Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Monday 3 February – Friday 14 February 2025
Monday 21 July 2025 – Wednesday 23 July 2025

Virtual Hearing

Name of Registrant:	Deojit Persand
NMC PIN	06G0021O
Part(s) of the register:	Nurses part of the register Sub part 1 RN1: Adult nurse, level 1 (3 July 2006)
Relevant Location:	East Sussex
Type of case:	Misconduct
Panel members:	Museji Ahmed Takolia (Chair, Lay Member) Helen Chrystal (Registrant Member) Joanna Bower (Lay Member)
Legal Assessor:	Graeme Sampson
Hearings Coordinator:	Maya Khan
Nursing and Midwifery Council:	Represented by Isabella Kirwan, Case Presenter
Mr Persand:	Present and represented by Catherine Collins instructed by the Royal College of Nursing (RCN)
No case to answer:	Charge 2, 6a, 6b, 6c, 6A (a), 6A (b), 6A (c), 6A (d), 6A (e), 7a
Facts proved by admission:	10a, 10b
Facts proved:	Charge 11

Facts not proved:	Charge 1, 3, 4, 5, 7b, 7c, 7d, 7e, 7f, 7g, 7h, 7i, 7j, 8a, 8b, 8c, 9a, 9
Fitness to Practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you a registered nurse Whilst employed at Ersham House Nursing Home:

1. On 2 March 2021 in response to Resident A's elevated blood sugar level you did not complete and/or did not document sufficient reviews of Resident A to ensure that her blood sugar level had decreased

2. On 15 April 2021 in response to Resident A's blood sugar level being 23.7mmol you did not administer a PRN dose of insulin and/or record why you decided not to administer insulin

3. Having taken a swab of the PEG dressing on 23 March 2021 did not record any follow up steps after notifying the GP

4. On 4 May 2021 you did not ensure that Resident A received pain relieving medication

5. On one or more occasions between February and May 2021 did not ensure that a reason was documented in Resident A's notes to explain why Resident A's medication was omitted

6. On one or more of the following dates you worked consecutive shifts at Ersham House Nursing Home: a. 30/31 March 2021 b. 13/14 March 2021 c. 27/28 April 2021

7. In your capacity of Home Manager at the Ersham House Nursing Home between May 2021 and September 2021:

    a) On or around 14 July 2021 did not ensure that adequate instructions were recorded/provided to staff regarding the use of silver nitrate to treat the over granulation of Resident A's PEG feed

    b) Did not escalate Resident A's over-granulated PEG feed to the GP until 14 July 2021

c) Did not ensure that Resident A received a diabetic review between 24 May 2021 and her admission to hospital on 16 July 2021 which was required before the PEG feed could be removed

d) Failed to notify AACC or ensure that AACC was notified of Resident A's admission to hospital on 16 July 2021

e) Did not contact AACC to discuss the hospital's request that the home provide 1:1 care for Resident A during her admission

f) On one or more occasions did not ensure that Resident A received timely treatment for headlice

g) Failed to ensure that Resident A received adequate PEG care from staff at Ersham House Nursing Home

h) Failed to ensure that Resident A received adequate wound care from staff at Ersham House Nursing Home

i) Failed to ensure staff understanding of podiatry instructions j. Failed to ensure that Resident A received prescribed antibiotics in a timely manner

Whilst employed at Prideaux Manor Nursing Home:

8. On 21 October 2021 you:

a) Demanded that Witness 6 cover a night shift at Prideaux Manor Nursing Home

b) Were verbally aggressive towards

c) Said that you would dismiss staff and employ other nurses if Witness 6 did not do the night shift or words to that effect

9. Your conduct at charge 8 above was:

a) Intended to intimidate Witness 6 into covering the shift

b) Amounted to bullying and/or harassing behaviour.

10. Following your resignation from Prideaux Manor Nursing Home around 29 October 2021, when applying for a role at the Devonshire Nursing Home on or around 2 November 2021 you:

a) Inaccurately stated on the job application form that you were previously employed as a band 6 staff nurse at Tunbridge Wells Hospital when in fact you were employed as a band 5 nurse

b) Inaccurately stated on your CV that you were employed at Prideaux Manor Nursing Home from February 2021 'until present' when in fact you were employed at Prideaux Manor Nursing Home from 4 October 2021 until 29 October 2021

11. Your conduct at charge 10 above was dishonest in that you deliberately provided information on your job application form and CV which you knew was incorrect

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

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

Ms Kirwan, on behalf of the Nursing and Midwifery Council, made a request that parts of this case be held in private on the basis that there may be reference to [PRIVATE] of a witness. The application was made pursuant to Rule 19(2) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Collins, on your behalf, did not object to this application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may

hold hearings partly or wholly in private if it is satisfied that it is justified by the interests of any party or by the public interest.

