. Prioritising people and acting with honesty and integrity are integral to the standards expected of a registered nurse and central to the Code.*

21. *Mr Hamilton's conduct fell far below what would be expected of a registered nurse and a finding of misconduct must follow.*

22. *The provisions of the Code constitute fundamental tenets of the profession and Mr Hamilton's actions have clearly breached these in so far as they relate to prioritising people and promoting professionalism and trust.*

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

**Decision and reasons on misconduct**

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

The panel was of the view that Mr Hamilton's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Hamilton's 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*
***1.5** respect and uphold people's human rights*

***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
*To achieve this, you must:*
***3.2** recognise and respond compassionately to the needs of those who are in the last few days and hours of life*

***5 Respect people's right to privacy and confidentiality***
*As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.*

*To achieve this, you must:*
***5.1** respect a person's right to privacy in all aspects of their care*
***5.3** respect that a person's right to privacy and confidentiality continues after they have died*

***10 Keep clear and accurate records relevant to your practice***
*This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*

*To achieve this, you must:*
***10.3** complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

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

***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:*
***14.2*** *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*
***20.8*** *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'*

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

The panel considered that Mr Hamilton had administered Morphine 10mg/ml to Resident A instead of the required medication of Hyoscine Hydrobromide 400mcg/ml. Mr Hamilton did

not report the medication error to the manager and did not also complete an incident form detailing the incident. The panel took into account that Morphine is a controlled drug and Mr Hamilton had stated in the Home's local interview form dated 15 June 2021 that he was aware of the Home's policy and procedure for the administration of medication as well as the Home's policy on reporting and managing a medication error. He had also received training in this regard.

The panel noted that Mr Hamilton had stated during his Police interview dated 23 March 2021 that the Morphine medication was stored together with the Hyoscine Hydrobromide and his medication error was a genuine mistake. Nevertheless, the panel was of the view that it was Mr Hamilton's duty as a registered nurse to ensure that he administers the appropriate medication to patients under his care and to seek relevant advice when confused about the medication. Therefore, the panel considered Mr Hamilton's conduct as a breach of fundamental aspects of nursing practice and amounted to a breach of his fundamental duty of care to Resident A.

The panel noted that the failure of Mr Hamilton to report the medication error to the manager and to complete an incident form, deprived his colleagues and the Home from being availed with the relevant information pertaining to the medication error and placed Resident A at risk of harm. The panel further noted that Mr Hamilton's conduct caused severe distress and stress to his colleagues and negatively affected the reputation of the Home as they were subjected to Police investigations, Care Quality Commission (CQC) and safeguarding inspections. The panel was of the view that Mr Hamilton had failed to discharge his duty of candour to Resident A, his colleagues and the Home and his conduct amounted to a breach of professional conduct and behaviour expected of a registered nurse.

Accordingly, the panel determined that Mr Hamilton's actions in charges 1, 6a and 6b were sufficiently serious and amounted to misconduct.

The panel considered that Mr Hamilton breached Resident A's confidentiality by removing a copy of Resident A's MAR chart from the Home. It took into account that during the Police interview on 22 March 2021, Mr Hamilton admitted to photocopying Resident A's MAR chart and handover notes and taking them home in order to assist him to prove his

innocence. Nevertheless, the panel was of the view that patient confidentiality is one of the fundamental tenets of the nursing profession as patients should be able to access clinical care with the confidence that their private and confidential information would be protected and not exploited for personal benefits. Therefore, the panel considered Mr Hamilton's conduct as a serious breach of the fundamental tenets of the nursing profession, and it fell short of the fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain.

Accordingly, the panel determined that Mr Hamilton's conduct in charge 5 amounts to misconduct.

The panel concluded that Mr Hamilton had incorrectly documented in Resident A's MAR chart indicating that Hyoscine Hydrobromide 400mcg/ml had been administered to them when it had not, attempted to conceal his medication error by altering Resident A's MAR chart and handover note, and attempted to mislead the Police and Home in this regard.

