Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 1 December 2025 – Thursday 11 December 2025

Virtual Hearing

Name of Registrant:	**Anthony J B D P Andrews**
NMC PIN:	98I1358E
Part(s) of the register:	Nursing Sub part 1 RNMH, Registered Nurse - Mental Health 15 September 2003
Relevant Location:	Wandsworth
Type of case:	Misconduct
Panel members:	Shaun Donnellan (Chair, Lay member) Vickie Glass (Registrant member) Margaret Stoddart (Lay member)
Legal Assessor:	Paul Housego
Hearings Coordinator:	Monowara Begum
Nursing and Midwifery Council:	Represented by Rushnay Sikander, Case Presenter
Mr Andrews:	Not present and not represented at the hearing
Facts proved:	Charges 1a, 1b(i), 1b(ii), 1c, 2a, 2b, 2c, 2d(i), 2d(ii), 2d(iii), 2d(iv), 3a, 3c(i), 3c(ii), 3c(iii), 3c(iv), 4, 5a, 5b, 5c, 5d and 6
Facts not proved:	Charge 3b
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**

Interim order: **Interim suspension order (18 months)**

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

At the outset of the hearing, the Chair stated that, pursuant to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules), the panel intended to hold this case partly in private on the basis that proper exploration of Mr Andrews' case involves reference to his health.

Ms Sikander, on behalf of the Nursing and Midwifery Council (NMC), indicated that she supported this course of action.

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

The panel determined to go into private session in connection with Mr Andrews' health as and when such issues are raised in order to protect his privacy.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Andrews was not in attendance and that the Notice of Hearing letter had been sent to Mr Andrews' registered email address by secure email on 30 October 2025.

Further, the panel noted that the Notice of Hearing was also sent to Mr Andrews' daughter, Ms Leonie Andrews, who is acting as his representative, on 30 October 2025.

Ms Sikander submitted that it had complied with the requirements of Rules 11 and 34.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and venue of the hearing and, amongst other things, information about Mr Andrews' right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

The panel was informed by Ms Sikander that there was a case conference meeting with Mr Andrews and his daughter, Ms Andrews, prior to the hearing taking place. Both Mr Andrews and Ms Andrews were notified during that meeting that the hearing will be taking place virtually via teams to assist with Mr Andrews' health conditions.

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

Decision and reasons on proceeding in the absence of Mr Andrews

The panel next considered whether it should proceed in the absence of Mr Andrews. It had regard to Rule 21 and heard the submissions of Ms Sikander who invited the panel to continue in the absence of Mr Andrews.

Ms Sikander submitted that there is a public interest in the expeditious disposal of this case. She submitted that eight witnesses have been warned to give live evidence. In one case there would be an application to adduce as hearsay. She submitted that adjourning a nine-day hearing would be disproportionate given that reasonable efforts have been made to secure Mr Andrews' attendance.

Ms Sikander told the panel that the hearings coordinator had managed to speak to Mr Andrews via telephone on the morning of 1 December 2025. Mr Andrews had informed the hearings coordinator that he had not received any of the previous correspondence in terms of emails. Mr Andrews was asked by the hearings coordinator to check his spam/junk box as well, however, he said that he was busy at the time of the phone call as

he was in the middle of taking medication. Mr Andrews was asked by the hearings coordinator if he was aware that the substantive hearing is due to take place today and he had confirmed that he knew. Mr Andrews was asked if he had received the bundles that was sent to him by the NMC on 30 October 2025, and he had said that he did not receive those bundles. Mr Andrews was asked if he had access to his emails, and he had said yes. The hearings coordinator informed Mr Andrews that the hearing had been adjourned until 14:00, 1 December 2025, to allow him and his representative time to join the hearing. Mr Andrews was asked to check his emails when it was convenient for him, but before 14:00 as the hearing was due to start then. The hearings coordinator told Mr Andrews that she was having difficulty getting hold of his representative, Ms Andrews, and asked if he could liaise with Ms Andrews before 14:00. The hearings coordinator had left a voicemail message on Ms Andrews' phone asking her to get in contact with an update on whether or not she will be attending the hearing.

Ms Sikander told the panel that Mr Andrews' daughter, Leonie Andrews, who has authority to deal with these matters on his behalf, had indicated earlier in the year that her father was suffering from health problems. Ms Sikander informed the panel that the NMC had repeatedly asked for information about Mr Andrews' health problems, but that they have stated they do not want to disclose any further medical information. Ms Sikander told the panel that the NMC were asking for that information for the purpose of putting special measures in place ensuring that any amendments could be made to assist Mr Andrews in engaging with the hearing, which they had requested to be held virtually.

Ms Sikander told the panel that Mr Andrews and Ms Andrews had attended the case conference meeting and Mr Andrews was able to respond to questions and was engaging with his daughter. She told the panel that Mr Andrews and Ms Andrews had suggested that the hearing was causing Mr Andrews stress, however, the NMC do not see this as a reason to postpone the hearing. She told the panel that at that meeting they had confirmed that they do not want to adjourn the hearing. She told the panel that Mr Andrews and Ms Andrews have both been sent a hard copy of the bundles too. She

further told the panel that, in the case conference meeting, Mr Andrews had confirmed that he had received the bundles.

Ms Sikander told the panel that there has been no response to the charges and there has been little effort from Mr Andrews and his representative to engage with the proceedings between the case conference meeting and today, 1 December 2025.

Ms Sikander submitted that it would be fair, appropriate and proportionate to proceed in the absence of Mr Andrews given that he has been given multiple opportunities to provide further information about his health if he considered he is unable to partake in the hearing. There are eight witnesses, it is a nine-day substantive hearing and there would unlikely be any availability to relist this hearing before July 2026.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mr Andrews. In reaching this decision, the panel considered the submissions of Ms Sikander and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *General Medical Council v Adeogba* [2016] EWCA Civ 162 and *General Medical Council v Hayat* [2018] EWCA Civ 2796 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Andrews;
- Mr Andrews and his daughter, Ms Andrews, who is representing him, had attended a case conference meeting prior to the hearing and had requested

for the hearing to be held virtually due to his health conditions. During that meeting they had not expressed any wish to adjourn the hearing;

- On the first day of the hearing, 1 December 2025, Mr Andrews in a telephone conversation with the hearings coordinator confirmed that he was aware of the substantive hearing taking place. He was informed by the hearings coordinator that the hearing was being adjourned until 14:00, 1 December 2025, to allow him and his representative, Ms Andrews, time to join the hearing. A voice message was left on Ms Andrews' phone informing her that it has been adjourned until 14:00 and to get in contact with the hearings coordinator before 14:00 regarding whether or not she will be attending the hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- In the event of an adjournment, it would be unlikely that the hearing would be listed before July 2026;
- Seven witnesses have been scheduled to give live evidence at this hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2023;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Andrews in proceeding in his absence. The evidence upon which the NMC relies was sent to him at his registered address. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Andrews'

decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge (as amended)

That you, a registered nurse:

1. On 8 September 2023 in relation to Patient A:
    a. Administered medication to a patient not under your care
    b. Administered medication through the subglottic port of a tracheostomy tube:
        i. when the subglottic port was not meant for administering medication, and
        ii. when you had not undergone the necessary training allowing you to work with patients with a tracheostomy tube.
    c. Did not seek appropriate supervision or guidance in relation to the care provided at charges 1(a) and 1(b).

2. On 8 September 2023 in relation to Patient A:
    a. Failed to verify Patient A's identity before administering medication
    b. Failed to check Patient A's medication records prior to administering any medication
    c. Administered medication to Patient A that was not prescribed for Patient A
    d. Failed to record the details of the medication administered to Patient A, including the:
        i. drug name; and / or
        ii. dosage; and / or
        iii. time; and / or
        iv. route.

3. On 8 September 2023 in relation to Patient B:
    a. Failed to check Patient B's medication records prior to administering medication
    b. Administered medication to Patient B which had already been administered by a colleague
    c. Failed to record the details of the medication administered to Patient B, including the:
        i. drug name; and / or
        ii. dosage; and / or
        iii. time; and / or
        iv. route.

4. You falsely represented to Colleague A that you held the appropriate qualifications and/or competencies in tracheostomy care when you did not.