Having heard that there may be reference to [PRIVATE] of witnesses, the panel determined to hold those parts of the hearing in private.

Background

The NMC received a referral on 21 October 2021 from Ersham Nursing Home (the Home) where you employed as a Home Manager and a registered nurse.

The Home consisted of 20-23 beds and supported vulnerable residents. Resident A was a high acuity patient with unstable Type 1 diabetes. She had previously sustained an acquired brain injury (ABI) following an accidental overdose of insulin. As a result of her brain injury Resident A exhibited challenging behaviour.

The Home raised concerns that between February 2021 and July 2021 in your roles as a registered nurse and for a short period as Home Manager. It is alleged that you failed to provide and oversee safe and effective care for Resident A, contributing to a significant deterioration in Resident A's condition and her subsequent emergency admission to hospital to treat an infected wound and bone infection. The extent of the wound's deterioration was such that it triggered an organisational safeguarding review (OSR) to investigate the circumstances that led to such an extensive injury.

You left your role at the Home on 3 September 2021, and you began working as a Home Manager at Prideaux Manor Nursing Home (the Prideaux) on 28 September 2021. It is alleged that you walked out of work without telling anyone, after some staff members raised concerns that you had allegedly behaved in a bullying manner towards colleagues, and you were not talking to residents.

You then applied to work as a registered nurse at the Devonshire Nursing Home on 2 November 2021. You allegedly provided dishonest information on your CV namely that you had been employed at the Prideaux since February 2021 concealing your employment at the Home where the safeguarding enquiry had been raised. In addition, you allegedly stated that you had been employed as a Band 6 nurse at Tunbridge Wells Hospital when in fact you worked as a Band 5 Nurse at the Prideaux.

The panel heard from a number of witnesses but noted that none of whom were in fact present at the Home during the timeframe of the alleged mischief.

The panel further noted that there were significant number of documents missing which included those relating to the ‘freestyle libre sensor’ which is the digital blood glucose monitoring system used by staff members at the Home to collect data from diabetic patients and which could then be downloaded, and then sent to the diabetic nursing team weekly and/or fortnightly. It further noted that it did not have sight of records from the ‘v care system’ which included PRN medication charts which were only accessible to nurses, it had no records or information from the diabetic team, it did not have the nurse communication book and therefore the evidence was mostly taken from records on the Nourish system.

Decision and reasons on application to admit the RCN letter dated 10 January 2025 as hearsay evidence

The panel heard an application made by Ms Kirwan under Rule 31 to allow the RCN letter dated 10 January 2025 from your representative into evidence. She referred the panel to a paragraph in the letter which stated:

> *‘Charge 6 denied – the staff rota is required, the registrant did not work night shifts. We also suggest someone else may have been using his login, TF33 entry 07/05/2021 17:59 talks about the registrant in the third person which the registrant would not have done if it was his entry.’*

She submitted that the NMC would seek to rely on this part because it confirms your position in relation to the working of night shifts. She submitted that this evidence is highly relevant and is likely to assist the panel with its later decision. She further submitted that you will not be disadvantaged by admitting this additional information, as the information is clearly already known to you and the RCN letter dated 10 January 2025 issued on your behalf by your RCN representative and therefore should be accepted as your instructions. She submitted that there is no prejudice to you.

Ms Collins submitted that the letter should not be admitted into evidence as the paragraph relates to submissions and submissions are not evidence. She submitted

that it is merely a lawyer submission that is made to RCN and it is not a document from you.

Ms Collins submitted that the paragraph is neither relevant nor fair, and it should not be admitted as evidence in these proceedings.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to the paragraph 6 of the RCN letter dated 10 January 2025 serious consideration. The panel determined that the material set out in the RCN letter dated 10 January 2025 was clearly relevant to the issues in dispute between the NMC and you. It determined that given the RCN letter dated 10 January 2025 came from your own representative and therefore it was reasonable to assume it was upon your own instruction.

