Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday, 16 – Thursday, 18 December 2025

Virtual Meeting

Name of Registrant:	**Christopher Law**
NMC PIN:	93C0817E
Part(s) of the register:	Registered Nurse – Learning Disabilities (RNLD) (24 February 1996)
Relevant Location:	Perth and Kinross
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, Lay member) Alison Thomson (Registrant member) Robin Barber (Lay member)
Legal Assessor:	Mark Ruffell
Hearings Coordinator:	Sharmilla Nanan
Facts proved:	Charges 1a, 1b, 2a, 2b, 3a, 3b, 3c, 4, 5a(ii), 5a(iii), 5b, 5c, 6a, 6b(i), 6b(ii), 6b(iii), 7b, 7c, 8a, 10
Facts not proved:	Charges 5a(i), 5a(iv), 7a and 9
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mr Law's registered email address by secure email on 22 October 2025.

Further, the panel noted that the Notice of Meeting was also sent to Mr Law's representative at Anderson Strathern on 22 October 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation and that the meeting will take place virtually on or after 26 November 2025. In the Notice of Meeting letter sent by the Nursing and Midwifery Council (NMC), Mr Law was invited to respond to the allegations and was asked to provide his responses by 20 November 2025. The panel also noted that Mr Law was afforded the opportunity to have the meeting held as a hearing however there has been no recent responses from Mr Law.

In the light of all of the information available, the panel was satisfied that Mr Law has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

At the outset of the hearing, the panel of its own volition considered whether this case should be held partly in private on the basis that proper exploration of Mr Law's case involves reference to his health and private life. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

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

Details of charge

That you, a Registered Nurse:

1) On 15 November 2019:
    a) left Memantine on top of the medications trolley;
    b) failed to administer Memantine to Patient A at 22:00 as prescribed.

2) Between 25 May 2020 and 2 June 2020:
    a) administered Quetiapine to Patient B;
    b) knew or should have known that this medication was prescribed for Patient C.

3) On 13-14 October 2020, in relation to Patient D, failed to:
    a) conduct positional changes;
    b) record observations every two hours;
    c) identify and/or record that they had soiled themselves.

4) On 14 March 2021, provided the incorrect liquid paracetamol medication to Patient E.

5) On 8 April 2021, in relation to Patient F, failed to:
    a) reduce the risk of them sustaining a fall by failing to:
        i) carry out two hourly checks throughout the night;
        ii) plug in a sensor in their room;
        iii) lay mats on the floor next to their bed;
        iv) lower their bed to the floor;
    b) identify and/or record that they had sustained a fall during the night;
    c) identify and/or record that they had soiled themselves during the night.

6) On 24-25 September 2022:
    a) failed to update Patient G's position chart;
    b) in relation to one or more of the patients in Schedule 1, failed to:

i) change them into their night wear;

ii) assist them to bed;

iii) make any record in their care notes.

7) On 25 September 2022, failed to:

a) reposition Patient G in accordance with their care plan;

b) administer medication to Patient J after it had been dispensed;

c) carry out and/or record any personal care in the elimination charts of one or more of the patients in Schedule 2.

8) On 26 September 2022, in relation to one or more of the patients in Schedule 3:

a) signed for medication after 06:00;

b) knew that the medication should have been administered at 22:00 on 25 September 2022.

9) On 3 October 2022, failed to complete care records for two patients that were incontinent during the night.

10) On one or more occasions, failed to assist Patient M to reposition when requested.

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

Schedule 1

Patient H

Patient I

Schedule 2

Patient K

Patient L

Schedule 3

Patient J

Patient M

Patient H
Patient N

Background

Mr Law was referred to the NMC on 31 October 2022 by HC-One in relation to alleged incidents which occurred at [PRIVATE] (the Home) between 2019 and 2022, while he was working as a registered nurse.

It is alleged that Mr Law failed to carry out a number of duties during his shift such as repositioning patients, ensuring patients had been changed or taken to bed, and ensuring that medication was provided and recorded.

There are also historic concerns regarding Mr Law's nursing practice which date back to 2019 and 2020 that were raised during the local investigation conducted by the Home. These were also included in the referral to the NMC. These allegations included medication errors, and a record keeping issue regarding positional changes in 2020. It is also alleged that a patient developed grade one pressure sores as a result of not being repositioned as required.

Mr Law resigned from the Home on 5 October 2022 before a formal disciplinary investigation by the Home could take place.

The Case Examiners sought undertakings from Mr Law, but he did not respond.

Mr Law was barred from carrying out regulated work with children and adults on 7 November 2024 by Disclosure Scotland for unrelated matters. It is believed that Mr Law is not currently working in a nursing role and has not been since his resignation from the Home.

Decision and reasons on facts

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: At the material time, was employed as a Nursing Assistant at the Home. She had a professional relationship with Mr Law. She worked the night shift on the top floor of the Home whilst Mr Law worked on the ground floor of the Home.

- Patient M: At the material time, was a resident at the Home who received care from Mr Law.

- Witness 3: At the material time, was the Home Manager of the Home. She had a professional relationship with Mr Law.

The panel also had regard to written representations from Mr Law dated 9 April 2024 and the email sent on by his representative dated 12 September 2024.

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

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

Charges 1a and 1b

"That you, a Registered Nurse:

1) On 15 November 2019:
    a) left Memantine on top of the medications trolley;
    b) failed to administer Memantine to Patient A at 22:00 as prescribed."

These charges are found proved.

In reaching this decision, the panel considered these charges together. It took into account the evidence of Witness 3.

The panel considered the NMC witness statement of Witness 3 dated 30 September 2024. Witness 3 stated *"On 15 November 2019, Mr Hunt-Law had left medicine (memantine) on top of the medications trolley which he had failed to administer to Patient A at 10pm as he was supposed to do. Memantine is prescribed to dementia patients and slows down brain deterioration."*

The panel next considered the 'Supervision / 1:1 Record' dated 19 November 2019. The document states *"Medicines found on top of the medication trolley 15/11/19, discovered to be memantine which is prescribed for [Patient A] at 2200hrs. You had stated it was there when you arrived on shift but had not reported to anyone? Spoke to day shift who state they seen no medicines on top of the trolley… Chris states it probably was him that left it and apologised."*

The panel noted that it did not have Patient A's medication administration record before it.

The panel considered all of the evidence before it. The panel took into consideration that Witness 3's NMC statement was written five years after the original incident and that she did not directly observe or witness this incident. It took into account that it did not have any evidence from any member of staff who had seen the Memantine left on the trolley.

The panel noted that the 'Supervision / 1:1 Record' was a contemporaneous document that had been signed and dated both by Mr Law and Witness 3 on 21 November 2019, within a few days of the incident taking place. The panel took into consideration the partial admission that Mr Law made within this signed document.

The panel was satisfied that Witness 3's NMC witness statement was corroborated by the 'Supervision / 1:1 Record' and could be relied upon.