5. Acted in breach of interim orders imposed on you by the NMC, in that you:
    a. Failed to immediately provide a copy of your Interim Conditions Order dated 7 July 2021, as required by paragraphs 4(a) and (b) of that same Order, to South West London and St George's Mental Health NHS Trust.
    b. Failed to notify the NMC within seven days, of a medication error that occurred in your practice on 18 May 2022, in accordance with your interim order dated 7 July 2021
    c. Failed to inform West London NHS Trust of an Interim Suspension Order imposed on you on 24 November 2023.
    d. Between 27 November – 1 December 2023 completed five shifts for West London NHS Trust, when you should not have done so as you were the subject of an interim suspension order dated 24 November 2023.

6. Your actions in charge 4 and / or charge 5 were dishonest in that you intended to mislead.

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

Background

The NMC received a referral on 11 September 2023 from the Royal Hospital for Neuro-Disability (the Hospital) in relation to Mr Andrews' practice.

Mr Andrews was employed as a registered mental health nurse by two agencies, Care Staff Solutions and Pulse Nursing. At the time of the incidents, Mr Andrews worked as a bank and/or agency nurse, and his work placements included, the Hospital, South West London and St George's Mental Health NHS Trust (the Trust) and the NHS Talking Therapies team at West London NHS Trust run by Hounslow Early Intervention Service.

Incidents at the Hospital

On 8 September 2023, during a shift at the Hospital, Mr Andrews was involved in two separate medication errors. The first incident occurred when Mr Andrews inappropriately administered medication through the subglottic port of a tracheostomy tube to Patient A, a patient that was not under his care, via a route not safe for medication administration. This incident led to immediate physical distress for the patient, who began to cough and show signs of respiratory distress before they were stabilised. Mr Andrews was allegedly not trained in tracheostomy care but had informed the ward manager, Witness 6, that he was competent, when this was not the case.

On the same day, it was alleged that Mr Andrews administered medication to another patient, Patient B, despite being explicitly informed by Witness 6 that this patient had already received their medication for that period.

Incident at the Trust

On 17 July 2021, an interim conditions of practice order was imposed on Mr Andrews' registration. This order was revoked on 24 May 2023. As part of this order, Mr Andrews was required to provide a copy of his interim conditions of practice order to his employer within seven days.

Mr Andrews completed a bank shift through the Trust on 18 May 2022 on the Aquarius Ward. It was alleged that Mr Andrews did not inform the bank team of his interim conditions of practice order until 16 June 2022.

During this bank shift on 18 May 2022, it was alleged that Mr Andrews incorrectly documented that he had administered 5mg of Fluoxetine to a patient, despite both the patient and their mother reporting that no medication was given. It was a condition of the interim order that Mr Andrews was required to inform his NMC case officer of any clinical incidents he was involved in. It was alleged that Mr Andrews did not inform the NMC of this alleged incident.

Breach of interim suspension order

After the NMCs application for an interim order for the substantive referral, and subsequent imposition of an interim suspension order on 24 November 2023, Mr Andrews allegedly completed five shifts at West London NHS Trust as a Band 6 agency Care Coordinator.

Mr Andrews is currently subject of the interim suspension order which was imposed on 24 November 2023.

Decision and reasons on application to admit hearsay evidence of Witness 1

The panel heard an application made by Ms Sikander under Rule 31, for the witness statement and exhibits of Witness 1, to be admitted into evidence as hearsay. She referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and submitted that this case laid out the following factors to be considered in admitting hearsay evidence and she addressed each factor respectively:

i. Whether the statements were the sole and decisive evidence in support of the charges:

Ms Sikander submitted that Witness 1's witness statement is not the sole and decisive evidence of the relevant charges, however, it does provide important factual evidence on each interim order that were in place and the subsequent breach of that.

ii. The nature and extent of the challenge to the contents of the statements:

Ms Sikander submitted that there has been no response from Mr Andrews apart from a deemed denial of the charges. She submitted that as Witness 1 outlined objective evidence which was unlikely to be challenged in cross-examination there would be no real benefit in hearing live evidence of this nature.

iii. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations:

Ms Sikander submitted that there has been no suggestion from the NMC or Mr Andrews that Witness 1 had some sort of motive to fabricate the content of his witness statement.

iv. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career:

Ms Sikander submitted that Witness 1's evidence is solely related to charge 5. She submitted that this is a dishonesty and misconduct case, and it is alleged that Mr Andrews had intended to mislead his employer. She accepted that this was a very serious charge. If the hearsay evidence was not admitted that might have a severe adverse impact not only on the NMC, and if the charge was not found proved by reason of the absence of the evidence of Witness 1 this could lead to a risk to the public.

v. Whether there was a good reason for the non-attendance of the witness:
vi. Whether the regulator had taken reasonable steps to secure the witness's attendance:

In relation to factors five and six, Ms Sikander submitted that Witness 1 no longer works at the NMC. The NMC felt that Witness 1's evidence provides an overview and a timeline of objective evidence. The NMC did not feel that it would be proportionate to warn this witness to give live evidence given that there are seven other witnesses.

vii. Whether the registrant did not have prior notice that the witness statement would be read:

Ms Sikander submitted that Mr Andrews is aware that the witness statement of Witness 1 would be read as this was disclosed in the case conference meeting.

In conclusion, Ms Sikander submitted that the hearsay evidence should be allowed, and it is up to the panel to consider what weight they attach to the hearsay evidence given that it has not been challenged.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application.

This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

As well as the case of *Thorneycroft*, he referred the panel to the cases of *El Karout v The Nursing and Midwifery Council* [2019] EWHC 28 (Admin), *Ogbonna v NMC* [2013] EWHC 1595 (Admin), *Bonhoeffer v GMC* [2011] EWHC 1585 (Admin) and *Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin), which set out that the test was whether the evidence was '*demonstrably reliable and in some respects was capable of being tested by other evidence*'.

In reaching its decision, the panel carefully considered the cases including *Thorneycroft*.

The panel considered the evidence of Witness 1 and determined that it is largely administrative. The panel noted that much of the witness statement of Witness 1 is to exhibit uncontested documents into evidence. The panel noted that the majority of the content of the witness statement is confirmed as accurate by the contents of the documents Mr Andrews provided to the panel.

The panel noted that the charges are serious and further noted that Witness 1 only speaks to one of the charges, namely charge 5b, for which Ms Sikander accepted it is the sole and decisive evidence. The panel considered that there is other evidence to indicate that Mr Andrews had been involved in a medication error during a shift in May 2022, therefore Witness 1's evidence was not necessary to establish that. Witness 1 states that Mr Andrews did not inform the NMC about this error. The panel considered that this was to report that he had inspected the case file which revealed no entry indicating that he had done so. The panel considered that this was administrative rather than evidence which would need to be tested by cross-examination and so did not consider it unfair to Mr Andrews to admit the evidence.

The panel noted that the NMC has made no effort to secure the attendance of Witness 1, nor to secure the attendance of another witness to attest to the matters contained within Witness 1's witness statements. It noted that, whilst the absence of a good reason for the non-attendance is an important factor, this does not automatically result in the exclusion of that evidence.

The panel further noted that, Mr Andrews was made aware in the recent case conference meeting that the evidence of Witness 1 will be read, and he did not object.

The panel was of the view that five out of the seven factors of *Thorneycroft* did not indicate to it that the application should be refused. It noted that in fairness to Mr Andrews, the hearsay application ought to be refused if there was a cross-examination to be undertaken, however given the nature of the evidence of Witness 1 it was unlikely that Mr Andrews would have cross-examined him.

The panel concluded that it would be fair and relevant to accept into evidence the witness statement and exhibits of Witness 1 in its entirety. After hearing all the evidence, the panel will decide how much weight should be attached to this evidence.

Decision and reasons on application for Witness 4's evidence to be held in private

On 3 December 2025, Ms Sikander addressed the panel concerning Witness 4, [PRIVATE], making an application under Rule 19.

The panel made further enquiries of Ms Sikander who reported to the panel that on the morning of 3 December 2025, Witness 4 had emailed the hearings coordinator stating that [PRIVATE]. Ms Sikander had spoken with Witness 4, during the pre-meeting on 3 December 2025, who was keen to give evidence notwithstanding her health condition, [PRIVATE].