In these circumstances, the panel came to the conclusion that it would be both fair and relevant to accept the letter into evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Application and decision on amending the charges

During the NMC's case, Ms Kirwan made an application under Rule 28 to add new charges. She submitted that in this case the panel should find that the amendments to the list of charges applied for is in the interests of justice.

The additional charge will read as below:

6A. In the time period between February 2021 to 3 September 2021, whilst working at Ersham House Nursing Home ("The Home"), you:

a) **Gave your log-on details for one or more of The Home's online system(s) to staff members or agency staff who were working at the Home and/or**

b) **Allowed staff members or agency staff at The Home to use your name and/or details on The Home's online system(s) and/or**

c) **Were aware or suspected that staff members or agency staff at The Home were logging-on in your name and/or using your name and/or details on The Home's online system(s);**

d) **Failed to take steps to ensure that staff or agency members at The Home did not to log-on in your name and/or use your name and/or details on The Home's online system(s), and/or**

e) **By your acts or omissions, enabled staff members or agency staff at The Home to log-on in your name, and/or use your name and/or details**

Ms Kirwan submitted that the panel can be satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. She submitted that the amendment relates to that which has already been advanced by your letter from your RCN representative dated 10 January 2025 which the panel has just seen and during cross examination. She submitted that you will also have the opportunity to give evidence in full on the new charges.

Ms Kirwan further submitted that it is appropriate for the panel to allow the proposed amendment in light of its overarching duty to public safety.

Ms Collins opposed the application on your behalf. She submitted that the wording of Rule 28 says that at any stage before making findings of fact, the fitness to practise committee may amend the charge set out in the notice of hearing or the facts set out in the charge on which the allegation is based, unless having regard to the merits of the case and fairness of proceedings. She submitted that the required amendment cannot be made without injustice and there are three broad matters that the panel must consider; the merits of the case, fairness and that the amendments can be made without injustice to you.

Ms Collins submitted that the only evidence that the panel has before it is the evidence of Witness 1 in which she makes an assertion that you worked night shifts after a day

shift and that you worked consecutive shifts. Witness 1 was unable to give any further assistance in cross examination as to how your name might have been included on the daily logs. She submitted that there is no evidence in written form as to how entries are made on the daily log and therefore an explanation had been produced by your lawyer in the written submissions dated 10 January 2025 suggesting that somebody else may have used your login. However, there is no evidence relating to the allegation that you had given somebody else your login details.

Ms Collins submitted that the witnesses attending the hearing have not worked with Resident A and therefore the amendments cannot be made without injustice unless the NMC invites one further witness who was actually present on the relevant nights to attend the hearing.

Ms Collins submitted that the wording of the charge is very wide as it states *'time period between February and September'* which is a period of over six months and therefore the question of how many times you have been alleged to have done this arises.

Ms Collins submitted that that it will be unjust to consider the new charge. Further, it does not meet the merits of the case, would not be fair to allow the charges as they are far too wide without specific particularity, nor is there is any evidence before the panel in relation to it other than submissions from a lawyer.

The panel accepted the advice of the legal assessor.

The panel decided that the amendments as applied for were fair and relevant.

In considering the merits of the case, the panel had regard to its overarching duty to ensure public safety concerns are properly adjudicated on in this hearing and therefore the proposed amendment would be appropriate for this panel to consider.

The panel then went on to consider fairness to you. It noted that the RCN letter dated 10 January 2025 was recent and made it clear that this was your case and would be advanced at the hearing. Therefore, it cannot be said that you would be taken by surprise or denied the opportunity to produce evidence you wished to produce.

The panel considered the injustice in relation to the late and wide-ranging nature of the amendment. It decided that the late nature does not impact on you as you are already aware of the issues in the proposed amendment. Regarding the wide-ranging nature, the panel determined that it has a duty to consider any conduct that impacts on patient safety.

The panel concluded that there is no unfairness to you in making these amendments at this stage and that the amendment could be made without injustice.

Therefore, the panel accepted all the amendments as applied.

Decision and reasons on application to amend charge 6b

On day 5 of the hearing, the panel heard an application made by Ms Kirwan, to amend the wording of charge 6b.

The proposed amendment was to amend the date of the charges to reflect that the that you worked shifts on 13/14 April 2021. It was submitted by Ms Kirwan that the proposed amendment would more accurately reflect the evidence.