With regard to Charge 1a, the panel determined that on the balance of probabilities Mr Law, a Registered Nurse on 15 November 2019 had left Memantine on top of the medications trolley.

The panel bore in mind that Mr Law was the nurse in charge of the shift and there was a duty on him to ensure that Patient A's medication was administered at 22:00 as prescribed.

The panel noted that Mr Law had been afforded with opportunities to explain the circumstances of whether he provided the medication to Patient A despite leaving it on the trolley. However, the panel had no explanation before it from Mr Law.

With regard to charge 1b, the panel noted its finding that as Mr Law had on the balance of probabilities left the Memantine on top of the medications trolley and that it was more likely than not that the medication had not been administered to Patient A as prescribed. The panel determined that Mr Law failed to administer Memantine to Patient A at 22:00 as prescribed.

The panel therefore found charges 1a and 1b proved.

Charges 2a and 2b

"2) Between 25 May 2020 and 2 June 2020:

a) administered Quetiapine to Patient B;

b) knew or should have known that this medication was prescribed for Patient C."

These charges are found proved.

In reaching this decision, the panel considered these charges together and took into account the evidence of Witness 3.

The panel considered the NMC witness statement of Witness 3 dated 30 September 2024. Witness 3 stated *"On 3 June 2020, it was discovered that Mr Hunt-Law had been administering medication (Quetiapine) to Patient B, … for nine (9) consecutive nights that was not his prescribed medication, but was medication prescribed to Patient C… Mr Hunt-Law did not check to see whose medication he was administering and to who. The residents have their own GP prescribed and labelled medications."*

The panel next considered the 'Supervision / 1:1 Record' dated 3 June 2020. The document states

- *"Patient C PRN Quetiapine was in [Patient B] medicines box this pm.*
- *For 9 nights consecutively [Patient B] had been receiving [Patient C] PRN Quetiapine.*
- *You had failed to comply with HC-Ones medicines policy in reading the box before dispensing this medication.*
- *This is unacceptable practice and does not follow medicines procedures as this is not the first time this has happened this week"*

It noted that the actions to be taken as recorded on this 'Supervision / 1:1 Record' was that Mr Law was *"To be reassigned meds module meds competency"* and to be monitored by another member of staff.

The panel had regard to the medication administration record of Patient B with the start date of *'18/05/2020'* and end date *'14/06/2020'.* It also had regard to the medication

administration record of Patient C with the start date of *'18/05/2020'* and end date *'14/06/2020'.*

The panel considered the evidence before it. The panel took into consideration that Witness 3's NMC statement was written four years after the original incident.

The panel noted that the 'Supervision / 1:1 Record' was signed and dated both by Mr Law and Witness 3 on 3 June 2020. The panel considered Mr Law's signature on this document as an acknowledgement of his mistake. The panel noted that this document was produced close to the date of the incident and was therefore a contemporaneous record.

The panel was satisfied that Witness 3's NMC witness statement was corroborated by the 'Supervision / 1:1 Record' and could be relied upon.

The panel bore in mind that Mr Law was the nurse in charge of the shift. The panel took into consideration that he was the registered nurse responsible for the administration of drugs to patients in the Home and there was a duty on him to ensure that drugs were appropriately administered to patients.

The panel determined that on the balance of probabilities between 25 May 2020 and 2 June 2020, Mr Law administered Quetiapine to Patient B and knew or should have known that this medication was prescribed for Patient C.

The panel therefore found charges 2a and 2b proved.

Charges 3a, 3b and 3c

"3) On 13-14 October 2020, in relation to Patient D, failed to:

a) conduct positional changes
b) record observations every two hours
c) identify and/or record that they had soiled themselves."

These charges are found proved.

In reaching this decision, the panel considered the evidence of these charges together. It took into account the evidence of Witness 3.

The panel considered the NMC witness statement of Witness 3 dated 30 September 2024. Witness 3 stated *"On 13-14 October 2020, Mr Hunt-Law did not do positional changes for Patient D every two (2) hours as he was supposed to do… The last positional change occurred at 2.30am and failing to undertake the required positional changes placed Patient D at risk for a grade one (1) pressure ulcer on her foot, especially as the resident's feet were overlapped."*

The panel had regard to the 'Position Change Chart' for Patient D dated 13 October 2020 and another one dated 14 October 2020. The charts stated that Patient D was to be turned on a 'two hourly' basis. The panel noted that on the 'Position Change Chart' dated 13 October 2020 that the entries went up to 18:50, and the first entry on the 'Position Change Chart' dated 14 October 2020 was at 00:10 and another at 02:30. The entries made on 14 October 2020 stated that there were *'no concerns'.* The panel noted that the initials next to these entries were marked as '[PRIVATE]' which may indicate that a care assistant completed these entries.

The panel considered the 'Elimination Record' dated the week commencing 12 October 2020 for Patient D. It noted that for 14 October 2020, there are missing entries between 02:27am and 9:00am. Patient D was required to be checked every two hours as to whether there were signs of incontinence and this should have been documented accordingly.

The panel had regard to the photographs of Patient D's pressure sores.

The panel considered the signed Staff Counselling Record dated 14 October 2020 which states *"Patient D found lying in soiled bed … on same side she was left and position chart not completed since 02.30 hours and as a result could have developed grade I pressure ulcer on inner aspect of right foot. She has further deteriorated since this morning."*

The panel bore in mind that Mr Law was afforded an opportunity at the time and also prior to this substantive meeting to respond to the allegations. The panel noted that Mr Law's

statement dated 9 April 2024 only refers to his treatment at the Home and does not refer to this incident.

The panel bore in mind that Mr Law was the nurse in charge of the shift. The panel took into consideration that as the registered nurse Mr Law was responsible for positional changes of patients to be conducted as well as the corresponding documentation of the positional changes. It noted that whilst these tasks may have been delegated to other staff, it was Mr Law's duty to ensure that the tasks were carried out as the nurse in charge on the shift.

The panel considered the evidence before it. The panel took into consideration that Witness 3's statement was made nearly four years from the original incident. However, Witness 3's statement was corroborated by the entries made on the 'Position Change Chart' for Patient D dated 13 October 2020 and on dated 14 October 2020. The panel noted that there were no entries on the 'Position Change Chart' dated 14 October 2020 to indicate that Patient D had been turned from 02.30-9.30am.

The panel also took into consideration that the Staff Counselling Record dated 14 October 2020 was signed and dated by Mr Law and Witness 3. The panel considered this as an acknowledgment by Mr Law of his failure to ensure positional changes were conducted for Patient D whether it be by him or another member of staff and that these entries were recorded as well as identifying and/or recording that Patient D had soiled themselves.

The panel determined that on the balance of probabilities on 13-14 October 2020, in relation to Patient D, Mr Law failed to conduct positional change, record observations every two hours and identify and/or record that Patient D had soiled themselves.

The panel therefore found charges 3a, 3b and 3c proved.

Charge 4

> "4) On 14 March 2021, provided the incorrect liquid paracetamol medication to Patient E."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3.