While accepting that the witness was willing to give evidence, the panel was concerned for her health [PRIVATE], of any unnecessary risk, and so declined to hear oral evidence from Witness 4.

Decision and reasons on application to admit hearsay evidence of Witness 4

The panel then heard an application made by Ms Sikander under Rule 31, for the witness statement and corresponding exhibits of Witness 4, in relation to charges 5c and 5d, to be admitted into evidence as hearsay. She referred the panel to the case of *Thorneycroft* and submitted that this case laid out the following factors to be considered in admitting hearsay evidence and she addressed each factor respectively:

i. Whether the statements were the sole and decisive evidence in support of the charges:

Ms Sikander accepted that Witness 4's witness statement is the sole and decisive evidence in support of charge 5c. She submitted that Witness 4's statement outlines the breaches within the interim order, and it is factual, objective evidence.

Ms Sikander submitted that in relation to 5d, the panel will hear live evidence from Witness 7 who will give evidence in relation to the further breaches of the interim order, and the panel will have the opportunity to ask him about his evidence.

ii. The nature and extent of the challenge to the contents of the statements:

Ms Sikander submitted that there was no response from Mr Andrews apart from a denial. She submitted that Witness 4's evidence will not be capable of being challenged by Mr Andrews because it outlines objective evidence. She submitted there would be no real benefit of hearing live evidence of this nature and no disadvantage to Mr Andrews.

iii. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations:

Ms Sikander submitted that there has been no suggestion that Witness 4 had any reason to fabricate the content of her witness statement.

iv. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career:

Ms Sikander submitted that this charge is of dishonesty. It is alleged that Mr Andrews intended to mislead his employer. While this was a negative factor for the hearsay application, this was of little weight in this case given the objective nature of Witness 4's evidence.

v. Whether there was a good reason for the non-attendance of the witness:

Ms Sikander read out the email correspondence from Witness 4 to the hearings coordinator dated, 3 December 2025. The email outlined Witness 4's current health condition [PRIVATE].

vi. Whether the regulator had taken reasonable steps to secure the witness's attendance:

Ms Sikander submitted that the NMC has taken reasonable steps to secure the attendance of Witness 4. She submitted that Witness 4 had attended the pre-meeting on the morning of 3 December 2025, and was ready to give evidence, however, it was the panel's decision that due to Witness 4's current health condition [PRIVATE], it would not be possible for her to give her best evidence, and given her health issues, inappropriate for her to give evidence at all.

vii. Whether the registrant did not have prior notice that the witness statement would be read:

Ms Sikander submitted that, given Mr Andrews' denial of the charges and given that he has not attended the hearing today, 3 December 2025, he would not be aware that the witness statement of Witness 4 would be read as a hearsay application due to Witness 4 being currently [PRIVATE].

In conclusion, Ms Sikander referred to the case of *El Karout*. She submitted that if the panel decided to accept the evidence of Witness 4 as hearsay it would then have to assess the weight to be given to that evidence.

The panel accepted the legal assessor's advice which was to reiterate the advice given earlier.

In reaching its decision, the panel considered the cases cited to it and to the NMC Guidance note DMA-6.

The panel considered the evidence of Witness 4 and determined that it is the sole and decisive evidence only in relation to the background facts of charge 5c, but not for the charge itself.

The panel was satisfied that the reliability of the evidence of Witness 4 could be tested by the evidence of Witness 7, who was due to give evidence about the same charge.

The panel took full account of the seriousness of the charge, but noted that there were two other similar allegations of breaching conditions of practice orders (charges 5a and 5b). While the facts alleged were different in respect of charge 5c, there was undisputed documentary evidence relevant to charge 5c. The panel also noted that it was unlikely that this evidence would be subject to cross examination (as opposed to clarificatory questions).

In all the circumstances the panel allowed the hearsay application in respect of Witness 4. The panel would decide on the weight to give to that evidence at the close of the NMC's case.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Sikander, on behalf of the NMC, to amend the wording of charges 5a, 5c and 5d.

The proposed amendment was to correct the name of the institutions. It was submitted by Ms Sikander that the proposed amendment would provide clarity, consistency and more accurately reflect the evidence. She submitted that the amendment does not materially alter the nature of the case and does not prejudice either party and therefore would be unjust to not allow the amendments.

"That you, a registered nurse:

5. Acted in breach of interim orders imposed on you by the NMC, in that you:

    a. Failed to immediately provide a copy of your Interim Conditions Order dated 7 July 2021, as required by paragraphs 4(a) and (b) of that same Order, to South West London **and St George's** Mental Health **NHS** Trust.

    c. Failed to inform ~~South~~ West London ~~Mental Health~~ **NHS** Trust of an Interim Suspension Order imposed on you on 24 November 2023.

    d. Between 27 November – 1 December 2023 completed five shifts for ~~South~~ West London ~~Mental Health~~ **NHS** Trust, when you should not

have done so as you were the subject of an interim suspension order dated 24 November 2023.

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

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Andrews, and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Sikander on behalf of 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 heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 2: Healthcare Assistant at the Royal Hospital for Neuro-Disability, based on the Devonshire Wing, at the time of the incidents

- Witness 3: Employed by South West London and St George's Mental Health NHS Trust as the Ward Manager on the Aquarius Ward, at the time of the incidents

- Witness 5: Healthcare Assistant at the Royal Hospital for Neuro-Disability in Greater London, based on the Devonshire Wing, at the time of the incidents

- Witness 6 (Colleague A): Employed as a Band 6 Charge Nurse at the Royal Hospital for Neuro-Disability, overseeing Devonshire Wing, at the time of the incidents

- Witness 7: Divisional Clinical Lead Nurse for nursing agency, Pulse Nursing, at the time of the incidents

- Witness 8: Employed as the Temporary Staffing Manager for the bank team for South West London and St George's Mental Health NHS Trust, at the time of the incidents

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

The panel scrutinised the evidence of the NMC's witnesses carefully. The panel perused carefully the 71-page bundle of documents provided by Mr Andrews. It considered the evidence of the NMC witnesses to be truthful and accurate. The panel gave less weight to hearsay evidence, but considered the documents exhibited to those witness statements to be reliable.

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

Charge 1a)

1. On 8 September 2023 in relation to Patient A:
    a. Administered medication to a patient not under your care

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and witness statements of Witness 2 and Witness 6. The panel carefully considered the contemporaneous local statement of Witness 2 dated 8 September 2023 and the 'Allocation List of Patients for Mr Andrews' document dated 8 September 2023.

The panel noted that in Mr Andrews' bundle to the NMC, he stated in the Regulatory Concerns Response form, dated 15 January 2024:

> *'…I was allocated to provide care for that patient as is recorded on the documentary evidence I have provided you with.'*

These documents included a handover sheet dated 8 September 2023. This showed that Patient A had been electronically identified as being the responsibility of Team 5. Mr Andrews had been allocated responsibilities for Team 4. He had no responsibility for patients cared for by Team 5.

Witness 6 confirmed in her oral evidence that Patient A was not under the care of Team 4. She further told the panel that she gave Mr Andrews the documentation outlining his patients and went round and introduced him to all the patients he was supposed to be looking after that day, and this did not include Patient A.

Witness 2 and Witness 6 confirmed in their written and oral evidence that medication was administered to Patient A. In his bundle of documents, Mr Andrews accepted that he administered medication to Patient A (as set out in charge 1b).

The panel found both Witness 2 and Witness 6 to be reliable and credible. It determined that both witnesses were internally consistent with their local statements which were contemporaneous.

Accordingly, the panel finds charge 1a proved.

Charge 1b)(i)(ii)

1. On 8 September 2023 in relation to Patient A:
    b. Administered medication through the subglottic port of a tracheostomy tube:
        i. When the subglottic port was not meant for administering medication, and
        ii. When you had not undergone the necessary training allowing you to work with patients with a tracheostomy tube.

These charges are found proved.

In reaching this decision, the panel took into account the witness statements and oral evidence of Witness 2 and Witness 6. It also had regard to the contents of Mr Andrews' bundle provided by him to the NMC.