> "That you, a Registered Nurse:
>
> 6. On one or more of the following dates you worked consecutive shifts at Ersham House Nursing Home:
>
> a) 30/31 March 2021
>
> ~~b) 13/14 March 2021~~ 13/14 **April** 2021
>
> c) 27/28 April 2021
>
> AND in light of the above, your fitness to practise is impaired by reason of your misconduct."

Ms Collins submitted that she does not oppose the application. She submitted that the amendment does not create any injustice. She told the panel that she cross examined

Witness 1 on the dates of 13/14 April 2021, and it is only when she looked further into matters that she noted that charge 6b was worded incorrectly.

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

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

Details of charges (as amended on 7 February 2025)

That you a registered nurse Whilst employed at Ersham House Nursing Home:

1. On 2 March 2021 in response to Resident A's elevated blood sugar level you did not complete and/or did not document sufficient reviews of Resident A to ensure that her blood sugar level had decreased

2. On 15 April 2021 in response to Resident A's blood sugar level being 23.7mmol you did not administer a PRN dose of insulin and/or record why you decided not to administer insulin

3. Having taken a swab of the PEG dressing on 23 March 2021 did not record any follow up steps after notifying the GP

4. On 4 May 2021 you did not ensure that Resident A received pain relieving medication

5. On one or more occasions between February and May 2021 did not ensure that a reason was documented in Resident A's notes to explain why Resident A's medication was omitted

6. On one or more of the following dates you worked consecutive shifts at Ersham House Nursing Home:

    a) 30/31 March 2021

b) 13/14 April 2021

c) 27/28 April 2021

6A. In the time period between February 2021 to 3 September 2021, whilst working at Ersham House Nursing Home ("The Home"), you:

a) Gave your log-on details for one or more of The Home's online system(s) to staff members or agency staff who were working at the Home and/or

b) Allowed staff members or agency staff at The Home to use your name and/or details on The Home's online system(s) and/or

c) Were aware or suspected that staff members or agency staff at The Home were logging-on in your name and/or using your name and/or details on The Home's online system(s);

d) Failed to take steps to ensure that staff or agency members at The Home did not to log-on in your name and/or use your name and/or details on The Home's online system(s), and/or

e) By your acts or omissions, enabled staff members or agency staff at The Home to log-on in your name, and/or use your name and/or details on The Home's online system(s).

7. In your capacity of Home Manager at the Ersham House Nursing Home between May 2021 and September 2021:

a) On or around 14 July 2021 did not ensure that adequate instructions were recorded/provided to staff regarding the use of silver nitrate to treat the over granulation of Resident A's PEG feed

b) Did not escalate Resident A's over-granulated PEG feed to the GP until 14 July 2021

c) Did not ensure that Resident A received a diabetic review between 24 May 2021 and her admission to hospital on 16 July 2021 which was required before the PEG feed could be removed

d) Failed to notify AACC or ensure that AACC was notified of Resident A's admission to hospital on 16 July 2021

e) Did not contact AACC to discuss the hospital's request that the home provide care for Resident A during her admission

f) On one or more occasions did not ensure that Resident A received timely treatment for headlice

g) Failed to ensure that Resident A received adequate PEG care from staff at Ersham House Nursing Home

h) Failed to ensure that Resident A received adequate wound care from staff at Ersham House Nursing Home

i) Failed to ensure staff understanding of podiatry instructions j. Failed to ensure that Resident A received prescribed antibiotics in a timely manner

Whilst employed at Prideaux Manor Nursing Home:

8. On 21 October 2021 you:

a) Demanded that Witness 6 cover a night shift at Prideaux Manor Nursing Home

b) Were verbally aggressive towards

c) Said that you would dismiss staff and employ other nurses if Witness 6 did not do the night shift or words to that effect

9. Your conduct at charge 8 above was:

a) Intended to intimidate Witness 6 into covering the shift

b) Amounted to bullying and/or harassing behaviour.

