Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday 17 February 2025 – Thursday 27 February 2025

Virtual Hearing

Name of Registrant:	**Nathan Mathew Smith**
NMC PIN	19D0051E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nurse – 17 September 2020
Relevant Location:	Bristol
Type of case:	Misconduct & Lack of competence
Panel members:	Suzy Ashworth (Chair, lay member) Catherine Cooper (Registrant member) Rachel Barber (Lay member)
Legal Assessor:	Trevor Jones
Hearings Coordinator:	Abigail Addai
Nursing and Midwifery Council:	Represented by Roisin Finnegan, Case Presenter
Mr Smith:	Not Present and unrepresented
Facts proved by admission:	1(a), 6(a),(b),(b)(i), (b)(ii), 8(b), 9(a), 9(b)
Facts proved:	Charges 3, 4(a), 4(b), 4(c), 5, 6(c), 6(c)(i), 7(a), 7(b), 8(a), 9(c) 10(a), 10(b), 10(c), 10(c)(i), 10(c)(ii), 10(c)(iii), 11(a), 11(b), 11(c)
Facts not proved:	Charges 1(b), 2, 10(c)(iv)

Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Smith was not in attendance and that the Notice of Hearing letter had been sent to Mr Smith's registered email address by secure email on 14 January 2025.

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

The panel accepted the advice of the legal assessor.

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

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

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision and reasons on proceeding in the absence of Mr Smith

The panel next considered whether it should proceed in the absence of Mr Smith. It had regard to Rule 21 and heard the submissions of Ms Finnegan who invited the panel to continue in the absence of Mr Smith. She submitted that Mr Smith had voluntarily absented himself.

Ms Finnegan referred the panel to the email correspondence from Mr Smith dated 11 February 2025 in which he expressed that he did not realise these proceedings would last longer than a day. Secondly, Mr Smith explained he would be working all week and therefore, the hearing can go on without him.

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'.*

The panel has decided to proceed in the absence of Mr Smith. In reaching this decision, the panel has considered the submissions of Ms Finnegan, the email correspondence from Mr Smith and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones (Anthony William) (No.2) [2002] UKHL 5* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Smith;
- Mr Smith has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- The panel has taken into account his email correspondence dated 11 February 2025 where he informed the NMC of his work commitments;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- The panel referred to NMC guidance on Proceeding with hearings when the nurse, midwife or nursing associate is absent (Reference: CMT-8) and noted it had complied with the rules;

- 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 2022;
- 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 Smith in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address he will not be able to challenge the evidence relied upon by the NMC 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 Smith's 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 Smith. The panel will draw no adverse inference from Mr Smith's absence in its findings of fact.

Details of charge [as amended]

That you a registered nurse, whilst working at Sirona Care & Health ('Sirona')

1) On 18 May 2022 whilst attending an unknown diabetic patient;
   a) Did not provide/ensure that the patient ate jelly babies as instructed by your clinical supervisor, Colleague Z.

b) Inaccurately informed Colleague Z that you had provided the patient with jelly babies.

2) Your actions at charge 1 (b) above were dishonest in that you sought to misrepresent that you had provided the unknown patient with Jelly Babies.

3) On 2 November 2022 did not attend a wound care visit for Patient A, as required.

4) On 3 November 2022 inaccurately recorded on the Egton Medical Information System ('EMIS') that;

a) You had attended Patient A's home address on 2 November 2022 at 10a.m. to undertake a wound care visit.
b) You had spoken to Patient A.
c) Patient A informed you that she did not require assistance.

5) Your actions in one or more of the above charges 4 (a), 4(b) & 4(c) were dishonest in that you falsified records to misrepresent that you had attended a wound care visit for Patient A.

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

That you a registered nurse, failed to demonstrate the standards of knowledge, skill, and judgment required to practise without supervision as a band 5 nurse, in that you;

6) On 15 June 2022 whilst attending an unknown patient requiring male catheterisation;

(a) Did not appropriately sterilise the procedure area;
(b) Did not wash your hands;
i) Prior to the procedure;
ii) After the procedure

(c) Did not appropriately identify and/or escalate the unknown patient's genital bifurcation, in that you;

(i) Did not ask for assistance from a senior colleague.

7) On 28 June 2022 whilst attending an unknown patient due for insulin administration;

(a) Had to be stopped from administering insulin without using a safety needle

(b) Did not wear gloves to check blood glucose levels and/or administer insulin;

8) On 10 October 2022;

(a) Did not make any records of your wound care visit with Patient B.

(b) Did not schedule a follow up visit for Patient B.

9) Between 24-27 October 2022;

(a) Did not check and/or identify that Patient C's patient specific direction ('PSD') had expired on 23 October 2022.

(b) Incorrectly administered insulin to Patient C, after the patient specific direction ('PSD') had expired on 23 October 2022.

(c) Did not sign and/or document that insulin had been administered to Patient C.

10) On 28 October 2022;

(a) Did not make any records of your wound care visit for an unknown patient;

(b) Did not schedule a follow up visit for the unknown patient.

(c) Drove around the community with exposed medical equipment in your car, namely;

i) Sharps bins;

ii) Dressing packs;

iii) Wound dressings;

iv) Blood pressure kits.

11) On 2 November 2022 did not attend and/or document in the EMIS records;

(a) A visit for Patient H.

(b) A wound care visit for Patient **I.**

(c) A visit for Patient J.

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

Case Management Forms

Ms Finnegan informed the panel that Mr Smith had filled out case management forms dated 29 October 2024 and 07 November 2024 respectively. She submitted that Mr Smith had admitted to the charges 1(a), 6(a), 6(b),(b)(i),(b)(ii), 8(b), 9(a) and 9(b) which was signed and declared by Mr Smith. However, Ms Finnegan told the panel charge 10 did not appear in its full form in October's case management form. Therefore, an addendum version was sent to Mr Smith to include the missing charges.

Ms Finnegan submitted that the case management form dated 07 November 2024, included Mr Smith's admission to charges 10 (c)(ii), 11(a), (b) and (c). However, this form contradicted the October case management form because Mr Smith did not admit to the facts alleged in charge 11 in the October form. Secondly, the addendum form was not signed and dated by Mr Smith. As a result, Ms Finnegan submitted that it is the matter for the panel to decide on what it wishes to do with the forms received.

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

The panel has decided to accept the case management form dated 29 October 2024. In doing so, it carefully considered the contents in both forms. The panel was content to rely on October's case management form because it had been signed and dated by Mr Smith. It was not satisfied with the apparent admissions in the subsequent form as it was unsigned and undated, and contradicted the signed October case management form.