The panel noted that Mr Andrews, in email correspondence to the NMC dated 20 September 2023, stated:

> *'…Yes I tried to dispense medication through the subglottic port of patient's tracheostomy. And I relented immediately when the patient's family told me I was not administering the medication the correct route…'*

Mr Andrews further goes onto state in the Regulatory Concerns Response form dated 15 January 2024:

> *'Yes, this was a completely guanine mistake on my part for which I am totally regret and feel very remorseful. For this reason, I have resigned from that Agency, and no longer work for them.'* [sic]

This is supported by the witness statement and oral evidence of Witness 2, in which she stated:

> *'…Patient A's mother grabbed me and I went in to Patient A's room right away...I asked Patient A's mother what was going on and she said Mr Andrews put Patient A's medication in his subglottic port. The subglottic port is a tube in a patient's tracheostomy tube, which is used to help a patient to breathe. Medication should not go in the subglottic port.'*

This is further supported by the witness statement and oral evidence of Witness 6. In her oral evidence, she confirmed that this was not the appropriate route to administer medication.

Mr Andrews, in the email correspondence to the NMC dated 20 September 2023, stated:

> *'I went to that job as a Mental Health Nurse, not a Tracheostomy Nurse so I was definitely not skilled and knowledgeable in that field… Because there was a Trache on his neck and I though there is where the medication was put through. Mind you I have had no training in this area…'* [sic]

Witness 6, in her oral evidence, told the panel that Mr Andrews had not undergone the necessary training. She told the panel that she had checked with Mr Andrews if he had undertaken the necessary training and he had reassured her that he had. She also said that Mr Andrews had told her that he had worked on that ward previously and in other wards in the hospital where patients had similar nursing requirements. Furthermore, she said she observed Mr Andrews administering medication via a PEG and was reassured by that.

The panel concluded that Mr Andrews accepted administering medication through the subglottic port of a tracheostomy tube when it was not meant for administering medication, and he has also admitted not having the necessary training to work with patients with a tracheostomy tube.

Accordingly, the panel finds charges 1b(i) and 1b(ii) proved.

Charge 1c)

1. On 8 September 2023 in relation to Patient A:
    c. Did not seek appropriate supervision or guidance in relation to the care provided at charges 1(a) and 1(b).

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 6 and Mr Andrews' bundle to the NMC.

Witness 6 in her witness statement stated:

> *'…Patient A's family reported to me they had tried to intervene and stop Mr Andrews. Despite their efforts, they reported that Mr Andrews ignored them and continued his actions of administering the medication into the tube…'*

Witness 6 further goes onto state:

> *'It is important for staff, especially those unfamiliar with specific procedures, to seek clarification or supervision from more experienced colleagues, including the charge nurse...'*

This was further corroborated in her oral evidence when she told the panel that she had reiterated this to Mr Andrews. She had told him that if he was in doubt he must seek help from other members of staff.

In Mr Andrews' bundle, in an email correspondence to the NMC, dated 20 September 2023, he stated:

> *'I went to that job as a Mental Health Nurse, not a Tracheostomy Nurse so I was definitely not skilled and knowledgeable in that field… Because there was a Trache on his neck and I though there is where the medication was put through. Mind you I have had no training in this area…'* [sic]

The panel concluded that Mr Andrews admitted that he did not have the relevant training in tracheostomy care. It determined that he did not seek appropriate supervision or guidance in relation to the care provided at charges 1(a) and 1(b), if he had done so then the incident would not have taken place. It noted that Patient A's relatives had expressed concerns, but Mr Andrews did not stop and seek out clarification, even though Witness 6 had stated to him the importance of doing so.

Accordingly, the panel finds charge 1c proved.

Charge 2a-c)

2. On 8 September 2023 in relation to Patient A:
    a. Failed to verify Patient A's identity before administering medication
    b. Failed to check Patient A's medication records prior to administering any medication
    c. Administered medication to Patient A that was not prescribed for Patient A

These charges are found proved.

The panel considered charges 2a, 2b and 2c together.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 6, Patient A's Medication Chart dated 8 September 2023 and Mr Andrews' bundle to the NMC.

Mr Andrews, in his bundle to the NMC, stated that he thought when dealing with Patient A that he was dealing with Patient B. It follows that he failed to check the identity of Patient A as if he had done so he would have realised that the patient was not Patient B.

As Mr Andrews had thought the patient was Patient B, he did not check the records of Patient A before administering medication, and he administered medication to Patient A

that was intended for Patient B (which at that time was not the same as what was prescribed for Patient A).

Witness 6 in her witness statement stated:

> *'…Mr Andrews' response was that he mistakenly thought he was attending to Patient B…'*

Witness 6, in her oral evidence told the panel that a registered nurse would be required to check the wristband of the patient to verify the patient's identity. Furthermore, she told the panel that a registered nurse administering medication would have an iPad with the electronic patient records on it which would outline what medication needed to be given, at what dose, via what route and at what time. She also told the panel that if the medication had already been given, an electronic signature of the nurse giving the medication would appear next to the medication.

In Mr Andrews' bundle, in an email to the NMC, dated 20 September 2023, he referred to the medication that he says that he gave to Patient A, stating that:

> *'I though 5mg of Folic Acid, 15mg of Codiene Sulphate and 1000mg of Paracetamol'* [sic]

Witness 6 in her witness statement stated:

> *'…However, upon checking Patient A's drug chart, we found that these medications did not correspond with his prescribed treatments…'*

The panel noted in Patient A's Medication Chart that although Patient A was prescribed 15mg of Codeine Sulphate this was not prescribed and started until 12 October 2023, and similarly although 1000mg of Paracetamol was prescribed that was not prescribed and

started until 9 October 2023. Folic Acid was not prescribed at all. Therefore, on 8 September 2023 none of these drugs had been prescribed for Patient A.

Therefore, the panel determined that Mr Andrews could not have checked Patient A's medication records prior to administering the medication, and had administered medication to Patient A that was not prescribed for Patient A at the time.

The panel concluded that there is a duty of care for a registered nurse to verify the patient and check the medication records before administering medication. It concluded that Mr Andrews did not verify the patient, did not check Patient A's medication records and had consequently administered the wrong medication to Patient A.

Accordingly, the panel finds charges 2a, 2b and 2c proved.

Charge 2d)(i-iv)

2. On 8 September 2023 in relation to Patient A:
    d. Failed to record the details of the medication administered to Patient A, including the:
        i. drug name; and / or
        ii. dosage; and / or
        iii. time; and / or
        iv. route.

These charges are found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 6 and closely examined Patient A's Medication Chart dated 8 September 2023.

Witness 6 in her witness statement stated:

'…Mr Andrews was unable to recall the specific medication he had prepared and administered…'

The panel looked at the medication chart to ascertain all the medication that was prescribed to Patient A at that time. The panel noted that on 8 September 2023 medication was given to Patient A, however, the panel could not see Mr Andrews' initials anywhere on the chart for the day and concluded that Patient A's medication chart did not show that Mr Andrews had signed for any medication or recorded any drug name, dosage, time or route of administration on that day.

Accordingly, the panel finds charges 2d(i), 2d(ii), 2d(iii) and 2d(iv) proved.

Charge 3a)

3. On 8 September 2023 in relation to Patient B:
    a. Failed to check Patient B's medication records prior to administering medication

This charge is found proved.

In reaching this decision, the panel took into account the witness statements and oral evidence of Witness 6 and Witness 5, and Patient B's Medication Chart.

Witness 6 in her witness statement stated:

'…I provided a handover to Mr Andrews and introduced him to Patient B, informing him that Patient B's medication had already been prepared and administered, and that it would be reflected in the Electronic Patient Record… I showed Mr Andrews the EPR to confirm that the medication for Patient B had been signed off, indicating that he had only five

remaining patients to care for. Patient B's medication chart shows my administration of Patient B's lunchtime medication and medication I administered prior to Mr Andrews arrival, which Mr Andrews had seen…'

The panel looked closely at Patient B's Medication Chart and determined that Witness 6's evidence is corroborated by this contemporaneous evidence.

Witness 5 in his witness statement stated:

'…Mr Andrews proceeded to give Patient B some medication…I was stood away from them and could see the back of Patient B. I saw Patient B raise his right arm and put his hand to his mouth…'

The panel determined that Mr Andrews had administered medication to Patient B, however, had he checked the medication record thoroughly he would have seen that Witness 6 had already administered the medication. Furthermore, although it was assumed at the time Mr Andrews had given a second dose of Patient B's prescribed medication, when he was questioned later, he could not fully remember what medication he had given and the medications he remembered were not those prescribed for Patient B. Given the panel's findings about charge 2b, it is likely that any inspection of the medication records of Patient B was cursory.