10. Following your resignation from Prideaux Manor Nursing Home around 29 October 2021, when applying for a role at the Devonshire Nursing Home on or around 2 November 2021 you:

a) Inaccurately stated on the job application form that you were previously employed as a band 6 staff nurse at Tunbridge Wells Hospital when in fact you were employed as a band 5 nurse

b) Inaccurately stated on your CV that you were employed at Prideaux Manor Nursing Home from February 2021 'until present' when in fact you were employed at Prideaux Manor Nursing Home from 4 October 2021 until 29 October 2021

11. Your conduct at charge 10 above was dishonest in that you deliberately provided information on your job application form and CV which you knew was incorrect

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

Decision and reasons on application to admit Witness 7's statement as hearsay evidence

On day 5 of the hearing after Witness 6's evidence, the panel heard an application made by Ms Kirwan under Rule 31 to allow Witness 7's witness statement into evidence because it is relevant and fair.

Ms Collins did not oppose this application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Witness 7's statement serious consideration. The panel noted that you have been provided with a copy of Witness 7's

witness statement. The panel took the view that Witness 7 is a professional and would not have any reason to fabricate the evidence.

In these circumstances, the panel came to the conclusion that it would be fair and relevant to accept Witness 7's statement into but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it. The panel also took into account that you had been informed that it was the intention of the NMC to invite the panel to adopt these statements and Ms Collins did not raise any objection.

Decision to adjourn the hearing

On day 5 of the hearing after Witness 6's evidence, Ms Kirwan made an application to adjourn the hearing until Monday 10 February 2025 afternoon (day 6). She told the panel that Monday 10 February 2025 afternoon is the earliest time Witness 8 would be able to attend the hearing and give evidence due to being out the country.

Ms Collins did not oppose this adjournment.

The panel accepted the advice of the legal assessor.

In all the circumstances, the panel determined that it would be appropriate do adjourn the hearing until the afternoon of Monday 10 February 2025.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Collins that there is no case to answer in respect of charges 2, 6, 6A and 7a. This application was made under Rule 24(7).

Ms Collins referred the panel to the relevant case law, including *Galbraith* and *Soni v General Medical Council [2015] EWHC 364 (Admin).*

In relation to charge 2, Ms Collins submitted that the NMC's evidence is in Witness 1's statement and the collated entries dated 15 April 2021. She submitted that the panel do not have any evidence to substantiate charge 2 because Witness 1 indicated during her oral evidence that she has not provided all the documents in relation to this matter and therefore the panel cannot be satisfied on the balance of probabilities that you did not administer insulin when there is a record of you administering four units albeit the time

of those units is not clarified in the evidence. She submitted that the NMC have not presented any evidence that states that you did not administer medication.

Ms Collins referred the panel to the RCN letter dated 10 January 2025 which makes reference to there being PRN medication charts however these have not been provided to the panel.

Ms Collins submitted that the panel have not heard evidence from the relevant witnesses as to their knowledge about what was done and not done and therefore the panel is being invited by the NMC to draw an inference. She submitted that NMC have not presented sufficient evidence in order to prove that the administration of insulin was not administered and invites the panel to find no case to answer in relation to charge 2.

In relation to charge 6 collectively, Ms Collins submitted that Witness 1 was not present in the Home on any of the nights of 30/31 March 2021, 13/14 April 2021 and 27/28 April 2021 and Witness 1 cannot give any direct evidence as to where you were or what you were doing overnight.

Ms Collins referred the panel to the weekly rotas dated March/April 2021 which shows that you were not on night duty however there was another registered nurse, who was on duty on those nights. She reminded the panel that it heard oral evidence from Witness 3 who said that there was only ever one nurse on duty on a night shift in the Home. She submitted that that there is nothing in the evidence that the panel have heard which would suggest that on those occasions the directors of the Home decided that two nurses were required on duty.

During cross examination of Witness 8, Ms Collins had taken the panel through the MAR charts dated from 8 March 2021 to 4 April 2021. She then cross-referenced these with the weekly rotas dated across March and April 2021. This confirmed that you did not work consecutive shifts on the dates 30/31 March 2021, 13/14 April 2021 and 27/28 April 2021.

Ms Collins submitted that there is no direct evidence that anyone has seen you working overnight on the relevant dates and therefore the panel cannot be satisfied that the evidence meets the requirements to enable it to find that there is a case to answer.

In relation to charge 6A collectively, Ms Collins submitted that this charge invites the panel to make inferences Colleague A that had used your login details which cannot be made.