The panel considered the NMC witness statement of Witness 3 dated 30 September 2024. Witness 3 stated *"On 14 March 2021, Mr Hunt-Law tried to give Patient E another resident's prescribed liquid paracetamol medication… Patient E liquid paracetamol was orange and the other resident's liquid paracetamol was white. Mr Hunt-law gave Patient E her usual dose, but the liquid paracetamol was white, so Patient E knew it wasn't her medication. When Patient E, who had full capacity, questioned Mr Hunt-Law, he shouted at her. He then gave her the correct medication and apologised and was nice to her for the rest of his shift. The following morning Patient E brought it to my attention, and I wrote a statement of the events…"*

The panel had regard to a typed note signed by Witness 3 which was dated 13 March 2021. The note states *"I went in to Patient E's room on 15/03/2021 to check on her. She stated to me she was ok apart from Chris who was on nightshift the night before. I asked what happened. She stated Chris gave her medicines to her around 2200hrs and she thought the color [sic] of the liquid medication was her usual color (liquid Paracetamol). She stated Chris came in and shouted at her… She stated Chris took the medicines away and comeback and stated it was out the wrong bottle and apologized".*

The panel had regard to Patient E's medication administration record which records that they are prescribed *'1000 Paracetamol 250mg/5ml oral suspension sugar free'.*

The panel also had regard to the Home's Medicines policy.

The panel considered the undated 'Staff Counselling Record' which states *"Discussed concern raised by resident Patient E 15th March 2021…You must adhere to HC-One Medicine Admin Policy & Procedure to reduce any possible errors/mistakes with administration of drugs so [Patient E] and others receive their own prescribed medication. You will be reassigned medicines touch modules to be completed asap."*

The panel considered the evidence before it. The panel noted that it did not have a statement made by Patient E and that Witness 3's typed note dated 13 March 2021 was a hearsay statement which had originated from a conversation that she had with Patient E. Despite this, the panel was of the view that Witness 3's typed note dated 13 March 2021, made at the material time, was a contemporaneous record which followed the initial incident. The panel was also of the view that Witness 3's typed note corroborated the account she provided in her NMC witness statement.

The panel took into consideration that Witness 3 spoke to Mr Law about this incident and that he did not make any denials about the incident as documented in the 'Staff Counselling Record' and corresponding documents. It noted that Mr Law signed this document to acknowledge that it is an accurate reflection of the discussion which took place.

The panel determined that on 14 March 2021, Mr Law provided the incorrect liquid paracetamol medication to Patient E. The panel therefore found charge 4 proved.

Charge 5

"5) On 8 April 2021, in relation to Patient F, failed to:
a) reduce the risk of them sustaining a fall by failing to:
i) carry out two hourly checks throughout the night;
ii) plug in a sensor in their room;
iii) lay mats on the floor next to their bed;
iv) lower their bed to the floor;
b) identify and/or record that they had sustained a fall during the night;
c) identify and/or record that they had soiled themselves during the night."

Charge 5a(i) is found not proved.
Charges 5a(ii) and 5a(iii) are found proved.
Charge 5a(iv) is found not proved.
Charges 5b and 5c are found proved.

In reaching this decision, the panel took into account the evidence of Witness 3.

The panel considered the NMC witness statement of Witness 3 dated 30 September 2024. Witness 3 stated *"On 8 April 2021, Patient F had a fall which wasn't documented by Mr Hunt- Law. … There was no documentation because Mr Hunt-Law didn't follow the proper process and didn't check on her during the night every two (2) hours as he was supposed to do. At the start of the day shift when the Care Assistants went into the room Patient F was on the floor. No sensor had been plugged in and there were no mats on the floor as there should have been. The resident suffered bruising and had wound that could have been prevented had Mr Hunt-Law checked on her every two (2) hours as he was supposed to do. Patient F could have received treatment sooner and reduced her stress, discomfort and anxiety."*

The panel had regard to Patient F's care notes. It noted that there were no entries on 8 April 2021 from approximately 03:37 until 11:25. The entry made at 11:25 states that *"Patient F Found on floor under chair in room. Assisted to chair. Red mark down neck, skin flap 0.5cm R hand plaster applied, bruise to R shin. Paracetamol given this AM, refused the rest of day. Eating and drinking well…"*

The panel also considered the 'Incident & Accident Reporting Form' dated 8 April 2021 completed by Witness 3. In the 'Description of How Incident Occurred' it states "*Patient F found at 8am on floor under arm chair. Made environment clear and assisted to chair. Sensor not alarmed"* and under 'Immediate action taken' it states "*First aid skin flap to R hand, 0.5cm mepare applied. Brusing to R shin. Graze back and mark on next to bruise. Low profiling bed now in."* It also noted on this document it stated that the last time the resident was seen before this incident was at *'6.35am'.*

The panel considered the 'Supervision / 1:1 Record' dated 8 April 2021. The record states *"On 8/4/21 F had a fall at 8am. No sensor on, no crashmats out. Failed paperwork input. Nothing recorded since 1900 7/4/21 night book charts claim sleeping all night. F was faecally incontinent when found on floor. See photographs of wounds bruises that could have been prevented. You as senior member of staff need to check care assistants paperwork on a nightly basis."* The panel noted that this record was completed by Witness 3 and was signed by both Witness 3 and Mr Law on 8 April 2021.

The panel noted that it did not have the night book before it.

The panel bore in mind that Mr Law was afforded an opportunity at the material time and also prior to this substantive meeting to respond to the allegations. The panel noted that Mr Law's statement dated 9 April 2024 only refers to his treatment at the Home and does not refer to this particular incident as outlined in the charge.

The panel bore in mind that Mr Law was the nurse in charge of the shift. The panel took into consideration that as the registered nurse Mr Law was responsible to ensure the risk of Patient F falling was minimised by conducting regular checks, ensuring sensors were plugged in, laying mats next to the bed and lowering the bed to the floor. He was also responsible to ensure that any falls were recorded and if Patient F had soiled themselves that they had received the appropriate care. It noted that whilst these tasks may have been delegated to other staff, it was Mr Law's duty to ensure that the tasks were carried out as the nurse in charge on the shift.

The panel considered the evidence before it.

Charge 5a(i)

With regard to charge 5a(i), the panel considered that it appears that there were entries made in the Home's night book but that this was not in front of the panel. The panel was of the view that there was clear evidence that Patient F was checked throughout the night.

The panel noted that Mr Law had signed 'Supervision / 1:1 Record' dated 8 April 2021' and as a result appears to accept the allegations.

The panel was not satisfied that the NMC had discharged its burden of proof that on 8 April 2021, in relation to Patient F, Mr Law failed to reduce the risk of them sustaining a fall by failing by carrying out two hourly checks throughout the night.

The panel therefore found charge 5a(i) not proved.