Accordingly, the panel finds charge 3a proved.

Charge 3b)

3. On 8 September 2023 in relation to Patient B:
    b. Administered medication to Patient B which had already been administered by a colleague

This charge is found NOT proved.

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

Witness 5 in his witness statement stated:

> *'…Mr Andrews proceeded to give Patient B some medication, although I do not know what medication it was…'*

Witness 6 in her witness statement stated:

> *'…upon checking the Patient B's medication chart, I do recall it did not match the medications listed on Patient's B medication chart…I am not aware of as Mr Andrews himself could not accurately recall the medication he administered'.*

The panel determined that although Mr Andrews did administer medication to Patient B, there was no evidence that he had administered medication which had already been administered by Witness 6. It noted that, Witness 6 had found out that it was not the same drugs she had administered.

Accordingly, the panel finds charge 3b not proved.

Charge 3c)(i-iv)

3. On 8 September 2023 in relation to Patient B:
    c. Failed to record the details of the medication administered to Patient B, including the:
        i. drug name; and / or
        ii. dosage; and / or
        iii. time; and / or

iv. route.

These charges are found proved.

In reaching this decision, the panel carefully considered Patient B's Medication Chart.

Having reviewed Patient B's Medication Chart the panel noted that the medications were administered on 8 September 2023, however, Mr Andrews' initials were not present on the chart for that day. Patient B's Medication Chart did not show that Mr Andrews had signed for any medication or recorded any drug name, dosage, time or route on that day.

Accordingly, the panel finds charges 3c(i), 3c(ii), 3c(iii) and 3c(iv) proved.

Charge 4)

4. You falsely represented to Colleague A that you held the appropriate qualifications and/or competencies in tracheostomy care when you did not.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 6 and Mr Andrews' bundle to the NMC.

Witness 6 in her witness statement stated:

> *'When I inquired about his competencies in handling tracheostomies, catheters, or administering feeds through PEG tubes, Mr Andrews assured both myself and my colleagues, and Raymunda Layos, band 5 bank staff of his proficiency in these areas. At the time of the incident involving Mr Andrews, we did not possess the necessary documentation to verify his competency. Ms Torres-Rivero, and I had each inquired*

about his competency in tracheostomy care on separate occasions and Mr Andrews confirmed his competence.'

Witness 6 further goes on to state:

'… we consistently inquire about their familiarity with specific care requirements, such as tracheostomy care or PEG feeding. If an agency staff member expresses uncertainty or inexperience with these tasks, our procedure is to reassign them to ensure that patients requiring specialised care are managed by competent nurses. Mr Andrews claimed to be competent in these areas…'

The panel accepted Witness 6's oral evidence that when it was someone she already knew, she would know that they had the competency as she had previously worked with them. However, when it was someone new, she would check that they knew what they were doing with tracheostomies, catheters and PEG feeds.

Witness 6 told the panel that Mr Andrews had told her that he had worked on Devonshire Ward previously and also within other wards in the hospital, where patients had similar nursing requirements, including tracheostomies, catheters and PEG feeds.

Mr Andrews in his bundle stated:

'Because there was a Trache on his neck and I though there is where the medication was put through. Mind you I have had no training in this area…' [sic]

The panel determined that Witness 6 in her oral evidence was honest and clear. She told the panel that she had a detailed discussion with Mr Andrews on his arrival on the ward and he had reassured her that he had the appropriate competencies, when he knew he did not.

Accordingly, the panel finds charge 4 proved.

Charge 5a)

5. Acted in breach of interim orders imposed on you by the NMC, in that you:
    a. Failed to immediately provide a copy of your Interim Conditions Order dated 7 July 2021, as required by paragraphs 4(a) and (b) of that same Order, to South West London and St George's Mental Health NHS Trust.

This charge is found proved.

In reaching this decision, the panel took into account the Interim Conditions of Practice Order Decision Letter dated 7 July 2021, the witness statements of Witness 1 and Witness 8, the oral evidence of Witness 8 and the email correspondence between Mr Andrews and Witness 8 dated 16 June 2022.

The panel noted that Mr Andrews was sent the outcome of the hearing decision letter by the NMC on 8 July 2021, by first class post to his registered address. This letter outlined the conditions that were imposed on Mr Andrews. The panel noted the requirements of condition 4a and 4b:

'*4. You must immediately give a copy of these conditions to:*
a) Any organisation or person you work for.
b) Any agency you apply to or are registered with for work.'

The panel noted that Witness 1 his witness statement stated:

'On 7 July 2021… Mr Andrews received an interim conditions of practice order for a period of 12 months…'

This is corroborated by Witness 8 in her witness statement:

> *'On 16 June 2022 Mr Andrews informed me that he was subject to an interim conditions of practice order... I believe that interim order was imposed in 2021 and he was required to provide his employer with a copy of it. However, Mr Andrews did not provide the bank team with a copy of it at the time it was imposed and he informed me on 16 June 2022…'*

This was further corroborated by Witness 8 in her oral evidence.

In the email correspondence with Witness 8, dated 16 June 2022, Mr Andrews stated:

> *'… I did not informed you 12 months ago when I was first referred to the NMC, this was a mistake on my part... I apologies for not informing you the first time around'* [sic]

The panel concluded that Mr Andrews had admitted to not immediately providing a copy of his Interim Conditions of Practice Order dated 7 July 2021 to his agency or to an organisation he worked for as required by conditions 4a and 4b.

Accordingly, the panel finds charge 5a proved.

Charge 5b)

5. Acted in breach of interim orders imposed on you by the NMC, in that you:
    b. Failed to notify the NMC within seven days, of a medication error that occurred in your practice on 18 May 2022, in accordance with your interim order dated 7 July 2021.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witness 1 and Witness 3.

Witness 1 in his witness statement stated:

> *'Condition five of the interim order required Mr Andrews to tell his NMC case officer, within seven days of becoming a[wa]re, of any clinical incident he was involved in and any investigation or disciplinary proceedings taken against him.*
> *…*
> *On 7 November 2023, the NMC were made aware by South West London and St George's Mental Health NHS Trust, that Mr Andrews had been involved in a medication error during a shift on 18 May 2022. I can confirm that Mr Andrews did not inform the NMC about this error, in breach of the conditions of his interim order.'*

The panel accepted Witness 3's witness statement which stated:

> *'On 18 May 2022, Mr Andrews completed a bank shift on the Ward. Mr Andrews recorded on Patient C's electronic medication patient record (EMPA) that he administered 5ml of Fluoxetine at 08:00... Patient C informed her doctor that she never received the medication…'*

The panel carried out a careful balancing exercise and determined that a medication error did occur on 18 May 2022. It determined that although Witness 1's hearsay evidence is the sole and decisive evidence to this charge, it is factual and not eye-witness evidence. There is no reason for Witness 1 to fabricate his evidence, and this evidence has not been disputed by Mr Andrews at any time.

Whilst the panel considered each charge individually, in considering charge 5b it also took into account that it was consistent with other findings of fact made in respect of other charges. Therefore, this would not be an isolated example of failure to act appropriately.

The panel concluded that, on the balance of probabilities it is more likely than not that Mr Andrews failed to notify the NMC within seven days of a medication error that occurred, as was required by his interim conditions of practice order.

Accordingly, the panel finds charge 5b proved.

Charge 5c)

5. Acted in breach of interim orders imposed on you by the NMC, in that you:
    c. Failed to inform West London NHS Trust of an Interim Suspension Order imposed on you on 24 November 2023.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 7, the email correspondence between Mr Andrews and the NMC dated 21 November 2023 and 27 November 2023.

Witness 7 in his witness statement stated:

> *'The last shift that Mr Andrews completed through Pulse Nursing was on 3 December 2023 (Mr Andrews did attend a shift for the morning of the 4th December 2023, and was called to leave the shift). Following the imposition of Mr Andrews' interim suspension order, that Pulse Nursing only became aware of on 4 December 2023 during a routine weekly check of the NMC register...'*

Witness 7 corroborated this in his oral evidence and told the panel that after finding out about Mr Andrews' interim suspension order he had blocked him from booking any further shifts through Pulse Nursing.