Application to admit part of Witness 2 statement as hearsay

The panel heard an application made by Ms Finnegan under Rule 31 to admit paragraph 12 of Witness 2's written statement into evidence. She submitted that this part of Witness 2's written statement referred to a conversation with the unknown patient's daughter, who is an unknown witness. Ms Finnegan informed the panel that it had not been possible for the NMC to engage the unknown patient's daughter and so Witness 2's evidence amounted to hearsay.

Ms Finnegan referred the panel to the NMC guidance on evidence (reference: DMA-6) which states:

> '*Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested.*'

Ms Finnegan then asked the panel to take into account the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) where the court made the following comments:

> '*45. For the purposes of this appeal, the relevant principles which emerge from the authorities are these*
>
> *1.1. The admission of the statement of an absent Witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.*
> *1.2. The fact that the absence of the Witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.*
> *1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the Witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.*

1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.'

Ms Finnegan asked the panel to consider the following matters from *Thorneycroft v Nursing and Midwifery Council* in making its decision:

i. 'whether the statements were the sole and decisive evidence in support of the charges;
ii. the nature and extent of the challenge to the contents of the statements;
iii. whether there was any suggestion that the Witnesses had reasons to fabricate their allegations;
iv. the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;
v. whether there was a good reason for the non-attendance of the Witnesses;
vi. whether the Respondent had taken reasonable steps to secure their attendance; and
vii. the fact that the Appellant did not have prior notice that the Witness statements were to be read.'

She submitted that the principles found in *Thorneycroft* are relevant to the matters in this application. First, Witness 2's evidence is the sole and decisive evidence in relation to charge 1(b). Secondly, Mr Smith has only accepted part of charge 1, namely charge 1(a). Thirdly, Ms Finnegan submitted that there is nothing to suggest that Witness 2 has fabricated their allegations. Ms Finnegan further submitted that the charges in the case are serious because they relate to the failure of administering jelly babies to a vulnerable patient and making a false declaration that the jelly babies had been administered. She

submitted that if the facts were found proved, there would be severe consequences to Mr Smith's professional life. Further, Ms Finnegan referred the panel to the relevant pages of the hearsay bundle and submitted that the NMC had sought to obtain the unknown patient's daughter's details. However, the email correspondence from Sirona Health on 1 November 2024 expressed the unknown patient is no longer on their case load as they are currently on end of life care, and they expressed a reluctance to contact the daughter because of the amount of time that has passed.

Ms Finnegan referred the panel to the points made in the case of *Mansaray v NMC* [2023] EWHC 730 (Admin), that there is no blanket prohibition on hearsay evidence, and that the there is an importance in ensuring that there are safeguards in place to minimise the handicap to the appellant. She submitted that this evidence could be challenged through cross examination and therefore, it is a matter for the panel on whether it considers paragraph 12 of Witness 2's statement can be admitted as hearsay.

The panel heard and accepted advice from the legal assessor.

Panel's decision and reasons to admit part of Witness 2's statement as hearsay

The panel determined in regard to the limbs of *Thorneycroft* and the NMC guidance (reference: DMA-6) that it would not be fair to adduce paragraph 12 of Witness 2 statement as hearsay. It considered the section to be relevant but unfair for the following reasons:

- Witness 2 is the sole and decisive evidence in relation to charge 1(b);
- The panel determined that Witness 2's statement would be likely to be challenged by Mr Smith if he were here;
- The panel was satisfied that the NMC did what it could to secure the attendance of the unknown patient's daughter;
- The panel noted that Mr Smith was given notice that this hearsay application would be made; and

- The panel had no reason to believe that Witness 2 would fabricate their evidence.

In light of above, the panel determined having balanced all of the factors and having taken specific account of the NMC guidance, it would not be fair to adduce the evidence as hearsay, because of its sole and decisive nature in respect of the charge and the likely extent of the challenge from Mr Smith.

Background

The charges arose whilst Mr Smith was employed as a registered nurse by Sirona Care & Health ('Sirona'). On 31 January 2023, the NMC received an employer referral from Sirona about Mr Smith who had been working for Sirona as a Band 5 Community Nurse. This alleged that on 18 May 2022, Mr Smith attended an unknown patient's home and called Witness 2 who was working as a point of escalation to provide clinical assistance. Mr Smith informed Witness 2 that the patient's blood sugar was out of range, that the patient was vulnerable and was living alone in the community although their daughter was often present and was present on this day. Mr Smith stated he wanted advice about the low blood sugar reading, and Witness 2 got off the phone to check the patient's medical records. After checking, Witness 2 called Mr Smith and instructed him to administer the patient some jelly babies alongside their insulin. Mr Smith was outside the property at the time of the call and informed Witness 2 that he had already provided jelly babies with the patient's medication. Witness 2 called the patient's daughter and they had told Witness 2 that no jelly babies had been administered.

It is alleged that on 2 November 2022, Mr Smith was allocated to carry out a planned patient ("Patient A") visit for wound care in the afternoon. At 6:40am on 2 November 2022 Patient A's notes documented that she had called the Sirona Single Point of Contact ("SPA") expressing she was experiencing pain in her right leg and checking that a nurse visit was allocated for that day. The SPA advised that a visit was allocated and to take analgesia in the meantime. Patient A called again at 9:05am to once again confirm the appointment and again expressed she was in a lot of pain. SPA once again confirmed an

appointment would be taking place that day. Patient A then called SPA a further four times throughout the day expressing she was in pain and that she had not yet been visited by a nurse. Witness 3 reviewed the patient's notes at around 7pm. Witness 3 noted that patient A's visit had not been recorded as having taken place and arranged for an out of hours team to attend to the patient. On 3 November 2022, Witness 3 checked Patient A's notes again and they showed that patient A had called SPA approximately five times throughout the day on 2 November 2022, a factor confirmed by Witness 4. Additionally, Witness 3 discovered there was a retrospective clinical entry which suggested that Mr Smith had visited the patient at 10am the previous day.

Due to the difference in information, the matter was escalated to the senior manager, Witness 1, who met with Mr Smith on 4 November 2022. Mr Smith reported that he had been to see the patient in question and knocked on the door and window of their home. Mr Smith reported that the patient appeared to be "zonked out" so he knocked on the window, and Patient A expressed to him that she felt OK and did not need a visit. Patient A was contacted by Witness 4 on 4 November 2022 in order to clarify whether a visit had taken place on 2 November and if she knew of anyone coming to her window. She confirmed she did not receive a visit until 8:15pm on 2 November 2022 when she was visited by the out of hours team; she did not recall speaking to anyone through the window that morning. Patient A also noted that the door to her property was left unlocked during the day to allow staff to visit.