Charges 5a(ii) and 5a(iii)

The panel noted it appears in 'Supervision / 1:1 Record' dated 8 April 2021' Witness 3 puts to Mr Law whether sensors were plugged in and crash mats were laid out for Patient F. Mr Law has signed this supervision record and appears to accept the allegations that he did not ensure that a sensor was plugged in and that crash mats laid out on the floor next to Patient F's bed.

The panel determined that on 8 April 2021, in relation to Patient F, failed to reduce the risk of them sustaining a fall by failing to plug in a sensor in their room and laying mats on the floor next to their bed.

The panel therefore found charges 5a(ii) and 5a(iii) proved.

Charge 5a(iv)

The panel note in 'Supervision / 1:1 Record' dated 8 April 2021' there is no mention of the allegation of the bed being lowered and this was not put to Mr Law by Witness 3.

The panel was not satisfied that the NMC had provided evidence that on 8 April 2021, in relation to Patient F, Mr Law failed to reduce the risk of them sustaining a fall by failing to lower their bed to the floor.

The panel therefore found charge 5a(iv).

Charges 5b and 5c

The panel noted it appears in 'Supervision / 1:1 Record' dated 8 April 2021', Witness 3 puts to Mr Law that there were no entries made in the night book since 1900 on 7 April 2021 and that Patient F was faecally incontinent when found on floor. It appears that Mr Law did not make any response to these allegations during this meeting as he has signed this supervision record and appears to accept the allegations.

The panel determined on 8 April 2021, in relation to Patient F, Mr Law failed to identify and/or record that they had sustained a fall during the night and identify and/or record that they had soiled themselves during the night.

The panel therefore found charges 5b and 5c proved.

Charge 6a

"6) On 24-25 September 2022:

a) failed to update Patient G's position chart"

This charge is found proved.

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

The panel considered the NMC witness statement of Witness 1. Witness 1 stated *"On 24 September 2022, Mr Hunt-Law phoned up around 11pm - midnight and asked me to assist him reposition residents to and put residents to bed. I assisted Patient G who was at end of life and her family was visiting to say their goodbyes… I assisted Mr Hunt-Law to reposition her… The carers usually updated the positional charts however because Mr Hunt-Law was working on his own downstairs, it was his responsibility to update the position change chart, and I am aware this did not happen. This may be because Mr Hunt-Law may have just forgotten to update the chart or maybe didn't want to do it while the family were there."*

The panel considered the 'Colleague Meeting Minutes' dated 29 September 2022. During this meeting Witness 1 was interview by Witness 3. Witness 1 said she assisted Mr Law with positioning changes for Patient G every two hours. Witness 1 did not mention Patient G's positioning chart during this interview.

The panel considered the document titled 'Concerns were raised from Night Duty nurse from 24th September into 25th September and 25th September into 26th September'. This

document was created by Witness 3. It states "*Patient G was not position changed at the appropriate time and went 4 hours without a position change.*"

The panel took into account the 'Colleague Meeting Minutes' dated 27 September 2022. The interview took place between Mr Law and Witness 3. Witness 3 asked Mr Law *"[Patient G]'s daughter said you didn't reposition until 11.30pm, there's no record of any positioning changes, did you do them?"* to which he replied *"Yes, every two hours through the night from 10pm. I will always to my best for someone when they are passing."* The panel noted that this interview was a contemporaneous record as it took place two days after the incident.

The panel noted that it did not have any positioning charts for Patient G before it.

The panel bore in mind that Mr Law was the nurse in charge of the shift and the only registered nurse on duty. The panel took into consideration that he was the registered nurse responsible to ensure that Patient G's repositioning was documented.

The panel considered the evidence before it. It noted the evidence from Witness 1 who helped Mr Law to reposition Patient G at the material time and Mr Law's comments in the 'Colleague Meeting Minutes' with Witness 1. The panel bore in mind that there appears to have been no documentation of the positional changes as mentioned in the 'Colleague Meeting Minutes' and there were no positioning charts for Patient G before the panel. The panel determined that on the balance of probabilities on 24-25 September 2022, Mr Law failed to update Patient G's position chart.

The panel therefore found charge 6a proved.

Charge 6b (i), (ii) and (iii)

"6) On 24-25 September 2022:

b) in relation to one or more of the patients in Schedule 1, failed to:

i) change them into their night wear;

ii) assist them to bed;

iii) make any record in their care notes."

These charges are found proved.

In reaching this decision, the panel considered these charges together. It took into account the evidence of Witness 1 and Witness 3.

The panel considered the NMC witness statement of Witness 1. Witness 1 refers to Patient J receiving assistance from her to put on his night bag and that he was still in his clothes from the day at 11pm. The panel noted that the schedule did not refer to Patient J.

The panel considered the 'Colleague Meeting Minutes' dated 29 September 2022. During this meeting Witness 1 was interview by Witness 3. Witness 1 said she assisted with putting Patient H's night bag on and that he had his day clothes on at approximately 11pm. She said that she saw Mr Law go into Patient I's room but she could not recall what time.

The panel considered Witness 3's NMC witness statement. Witness 3 stated *"On 24 September 2022 Patient I was not changed into her night wear or put to bed and had slept in her chair overnight. There was nothing recorded in her Care Notes … that provided any Reason Patient I was not put to bed."*

Witness 3 also stated in her NMC statement *"On the same morning, Care Assistants observed that Patient H was sitting in his chair dressed in the same clothes as the previous day. Patient H said that he had not been asked to go to bed by Mr Hunt-Law. There was nothing recorded in 's Care Notes by Mr Hunt-Law…"*

The panel considered the document titled 'Concerns were raised from Night Duty nurse from 24th September into 25th September and 25th September into 26th September'. This document was created by Witness 3. It states *"Patient I was not put to bed on 25th September, nor had her clothes been changed. She slept in her chair. Patient H was not put to bed on 25th September and still had his same clothes on from previous day. position changed at the appropriate time and went 4 hours without a position change."* The panel was of the view that this was a contemporaneous record as it was made close to the date of the incidents.

The panel took into account the 'Colleague Meeting Minutes' dated 27 September 2022. The interview took place between Mr Law and Witness 3. The minutes state:

> *"[Witness 3]: It was also noted that [Patient I] and [Patient H] were sleeping in their clothes from the previous day in their chairs.*
> *CH: Were they? If that's the case I can't really defend that*
> *[Witness 3]: I was up to the toilet three times during the night, why did you not change her clothes?*
> *CH: I did assist her to the toilet and I should have changed her*
> *[Witness 3]: Why was she not in bed?*
> *CH: I don't know*
> *[Witness 3]: and [Patient H]*
> *CH: He was in clothes? I don't know but I will take responsibility. If I have a made a mistake I'll be the first to admit."*

The panel had regard to the care notes of Patient I and Patient H. It noted that there was no information documented in their respective care notes as to why each of these patients were not changed into their nightwear and assisted to bed.

The panel bore in mind that Mr Law was the nurse in charge of the shift. The panel took into consideration that he was the registered nurse responsible to ensure that patients were changed into nightwear, assisted to bed and the necessary care notes for each respective patient was documented.