The email correspondence between Mr Andrews and the NMC dated 21 November 2023 establishes that Mr Andrews was aware that the hearing was taking place and states that:

> *'I though I heard you say that you will be holding a panel meeting to discuss the matter. But I have to tell you that the 24-11-23 I won't be in London, but in Reading to bring back some things back to London and fortunately for me, you did say if I cannot attend the meeting then I can send my submission. And this is it.'* [sic]

The email correspondence between the NMC and Mr Andrews dated 27 November 2023 stated:

> *'Further to my previous email, please find attached the decision letter.*
>
> *If you have any questions regarding the decision letter, please contact the case officer. Their details will be on the decision letter.'*

The panel accepted Witness 7's evidence. It noted that Witness 7 had stopped Mr Andrews from working on 4 December 2023. It noted that the interim suspension order was imposed on 24 November 2023.

The panel noted that Mr Andrews was aware of the hearing taking place and that there would be an outcome at the end of the hearing. Therefore, there was a duty on Mr Andrews as a registered nurse to find out the outcome of the regulatory proceedings, which he knew were taking place on 24 November 2023. It noted that an email was sent to Mr Andrews on 27 November 2023 with the decision letter attached. It determined that Mr Andrews had wilfully not checked his email, and he has a duty to engage with the

regulatory proceedings appropriately, which includes checking to establish the outcome of regulatory proceedings affecting him and acting in accordance with any order made.

The panel concluded that Mr Andrews had failed to inform West London NHS Trust of his interim suspension order because he did not open his email in which the outcome was contained, and he carried on working there after 24 November 2023.

Accordingly, the panel finds charge 5c proved.

Charge 5d)

5. Acted in breach of interim orders imposed on you by the NMC, in that you:
    d. Between 27 November – 1 December 2023 completed five shifts for West London NHS Trust, when you should not have done so as you were the subject of an interim suspension order dated 24 November 2023.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witness 4 and Witness 7, the Staff Roster document and the 'Summary of Shifts Mr Andrews completed through Pulse Nursing' document.

Witness 4 in her witness statement stated:

> *'I can confirm that Mr Andrews completed the following six shifts when his registration was suspended by the NMC:*
>
> *i. 24 November 2023, 9:00 – 17:00;*
> *ii. 27 November 2023, 9:00 – 17:00;*
> *iii. 28 November 2023, 9:00 – 17:00;*
> *iv. 29 November 2023, 9:00 – 17:00;*

v. 30 November 2023, 9:00 – 17:00; and
vi. 1 December 2023, 9:00 – 17:00.'

This is corroborated by Witness 7's evidence which stated:

'The last shift that Mr Andrews completed through Pulse Nursing was on 3 December 2023 (Mr Andrews did attend a shift for the morning of the 4th December 2023, and was called to leave the shift).'

The panel accepted Witness 4's evidence and noted that although Witness 4's hearsay evidence is the sole and decisive evidence to this charge, it is factual and not eye-witness evidence. There is no reason for Witness 4 to fabricate her evidence, and this evidence has not been disputed by Mr Andrews.

The panel carefully examined the Staff Roster document and the 'Summary of Shifts Mr Andrews completed through Pulse Nursing' document. It noted that the summary of the shifts Mr Andrews worked from 24 November 2023 to 3 December 2023 supported the hearsay evidence of Witness 4.

The panel concluded that Mr Andrews should have enquired about the outcome of his hearing as he has a duty to engage with his regulator and to abide by the outcome of any regulatory hearings.

Accordingly, the panel finds charge 5d proved.

Charge 6)

6. Your actions in charge 4 and / or charge 5 were dishonest in that you intended to mislead.

This charge is found proved.

In reaching this decision, the panel considered the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67.

In relation to charge 4, the panel noted that Mr Andrews has admitted the fact that he was not experienced and yet when he was asked by Witness 4, he reassured her that he was competent.

Mr Andrews, in his bundle to the NMC, in an email dated 21 September 2023 stated:

> *'…And so is the ward I went to worked on as a Tracheostomy nurse that day. I never had a training from they even for a day…'* [sic]

The panel determined that Mr Andrews was dishonest, in that he knowingly accepted a shift when he knew he did not have the skills and expertise required to work with patients in need of tracheostomy care, intentionally and deliberately misleading the ward manager by lying in saying that he was competent and trained to do so. The panel determined that there was an obligation on Mr Andrews to be open and honest and inform Witness 6 that he was not competent in that area. It noted that there were numerous opportunities for Mr Andrews to decline working in that ward. The panel heard from Witness 6 in her oral evidence that if nurses did not acquire the skills and experience required to work with particular patients, they would be reallocated to another patient for whom they have the expertise to provide care. The panel determined that ordinary decent people would regard Mr Andrews' actions in charge 4 as dishonest.

In relation to charge 5a, the panel determined that Mr Andrews knew that he had an interim conditions of practice order imposed on him, and he must have been aware that he needed to present a copy of his interim order to his agency and place of work as required by condition 4a and 4b:

> '*You must immediately give a copy of these conditions to:*
> *a) Any organisation or person you work for.*

b) Any agency you apply to or are registered with for work.'

The panel determined Mr Andrews had disregarded his regulatory responsibilities. It determined that Mr Andrews had a reason to conceal his interim conditions of practice order as there was advantage to him in not disclosing it. The panel determined that ordinary decent people would regard Mr Andrews' actions in charge 5a as dishonest.

In relation to charge 5b, the panel noted that it was a requirement of Mr Andrews in his interim conditions of practice order:

'*You must tell your case officer, within seven days of your becoming aware of:*
a) Any clinical incident you are involved in.'

The panel considered both the limbs of *Ivey* and determined that Mr Andrews was dishonest by his action in charge 5b. It determined that ordinary decent people would regard Mr Andrews' conduct in charge 5b as dishonest.

In relation to charge 5c, the panel determined that there was an onus on Mr Andrews to find out the outcome of the hearing held on 24 November 2023. It determined that Mr Andrews was dishonest in not finding out the outcome from that hearing and knowingly accepting shifts subsequently.

Mr Andrews was emailed the decision letter on 27 November 2023, however the panel concluded that, on the balance of probabilities, he intentionally chose not to check his email. It determined that Mr Andrews had deliberately avoided finding out the outcome to avoid the impact the decision may have on him. The panel determined that ordinary decent people would expect a registered nurse to find out what the outcome was of their hearing, and therefore would find Mr Andrews' action in charge 5c dishonest.

In relation to charge 5d, the panel determined that Mr Andrews was aware that regulatory proceedings were being held but he still went into work and completed five shifts without checking the outcome of the hearing which he knew would have taken place. There was a duty on Mr Andrews to check the outcome of the hearing. Mr Andrews did not check the email containing the outcome until after he was stopped from working at his shift by his agency which had discovered the interim suspension order in a routine weekly check. The panel decided that it was more likely than not he was concerned that the outcome would not be in his favour, which might prevent him from working. The panel determined that, even if Mr Andrews did not know the outcome of the regulatory proceedings, this was because he wilfully did not check and that was dishonest on his part. The panel determined that ordinary decent people would find Mr Andrews' conduct in charge 5d dishonest.

Accordingly, the panel finds charge 6 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 Andrews' 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 ability to practise kindly, safely and professionally.

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 Andrews' fitness to practise is currently impaired as a result of that misconduct.

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

The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Submissions on misconduct

Ms Sikander invited the panel to take the view that the facts found proved amount to misconduct, in that Mr Andrews' actions and omissions fell short of what would be proper in the circumstances, as set out in the NMCs Guidance on Misconduct (FTP-2a).

Ms Sikander referred the panel to the case law of *Roylance v General Medical Council* [1999] UKPC 16, *Calhaem v GMC* [2007] EWHC 2606 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Ms Sikander further referred the panel to the NMC Guidance, Sanctions for Particularly Serious Cases (SAN-2). She submitted that Mr Andrews' behaviour in respect of charge 5 was repeated multiple times, and as the facts found were within the definition of serious cases the charges found proved were misconduct. There has been no effort to correct the concerns, and Mr Andrews has failed to attend his substantive hearing without proper notice or sufficient reason.