On 15 June 2022 whilst being supervised by Witness 3, it is alleged that Mr Smith failed to sterilise the procedure area and wash his hands before and after the procedure. Further it is alleged that he did not identify or escalate an unknown patient's genital bifurcation to Witness 3. On 28 June 2022, Mr Smith was being supervised by Witness 3 in administering insulin. However, Mr Smith had to be stopped by Witness 3 because he was going to administer insulin without using a safety needle and failed to wear gloves whilst checking blood glucose levels. In relation to charge eight the incident occurred on 10 October 2022 where Mr Smith visited a patient but no notes were made, and on 21 October 2022, Witness 3 received a call from patient B stating that they had not received a

follow-up visit as promised. Witness 3 ascertained that no follow up visit had been scheduled.

Further concerns were then raised between 24-27 October 2022. Witness 3 identified that Mr Smith had failed to check a patient's Patient Specific Direction ('PSD') which had expired on 23 October 2022 and had continued to administer insulin after that date. Additionally, he failed to sign that insulin had been administered to Patient C. On 28 October 2022, Witness 4 alleged that she had seen Mr Smith driving around the community with sharp bins and equipment on show in the back seat of his car. Witness 4 highlighted that Sirona policy states that all equipment used for work including dressing packs, sharp bins, wound dressings and blood pressure kits must be stored in the car boot and not on show. The final charges relate to Mr Smith's various visits to Patients H, I and J on 2 November 2022. In respect of these visits, there were no notes on the system.

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

During the course of Witness 3's evidence, the panel identified that there would be references to Mr Smith's [PRIVATE]. The application was made pursuant to Rule 19.

Ms Finnegan indicated that she supported the application to the extent that any reference to Mr Smith's [PRIVATE].

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 hold parts of the hearing in private to protect Mr Smith's privacy.

Application to admit part of Witness 4's statement as hearsay

The panel heard an additional application made by Ms Finnegan under Rule 31 to admit paragraphs five and six of Witness 4's written statement into evidence. She referred the panel to email correspondence dated 14 November 2022, where Witness 4 expressed that she had spoken to Patient A in respect of the visit that is the subject of charges 3 and 4. Ms Finnegan submitted the reason for the application is because Patient A is deceased. Ms Finnegan reminded the panel of the NMC guidance on evidence (reference: DMA-6) referred to above, and also to the case of *Thorneycroft*, referred to above.

She submitted the principles of *Thorneycroft* are relevant to this application as follows. She submitted that Witness 4's evidence about the conversation is not the sole and decisive evidence regarding these charges, as the panel may also consider the evidence of Witnesses 1 and 3 and Patient A's notes. Ms Finnegan submitted the panel should consider that Mr Smith might challenge this evidence but there is nothing to suggest Witness 4 has fabricated the evidence because it has been documented close to the time in a professional environment. Further, the charges of this case are serious because they relate to a failure to conduct a wound care visit as required.

Ms Finnegan submitted the NMC had given Mr Smith notice that this application will be made in email correspondence sent on 17 February 2025. However, Mr Smith has not responded. Therefore, she submitted that the panel could find it fair that the evidence could be adduced as hearsay.

The panel heard and accepted advice from the legal assessor.

Panel's decision and reasons to admit part of Witness 4's statement as hearsay

The panel determined in regard to the limbs of *Thorneycroft* and the NMC guidance (reference: DMA-6) that it would be fair to adduce paragraph five and six of Witness 4 statement as hearsay. It considered the paragraphs to be relevant, and fair for the following reasons:

- Witness 4's evidence is not the sole and decisive evidence in relation to charges 3 and 4;
- The panel has no evidence or reason to believe that Witness 4 may have fabricated the evidence;
- Charges 3 and 4 are serious charges which relate to the failure to provide wound care;
- There is good reason for the witness's non-attendance because Patient A is deceased;
- The panel determined that Witness 4's statement might be challenged by Mr Smith, however, Mr Smith was given notice that this hearsay application would be made.

In light of the above, the panel determined having balanced all of the factors, it would be relevant and fair to adduce paragraphs five and six of Witness 4's evidence as hearsay.

Decision and reasons on application to amend the charge

Before the NMC closed its case on the facts, the panel sought clarification from Ms Finnegan as to charges 7(a) and 11(a). Ms Finnegan then submitted an application to amend the charges so that they would be clearer when the panel came to make its independent findings of fact.

The proposed amendment to charge 7(a) was to clarify that the evidence suggested that there had been an attempt to administer insulin without a safety needle, rather than that insulin had been administered without a safety needle. Additionally, the panel considered the words 'wound care' in charge 11(a) inaccurate as the evidence suggested that Patient H was scheduled for a B12 injection on 2 November 2022, the date in question, rather than a wound care visit.

Ms Finnegan on behalf of the NMC supported the amendments because they would provide clarity and more accurately reflect the evidence.

Ms Finnegan proposed that the charges should be amended as follows:

7) On 28 June 2022 whilst attending an unknown patient due for insulin administration;

~~(a) Did not use a safety needle to administer the insulin;~~ **Had to be stopped from administering insulin with a self-administration needle.**

11) On 2 November 2022 did not attend and/or document in the EMIS records;

(a) ~~A wound care visit for Patient H.~~ **A wound care/or visit for Patient H**

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel determined that charge 7(a) should be amended as follows:

7) On 28 June 2022 whilst attending an unknown patient due for insulin administration;

~~**(a)** Did not use a safety needle to administer the insulin;~~ **Had to be stopped from administering insulin without using a safety needle**

The panel was satisfied that there would be no prejudice to Mr Smtih and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment to ensure clarity and accuracy.

The panel determined that charge 11(a) should be worded as follows:

11) On 2 November 2022 did not attend and/or document in the EMIS records;

~~**(a)** A wound care visit for Patient H.~~ **A visit for Patient H**

The panel determined that this amendment would cause no unfairness to Mr Smith, and that it was in the interests of justice.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Finnegan who informed the panel that Mr Smith made admissions to some charges.

The panel therefore finds the below charges proved by Mr Smith's admissions:

Charges 1(a), 6(a), (b)(i),(b)(ii), 8(b), 9(a), 9(b)

The panel heard live evidence from the following Witnesses called on behalf of the NMC:

- Witness 1: Integrated network team manager at Sirona at the time of the concerns;
- Witness 2: Advanced Care Practitioner at Sirona at the time of the concerns;
- Witness 3: Team Leader Community Nurse at Sirona and Mr Smith's Line Manager at the time of the concerns; and
- Witness 4: Advanced Clinical Practitioner at Sirona at the time of the concerns.

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.