The panel was of the view that Mr Hamiton's conduct in falsification of Resident A's records demonstrated a lack of accountability and transparency on his part and constituted a breach of duty of candour. The panel considers honesty, integrity and trustworthiness to be the bedrock of the nursing profession and, in being dishonest, it found Mr Hamilton to have breached a fundamental tenet of the nursing profession and brought the reputation of the nursing profession into disrepute. The panel considered Mr Hamilton's actions to be extremely serious and unprofessional, and that they would be seen as deplorable by other members of the profession and members of the public. It determined that to characterise Mr Hamilton's actions as anything other than misconduct would send the wrong message about the nursing profession. Therefore, the panel was in no doubt that Mr Hamilton's actions in charges 2, 3a, 3b, 4, 7, 8, 9, 10 and 11 amounts to misconduct.

Consequently, having considered the proven charges individually and as a whole, the panel determined that Mr Hamilton's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

**Conviction charge and submissions**

After the panel had reached its determination on misconduct, in compliance with Rule 29 (2), it was provided with a further set of papers that related to Mr Hamilton's conviction for fraud by false representation on 1 June 2022 at Newcastle Upon Tyne Crown Court.

**Details of charge**

That you a registered nurse;

1. On 1 June 2022 at Newcastle-Upon-Tyne Crown Court were convicted of fraud by false representation.

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

The panel was satisfied that the notice of the conviction charge was served on Mr Hamilton at his registered email address, at the same time as the notice of misconduct.

Due to Mr Hamilton's non-engagement with the NMC and lack of a formal response to the charge, the NMC is required to prove the fact of the conviction on the balance of probabilities.

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

**Decision and reasons on facts**

The charge arose from Mr Hamilton's conviction on 1 June 2022 when he was convicted of Fraud by False Representation contrary to Section 2 of the Fraud Act 2006. Mr Hamilton was sentenced to ten months imprisonment, suspended for twenty-four months, alongside unpaid work of one hundred and fifty hours to be completed within twelve months, and a victim surcharge of £156.

Having been provided with a copy of the certificate of conviction and the Police report concerning the offence, the panel finds that charge 1 is found proved in accordance with Rule 31 (2) and (3). This states:

*‘**31.**— (2) Where a registrant has been convicted of a criminal offence—*

*(a) a copy of the certificate of conviction, certified by a competent officer of a Court in the United Kingdom (or, in Scotland, an extract conviction) shall be conclusive proof of the conviction; and*

*(b) the findings of fact upon which the conviction is based shall be admissible as proof of those facts.*

*(3) The only evidence which may be adduced by the registrant in rebuttal of a conviction certified or extracted in accordance with paragraph (2)(a) is evidence for the purpose of proving that she is not the person referred to in the certificate or extract.’*

The panel noted that by virtue of his conviction, Mr Hamilton was in breach of paragraph 20.4 of the Code which provides that registered nurses must ‘*keep to the laws of the country in which [they] are practising’.*

**Representation on impairment**

In relation to Mr Hamilton’s misconduct, the NMC made the following representations:

***‘Impairment***

23. *It is submitted that Mr Hamilton’s fitness to practice is impaired by reason of his misconduct on both grounds of public protection and public interest.*

24. *Impairment needs to be considered as at today’s date, i.e., whether the nurse’s fitness to practice is currently impaired. The NMC defines impairment as a nurse’s suitability to remain on the register without restriction.*

25. *The NMC’s guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. The question that will help decide whether a professional’s fitness to practise is impaired is:*

***"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"***

26. *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.*

27. *Answering this question involves a consideration of both the nature of the concern and the public interest. In addition to the following submissions the panel is invited to consider carefully the NMC's guidance on impairment.*

28. *When determining whether the Registrant's fitness to practise is impaired, the questions outlined by* ***Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin))*** *are instructive. Those questions were:*

    1. *has Mr Hamilton in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
    2. *has Mr Hamilton in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*
    3. *has Mr Hamilton in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or*
    4. *has Mr Hamilton in the past acted dishonestly and/or is liable to act dishonestly in the future.*

29. *It is the submission of the NMC that (1), (2), (3) and (4) can be answered in the affirmative in this case. Dealing with each one in turn:*

30. *Mr Hamilton's actions of administering wrong medication placed Resident A at risk of harm. Although Mr Hamilton's actions were not the direct cause of harm or fatality, there is a real risk of harm to patients or service users, if repeated.*