In relation to 6A(a), 6A(b) and 6A(c), Ms Collins submitted that the RCN letter dated 10 January 2025 by your solicitor makes the suggestion that somebody else used your login details however you have denied working those shifts and therefore could not have been aware that somebody else used your login details. Ms Collins further submitted that the panel do not have any evidence as to why you would have given your login details to another registered nurse in the Home. She submitted that the oral evidence heard from Witness 3 is particularly weak as he said he was not familiar with the computer systems. She further submitted that a potential explanation as to why Colleague A had completed Nourish records with your login details is because desktops can automatically save details and perhaps this is what may have occurred. However, the panel have not received any clear evidence allowing it to make the inference that you gave your details to another staff member in the Home.

In relation to 6A(d), Ms Collins submitted that the panel would have to be satisfied that there is evidence that you were aware you had a duty to take steps, and the panel has no evidence regarding this. She submitted that there is no case to answer.

In relation to 6A(e), Ms Collins submitted that the panel do not have any evidence before it which indicates that there was any act or omission on your part.

In relation to charge 7a, Ms Collins submitted that the panel do not have any evidence showing that the silver nitrate pen had actually been delivered to the Home at any time and therefore nobody at the Home was required to use it. She submitted that there is no evidence from any nurse at the Home who might have had a cause to use the silver nitrate pen and Witness 3 during his oral evidence accepted that it was a nurse's own duty to determine whether or not they were skilled enough to use the silver nitrate pen.

Ms Kirwan, in relation to charge 2, referred the panel to the entry on 15 April 2021 at 10:58 by Colleague B which stated:

'Roshan [knows] about it being high and has told me to get her to drink water

- *Blood sugar results: 23.7 (mmol)…'*

Ms Kirwan submitted that it appears from the evidence that you did not administer a dose of insulin as this was not recorded on the system. She submitted that this charge is capable of being proved.

In relation to charge 6 collectively, Ms Kirwan submitted that the key evidence is that your name had been entered onto the system on each of those dates and therefore this charge could be found proved on a balance of probabilities and therefore there is a case to answer.

In relation to charge 6A collectively, Ms Kirwan submitted that the weekly rotas dated March/April 2021 indicates that you were not on shift combined with your RCN representative's response in the letter dated 10 January 2025 stating that the only explanation for why his login would be used would be because somebody else had used it and therefore it was her submission that at least one of the subsections is capable of being proven on a balance of probabilities.

In relation to charge 7a, Ms Kirwan referred the panel to the instructions from the GP on how to use the silver nitrate pen. She submitted that the panel does not have to decide whether those instructions were adequate or not.

Ms Kirwan submitted that there is evidence upon which the panel could find each of the allegations in this application to be made out and the panel can be satisfied that there is sufficient evidence to support the charges at this stage and therefore the application of no case to answer should be refused.

In respect of the submissions for no case to answer, the panel took account of the submissions made by the parties and accepted the advice of the legal assessor.

In relation to charge 2, the panel noted the RCN letter dated 10 January 2025 states:

> *'…the correct times will be shown on those, the NMC have not obtained the E-Mar or V- care apps data. Given this is an administration failure charge we submit that the medication chart is required…'*

The panel has not seen the evidence mentioned above and it further noted that Witness 1 admitted during cross examination that she had not seen the PRN medication charts on which insulin would have been recorded.

The panel further noted that Colleague B appears to be material to this evidence, and he is not present to give evidence.

The panel therefore determined there is no case to answer in relation to charge 2.

In relation to charge 6 collectively, the panel noted that the MAR charts indicate that Colleague A was working the night shift. There was evidence in the weekly rotas dated March/April 2021 which show that you worked the day shifts. The panel noted that you prefer working day shifts only and it also had regard to Witness 3's oral evidence, in which he said that there is only one nurse per night.

The panel hard regard to the case of *Soni v General Medical Council* [2015] EWHC 364 (Admin). It considered that the only evidence that indicates that you worked consecutive shifts is the Nourish records which show entries made in your name. The panel considered that there were alternative explanations as to why your login was used and was therefore minded to avoid speculation.

The panel determined there was insufficient evidence and therefore did not find a case to answer in respect of charge 6 collectively.

In relation to charge 6A(a), the panel determined that it had no evidence before it that you *'gave'* your login details to anybody.

In relation to charge 6A(b), the panel determined that it had no evidence before it that you '*allowed*' or caused or permitted to use your login details to anybody.