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

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

Misconduct

Charge 1(b)

> *1) On 18 May 2022 whilst attending an unknown diabetic patient;*
> *(b) Inaccurately informed Colleague Z that you had provided the patient with jelly babies.*

This charge is found NOT proved.

In reaching this decision, the panel took into account Mr Smith's admission to Charge 1(a) and Witness 2's evidence.

The panel went through the background of the charge, namely that Mr Smith was scheduled to visit the unknown diabetic patient on 18 May 2022. It had regard to paragraphs 5, 10, 12 and 13 of Witness 2's statement and the email correspondence 14 November 2022 and Witness 2's oral evidence to the panel. It had particular regard to paragraph 10 of Witness 2's Witness statement which reads:

'I came off the phone with Mr Smith and checked the record again to see what was happening to ensure we could plan for safe insulin levels in the future. I noted that the patient had been running quite low blood sugar levels for a few days. I called Mr Smith back and advised that it would be best to give the patient some jelly babies along with her insulin. Mr Smith was outside the property at this stage and advised me that he had already done that and given her some jelly babies with her dosset box medications.'

The panel noted that Mr Smith had told Witness 2 he had given the patient jelly babies with her other medication but had not seen the patient eat them. This was identified in Mr Smith's admission to charge 1(a). The panel noted that Witness 2 had spoken to the patient's daughter and had spoken to Mr Smith and believed the 'matter had been resolved'. The panel could identify no evidence to support that Mr Smith did not provide the jelly babies with the dosset box medication as he had said.

The panel noted the incident had taken place on 18 May 2022 however, it was not mentioned in his probation review on 15 June 2022, signed by Witness 3. The panel was of the view that this indicated that there was no concern about this incident. It was of the view that there was insufficient evidence to suggest that further concerns had come to light later and that what Mr Smith said was inaccurate, even after Witness 2 had visited the patient later to check her blood sugar levels.

On the balance of probabilities, the panel finds charge 1(b) not proved.

Charge 2

> *2) Your actions at charge 1 b) above were dishonest in that you sought to misrepresent that you had provided the unknown patient with Jelly Babies.*

This charge is found NOT proved.

This charge is dependent on finding Charge 1(b) proved; the panel found Charge 1(b) not proved.

The panel accordingly finds charge 2 not proved.

Charge 3

3)That you, a registered nurse, on 2 November 2022 did not attend a wound care visit for Patient A, as required.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 1, 3 and 4.

The panel heard that Witness 3 had checked EMIS (Sirona's electronic patient record system) on 2 November 2022 at around 7pm after SPA called her enquiring whether anyone had visited Patient A that day. After Witness 3 had checked EMIS, she discovered Mr Smith was allocated to visit Patient A but there was no record of his visit. As a result, Witness 3 arranged for an out-of-hours (OOH) team to visit the patient.

The panel noted that Witness 3 had checked the notes on 3 November 2022 to ensure that the OOH team had attended to Patient A, Witness 3 had found a retrospective entry made by Mr Smith which suggested that he had visit Patient A at 10am on 2 November 2022 and that the patient had 'declined any intervention'. The panel identified that Witness 3 had escalated this matter to Witness 1, her manager, who had given an account of having discussed the matter in a meeting with Mr Smith on 4 November 2022. The panel heard how Mr Smith had described having looked through the window and having seen Patient A 'zonked out' on the sofa, and having said that she did not need a visit.

The panel found the evidence of Witnesses 1 and 3 in respect of this matter to be consistent, reliable and credible.

The panel considered Mr Smith's claim that Patient A did not need to be attended to. In doing so, it had regard to Witness 3's evidence and the EMIS records documenting that Patient A had called repeatedly during the day to ask for wound care, which contradicted Mr Smith's suggestion that she had said that she did not need a visit. It noted Witness 1's

evidence that a clinical assessment would be necessary to determine whether a visit was or was not needed.

The panel had regard to Mr Smith's claims that he experienced IT issues on the day which prompted his late entry. However, the oral evidence proved by Witness 1 highlighted that connectivity issues were uncommon, and that further investigation had shown that Mr Smith had not raised concerns to the IT team.

The panel also took into account the evidence of Witness 4 who described speaking to Patient A on 3 November 2022, who informed her that the only visit that took place on 2 November 2022 was from the OOH team after 8pm. Further, Mr Smith alleged that he knocked on the window but Witness 4 reported that Patient A did not recall this happening.

Whilst bearing in mind that Mr Smith does not have to prove anything in these proceedings, the panel took into account the representations made by Mr Smith in his responses to the charges, and recent email, that he had visited Patient A on 2 November 2022. However, the panel found that the weight of evidence indicated that this was not likely to be correct.

Having considered all the evidence, the panel found it likely that Mr Smith had not attended a wound care visit for Patient A on 2 November 2022.

On the balance of probabilities, the panel finds charge 3 proved.

Charge 4

4) That you, a registered nurse, on 3 November 2022 inaccurately recorded on the Egton Medical Information System ('EMIS') that;

(a) You had attended Patient A's home address on 2 November 2022 at 10a.m. to undertake a wound care visit.

(b) You had spoken to Patient A.

(c) Patient A informed you that she did not require assistance.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1, 3 and 4's evidence. In particular, it had regard to paragraph four to seven of Witness 4's statement, Witness 4's email correspondence dated 14 November 2022, Witness 1's meeting notes from 4 November 2022, paragraphs 9-13 of Witness 1's witness statement, Sirona Health's Policy for Non-Complete Visits, clinical notes by Mr Smith dated 2 November 2022 and Patient A's records.

In respect to charge 4(a), the panel found it likely that Mr Smith had not visited Patient A on 2 November 2022.

In respect to charge 4(b), the panel determined that there was clear evidence from Witness 4 that Patient A did not recall Mr Smith having visited and/or spoken to Patient A her, and this contradicted the clinical notes. The panel noted Witness 4's evidence that there was no reason to believe that Patient A would not have remembered an encounter with Mr Smith on 2 November 2022.

In respect to charge 4(c), the panel noted that Witness 4 had established that patient A had only been visited after 8pm by two OOH nurses. The panel found Witness 4's evidence on the charge to be reliable, credible and consistent, and it was satisfied in all the circumstances that the record made by Mr Smith of a visit to Patient A on 2 November 2022 was likely to have been inaccurate.

Having referred to the number of calls made by Patient A to the SPA on 2 November 2022 requesting assistance, and taking into account Mr Smith's submissions in respect to this charge, including an email dated 17 February 2025, the panel determined that it was

implausible to suggest Patient A would have said to Mr Smith that she did not require assistance.

Having considered all the evidence, the panel was satisfied that it was more likely than not that the record made by Mr Smith in respect of a visit to Patient A on 2 November 2022 was made inaccurately.