Ms Sikander submitted that acting with honesty and integrity is an integral part of the NMC Code of Conduct. She submitted that this case is serious because it calls into question Mr

Andrews' ability to uphold fundamental tenets of the professions and his conduct represents significant breaches of the Code.

Ms Sikander identified the specific, relevant standards where she submitted that Mr Andrews' actions amounted to misconduct and were breaches of the Code, in particular, 20.1, 20.2, 20.3 and 20.8. She submitted that Mr Andrews' conduct represents serious breaches of fundamental tenets of the profession.

Submissions on impairment

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

Ms Sikander submitted that Mr Andrews is impaired by reason of his misconduct and dishonesty. She submitted that all four limbs of the *Grant* test were engaged in this case.

In relation to the first limb, Ms Sikander submitted that Mr Andrews in the past has acted and is liable in the future as so to put a patient or patients at unwarranted risk of harm. The charges found proved relate to fundamental skills and basics of nursing. There is no evidence that Mr Andrews has addressed any areas of concern. If Mr Andrews were to practice without restrictions patients would be placed at unwarranted risk of harm.

In relation to limb two, Ms Sikander submitted that Mr Andrews' actions fell significantly short of what is expected of a registered nurse and are a serious departure from the standards expected of a registered nurse. She submitted that Mr Andrews' actions have brought the profession into disrepute and are likely to erode the trust and confidence of the public in the nursing profession.

In relation to limb three, Ms Sikander submitted that Mr Andrews breached the fundamental tenets of the nursing profession and subsequently breaching the Code.

In relation to limb four, Ms Sikander referred the panel to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin). She further referred the panel to the NMC Guidance FTP-15a, FTP-15b and FTP-15c. Ms Sikander submitted that Mr Andrews has shown little to no insight. There appears to be no evidence of steps taken to address the concerns in this case. There appears to be little real sense of responsibility taken. She submitted that the concerns in this case cannot be said to have been satisfactorily addressed and managed, and therefore there is a high risk of repetition.

Ms Sikander submitted that in respect of public interest, in this case the concern clearly constitutes matters that are serious, and a finding of impairment is required to uphold professional standards. She submitted that if a finding of impairment is not made then this would undermine public confidence and trust in the regulatory process and the NMC as a regulator.

Ms Sikander invited the panel to find that Mr Andrews is currently impaired on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council*, *CHRE v (1) NMC v Grant*, *Cohen v GMC*, *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), and *Remedy UK Ltd, R (on the application of) v The General Medical Counci*l [2010] EWHC 1245 (Admin). In respect of dishonesty, he referred the panel to *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords)* [2017] UKSC 67. He referred the panel to the NMC Guidance note FTP-2a on Misconduct, and DMA-1 on Impairment.

Decision and reasons on misconduct

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

The panel was of the view that Mr Andrews' actions did fall significantly short of the standards expected of a registered nurse, and that Mr Andrews' 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*
>
> ***6 Always practise in line with the best available evidence***
> ***To achieve this, you must:***
>
> *…*
>
> *6.2 maintain the knowledge and skills you need for safe and effective practice*
>
> ***8 Work co-operatively***
> ***To achieve this, you must:***
>
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
>
> *8.2 maintain effective communication with colleagues*

…

…

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

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

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

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

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:

…

…

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

…

13.5 complete the necessary training before carrying out a new role

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations
To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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

…

…

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

23 Cooperate with all investigations and audits
This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.
To achieve this, you must:

…

…

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body'

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

The panel determined that in respect of charge 1a, Mr Andrews' conduct showed a disregard for what one would expect a registered nurse to do in terms of administering medication to patients, and only administering medication to those under their care. Mr

Andrews of his own volition administered medication to Patient A, which was not appropriate, and in turn stepping over boundaries in caring for a patient who was not allocated to him. In the context of the other sub charges of charge 1 found proved this charge amounted to misconduct.

In respect of charge 1b(i), the panel determined that it is very serious to administer medication via an incorrect route. It determined that all registered nurses should know that a subglottic port is not a route used to administer liquid medication. Mr Andrews had to use considerable force to cause the patient to ingest the liquid medication via the subglottic port, and he did not stop despite the family of Patient A objecting. Furthermore, Patient A also had a PEG in situ which would have been the correct route of medication administration and if Mr Andrews was confused as to which port to use, he should have asked advice from a colleague. This charge was serious misconduct. The consequences could have been very serious had the family not called another staff member who promptly obtained expert nursing and medical care.

In respect of charge 1b(ii), the panel determined that Mr Andrews was working beyond his limits of capability and competence in dealing with tracheostomy care which requires proper and necessary training, which he did not have. It determined that it fell far below the standards required of a registered nurse to undertake such a task without the necessary training. Therefore, this charge amounts to misconduct.

In respect of charge 1c, the panel determined that it is a fundamental tenet of the nursing profession to seek help or guidance if you are unsure about any aspect of a patient's care including how to undertake a nursing task. The family of Patient A tried to stop Mr Andrews because they realised what he was doing was incorrect. Despite this he did not stop and so they had to go and seek help from another staff member. It determined that a registered nurse must work within limits of their competence. This was a serious falling short, and therefore, this charge amounts to misconduct.

In respect of charge 2a, the panel determined that this charge amounts to misconduct. It determined that it is a significant falling short of nursing standards to administer the wrong medication to the wrong patient (and by the wrong route) and could pose a serious risk to patients.

In respect of charge 2b, the panel determined that this charge amounts to misconduct. It determined that it is essential to check the medication records before administering medication to make sure you have the correct medication, the correct dose, you are administering it at the correct time, and administering it by the correct route. It also allows you to be certain that another member of staff has not already given the medication as doubling the dose with certain medications could result in very serious harm to the patient.

In respect of charge 2c, the panel determined that there is a risk and danger in administering medication that has not been prescribed to the patient. The medication might be contraindicated in the condition the patient is suffering from and there is also the possibility of a drug/drug interaction with the medication the patient has been prescribed. This could result in very serious harm to the patient. It may have an effect deleterious to that patient. It is a failure in a basic principle of nursing. Therefore, this charge amounts to misconduct.

In respect of charge 2d, the panel determined that there is a real danger in not being able to recall and record the details of the medication prescribed to Patient A as other members of staff will not know what medication the patient was administered. Therefore, this charge amounts to misconduct.

The panel found misconduct on each part of charge 2 in the context of the overall circumstances relating to Patient A.

In respect of charge 3a, the panel determined that this charge amounts to misconduct for the same reasons as charge 2b.

In respect of charge 3c, the panel determined that this charge amounts to misconduct for the same reasons as charge 2d.

In respect of charge 4, the panel determined that Mr Andrews conduct was egregious and deplorable. It is a fundamental tenet of nursing that registered nurses are honest and open. It was very wrong of Mr Andrews to say that he was competent to give tracheostomy care, and to attempt to administer medication via a subglottic port when he was not trained and was not competent to deliver tracheostomy care. While this charge also carried a charge of dishonesty, it was misconduct whether or not the actions were dishonest.

In respect of charge 5, the panel determined that any breach of an interim order is very serious. An interim order is there to protect the public and disregarding it amounts to misconduct.

In relation to charge 5a, the panel determined that this charge amounts to misconduct. Mr Andrews failed to comply with a direction from the regulator and breached a requirement of the interim order.

In relation to charge 5b, the panel determined that it is important to follow the directions of an interim order set by the regulator. It determined that medication error is a clinical incident. This is a patient safety issue and so not notifying the regulator is serious. This is because the regulator is prevented from reassessing the risks identified when the order was made. Therefore, this charge amounts to misconduct.

In relation to charge 5c, the panel determined that the imposition of an interim suspension order reflects heightened risk to patients. Mr Andrews should not have been working as a registered nurse after the interim suspension order was made. The interim suspension order is there to protect the public and uphold the professional standards of the nursing profession. In light of the findings made, the panel determined this charge amounts to misconduct.

In relation to charge 5d, the panel determined that this charge amounts to misconduct as Mr Andrews had deliberately ignored his regulator by not checking the outcome of the hearing and by carrying on working as a nurse subsequently. There is no reason to suggest that if the agency's routine check had not been carried out, he would have carried on working as a nurse indefinitely while suspended from the register.