31. *Mr Hamilton's conduct has brought the profession into disrepute. His conduct is of a serious nature, and aggravated because Mr Hamilton has been dishonest in*

*that following the medication error, he incorrectly recorded the medication chart, altered the medication chart and breached patient confidentiality. Mr Hamilton knowingly attempted to mislead the Home and maintained his story for his own benefit. Mr Hamilton has therefore taken advantage of his privileged position as a nurse and has failed to keep to and uphold the standards and values set out in the Code and as such has failed to uphold the reputation of the profession. The public has the right to expect high standards of registered professionals.*

32. *Mr Hamilton's actions demonstrate a flagrant departure from the standards expected of a registered nurse and a breach of the fundamental tenets of the profession.*

33. *Mr Hamilton has acted dishonestly throughout the entire internal investigation. It is very clear that he is liable to act dishonestly in the future as we can see a pattern of behaviour since the medication error on 7 March 2021.*

34. *Impairment is a forward-thinking exercise which looks at the risk the registrant's practice poses in the future. NMC guidance adopts the approach of* ***Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin)*** *by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.*

35. *It appears that there are attitudinal concerns here. It is often said that conduct of an attitudinal nature is difficult to remediate. The* ***NMC guidance entitled: Can the concern be addressed? (Reference: FTP-13a)*** *is likely to be of assistance:*

    *"Decision makers should always consider the full circumstances of the case in the round when assessing whether or not the concerns in the case can be addressed. This is true even where the incident itself is the sort of conduct which would normally be considered to be particularly serious.*

*The first question is whether the concerns can be addressed. That is, are there steps that the nurse, midwife or nursing associate can take to address the identified problem in their practice?*

*It can often be very difficult, if not impossible, to put right the outcome of the clinical failing or behaviour, especially where it has resulted in harm to a patient. However, rather than focusing on whether the outcome can be put right, decision makers should assess the conduct that led to the outcome, and consider whether the conduct itself, and the risks it could pose, can be addressed by taking steps, such as completing training courses or supervised practice.*

*Decision makers need to be aware of our role in maintaining confidence in the professions by declaring and upholding proper standards of professional conduct. Sometimes, the conduct of a particular nurse, midwife or nursing associate can fall so far short of the standards the public expect of professionals caring for them that public confidence in the nursing and midwifery professions could be undermined. In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.*

*Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*

*dishonesty, particularly if it was serious and sustained over a period of time, or directly linked to the nurse, midwife or nursing associate's practice".*

36. *It is submitted that Mr Hamilton has displayed no insight and has failed to provide a reflective statement acknowledging the seriousness of his conduct. Mr Hamilton has not provided any responses with regards to the NMC investigation or the*

*regulatory concerns. It appears that Mr Hamilton is now working in the railway industry, and therefore has no desire to get back into nursing.*

37. *In* ***Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J*** *commented that:*

    *"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."*

38. *Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.*

39. *It is submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behavior. Honesty and integrity form fundamental tenets of the profession. It is expected of a nurse to administer correct medication and correctly document the medication administered. Once the resident sadly passed away, Mr Hamilton altered the MAR charts and handover notes, as opposed to engaging with the Home. Mr Hamilton attempted to mislead the investigation and further breached confidentiality by removing the MAR charts from the Home. Nurses must be honest, open and act with integrity. They must make sure that their conduct at all times justifies the public's trust in the profession.*

40. *It is submitted that a member of the public appraised of the facts, would be shocked to hear that a registered nurse was entitled to practice without restriction. As such, the need to protect the wider public interest calls for a finding of*

*impairment to uphold standards of the profession, maintain trust and confidence in the profession and the NMC as its regulator. Without a finding of impairment, public confidence in the profession, and the regulator, would be seriously undermined, particularly where there is a high risk of repetition and a pattern of behavior as is present in this case.'*

In relation to Mr Hamilton's conviction, the NMC made the following representations on impairment:

**'Impairment**

22. *The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. The question that will help decide whether a professional's fitness to practise is impaired is:*

    *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

23. *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.*

24. *Answering this question involves a consideration of both the nature of the concern and the public interest. In addition to the following submissions the panel is invited to consider carefully the NMC's guidance on impairment.*

25. *When determining whether the Registrant's fitness to practise is impaired, the questions outlined by* ***Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)****) are instructive. Those questions were:*