On the balance of probabilities, the panel finds charges 4(a), (b), and (c) proved.

Charge 5

> *5) Your actions in one or more of the above charges 4 (a), 4 (b) & 4 (c) were dishonest in that you falsified records to misrepresent that you had attended a wound care visit for Patient A.*

This charge is found proved.

The panel took into account its findings in respect of charges 4(a), 4(b) and 4(c). The panel determined there was evidence that the team tried to call Mr Smith on 2 and 3 November 2022 to investigate concerns about a potential failure to visit Patient A. However, they were unable to get hold of him. The panel noted that Mr Smith had made notes of his alleged interaction with Patient A on 3 November 2022, a day after the intended date of visit.

In reaching its decision on charge 5, the panel took into account the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67, paragraph 74:

'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to

whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards dishonest.'

The panel noted that Mr Smith's subjective state of mind would have been that the record was not correct. Additionally, the panel noted that an objective reasonable observer would consider Mr Smith's actions as dishonest.

As a result, the panel found it likely that the inaccurate record demonstrated an attempt to misrepresent what had happened, and was dishonest.

On the balance of probabilities, the panel finds charge 5 proved.

Lack of competence

Charge 6(c)

6) On 15 June 2022 whilst attending an unknown patient requiring male catheterisation;

(c) Did not appropriately identify and/or escalate the unknown patient's genital bifurcation, in that you;

(i) Did not ask for assistance from a senior colleague

This charge is found proved.

In reaching its decision, the panel took into account Witness 3's evidence including notes made by Witness 3 of the incident. It noted that Witness 3 was present at the event. Witness 3 spoke about her expectations of escalation in these clinical circumstances, and that Mr Smith should have asked her to assist with catheterisation of this patient with

genital bifurcation. The panel noted Witness 3's statement that the failure to escalate in these circumstances led to the patient's distress.

The panel was satisfied that Witness 3 was clear, reliable and consistent in her evidence. The panel acknowledged that Witness 3 had given Mr Smith the opportunity to ask for her assistance to catheterise the patient, and that he had not done so, which meant that she had needed to step in. This was supported by her contemporaneous supervision notes and Mr Smith's need to demonstrate catheterisation as a training and development need within his probation.

On the balance of probabilities, the panel finds charge 6 proved.

Charge 7

7) On 28 June 2022 whilst attending an unknown patient due for insulin administration;

(a) Had to be stopped from administering insulin without using a safety needle

(b) Did not wear gloves to check blood glucose levels and/or administer insulin;

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's evidence and her contemporaneous supervision notes. The panel heard that Mr Smith was preparing to use an incorrect needle to administer the insulin, and that Witness 3 had to stop him and ensure that he administered the insulin using a safety needle. The panel accepted this evidence and was satisfied that Charge 7(a) is proved.

In respect of charge 7(b), the panel noted Witness 3's evidence that Mr Smith did not wear gloves to check the patient's glucose levels, and found this to be credible and consistent.

The panel was satisfied that Witness 3 had directly observed Mr Smith in respect of this incident. The panel was satisfied that Mr Smith did not follow the correct infection control policies on this occasion, and did not wear gloves as would have been appropriate.

On the balance of probabilities, the panel finds charge 7(b) proved.

Charge 8(b)

On 10 October 2022;

(b) Did not schedule a follow up visit for Patient B.

This charge is found proved.

The panel took into account the evidence of Witnesses 1 and 3 and Patient B's notes. Witness 3 informed the panel that she had received a call on 21 October 2022 from Patient B who stated that Mr Smith had conducted a wound care visit on 10 October 2022 and had said he would call again, but had not. She later determined that Mr Smith did not make any record of the visit on 10 October 2022 or schedule the required follow-up visit on EMIS.

The panel considered whether there was evidence to suggest that Mr Smith may have had IT issues that impacted his ability to use the EMIS system. It noted the evidence of Witness 1 who explained the steps that Mr Smith could have taken to address any such issues, and that he had ascertained that no concerns had been flagged up by Mr Smith to the organisation's IT team. The panel also noted Witness 3's evidence that Mr Smith had informed her that he had resolved these IT issues. Additionally, all witnesses informed the panel that it was not common for practitioners to experience issues with EMIS and there was an expectation for employees to use their laptops to write notes on the day of the relevant patient contact, by the end of the shift. Therefore, the panel were not persuaded

that Mr Smith experienced issues with EMIS that could have prevented him from making this record.

On the balance of probabilities, the panel finds charge 8(b) proved.

Charge 9(c)

Between 24-27 October 2022;

9(c) Did not sign and/or document that insulin had been administered to Patient C.

This charge is found proved.

The panel took into account Witness 3's evidence. Witness 3 informed the panel that insulin patients have paper notes at home, and when insulin is administered, employees must record the time it was given and sign the record. The panel noted an entry on EMIS on 28 October 2022 by a Team Leader which stated that no record of insulin administration had been made on the previous day. The panel heard evidence from Witness 3 that Mr Smith had visited the patient on 27 October 2022, and that it was his responsibility to make the record in the patient's home.

The panel were satisfied that the EMIS notes and evidence of Witness 3 were consistent. It noted Witness 3's contemporaneous supervision notes which state:

'It has been bought to my attention that Nathan visited a Patient C for insulin administration on 24th, 25th, 26th & 27th Oct 2022 but PSD was out of date on 23/10/22 & Nathan continued to administer insulin without an in date PSD for this amount of time. It was highlighted by one of the team leaders on 28/10/22 who visited the patient that day. There was also no signature for insulin administration/CBG documented within the patients notes. I will discuss this with Nathan on 1/11/22'

The panel found the evidence of Witness 3 in respect of this incident to be consistent and reliable and was satisfied that Mr Smith did not sign to record that he had administered insulin on 27 October 2022.

On the balance of probabilities, the panel finds charge 9(c) proved.

Charge 10

10) On 28 October 2022;

(a) Did not make any records of your wound care visit for an unknown patient;
(b) Did not schedule a follow up visit for the unknown patient.

Charge 10(a) and 10(b) are found proved.

In respect of charge 10(a), the panel relied on the evidence provided by Witness 1, Witness 3 and Witness 4. It had particular regard to paragraph 7 of Witness 1's statement which reads:

'The patient called on 31 October 2022 to say that they had not had a follow-up visit. Again, it appears that Mr Smith did not make any notes from his visit on 28 October and did not schedule a follow-up visit. This again shows that Mr Smith's practice was not up to the standard expected of him as a band 5 nurse. We have been unable to identify who the patient is and obtain the patient's notes.'