The panel considered the evidence before it. It noted that Witness 1 had been on the ground floor to assist Mr Law and had not mentioned in her interview with Witness 3 that she saw Patients I and H in their day clothes. The panel bore in mind that Mr Law made admissions in his interview with Witness 3 that he failed to assist these patients. The panel determined on 24-25 September 2022, Mr Law in relation to Patients H and I as set out in Schedule 1, failed to change them into their night wear, assist them to bed and make any record in their care notes.

The panel therefore found charges 6b (i), (ii) and (iii) proved.

Charge 7a

"7) On 25 September 2022, failed to:

a) reposition Patient G in accordance with their care plan"

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 3.

The panel considered Witness 3's NMC witness statement. Witness 3 stated *"Patient G was at end-of-life care, was paralysed and couldn't move a muscle herself. She was repositioned at 7-8pm and then not until after 11pm after the family had left."*

The panel took into account that Patient G's care plan was not before the panel. The panel did have the 'Position change Chart' for Patient G dated 20 September 2022 and noted that there were entries made at 00:11, 02:11, 04:11 and 06:15. The panel took into account that the handwriting in these entries were difficult to read.

The panel considered the document titled 'Concerns were raised from Night Duty nurse from 24th September into 25th September and 25th September into 26th September'. This document was created by Witness 3. It states, *"Patient G was not position changed at the appropriate time and went 4 hours without a position change."*

The panel took into account the 'Colleague Meeting Minutes' dated 27 September 2022. The interview took place between Mr Law and Witness 3. The minutes state:

"*"[Witness 3]: Patient G's Daughter said you didn't reposition until 11.30pm, there's no record of any positioning changes, did you do them?*
CH: Yes, every two hours throughout the night from 10pm. I will always to my best for someone when they are passing."

The panel bore in mind that Mr Law was the nurse in charge of the shift. The panel took into consideration that he was the registered nurse responsible to ensure Patient G was repositioned in accordance with their care plan.

The panel considered the evidence before it. The panel noted that it did not have Patient G's care plan however it did have the 'Position change Chart' for Patient G dated 20 September 2022 which had documented two hourly entries over the course of the night. It also took into account the 'Colleague Meeting Minutes' dated 27 September 2022, in which documents Mr Law's denial and that he said Patient G was repositioned every two hours. The panel was of the view that the NMC has not discharged its burden of proof in relation to this charge and it was not satisfied that on 25 September 2022, Mr Law failed to reposition Patient G in accordance with their care plan.

The panel therefore found charge 7a not proved.

Charge 7b

"7) On 25 September 2022, failed to:

b) administer medication to Patient J after it had been dispensed"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3.

The panel considered Witness 3's NMC witness statement. Witness 3 stated *"Patient J had capacity, and she raised her concern the following morning. A medication count was conducted and was correct. The medication had been dispensed but what happened to the medication afterwards couldn't be determined. Patient J provided a statement, … saying that Mr Hunt-Law was erratic when doing his medication rounds and that he never waits to see if residents have swallowed the medication as he is supposed to do."*

The panel considered the document titled 'Concerns were raised from Night Duty nurse from 24th September into 25th September and 25th September into 26th September'. This document was created by Witness 3. It states, *"Patient J reported she had no medication*

on the night of 25th of September. On investigation all medication was signed for at 6.27am."

The panel had regard to Patient J's Emed form and that it recorded that the medication was administered at 6.18am.

The panel had regard to Patient J's statement signed by Witness 3 and Patient J dated 27 September 2022. The statement states *"One night, before last didn't get medication. States Chris was on. Stated to Chris about her peptac stated there was here until the beginning of the week. The night staff nurse that is on is Chris when medications are erratic when he is on. Never waits to see if you have taken them (medication)…"*

The panel had regard to Safeguarding report which states *"[Patient J] stated she did not get her medication on 25th September. On further inspection medicines were not signed on E-Meds. She states he often does not give her her [sic] medication."*

The panel took into account the 'Colleague Meeting Minutes' dated 27 September 2022. The interview took place between Mr Law and Witness 3. It noted that the minutes did not specifically refer to Patient J but that Mr Law was recorded as stating *"That's my bad, I forgot to put the medication through and sign it off on the system. I did the meds individually and just didn't put it on Emeds… I know the residents. I'll put my hand up and say that was a mistake though… I will admit I did not upload the medication to Emeds at the time of administration.*"

The panel bore in mind that Mr Law was the nurse in charge of the shift. The panel took into consideration that he was the registered nurse responsible to ensure that medications were administered to patients after they were dispensed.

The panel considered the evidence before it and that Patient J is clear in her evidence that she didn't receive the medication from Mr Law. It noted that Patient J's Emed records show that she received her medications at 6.18am as opposed to the night before. Consequently, the panel was of the view that it was not clear that Mr Law administered the medication to Patient J. The panel noted Mr Law's denials as recorded in the 'Colleague

Meeting Minutes' dated 27 September 2022 however, he did not specifically refer to Patient J.

The panel determined on a balance of probabilities that on 25 September 2022, Mr Law failed to administer medication to Patient J after it had been dispensed.

The panel therefore found charge 7b proved.

Charge 7c

"7) On 25 September 2022, failed to:

c) carry out and/or record any personal care in the elimination charts of one or more of the patients in Schedule 2."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3.

The panel considered Witness 3's NMC witness statement. Witness 3 stated *"On 25 September 2022, Mr Hunt-Law failed to document in Patient K elimination chart … that the resident was discovered being incontinent of urine and faeces."*

The panel considered the local statement of Ms 4 which was dated 29 September 2022. Ms 4's statement stated, *"Staff also came to myself and stated that resident Patient L had been left very wet and soiled in her bed and looked as though she had not been checked at all over night."*

The panel had regard to Patient K's elimination record dated the week commencing 23 September 2022. It noted that there were no entries made on 25 September 2022 other than 'Independent' which was written across the columns 'TIME', 'CODES' and 'INTL'

The panel had regard to Patient L's elimination record dated the week commencing 22 September 2022. It noted that there were no entries made after 21:40 on 25 September 2022 and there was no mention of any personal hygiene completed for the patient.

The panel had regard to the Care Inspectorate Report states *"L – left being inconstant of Faeces and urine K – Incontinent of urine and faeces no personal hygiene chart completed".*

The panel considered the Safeguarding Referral for Resident M for the incident dated 25 September 2022. The referral stated *"Patient K had been incontinent of urine and faeces. No documentation noted of personal care."*

In the Perth and Kinross Council report dated 6 October 2022, it stated *"On the 3rd of October 2022, a further 2 incident forms were received for 2 different residents. 1 incident form was for [redacted] which stated that he was doubly incontinent however no care notes were completed on the night shift of the 25th September."*

The panel considered the evidence before it and that there was no documentation that personal hygiene care had been completed for Patient K and Patient L. The panel also had regard to the hearsay statement of Ms 4. The panel determined that on a balance of probabilities on 25 September 2022, Mr Law failed to carry out and/or record any personal care in the elimination charts of one or more of the patients in Schedule 2.