    1) *has Mr Hamilton in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
    2) *has Mr Hamilton in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*

3) *has Mr Hamilton in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or*

4) *has Mr Hamilton in the past acted dishonestly and/or is liable to act dishonestly in the future.*

26. *It is the submission of the NMC that (1,) (2), (3) and (4) can be answered in the affirmative in this case. Dealing with each one in turn:*

27. *Mr Hamilton's actions of administering wrong medication placed Resident A at risk of harm. Although Mr Hamilton's actions were not the direct cause of harm or fatality, there is a real risk of harm to patients or service users, if repeated.*

28. *Registered professionals occupy a position of privilege and trust in society and are expected to be professionals at all times. Mr Hamilton's conviction is in relation dishonesty, particularly in relation to attempting to mislead the Home and the Police regarding the medication administered and the MAR charts.*

29. *The seriousness of this conviction is such that it calls into question Mr Hamilton's continuing suitability to remain on the register. Mr Hamilton received a custodial sentence of 10 months' imprisonment, suspended for 24 months, with the requirement to unpaid work of 150 hours to be completed within 12 months, and a victim surcharge of £156. This therefore has a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute.*

30. *The Code divides its guidance for nurses in to four categories which can be considered as representative of the fundamental principles of nursing care. These are:*

    a) *Prioritise people;*
    b) *Practice effectively;*
    c) *Preserve safety and*
    d) *Promote professionalism and trust*

31. *The NMC have set out above how, by identifying the relevant sections of the Code, Mr Hamilton has breached fundamental tenets of the profession. These sections of the Code define, in particular, the responsibility to promote professionalism and trust to ensure safe conduct and practise.*

32. *Impairment is a forward-thinking exercise which looks at the risk Mr Hamilton's practice poses in the future. NMC guidance adopts the approach of* ***Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin)*** *by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.*

33. *The NMC's guidance entitled* ***"Can the concern be addressed?" FTP-13a*** *states as follows:*

    *"Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*

    - *Criminal convictions that led to custodial sentences*
    - *Dishonesty, particularly if it was serious and sustained over a period of time, or directly linked to the nurse, midwife or nursing associate's practice."*

34. *Whilst Mr Hamilton's actions did not lead to the death of Resident A's, the conviction relates to Mr Hamilton's attempt to cover his failings and wrongdoing as a nurse. Offences of this nature is often indicative of underlying attitudinal concerns, which are difficult to put right and are likely to lead to restrictive regulatory action.*

35. *Mr Hamilton has not provided any responses with regards to the NMC investigation or the regulatory concerns. Mr Hamilton has indicated that he no longer wishes to practise as a nurse and states that he is now employed in the railway industry.*

36. *Mr Hamilton has therefore not provided any insight or reflection.*

37. *The panel may also find it useful to consider the comments of* ***Cox J in Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 101****:*

    *"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case".*

38. *Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/or to maintain public confidence in the profession.*

39. *In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which hasn't been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.*

40. *However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.*

41. *The NMC consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. The public expect nurses to act with honest and integrity so that patients and their family members can trust registered professionals.'*

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

**Decision and reasons on impairment**

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

Registered nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust registered nurses with their lives and the lives of their loved ones. To justify that trust, registered 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/their fitness to practise is impaired in the sense that S/He/They:*

*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 found that all limbs of the Grant test are engaged in this case. At the time of the incidents, Mr Hamilton's misconduct placed patients under his care at unwarranted risk of harm, brought the nursing profession into disrepute, breached fundamental tenets of the nursing profession, relating to adequate patient care and he had acted dishonestly as confirmed by his conviction.

The panel had regard to the NMC Guidance on Impairment especially the question which states:

> '*Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

The panel is aware that this is a forward-looking exercise and, accordingly, it went on to consider whether Mr Hamilton's misconduct is remediable and whether he had strengthened his nursing practice.

The panel had regard to the case of *Cohen v GMC,* where the court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

The panel considered whether Mr Hamilton's conduct found in the charges proved is easily remediable. It was of the view that although Mr Hamilton's medication error was generally capable of remediation, it considered that his dishonest conduct in concealing his medication error and his breach of patient confidentiality are suggestive of deep-seated attitudinal concerns which are difficult to remediate.