In respect of charge 6, the panel noted that this charge is of dishonesty. It relates directly to patient safety and upholding professional standards of the nursing profession. The panel determined that there was dishonesty on several occasions. This was not an isolated one-off incident or a momentary aberration. The matters all have the potential to put patients at risk of harm and bring the profession into disrepute.

Given that charges 4 and 5 were found to be of dishonest in the course of nursing practice, these are self-evidently so serious as to amount to misconduct. It determined that there was dishonesty in Mr Andrews' conduct, dishonesty in ignoring the regulator and upholding the professional standards, therefore this charge amounts to misconduct.

To conclude, the panel found that Mr Andrews' actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'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?”

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

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

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

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

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

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

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

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

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

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

The panel concluded that all four limbs of the *Shipman* test were potentially engaged in this case.

The panel determined that patients were put at risk and there was serious potential risk of harm as a result of Mr Andrews' misconduct. Mr Andrews' misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. The panel had concluded that Mr Andrews' actions fell significantly short of the proper professional standards and expectations of a registered nurse.

The panel went on to consider insight. It took into account Mr Andrews' bundle to the NMC and determined that there was some remorse but no evidence before it today from Mr Andrews demonstrating any insight on the seriousness of his actions and its impact on patient safety.

The panel determined that the misconduct in this case is very difficult to address. The attitudinal issues of undertaking tasks for which he was not trained and was not competent

to undertake, deceiving those with whom he worked, and flouting orders of his regulator are varied and are very serious.

The panel next considered whether the concerns had been remediated. The panel concluded that they had not. There was no evidence of insight, and the only response of Mr Andrews was to complain about the effect on him of the interim orders. There was nothing before the panel to suggest that Mr Andrews has taken steps to remedy his failings or mitigate the risks identified.

The panel did not consider that it was highly unlikely that the actions of Mr Andrews would not be repeated. He displayed no insight and the panel considered that the unaddressed attitudinal issues meant that there was a high likelihood of repetition.

The panel determined that there is a risk to the public as Mr Andrews' conduct was dangerous and dishonest and is unremedied. Due to a lack of insight, remediation and strengthening of practice, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because Mr Andrews' failings were very serious and of dishonesty in practice. He had disregarded his regulator and the interim orders imposed on him. He was dishonest in his practice by lying about his competency. The panel concluded that public confidence in the profession and its regulator would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Andrews' fitness to practise impaired on the grounds of public interest.

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

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 Andrews off the register. The effect of this order is that the NMC register will show that Mr Andrews 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.

Submissions on sanction

In the Notice of Hearing, dated 30 October 2025, the NMC had advised Mr Andrews that it would seek the imposition of a striking-off order if it found Mr Andrews' fitness to practise currently impaired.

Ms Sikander informed the panel that an interim suspension order was imposed on Mr Andrews on 24 November 2023 for a period of 18 months. The interim order was extended by the High Court until 22 February 2026.

Ms Sikander referred the panel to the NMC Guidance SAN-3e on striking-off order and SAN-2 on cases involving dishonesty.

Ms Sikander submitted that nothing but a striking-off order is appropriate in this case. She submitted that Mr Andrews' actions posed a direct risk to patients receiving care, and a deliberate breach of his professional duty of candour. In any event, Mr Andrews' actions did cause harm to patients under his care.

Ms Sikander, referred to SAN-2 which states:

> *'Nurses … who have behaved dishonestly can engage with the Fitness to Practise Committee to show that they feel remorse, that they realise they acted in a dishonest way, and tell the panel that it will not happen again. Where the professional denies dishonesty, it is particularly important that they make every effort to attend the hearing so that the Committee can hear at first hand their response to the allegations.'*

Ms Sikander submitted that this is not the case in respect of Mr Andrews' actions in not responding and failing to attend his substantive hearing.

Ms Sikander submitted that cases involving deliberately using or referring to false qualifications or giving a false picture of employment history which hides clinical incidents in the past, not telling employers that their right to practice has been restricted or suspended, practising or trying to practise in breach of restrictions or suspension imposed by the NMC are considered very serious.

Ms Sikander outlined the following aggravating features:

- Mr Andrews failed to listen to instructions
- Willingness to take risks with patients, placing them at risk of serious harm
- Two medication errors in a short space of time involving different patients, therefore a potential for high risk of repetition
- Mr Andrews knew he was not qualified to work with patients with tracheostomy
- Mandatory training still outstanding and no steps taken to strengthen his practice
- Previous non-adherence to interim conditions of practice order
- Lack of insight
- Poor record keeping
- Dishonesty

Ms Sikander outlined the following mitigating features:

- Mr Andrews has stated that his actions were a genuine error
- Limited admission

Ms Sikander submitted that taking no further action would not be suitable in this case as there is a need to protect the public and uphold the public interest. She submitted that a caution order is not suitable in this case as the concerns have not been fully addressed.

Ms Sikander submitted that a conditions of practice order would not be suitable as it does not protect the public and meet the public interest in this case. She submitted that conditions must be workable, measurable and proportionate. Mr Andrews has previously failed to comply with an interim conditions of practice order.

Ms Sikander submitted that a suspension order would be insufficient given the context of the dishonesty element of the charges.

Ms Sikander submitted that there are concerns for the safety of the public due to the attitudinal concerns shown by Mr Andrews. Telling an employer that he was qualified to work with vulnerable patients with a tracheostomy tube when this was not the case, risking patient safety issues, the potential for legal liability for the employing Trust and failing to disclose to a new employer that he was subject to an interim suspension order. She submitted that the public interest, in particular regarding the premeditated dishonesty would warrant a striking-off order in this case.

Decision and reasons on sanction

Having found Mr Andrews' 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:

- Lack of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put people receiving care at risk of suffering harm
- Dishonesty relating to vulnerable patients; direct risk to people receiving care
- Not an isolated one-off incident
- Disregard of the regulator

The panel also took into account the following mitigating features:

- Very limited remorse
- Very limited admissions

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Andrews' 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 Andrews' misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Andrews' registration would be a sufficient and appropriate response. The panel is of the view that

there are no practical or workable conditions that could be formulated, given the nature and seriousness of the charges in this case. The panel determined that there are elements of attitudinal issues and therefore not something that can be addressed through retraining. It determined that there is no evidence of any insight, strengthening of practice or full engagement with the regulatory proceedings, therefore it was not satisfied that Mr Andrews could respond positively to retraining. It noted that Mr Andrews has previously disregarded his interim conditions of practice order, therefore it was not satisfied that he would adhere to any conditions placed on him. Furthermore, the panel concluded that the placing of conditions on Mr Andrews' registration would not adequately address the seriousness of this case and would not protect the public nor meet the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel determined that Mr Andrews' conduct was not a single one-off incident as there were several occasions of dishonesty, therefore displaying attitudinal concerns. There was no evidence before the panel of any insight or strengthening of practice, therefore it determined that the unaddressed attitudinal issues meant that there was a high likelihood of repetition. The panel considered that the serious breach of the fundamental tenets of the profession evidenced

by Mr Andrews' actions is fundamentally incompatible with Mr Andrews remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel decided that the answers to all three questions indicated that a striking-off order was required.

Mr Andrews' actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Andrews' actions were serious 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 the effect of such an order on Mr Andrews and 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 Andrews' actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

Ultimately, the combination of three issues of serious misconduct in practice, dishonesty towards other practitioners and dishonestly breaching fitness to practise orders meant that a striking-off order was the only sanction sufficient to protect patients, members of the public, and maintain professional standards.

This will be confirmed to Mr Andrews 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 Andrews' own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Decision and reasons on application for interim order application to be held in private

Ms Sikander submitted, pursuant to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules), the interim order application to be held partly in private on the basis that proper exploration of Mr Andrews' case involves reference to his health.

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

The panel determined to go into private session in connection with Mr Andrews' health as and when such issues are raised in order to protect his privacy.

Submissions on interim order

The panel took account of the submissions made by Ms Sikander. She made an application for an interim suspension order to cover the appeal period of 28 days. She asked for an order on the grounds of public protection and the wider public interest. She requested the order be made for a period of 18 months to enable any appeal to conclude.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

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

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

That concludes this determination.