The panel therefore found charge 7c proved.

Charge 8a and 8b

"8) On 26 September 2022, in relation to one or more of the patients in Schedule 3:

a) signed for medication after 06:00;

b) knew that the medication should have been administered at 22:00 on 25 September 2022."

These charges are found proved.

In reaching this decision, the panel considered the evidence of these charges together. It took into account of the evidence of Witness 3.

The panel considered the NMC witness statement of Witness 3. Witness 3 stated *"On 25 September 2022, Patient M who has fluctuating capacity, said she didn't receive her evening medication, however later she said that she did receive it. The Home has an electronic medication administration system called EMed. When medication rounds are being done, there is a tablet pad kept on the medication trolley which the nurses use when administering the medications. The process is simple. All you need to do is click on the button after popping the tablet out of its packaging, administer the tablet, wait for it to be swallowed, and then tick the box on the tablet saying the medication has been administered. EMed time stamps each entry. EMed, was checked to see if Patient M had been given her medication and it was discovered that Mr Hunt-Law, who was the night duty nurse, had signed for the medication in the morning around 6am, and not at 10pm when it should have been signed. This was problematic because; a) It couldn't be evidenced that Mr Hunt-Law actually administered the medications at 10pm, when the medication should have been administered. b) By signing off on the medication in the morning meant that the EMed system is locked and will make you wait until the next dose is due before you are able to sign that the medication has been administered."*

The panel took into account the 'Colleague Meeting Minutes' dated 27 September 2022. The interview took place between Mr Law and Witness 3. The minutes state that Mr Law said, *"That's my bad, I forgot to put the medication through and sign it off on the system. I did the meds individually and just didn't put it on Emeds… I know the residents. I'll put my hand up and say that was a mistake though… I will admit I did not upload the medication to Emeds at the time of administration".*

The panel had regard to the Emeds pages for Patient J, Patient M, Patient H, Patient N each respectively dated 25 September 2022 and that show that the patients were due their medication at 22:00PM and were administered at various times after 6:00AM.

The panel considered the evidence before it and was satisfied that there was documentary evidence to support that Mr Law had signed for medication after 6:00am for Patient J, Patient M, Patient H and Patient N. It bore in mind Mr Law's admissions recorded on the 'Colleague Meeting Minutes'. The panel determined that on 26 September 2022, in relation to one or more of the patients in Schedule 3, Mr Law signed for medication after 06:00 and knew that the medication should have been administered at 22:00 on 25 September 2022.

The panel therefore found charges 8a and 8b proved.

Charge 9

> "9) On 3 October 2022, failed to complete care records for two patients that were incontinent during the night."

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 3.

The panel considered Witness 3's NMC witness statement. Witness 3 stated "*On 3 October 2022, two residents that were incontinent during the night had no care notes completed."*

The panel considered the evidence before it. The panel took into account that Witness 3's statement was made nearly two years after the incident outlined in this charge took place. The panel also considered that it had not been provided with any identifying information as to who the patients were, any related documentation for the patients or statements from the staff members who identified that these patients were left incontinent during the night. The panel was not satisfied that the NMC had discharged its burden of proof in relation to this charge.

The panel was not satisfied that on 3 October 2022, Mr Law failed to complete care records for two patients that were incontinent during the night. The panel therefore found charge 9 not proved.

Charge 10

> "10) On one or more occasions, failed to assist Patient M to reposition when requested."

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient M and Witness 3.

The panel considered the NMC statement of Patient M dated 9 January 2024. Patient M stated *"I recall on 25 September 2022 I asked Mr Law a couple of times to help me to pull myself up on the bed so I could get my feet covered which were cold. I was finding I couldn't get to sleep so needed my position to be adjusted and was not able to move my own legs. Mr Law said he was on his own that night and I took that to mean as he was on his own, and two (2) people were required to reposition me, that I wouldn't be repositioned that night… On 29 September 2022, though I can't recall the conversation, I spoke to [Witness 3] and Administrator … and told them that Mr Law had not been repositioning me after asking him to help me to get more comfortable."*

The panel considered the 'Colleague Meeting Minutes' dated 29 September 2022. The interview took place between Witness 3 and Patient M. The notes state:

> *"[Witness 3]: Thank you, so did you have any problems with the nursing staff that was on Sunday night?*
> *[Patient M]: That was CH? I did ask him a few times if he would be able to pull me up on the bed, usually my feet are sticking out the bed and they get cold so I like to have them covered.*
> *[Witness 3]: did he come and help you?*
> *[Patient M]: He didn't, he said he was on his own and couldn't help me."*

The panel considered the NMC statement of Witness 3. Witness 3 stated *"On 24, 25 and 26 September 2022, Patient M had asked Mr Hunt-Law on several occasion to do a positional change and he told her was unable to do that because there were no other staff members on with him to assist, which was incorrect. As part of the investigation, I spoke to Patient M on 29 September 2022 who also said that she had asked Mr Hunt-Law on other occasions prior to 24 - 26 September 2022 for a positional change and Mr Hunt-Law said he couldn't do it."*

The panel considered the document titled ‘Concerns were raised from Night Duty nurse from 24th September into 25th September and 25th September into 26th September’. This document was created by Witness 3. It states *“Patient M reported she asked night shift nurse to reposition her. He stated No he didn’t have another member of staff on with him. She reported that he had said this before.”*

The panel was of the view that this was a contemporaneous record as it was made close to the date of the incidents.

The panel bore in mind that Mr Law was the nurse in charge of the shift. The panel took into consideration that he was the registered nurse responsible to ensure that patients were repositioned and made comfortable as highlighted to him.

The panel considered the evidence before it. The panel was of the view that the account that Patient M provided in his NMC witness statement was corroborated by the account he provided in the ‘Colleague Meeting Minutes’ with Witness 3 and the account provided by Witness 3 in her witness statement. It noted that Patient M and Witness 3 did not provide live evidence to the panel. The panel noted that ‘Colleague Meeting Minutes’ are a contemporaneous record as they were made at the material time of the incident.

The panel took into account that following this incident Mr Law was not asked about it by the Home.

The panel determined that on the balance of probabilities, on one or more occasions, Mr Law failed to assist Patient M to reposition when requested.

The panel therefore found charge 10 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 Law’s fitness to practise is currently impaired. There is no statutory definition of fitness to

practise. However, the NMC has defined fitness to practise as a registrant's 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 Law's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct

The NMC in its written representations, referred the pane to the case of *Roylance v GMC (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.'* It also referred the panel to the cases of *Calheam v GMC* [2007] EWHC 2606 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The NMC referred the panel to ''The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision and identified the specific, relevant standards where Mr Law's actions amounted to misconduct.