Regarding insight, the panel was of the view that Mr Hamilton has failed to show insight into his conduct. It considered that although Mr Hamilton later made admissions to the Police, he had initially denied the allegations during the Home's investigation and in his initial interviews with the Police. At various occasions, Mr Hamilton sought to provide justifications for his actions and deflect responsibility for his conduct. The panel noted that Mr Hamilton failed to demonstrate any insight on the impact of his conduct on Resident A, their family, the Home, the nursing profession and the wider public. It was concerned that Mr Hamilton did not demonstrate any understanding of the seriousness of his misconduct, nor did he provide any information about detailed steps he would take to prevent such a situation re-occurring in the future.

In considering whether Mr Hamilton had strengthened his nursing practice, the panel noted that there was no evidence before it to indicate that Mr Hamilton had strengthened his nursing practice in the areas of concern and addressed his failings. Mr Hamilton has not provided any evidence of training nor testimonials to demonstrate any positive steps he had taken to remediate his failings and strengthen his nursing practice.

In light of this, this panel determined that there is a high risk of repetition of Mr Hamilton's misconduct and a consequent risk of harm to the public. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

Specifically in relation to Mr Hamilton's conviction for fraud by false representation, the panel had regard to the following matters:

- The seriousness of the conviction is demonstrated by the sentence of ten months imprisonment, suspended for twenty-four months together with a requirement to

complete one hundred and fifty hours unpaid work within twelve months and pay a victim surcharge of £156.

- The comments of the Judge upon passing sentence.
- The NMC's guidance entitled 'Can the concern be addressed?' FTP-13a states as follows:

  *'Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*

  - *Criminal convictions that led to custodial sentences*
  - *Dishonesty, particularly if it was serious and sustained over a period of time, or directly linked to the nurse, midwife or nursing associate's practice.'*

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 had regard to the serious nature of Mr Hamilton's misconduct and his conviction and determined that public confidence in the profession, particularly as it involved dishonesty in clinical care, would be undermined if a finding of impairment were not made in this case. It was of the view that a fully informed member of the public, aware of the proven charges in this case and Mr Hamilton's failure to strengthen his nursing practice, would be very concerned if Mr Hamilton were permitted to practise as a registered nurse without restriction. For this reason, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold the proper professional standards for members of the nursing profession.

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

**Sanction**

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

**Representations on sanction**

With respect to Mr Hamilton's misconduct, the NMC made the following representations on sanction:

> ***<u>'Sanction</u>***
>
> 41. *Taking into account the NMC Sanctions Guidance, the NMC considers that the appropriate and proportionate sanction in Mr Hamilton's case is a* ***Strike Off Order.***
>
> 42. *The aggravating features in this case include:*
>
>     - *Mr Hamilton is an experienced nurse*
>     - *The conduct suggests deep-seated attitudinal behaviour*
>     - *The dishonesty is deliberate, long-standing, pre-meditated, systematic, linked to Mr Hamilton's practice, and is fraudulent*
>     - *Mr Hamilton has abused his position and trust • Mr Hamilton's conduct lacks integrity*
>     - *No reflection, insight or remorse.*
>
> 43. *There are no mitigating factors.*

44. *Taking the least serious sanctions first, it is submitted that taking **no further action** would not be appropriate in the circumstances of this case. The allegations are too serious to take no further action. So as to achieve the NMC's overarching objective of public protection, action does need to be taken to secure public trust in nurses and to promote and maintain proper professional standards of conduct.*

45. *A **Caution Order** is only appropriate if there is no risk to the public or the patients requiring the nurse's practice to be restricted. There is a risk of repetition present in this case as Mr Hamilton's behaviour and conduct is such that it is not possible to remediate and therefore a future risk remains present. In those circumstances, a caution order would not be appropriate as it would not be a sufficient sanction to ensure the public are protected, and the conduct cannot be regarded as being at the lower end of impaired fitness to practise.*

46. *Imposing a **Conditions of Practise Order** is not appropriate or proportionate, in that there are no identifiable areas of nursing practise which require assessment and/or retraining. Additionally, the dishonesty in this case is severe and indicates a strong deep seated personality issue. There are no workable or measurable conditions that could be imposed to address the conduct demonstrated by Mr Hamilton in this case.*