Further, the panel noted the evidence of Witness 4:

'I understand that on 28 October 2022, Mr Smith visited a patient for wound care to the patient's ankle but did not create a schedule for follow up appointments. The clinical system does not show schedules that were not created and only shows records that were created, cancelled or ended'

In light of above, the panel determined that the evidence was consistent and reliable and was satisfied that charge 10(a) should be found proved.

In respect to charge 10(b) the panel took into account Witness 3's evidence that no schedule for follow-up had been made on EMIS, which it found to be reliable and consistent, and supported by her contemporaneous supervision notes.

The panel therefore finds charges 10(a) and 10(b) proved.

Charge 10 (c)

On 28 October 2022;

Drove around the community with exposed medical equipment in your car, namely;

i) Sharps bins;

ii) Dressing packs;

iii) Wound dressings;

iv) Blood pressure kits.

Charges 10(c)i-iii are found proved; Charge 10(c)iv is not proved

The panel was satisfied, on the evidence of Witness 4, that she had seen Mr Smith driving in the community with exposed sharps bins, dressing packs and wound dressings in contravention of Sirona policy. The panel noted an inconsistency in the witness's contemporaneous notes regarding whether or not there was a parcel shelf in Mr Smith's car, but was satisfied with Witness 4's clarification of that inconsistency and in any event determined that this was not material to the charge. The panel was satisfied that charge 10(c)i, 10c()ii) and 10(c)iii were proved.

The panel heard no evidence that Witness 4 saw blood pressure kits in Mr Smith's car; only that policy prevented these being on show. The panel therefore found charge 10(c)iv not proved.

Charge 11

On 2 November 2022 did not attend and/or document in the EMIS records;

(a) A visit for Patient H.

(b) A wound care visit for Patient I.

(c) A visit for Patient J.

This charge is found proved.

In respect of charge 11 the panel took into account Witness 1's evidence, and documentary evidence of the records of Patients H, I and J and of Mr Smith's EMIS diary for 2 November 2022, which recorded that he was due to visit Patients H, I and J.

In respect of Charge 11(a) the panel was satisfied on the evidence that between 28 October and 3 November no visit had been recorded for Patient H therefore there was no documentation of a visit by Mr Smith on 2 November 2022. In light of above, the panel found charge 11(a) proved.

In respect of Charge 11(b), the panel noted that Witness 1 stated:

'The next entry regarding Patient I was 6 November 2022. Patient I's EMIS record shows that Mr Smith did not complete the notes although the EMIS report shows that Mr Smith had to complete another visit'

The panel was satisfied that no visit was recorded for Patient I on 2 November 2022, when Mr Smith was the nurse responsible for the visit.

In respect of charge 11(c) the panel was satisfied that no clinical entry was made on EMIS regarding a visit to Patient J on 2 November 2022, when Mr Smith's diary showed that he

was due to visit this patient. On the balance of probabilities, the panel finds charge 11(c) proved.

The panel therefore finds charge 11 proved in its entirety.

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/or lack of competence, and if so, whether Mr Smith'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 and/or lack of competence. Secondly, only if the facts found proved amount to misconduct and/or lack of competence, the panel must decide whether, in all the circumstances, Mr Smith's fitness to practise is currently impaired as a result of that misconduct and/or lack of competence.

Submissions on misconduct

Ms Finnegan drew the panel's attention 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.'*

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

Ms Finnegan identified the specific, relevant standards where Mr Smith's actions amounted to misconduct and asked the panel to consider the comments by Jackson J made in *Calhaem v GMC [2007] EWHC 2606 (Admin),* Collins J in *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and Sirona's Policy on gaining access to the housebound service user's/patient's homes in the event of no response.

Ms Finnegan invited the panel to find that charges 1(a), 3, 4 and 5 amounted to misconduct.

Ms Finnegan submitted that the charges included a failure to ensure a patient ate jelly babies and not attending a wound care visit to Patient A. She reminded the panel that it had found evidence of dishonesty because Mr Smith had falsified records to suggest that he had attended to Patient A, and that his failure to assess Patient A as required had risked her safety. She submitted that the panel could find that charges 1(a), 3, 4 and 5 represented serious misconduct.

She referred the panel to The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and submitted that Mr Smith had breached the fundamental tenets of the nursing profession as set out therein, and numerous sections of the Code: sections 1.2, 10, 10.1 to 10.3, 14 and 20.

Submissions on impairment of fitness to practise on account of misconduct

Ms Finnegan addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. She made reference to the cases of *Council for Healthcare Regulatory Excellence v (1)*

Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin) and the NMC Guidance on Impairment (Reference: DMA-1), which considers public interest and the nature of the concerns. These are:

- Whether the professional has acted and or/is liable in the future to act so as to put a person receiving care at unwarranted of harm
- Whether the professional has in the past breached and/or is liable in the future to breach a fundamental tenet of the profession
- Whether the professional has in the past acted and/or is liable in the future to act dishonestly
- Context of the error/conduct involved in the concern
- Whether it's highly unlikely that the conduct will be repeated

Ms Finnegan submitted that charges 1(a), 3, and 4 were likely to have put the unknown patient and Patient A at risk of harm. As a result, fundamental tenets of the nursing practice have been breached. She submitted that Mr Smith had acted dishonestly because he misrepresented the visit made to Patient A and falsified records on EMIS. Ms Finnegan referred the panel to the relevant pages of Mr Smith's response bundle [PRIVATE]. However, she invited the panel to not give significant weight to these [PRIVATE], and referred the panel to Mr Smith's correspondence where he stated [PRIVATE] did not play a role in his actions. Ms Finnegan invited the panel to note that there is no evidence to suggest that Mr Smith's workplace environment was a negative one.

Ms Finnegan referred the panel to the NMC guidance from November 2021 which considers whether regulatory concerns have been addressed. She submitted that Mr Smith did reflect and acknowledged the distress he caused to Patient A, but did not demonstrate understanding of the standards of nursing. When considering whether the facts found proved are unlikely to be repeated, she submitted that there were attitudinal and clinical concerns about Mr Smith that had not been addressed. She submitted the

dishonesty concerns were difficult to remediate and that Mr Smith remains a risk to the public because of his lack of insight and remorse.

Submissions on lack of competence

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'*

Ms Finnegan referred the panel to NMC Guidance on lack of competence (Reference: FTP-2b), The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and Sirona's Policy on Driving at Work.

Ms Finnegan invited the panel to find that the charges six-eleven found proved amounted to lack of competence. She gave a background of the charges and submitted Mr Smith had breached the fundamental tenets of the code, and the specific requirements of the Code in sections 1.2, 8, 10, 16 and 20.