The NMC stated in its written representations that Mr Law's actions, as detailed in the charges, fell significantly short of what would be expected of a registered nurse and that the areas of concern are wide ranging and were repeated. The NMC acknowledged that whilst not every breach of the Code will amount to professional misconduct, it submitted that Mr Law's behaviour amounts to professional misconduct. There are numerous

allegations over a significant period of time in respect of Mr Law's nursing practice. The NMC submitted that Mr Law's conduct breached the obligations of a registered professional to comply with the Code and that his conduct was a significant departure from the fundamental principles of the Code namely; prioritising people, practicing effectively and promoting professionalism and trust in the professions. The NMC submitted that Mr Law's conduct towards patients amounts to misconduct.

Representations on impairment

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel was referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and Dame Janet Smith's "test" which was applied to the circumstances of this case. The panel was also referred to the case of *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin).

The NMC invited the panel to find Mr Law's fitness to practise impaired on the grounds that public protection and public interest.

The NMC submitted that Mr Law has not shown sufficient insight and therefore there is a risk of repetition. The NMC referred the panel to Mr Law's reflective statement and noted that he did accept some of the concerns at a local level at the Home but provided limited insight on the risk to patients, colleagues and the public. It submitted that Mr Law has provided some evidence of online courses he has completed but that he is in the early stages of the remediation process. The NMC submitted that Mr Law has since disengaged with the NMC process.

The NMC submitted that the panel will have to consider what concerns, if any, can be addressed by training or if Mr Law has an underlying attitudinal issue. The NMC submitted that attitudinal issues are difficult to address. The NMC submitted that public interest is engaged as there is no evidence to suggest that the concerns identified have been completely remediated.

The panel had no submissions before it from Mr Law regarding misconduct and impairment.

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

Decision and reasons on misconduct

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

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

*'1 **Treat people as individuals and uphold their dignity***
To achieve this, you must:
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
1.5 respect and uphold people's human rights

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:
3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

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

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'

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

The panel considered each of the charges found proved as to whether Mr Law's conduct was sufficiently serious to amount to misconduct.

The panel first considered charges 1a and 1b. The panel bore in mind that the Home cared for vulnerable patients some of who were living with dementia and that it was unsafe to leave drugs on top of a drugs trolley whereby a patient could have inadvertently taken it with unknown consequences. The panel was of the view that the conduct found proved in these charges did not adhere to the standards expected of a registered nurse. The panel was of the view that the conduct in these charges individually and in isolation were not sufficiently serious to amount to misconduct. However, when taking these charges together with the other charges found proved, the panel was of the view that the conduct was sufficiently serious to amount to misconduct.

The panel next considered charges 2a and 2b. The panel took into account that Mr Law's conduct was in breach of the Home's medication policy of how medication should be administered to patients as the wrong medication had been given to Patient B when it was in fact for Patient C. The panel was of the view that the conduct found proved in these charges did not adhere to the standards expected of a registered nurse. The panel concluded that Mr Law's conduct as found proved in these charges are serious enough to amount to misconduct.

With regard to Charges 3a, 3b and 3c, the panel took into consideration that this was an incident that took place between the nightshift of 13-14 October 2020. The panel bore in mind that Patient D was a vulnerable patient who was wholly reliant on Mr Law for support as they could not reposition themselves and were reliant on others to care for them when they had soiled themselves. The panel considered the support required to be provided to Patient D was a fundamental and basic standard of care. The panel was of the view that the conduct found proved in these charges did not adhere to the standards expected of a registered nurse. The panel concluded that Mr Law's conduct as found proved in this charge was serious enough to amount to misconduct.

The panel considered the conduct as found proved in charge 4. The panel took into account that Mr Law's conduct was in breach of the Home's medicines policy whereby the incorrect formulation of medication was provided to the patient and was identified by the patient. The panel considered that there could have been an adverse impact on the patient from receiving this medication and that Mr Law's conduct in this charge could have amounted to misconduct.

The panel took into account the conduct found proved in charge 5. The panel noted that the conduct found proved in in this charge took place over a single night shift on 8 April 2021. The panel took into consideration that Mr Law failed to complete the relevant safety checks for a vulnerable patient who was wholly reliant on his care and support. The panel was of the view that the conduct found proved in these charges did not adhere to the standards expected of a registered nurse. The panel concluded that Mr Law's conduct as found proved in these charges are serious enough to amount to misconduct.

The panel next considered the conduct found proved in charge 6. The panel was of the view that it was a basic fundamental of nursing to provide patients with dignity and care when caring for patients. The panel bore in mind that it had no information to indicate that there was a reason for not changing the patients and vulnerable patients would expect to be changed into nightwear and assisted to bed. The panel took into consideration that the patients were not able to change themselves and get into bed. The panel was of the view that the conduct found proved in these charges did not adhere to the standards expected of a registered nurse. The panel concluded that Mr Law's conduct as found proved in these charges are serious enough to amount to misconduct.

In relation to the conduct found proved in charge 7, the panel was of the view that Mr Law's conduct with regard to dispensing medication and ensuring personal care checks were carried out are fundamental elements of nursing care for vulnerable patients. The panel was of the view that the conduct found proved in these charges did not adhere to the standards expected of a registered nurse. The panel concluded that Mr Law's conduct as found proved in these charges are serious enough to amount to misconduct.

The panel considered the conduct as found proved in charge 8. It noted that four patients were administered their medication, but this had not been recorded on the Emeds system during the course of a single shift. The panel noted that difficulties that oncoming nurses would face when caring for these patients and trying to record the next medication administration. The panel was of the view that this demonstrates a lack of care to vulnerable patients by Mr Law. The panel was of the view that the conduct found proved in these charges did not adhere to the standards expected of a registered nurse. The panel concluded that Mr Law's conduct as found proved in these charges are serious enough to amount to misconduct.

With regard to the conduct found proved in charge 10, a vulnerable patient had made a clear and reasonable request to maintain their dignity which Mr Law did not respond to. This conduct was a fundamental and basic element of nursing care. The panel was of the view that the conduct found proved in these charges did not adhere to the standards expected of a registered nurse. The panel concluded that Mr Law's collective conduct as found proved in these charges are serious enough to amount to misconduct.

The panel was of the view that the conduct in the charges found proved collectively amount to misconduct.

The panel found that Mr Law's 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 Law's 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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

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

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

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

d) *…'*

The panel first considered whether any limbs of Dame Janet Smith's "test" were engaged.

The panel finds that vulnerable patients were put at risk and were caused direct harm as a result of Mr Law's misconduct in the past as he failed to administer medication, failed to make the appropriate entries in the care notes, did not attend to patients and their needs as appropriate and did not ensure the safety of patients (ensuring that there was a mat and sensors in place as required). It determined that limb a of Dame Janet Smith's "test" was engaged in the past.

The panel was of the view that Mr Law's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel noted that the facts and misconduct found proved had demonstrated that Mr Law had failed to keep and uphold the values of the Code. It noted that the fundamentals of nursing care, namely, prioritising people, preserving safety, practising effectively, and promoting professionalism and trust were not adhered to by Mr Law. It determined that limbs b and c of Dame Janet Smith's "test" were engaged in the past.