47. *The NMC guidance on **Suspension Orders** states that this sanction may be appropriate where there is a single isolated incident and where there is no evidence of a deep seated and/or harmful attitudinal issue.*

48. *Mr Hamilton has displayed attitudinal concerns which are taken very seriously by the regulator and it is submitted that they engage the public protection and public interest at a high level. Mr Hamilton displayed dishonest behaviour following a medication error which placed Resident A at risk of harm. Mr Hamilton attempted to conceal the medication error as opposed to addressing and reflecting. Mr Hamilton attempted to conceal the error by altering records, and breaching patient confidentiality. This therefore suggests that the conduct was designed to obstruct an investigation with the possibility of remaining employed or avoiding*

*prosecution. The conduct raises fundamental questions about Mr Hamilton's professionalism and trust.*

49. *Mr Hamilton has provided no real explanation or remediation for his actions, albeit dishonesty cannot be easily remediated. It is therefore submitted that a suspension order is neither appropriate nor proportionate in this case.*

50. *In light of the above, the NMC submit that the only appropriate and proportionate sanction in all the circumstances of this case is a* ***Striking Off Order.***

51. *Mr Hamilton's behaviour is wholly incompatible with remaining on the nursing register. Mr Hamilton's conduct raises fundamental questions about his professionalism and trust. The confidence the public places in the profession would therefore be severely undermined if Mr Hamilton was not removed from the register. The NMC therefore submit that this sanction is the only sanction that is sufficient to protect patients, members of the public and maintain standards and confidence within the profession and the NMC as its regulator.'*

With respect to Mr Hamilton's conviction, the NMC made the following representations on sanction:

***'Sanction***

42. *The NMC consider the appropriate and proportionate sanction in this case to be a* ***Striking-Off Order****.*

43. *With regard to our sanctions guidance the following aspects have led us to this conclusion:*

44. *The aggravating factors in this case include:*

    - *Mr Hamilton is an experienced nurse*
    - *Deep-seated attitudinal behaviour*

- *Dishonesty that is deliberate, long-standing, pre-meditated, systematic, linked to Mr Hamilton's practice, and is fraudulent*

- *Abuse of position and trust*
- *Lack of integrity*
- *Lack of insight/remediation.*

45. *There are no mitigating factors in this case.*

46. *The following aspects have led the NMC to this conclusion:*

47. ***No further action and Caution Order** – Mr Hamilton has been convicted of Fraud by False Representation. Taking no action would be wholly inappropriate and would send entirely the wrong message. According to the NMC Guidance **(SAN-3a and SAN-3b),** a caution order would also not be appropriate as this would not make the seriousness of the offences and would be insufficient to protect the public or maintain high standards within the profession or the trust the public place in the profession. Therefore, it is submitted that a caution order would not be appropriate in this case.*

48. ***Conditions of Practice Order** – The Guidance (**SAN-3c**) states that a conditions of practice order may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):*

    - *no evidence of harmful deep-seated personality or attitudinal problems*
    - *identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining*
    - *no evidence of general incompetence*
    - *potential and willingness to respond positively to retraining*
    - *the nurse, midwife or nursing associate has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision*

- *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*
- *conditions can be created that can be monitored and assessed.*

49. *The offences listed in the charges, and the facts behind those offences, indicate harmful deep-seated personality or attitudinal problems. The offences are too serious to be addressed by a conditions of practice order. In any event, there are no areas of clinical concern which might be more readily be addressed by way or training or assessment. Further, there are no practical conditions that could be in the public interest.*

50. ***Suspension Order*** *– The Guidance (**SAN-3d**) details the following:*

    *Key things to weigh up before imposing this order include:*

    - *Whether the seriousness of the case require temporary removal from the register?*
    - *Will a period of suspension be sufficient to protect patients, public confidence in nurses, midwives or nursing associates, or professional standards?*

*Use the checklist below as a guide to help decide whether it's appropriate or not. This list is not exhaustive:*

- *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, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour.*

51. *Mr Hamilton's criminal conviction is for covering up/falsifying patient records. There is evidence of deep-seated personality or attitudinal problems. Mr Hamilton continued to cover up/falsify records, despite being repeatedly requested to be open and honest about falsifying the MAR chart, by the Police and the Home. The conviction breaches the fundamental tenets of the profession and brings the profession into disrepute. It is so serious that temporary removal would not protect the public or meet the public interest.*