Submissions on impairment of fitness to practise on account of lack of competence

Ms Finnegan reminded the panel of the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

She referred to the NMC Guidance on Impairment (Reference: DMA-1) and invited the panel to find Mr Smith's fitness to practise impaired on account of his lack of competence. She submitted that Mr Smith had put patients at risk of harm by failing to adhere to infection control and safety protocols, to make records and schedule follow up

appointments, to escalate concerns, and by not delivering the fundamentals of care in line with required standards.

Ms Finnegan submitted that the same contextual factors were relevant to Mr Smith's lack of competence. She acknowledged that the concerns raised could in theory be remediated, but noted that the panel does not have before it any relevant training, development, or evidence of reflection from Mr Smith. As a result, she said, there still remains a risk of repetition and a risk to patient safety.

Ms Finnegan submitted also that a finding of impairment is necessary in the public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *NMC Guidance Misconduct (Reference: FTP-2a), R (Vali) V GOC [2011] EWHC 310 (Admin), The Nursing and Midwifery Council (Fitness to Practise) Rules 2004* and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

The panel took account of the NMC's guidance in respect of misconduct (FTP-2a). It considered the representations made by the case presenter and the representations made by Mr Smith to the NMC during the course of the regulatory process. It did not draw adverse inferences from Mr Smith's denial of any of the charges, or from his absence.

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

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 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 delay'

'8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

'10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

'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

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

The panel was not satisfied that Charge 1(a) represented misconduct: the panel found it likely in the circumstances that Mr Smith had provided the jelly babies but had failed to ensure that they were eaten, and that this would not reach the standard required for serious misconduct.

The panel determined that charges 3, 4 and 5 represented misconduct. In respect of charges 3 and 4, the panel was satisfied that by failing to attend a wound care visit for a vulnerable patient and falsely recording that he had done so, Mr Smith had acted in a way that his peers would consider deplorable. In respect of charge 5, the panel was satisfied that Mr Smith's dishonesty represented serious professional misconduct, and demonstrated a significant concern about his professionalism.

The panel found that Mr Smith's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code). In particular, the following standards:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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

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

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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

13.4 take account of your own personal safety as well as the safety of people in your care

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

To achieve this, you must, as appropriate:

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

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 took account of the NMC's guidance in respect of lack of competence (FTP-2b) and the case of *Calhaem.* It considered the representations made by Ms Finnegan and the representations made by Mr Smith to the NMC during the course of the regulatory

process. It did not draw adverse inferences from Mr Smith's denial of any of the charges, or from his absence.

The panel noted that they had been asked to consider whether Mr Smith had displayed an unacceptably low standard of professional performance, judged on a fair sample of his work, which could put patients at risk.

The panel noted that the facts found proved in respect of lack of competence related to a period of time between 15 June 2022 and 2 November 2022, and observed that they had heard evidence from Mr Smith's direct supervisor and three other registered professionals who had worked with him at Sirona about the standard of Mr Smith's work during that time. The panel noted that the wider evidence relating to Mr Smith's practice indicated that this was not of a consistent standard, and had caused his colleagues concern throughout the period of his employment which included the extension of his probationary period, but that Mr Smith had also practised without causing concern on some occasions. The panel did note that there were no concerns raised in Mr Smith's subsequent employment, although this was only for a three-month period, and in a more structured ward environment. The panel was satisfied, considering all the evidence, that the facts found proved related to a fair sample of Mr Smith's work.

The panel identified that failure to follow infection control and safety procedures (Charges 6(a) and (b) and (7), 10(c)), failure to ask for assistance when required (Charge 6c)), failure to adhere to protocol in respect of a Patient Specific Direction (Charge 9(a) and b)) failure to complete records appropriately and in some cases to schedule follow-up visits (Charges 8, 9(c), 10(a) and 10(b), 11)) could have put patients at risk. In respect of charge 10(c), the panel noted that although this did not directly put patients at risk of harm, it did potentially put the public at risk of harm from the theft and misuse of equipment.

Having considered all the evidence, the panel was satisfied that the facts found proved represented a pattern of unacceptably low professional performance and did amount to a lack of competence on the part of Mr Smith.

Decision and reasons on impairment of fitness to practise

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'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 was satisfied that all four limbs of the *Grant* test are engaged in Mr Smith's case as to past misconduct. Mr Smith's actions in respect of Charge 3 put Patient A at risk of harm and did cause her distress and discomfort, and his actions at Charges 3, 4 and 5 breached the fundamental tenets of the nursing profession and had the potential to bring it into disrepute. Mr Smith's dishonesty in making a false record engaged limb d of the Grant test.

The panel finds that patients were put at risk and were caused physical and emotional harm as a result of Mr Smith's misconduct. Mr Smith's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Further, it was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

In respect of future risk, the panel was mindful that although clinical concerns may more easily be remediated, dishonesty represents misconduct that may be difficult to remediate. The panel found that Mr Smith's misconduct would potentially be remediable, however, if he had shown insight into his failings, and remorse, and had shown efforts to strengthen his practice. The panel reviewed Mr Smith's statements to the NMC over the course of the investigation, and found that although he had shown some insight in that he accepted that he had not appropriately conducted the visit to Patient A and had apologised for this during the regulatory process, this insight fell far short of what would be required to demonstrate remediation in the circumstances of the panel's findings. In the circumstances, the panel was not satisfied that the misconduct was highly unlikely to be repeated.

The panel therefore determined that Mr Smith's fitness to practise is currently impaired by his misconduct on public protection grounds.

The panel was also satisfied that a finding of impairment of fitness to practise on the basis of the misconduct identified is required on public interest grounds, as this is necessary to protect the reputation of the profession and the NMC as the regulator.

The panel considered whether Mr Smith's fitness to practise is currently impaired by his lack of competence. The panel took account of the Dame Janet Smith 'test' as previously noted.

The panel was satisfied that the first three limbs of the *Grant* test are engaged in Mr Smith's case as to past lack of competence. Mr Smith's actions in respect of Charges 6), 7), 8), 9), 10(a), 10(b) and 11)) potentially put patients at risk of harm by his failing to

complete tasks as expected and to follow the protocols required of him as a registered nurse at his level. The panel was satisfied that all of the charges found proved as demonstrating lack of competence had breached the fundamental tenets of the nursing profession and had the potential to bring it into disrepute.

In respect of future risk, the panel was satisfied that the clinical failings identified could potentially be remediated by Mr Smith if he were to commit to a period of retraining, supervision and reflection. The panel identified that the charges related to basic clinical concerns and that there was nothing to suggest that Mr Smith would be unable to reach the required standards. The panel considered whether any contextual factors could have affected Mr Smith's performance at the time, and found that it had insufficient evidence to demonstrate that this was the case. However, the panel identified that although there was some evidence that Mr Smith had acknowledged the competence issues identified in his practice, there was no evidence that he had taken any action to strengthen his practice as a result. The panel was therefore satisfied that it was not highly unlikely that Mr Smith's lack of competence would put patients at risk of harm in the future.