The panel considered the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin). The panel was of the view that the individual misconduct could be remediated with training. However, it bore in mind that the number of charges found

proved for the period of 2019 to 2022, the number of affected vulnerable patients, the repeated incidents and the wide-ranging areas of concern found in Mr Law's practice. The panel considered that when these factors were considered together it may suggest that there is an attitudinal issue within Mr Law's nursing practice.

The panel went on to consider Mr Law's insight.

The panel noted that Mr Law made apologies to the Home and to some of the patients at the material time regarding his mistakes.

The panel took into account the training courses that Mr Law has completed and that these address some of the areas of misconduct. The training courses which Mr Law completed include:

- Communication and interpersonal Skills at Work – 87% overall score – issued on 5 March 2023
- Caregiving, Dementia and Incontinence – 0% overall score - issued on 5 February 2023
- Human Factors in a Healthcare Environment - issued on 25 February 2023
- Developing Clinical Empathy: Making a difference in Patient Care – issued on 16 February 2023
- Workplace Essentials: Health and Safety - issued on 16 January 2023
- Medicines Administration for Carers – 0% overall score - issued on 16 January 2023
- Improving Palliative Care in Care Homes for Older People – Issued on 2 May 2020

However, the panel bore in mind that the most recent course completed by Mr Law was issued nearly two years ago and that as he has not been working as a registered nurse he has not demonstrated that he has implemented the skills he has learned into his nursing practice.

The panel took into consideration that Mr Law has not been practising as a registered nurse since 2022 and has no information as to what he is currently doing.

The panel considered Mr Law's reflective statement dated 9 April 2024. It was of the view that Mr Law addressed the impact that the NMC process has had on him personally and provided context of working at the Home. The panel took into account Mr Law stated *"[PRIVATE]… I was shown no professional support within a constant bullying and intimidating management. [PRIVATE]"* and that it did not have any supporting medical evidence for the issues he raised. The panel was of the view that Mr Law failed to address the concerns in any meaningful way. It bore in mind that he has not considered the impact his actions had on the vulnerable patients in his care, how his conduct would affect the reputation of the nursing profession or what he could do differently in the future. The panel concluded that Mr Law's reflective statement showed limited evidence of insight.

The panel bore in mind that Mr Law's reflective statement contrasted with his resignation letter, dated 5 October 2022, which stated *"I would like to express my sincere gratitude for giving me the opportunity to work for this esteemed organization. My heartfelt thanks to you and all my colleagues, who directly or indirectly helped and assisted me throughout my professional journey."*

The panel was not satisfied that the concerns identified in the charges found proved have been remediated. The panel is of the view that there is a risk of repetition based on Mr Law's limited remorse, lack of insight and lack of recent evidence of strengthened practice. The panel determined that that the limbs a, b and c of Dame Janet Smith's "test" were engaged in the future. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because informed members of the public would be concerned to learn that Mr Law working with vulnerable patients and had made a significant number of wide-ranging mistakes that he had repeated despite having assistance from the Home. Also, the panel was of the

view that a member of the public would be concerned to allow a registrant with the concerns outlined in this case to practice with their loved ones.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Law's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Law's 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 Law's name off the NMC register. The effect of this order is that the NMC register will show that Mr Law has been struck-off the register.

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

Representations on sanction

The NMC provided submissions on Sanction and submitted that any sanction imposed must be appropriate and proportionate in the circumstances of Mr Law's case. The NMC referred the panel to the relevant NMC guidance when making its decision and provided submissions on all the sanctions available to it and the appropriateness of each. The NMC also provided submissions on the aggravating and mitigating features of the care. The NMC submitted that a striking-off order is the appropriate and proportionate order.

The panel also bore in mind that it had no submissions before it from Mr Law regarding sanction.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Lack of insight into failings
- Conduct that involved vulnerable patients some who wholly relied on others for their care
- Conduct which put patients receiving care at risk of suffering harm and conduct in which patients receiving care were caused actual harm
- A pattern of misconduct over a period of time

The panel also took into account the following mitigating features:

- Apologies and admissions made by Mr Law at the material time
- Remediation by way of relevant training
- Mr Law highlighted that there were staffing issues at the Home

The panel noted that Mr Law was barred from carrying out regulated work with children and adults on 7 November 2024 by Disclosure Scotland.

The panel had regard to the NMC Guidance 'Sanctions for particularly serious cases SAN-2' updated 6 May 2025 which states *"When considering sanctions in cases involving the abuse or neglect … vulnerable adults, panels will, as always, start by considering the least severe sanction first and move upwards until they find the appropriate outcome. However, as these behaviours can have a particularly severe impact on public confidence, a professional's ability to uphold the standards and values set out in the Code, and the safety of those who use services, any nurse, midwife or nursing associate who is found to have behaved in this way will be at risk of being removed from the register…"*

The panel bore in mind that this case involved vulnerable patients of the Home some who did not have full capacity and some who were wholly reliant on others to support them with their basic and fundamental needs. The panel was of the view that whilst Mr Law's conduct was not abusive in nature, there was a failure to care for patients which could be viewed as neglect.

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 Law's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Law's 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 Law's registration would be a sufficient and appropriate response. The panel is of the view that whilst there are conditions that are workable and could be formulated Mr Law has not recently provided any meaningful engagement to indicate that he would engage with a conditions of practice order. The misconduct identified in this case was not something that can be addressed solely through retraining given the attitudinal issues identified. Furthermore, the panel concluded that the placing of conditions on Mr Law's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The 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 panel bore in mind that the misconduct in this case was a series of incidents some of which individually were not at the most serious end of the seriousness spectrum. However, when each of the incidents are considered together with regard to the significant period of time over which they occurred, the number of vulnerable patients affected, the repeated incidents of a similar nature and the wide-ranging areas of concern identified in Mr Law's practice despite receiving support from the Home, a suspension order was not appropriate. The panel also concluded that there is some evidence of attitudinal issues within Mr Law's nursing practice.

The panel bore in mind its finding that Mr Law has demonstrated limited remorse, a lack of insight and a lack of evidence of recent strengthened practice. As a consequence, the panel determined there is a risk of repetition.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Law's actions is fundamentally incompatible with Mr Law 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?*

Mr Law's 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 Law's actions were serious as they related to numerous failings over a significant period of time. This involved a number of vulnerable patients and despite Mr Law being supported by the Home for the wide-ranging concerns identified he continued to repeat his failings. The panel concluded that to allow Mr Law to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mr Law's 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 a striking-off order would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

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

Representations on interim order

The panel took account of the representations made by the NMC that if a finding is made that Mr Law's fitness to practise is impaired and a restrictive sanction imposed, it considered it is necessary for the protection of the public and otherwise in the public interest to impose an interim order.

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 cover any potential period of appeal.

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

That concludes this determination.