52. *A suspension order would not be sufficient in this case to mark the seriousness of Mr Hamilton's actions. Mr Hamilton's conduct raises questions about his professionalism and suitability to stay on the register. If he were to stay on the register, this would risk suitability undermining public confidence in the profession, given the nature of the conviction.*

53. ***Strike Off Order –*** *A striking-off order would be the most appropriate and proportionate sanction to impose in this case. The guidance on criminal convictions and cautions* ***(FTP-2c)*** *states that in cases where the conviction relates directly to nurse or midwife's practice, it is likely that regulatory action would need to be taken to maintain professional standards and public confidence in nurses.*

54. *The guidance (**SAN-2**) states that;*

> *"cases about criminal offending by nurses, midwives or nursing associates illustrate the principle that the reputation of the professions is more important than the fortunes of any individual member of those professions. Being a registered professional brings many benefits, but this principle is part of the 'price' "(**Bolton v Law Society [1994] 1 WLR 512)**.*
>
> *The law says that, when making its decision on sanction, the Fitness to Practise Committee should consider: the fact that a nurse, midwife or nursing associate convicted of a serious offence is still serving their sentence (even if on*

*probation), and whether the nurse, midwife or nursing associate should be able to restart their professional practice before they have completed their sentence*

*In general, the rule is that a nurse, midwife or nursing associate should not be permitted to start practising again until they have completed a sentence for a serious offence.* ***(Council for the Regulation of Health Care Professionals v (1) GDC and (2) Fleischmann [2005] EWHC 87 QB).*** *This is a general rule that it would be right for the Fitness to Practise Committee to consider, but it does not mean that the Committee has no choice but to remove the nurse, midwife or nursing associate from the register permanently* ***Chandrasekera v Nursing and Midwifery Council [2009] EWHC 144 (Admin).***

*55. The conduct and behaviour displayed by Mr Hamilton is extremely serious and regarded as being fundamentally incompatible with being a registered professional. Allowing continued registration would be seriously damaging to public confidence and the reputation of the profession.'*

**Decision and reasons on sanction**

Having found Mr Hamilton'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 Hamilton's conduct suggests deep-seated attitudinal concerns.
- Mr Hamilton's dishonesty was deliberate, long-standing, pre-meditated, systematic, linked to his practice, and was fraudulent.
- Mr Hamilton abused his position of trust.
- Mr Hamilton's conduct lacks integrity.
- No evidence of reflection, insight or remorse.

- No evidence to demonstrate remediation or strengthened practice.

The panel did not identify any mitigating factors involved in this case.

The panel had regard to the NMC Guidance on Considering sanctions for serious cases, in particular, Cases involving dishonesty, SAN-2. It also had regard to the NMC Guidance on Factors to consider before deciding on sanctions, SAN-1 which states:

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

The panel also specifically considered that the NMC Guidance (**SAN-2**) states that;

> *'Cases about criminal offending by nurses, midwives or nursing associates illustrate the principle that the reputation of the professions is more important than the fortunes of any individual member of those professions. Being a registered professional brings many benefits, but this principle is part of the 'price'* "(***Bolton v Law Society [1994] 1 WLR 512)***.
>
> *The law says that, when making its decision on sanction, the Fitness to Practise Committee should consider: the fact that a nurse, midwife or nursing associate convicted of a serious offence is still serving their sentence (even if on probation), and whether the nurse, midwife or nursing associate should be able to restart their professional practice before they have completed their sentence.*
>
> *In general, the rule is that a nurse, midwife or nursing associate should not be permitted to start practising again until they have completed a sentence for a serious offence.* ***(Council for the Regulation of Health Care Professionals v (1) GDC and (2) Fleischmann [2005] EWHC 87 QB).*** *This is a general rule that it would be right for the Fitness to Practise Committee to consider, but it does not mean that the Committee has no choice but to remove the nurse, midwife or nursing associate from*

*the register permanently **Chandrasekera v Nursing and Midwifery Council [2009] EWHC 144 (Admin).'***

The panel noted that Mr Hamilton deliberately breached the duty of candour by taking several steps to conceal his medication error over a period of time. Mr Hamilton's conduct was not a one-off incident nor was it a spontaneous reaction, but a premeditated longstanding deception intended to mislead the Home and the Police about his medication error. He had at several occasions during the Home's local investigation and police interviews, maintained his denial of the allegations and sought to act as the victim of the incidents.