The panel therefore determined that Mr Smith's fitness to practise is currently impaired by his lack of competence on public protection grounds.

The panel was also satisfied that a finding of impairment of fitness to practise on the basis of the lack of competence identified is required on public interest grounds, as this is necessary to protect the reputation of the profession and the NMC as the regulator.

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.

Having regard to all of the above, the panel was satisfied that Mr Smith'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. The panel was mindful that it was exercising this power in respect of the misconduct identified, and not in respect of the lack of competence. It directs the registrar to strike Mr Smith off the register. The effect of this order is that the NMC register will show that Mr Smith 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

Ms Finnegan informed the panel that in the Notice of Hearing, dated 14 January 2025, the NMC had advised Mr Smith that it would seek the imposition of a striking-off order if the panel found his fitness to practise currently impaired.

Ms Finnegan submitted that the following aggravating factors were present in this case:

- An abuse of a position of trust
- A pattern of misconduct demonstrating the neglect of vulnerable patients
- Failures across fundamental areas of nursing practice
- Mr Smith's dishonesty and misconduct are directly related to his clinical practice
- Premediated dishonesty in an attempt to create an impression of providing care
- A lack of meaningful remorse, remediation and insight

- Evidence of deep-seated personality and attitudinal issues

Ms Finnegan submitted that in terms of aggravating factors:

- Mr Smith has no previous regulatory findings
- Mr Smith has engaged with the NMC
- Mr Smith has made partial admissions to the concerns
- Mr Smith's colleagues spoke positively of him

Ms Finnegan referred the panel to NMC guidance: '*Considering sanctions for serious cases'* (reference: SAN-2) and directed the panel to the section that discusses dishonesty. She submitted the guidance states where a professional denies dishonesty, it is important the registrant attends the hearing. However, Mr Smith has not participated in these proceedings.

Ms Finnegan submitted the charges found proved were wide ranging and covered a number of clinical concerns such as failing to carry out patient assessments and the falsification of patient records. She submitted that while the inadequate record keeping and other competency concerns could be remediated, the panel has not seen any steps taken to address these concerns. Ms Finnegan submitted that Mr Smith's dishonesty and attitudinal issues are serious and more difficult to address and they raise fundamental questions about Mr Smith's trustworthiness.

Ms Finnegan referred the panel to NMC guidance: *'Striking-off order'* (reference: SAN-3e), '*How we determine seriousness'* (reference: FTP-3) and '*Serious concerns which are more difficult to put right (reference: FTP-3a)*. Ms Finnegan submitted that the regulatory concerns present in this case raise fundamental questions about Mr Smith's professionalism and trustworthiness. She submitted that the range and nature of the charges and the dishonesty element must be addressed in order for public confidence to be maintained in the nursing profession. Therefore, Ms Finnegan invited the panel to find that Mr Smith's actions departed from the standards of nursing and are incompatible with him remaining on the register.

In response to the questions from the panel, Ms Finnegan confirmed that the panel are not to consider separate sanctions for the different headings of impairment. She submitted that if a striking off order is imposed, this will be in respect of Mr Smith's misconduct and no further action would be necessary for his lack of competence. Ms Finnegan informed the panel informed that, if it were to consider a suspension order appropriate, Mr Smith's previous interim order may be taken into consideration at the panel's discretion because of the length of time that he has been subjected to the order. She submitted that Mr Smith has not engaged and/or demonstrated any meaningful level of insight, remorse and strengthening practice.

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

Decision and reasons on sanction

Having found Mr Smith'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:

- Conduct which put patients at risk of suffering harm.

The panel did not find any mitigating features in this case.

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 nor would this offer any protection to the public.

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 Smith'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 Smith'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, nor would such a disposal offer any public protection element.

The panel next considered whether placing conditions of practice on Mr Smith's registration would be a sufficient and appropriate response. The panel considered that if the failings identified represented lack of competence alone, it may have been possible to formulate appropriate conditions if it had evidence that Mr Smith would be willing to engage with them.

However, the panel found that there are no practical or workable conditions that could be formulated, given the nature of the misconduct identified in this case. The misconduct identified in this case, which involved dishonestly falsifying clinical records, was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Smith'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;*
- *…*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel noted that a suspension order could mark the seriousness of the lack competence, afford the public appropriate protection and give Mr Smith the opportunity to demonstrate insight and strengthen his practice.

However, in respect of the misconduct found in this case, the panel determined that a suspension order does not sufficiently mark the public interest. The dishonesty found proved related directly to Mr Smith's clinical practice, including neglecting a vulnerable patient, falsifying records and giving an inaccurate account to managers. The panel identified very limited evidence of insight, remorse and strengthening practice and concluded that there is a risk of repetition. The panel noted that in Mr Smith's recent email to the NMC dated 17 February 2025 he appears to blame the SPA team for his misconduct suggesting they '*did not follow procedure to let the nurse looking after the patient know she needed them'.* The panel found that this supported its concerns about Mr Smith's attitude and lack of insight. It determined that a suspension order would not be a sufficient, appropriate or proportionate sanction or mark the public interest and protect the reputation of the profession.

The panel determined that Mr Smith's misconduct was a significant departure from the standards expected of a registered nurse. The panel was satisfied that the serious breach

of the fundamental tenets of the profession evidenced by Mr Smith's dishonesty is fundamentally incompatible with Mr Smith remaining on the register.

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 Smith's misconduct was a significant departure from the standards expected of a registered nurse, and is fundamentally incompatible with him remaining on the register. The panel determined that the findings in this particular case demonstrate that Mr Smith's dishonesty was 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 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 Smith's dishonesty in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

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

The panel wishes Mr Smith to understand that a nurse may make an application to the NMC for restoration to the register in a period of five years from the taking effect of this order. Should Mr Smith wish to consider this path, the panel would invite him to have fully and candidly reflected on his misconduct and clinical shortfalls, and to be in a position to take genuine steps to strengthen his practice.

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

Submissions on interim order

The panel took account of the submissions made by Ms Finnegan. She invited the panel to make an interim suspension order for a period of 18 months to cover any appeal period until the substantive striking-off order takes effect. She submitted that such an order is necessary for the protection of the public and is otherwise in the public interest

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to ensure that Mr Smith cannot practise unrestricted before the substantive striking-off order takes effect, not to impose an interim suspension order would be inconsistent with the panel's earlier finding.

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

That concludes this determination.