The panel therefore found the dishonesty in this case to be extremely serious and at the high end of the spectrum of dishonesty.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. It had found that Mr Hamilton posed a risk of harm, had breached fundamental tenets of the nursing profession and his misconduct and conviction would undermine the public's confidence in the nursing profession if he were allowed to practise without restriction. The panel therefore determined that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Hamilton's nursing 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 Hamilton's misconduct and conviction were 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 Mr Hamilton'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:

*'Conditions may be appropriate when some or all of the following factors are apparent:*

- *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;*
- *no evidence of general incompetence;*
- *potential and willingness to respond positively to retraining;*
- *……..;*
- *patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *the conditions will protect patients during the period they are in force; and*
- *conditions can be created that can be monitored and assessed.'*

The panel was of the view that although the medication error could potentially be addressed through retraining, however, it had found that Mr Hamilton's dishonesty, as demonstrated by his misconduct and conviction, and breach of patient confidentiality are suggestive of deep-seated attitudinal concerns which are difficult to remediate and be addressed through retraining.

The panel determined that given the seriousness of the concerns, the deep-seated attitudinal problems and Mr Hamilton's lack of insight into the severity and impact of his actions on Resident A, his colleagues, the Home, the nursing profession and the public, there are no practical or workable conditions that could be formulated. The panel had no evidence before it to suggest that Mr Hamilton would comply with any conditions of practice order, given that he has not provided this panel with any evidence of positive steps taken to strengthen his nursing practice. It noted that Mr Hamilton is not currently working as a registered nurse, and he has expressed his intention to not return to the nursing profession. The panel also noted that Mr Hamilton is still subject to a suspended

prison sentence. Furthermore, a conditions of practice order would not address the risk of repetition and this poses a risk of harm to the public. Consequently, the panel decided that any conditions of practice order would not protect the public nor be in the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a suspension order may be appropriate where some of the following factors are apparent:

- *'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 considered that Mr Hamilton's misconduct which resulted to his conviction was not a single instance but rather a sustained pattern of dishonest conduct over a period of time. It noted that Mr Hamilton has failed to demonstrate insight into the severity and the impact of his actions on Resident A, their family, his colleagues, the Home, the nursing profession and the wider public. The panel found that there was no evidence to show that Mr Hamilton has taken any positive steps to strengthen his nursing practice or to remediate his failings. The panel was of the view that Mr Hamilton's lack of insight, his failure to strengthen his nursing practice and his serious dishonest conduct, indicates deep-seated attitudinal problems which heightens the significant risk of repetition.

Consequently, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction and would not protect the public nor satisfy the public interest consideration in this case.

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?’*

In the panel’s judgement, the answer to questions one and three is *‘Yes’* and the answer to question two is *‘No’.* Therefore, the panel was of the view that all of the criteria as set out above, are met in this case.

The panel determined that Mr Hamilton’s misconduct, as highlighted by the facts found proved, and his conviction constituted a serious breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. The panel found that Mr Hamilton’s actions were significant departures from the standards expected of a registered nurse.

The panel concluded that the serious breach of fundamental tenets of the profession, evidenced by Mr Hamilton’s actions and dishonest conduct, is fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case raises serious and significant questions about Mr Hamilton’s professionalism and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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 effect of Mr Hamilton’s actions in bringing the nursing 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 a striking-off order 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 standards of behaviour expected and required of a registered nurse.

This will be confirmed to Mr Hamilton 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 Mr Hamilton's own interests until the striking-off sanction takes effect.

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

**Representations on interim order**

The panel took account of the representations made by the NMC which stated:

> *' In the event that a sanction resulting in the restriction of Mr Hamilton's practice is imposed, it is also necessary for the protection of the public and otherwise in the public interest for there to be an interim suspension order of 18 months to cover the appeal period.'*

**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 in order to protect the public and otherwise in the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

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

That concludes this determination.