In relation to charge 6A(c), the panel determined that it had no evidence before it that you '*were aware or suspected'* that staff members or agency staff at the Home were logging-on in your name and/or using your name and/or details in the Home.

In respect of charge 6A(d), the panel noted that it would first have to establish whether you had a duty to take steps to prevent another staff member using your login details. It

did not have any evidence or information before it that this was part of your job description. The panel was satisfied that taking the evidence at its highest, the panel could not, if properly applying the burden of proof at the fact-finding stage, find the charge proved. The panel therefore determined there is no case to answer in relation to charge 6A(d).

In relation to charge 6A(e), the panel noted that it had no evidence that you were aware of somebody else using your login details. Moreover, that the NMC had failed to identify any act or omission which would have enabled somebody else to use your login details. The panel was satisfied that taking the evidence at its highest, the panel could not, if properly applying the burden of proof at the fact-finding stage, find the charge proved. The panel therefore determined there is no case to answer in relation to charge 6A(e).

In relation to Charge 7a, the panel noted that it had no evidence of the silver nitrate pen being delivered onto the ward nor did it have any evidence that staff received training on how to use it.

The panel took account of Witness 1's oral evidence during cross-examination in which she accepted that there was a nurse book on the ward used for communication and entries made with explicit instructions or information. This was not available to the panel.

The panel noted Witness 1's written statement which stated:

> *'I did not consider that the above instructions were enough, as Mr Persand let staff get on with it. Mr Persand's entry on Resident A's records states that their instruction was too long to record, however, they outlined to dab the coloured ink against the tissue. I do not consider that any nurse at the Home would read this previous entry in Resident A's records. Therefore, I was concerned whether Mr Persand passed information on in the correct manner. Moreover, Mr Persand did not confirm that everyone was trained at the Home to use silver nitrate.'*

The panel has noted that there is no evidence of a silver nitrate pen being delivered to the Home. It took the view that Witness 1 had inferred that you did not ensure that

adequate instructions were recorded/provided to staff regarding the use of silver nitrate to treat Resident A.

The panel also noted the oral evidence of Witness 3 who said that nurses would have to be skilled before they use the silver nitrate pen and there is no evidence to show that staff had requested training on this.

The panel was satisfied that taking the evidence at its highest, it could not, if properly applying the burden of proof at the fact-finding stage, find the charge proved. The panel therefore determined there is no case to answer in relation to charge 7a.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case, together with the submissions made by Ms Kirwan and Ms Collin.

Ms Collin submitted that you have made clear and unequivocal admissions to charge 10a and 10b.

Ms Kirwan invited the panel to find that you made full admissions to charges 10a and 10b.

The panel therefore found charges 10(a) and 10(b) proved by way of admission.

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

- Witness 1: Case Manager at All Age Continuing Care (AACC) now known as Continuing Health Care (CHC), at East Sussex County Council

- Witness 2: Lead Enquiry Officer for Adult Social Care within the CHC team, at East Sussex County Council
- Witness 3: Registered Nurse employed by Ersham House Nursing Home (the Home)
- Witness 4: Registered Manager and Registered Nurse employed by Devonshire Nursing Home
- Witness 5: Registered Operations Director for Prideaux Manor
- Witness 6: Registered Nurse previously employed by Prideaux Manor
- Witness 8: Consultant Podiatrist

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, who referred it to the cases of *Ivey v Genting Casinos* [2017] UKSC 67 and *R v Barton and Booth* [2020] EWCA Crim 575. 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.

Charge 1

That you a registered nurse Whilst employed at Ersham House Nursing Home:

On 2 March 2021 in response to Resident A's elevated blood sugar level you did not complete and/or did not document sufficient reviews of Resident A to ensure that her blood sugar level had decreased**.**

This allegation in charge 1 originates from paragraph 110 of Witness 1's statement which stated:

'I have concerns that there are no entries regarding the extra monitoring put in place or actions taken, following Mimi Anderson's following of protocol and documenting the below reading of 27.1 for Resident A on 2 March 2021 (Exhibit TF20). This involved Mr Persand and I refer to the entry below:

02/03/2021 Blood Sugar Levels Test Mimi Anderson Status:

OK Blood sugar results:: 27.1 (mmol/L)

Sugar Level : 27.1'

The panel then had sight of the Nourish record entry completed by you at 12:18 on 2 March 2021 showing a reduction in Resident A's blood sugar levels. Your entry stated:

'Attended, blood glucose level 25.6mmol/L, blood ketone level was 0/negative. 2 u of Fiasp given and ongoing monitoring of the blood sugar by care staff until level reach target. Keep nurse informed'

The panel considered that there were very few instances in the Nourish records where blood sugars and insulin was recorded. It also noted references to the 'freestyle libre sensor' which recorded blood glucose levels, for example an entry on the Nourish records completed by you on 25 March 2021 at 12:31 showing that the reviews of Resident A were completed on a different record system called 'freestyle libre sensor'. It stated:

'…(Diabetic Nurse Specialist) reviewed Resident A blood sugar level and insulin regime by telephone call…Advised to update all data from Freestyle libre sensor…'

Having regard to the evidence, the panel was not satisfied that charge 1 was proved because Resident A's blood sugar was regularly reviewed by others and the diabetic team and that blood sugar reduction was also recorded by you on 12:18 on 2 March 2021.

This charge is found NOT proved.

Charge 3

> Having taken a swab of the PEG dressing on 23 March 2021 did not record any follow up steps after notifying the GP

This allegation in charge 3 originates from paragraph 145 of Witness 1's statement which stated:

> *'Resident A's PEG was weeping in March 2021, which appeared infected and a swabwas taken…there are two entries dated 9 March 2021 and 23 March 2021. The entry dated 23 March 2021 illustrates that a swab of Resident A's PEG dressing was being taken by Mr Persand. If Resident A's swab was taken at 19:04, I am concerned that the swab would stay in the fridge and await collection for hospital testing. I therefore question why the swab was not taken in the morning, or whether the swab was taken in the morning, but was not recorded at time of taking. The GP was informed of the matter by Mr Persand, however Mr Persand would not have informed the GP at this time of the night. My concerns relate to whether Mr Persand followed-up on this matter, as there is nothing in the notes to confirm that Mr Persand had done so.'*

The panel first considered that the swab was taken by you and was recorded in an entry completed by you on the Nourish records dated 23 March 2021 at 19:04 which stated:

> *'Site of Wound: PEG site/stoma dressing applied – Site Cleaned and applied hydrocortisone cream as prescribed and secured with Adhessive mepore dressing 9 x 10 cm Wound appeared infected with pus discharging. Swab taken and GP informed. Continue daily dressing regime or as when needed.'* [sic]

The panel noted your recorded entry on the Nourish records dated 26 March 2021 at 19:04 which stated:

> *'Site Of Wound: PEG site / stoma dressing applied- Site Cleaned and apllied hydrocortisone cream as prescribed and securred with Adhessive Mepore dressing 9 x 10cm Continue Daily dressing regime or as when neded'* [sic]

The panel further noted that you recorded an entry on the Nourish records dated 30 March 2021 at 16:44 which stated:

> *'Site Of Wound: PEG site / stoma dressing applied- Site Cleaned and apllied hydrocortisone cream as prescribed and securred with Adhessive Mepore dressing 9 x 10cm Continue Daily dressing regime or as when neded'* [sic]

The panel identified a number of steps taken and recorded on the Nourish system after you initially took the swab on 23 March 2021 at 19:04. This included an entry on 29 March 2021 in the GP records:

> *'…lab results, routine culture (25/3/21) – some thrush detected, some treatments sent…'*

This suggests the swab you took was sent to by the GP to the lab and results were received back to the GP within a week. The panel noted a further entry in the GP records on 31 March 2021 regarding a telephone call on between the GP and a nurse confirming that the PEG site had grown candida, and a prescription had been sent for Metronizole.

The panel concluded there to be effective communication which ensured that Resident A received the effective follow up and treatment.

Having regard to the evidence, the panel was not satisfied that charge 3 was proved.

This charge is found NOT proved.

Charge 4

On 4 May 2021 you did not ensure that Resident A received pain relieving medication

This allegation originates from concerns raised by Witness 1 where at paragraph 121 of her statement, she refers to the following Nourish entries:

'…04/05/2021

16:11

Day Progress Report […] AGENCY CARER Status: Low Warning Closed by Colleague C Resident A is constantly asking to use the toilet. She say she is in pain down below . I have done a ketone test and reported to Rashan about the toilet issue . Ketone reading is negative reported to Rashan. Also Resident A Peg area is very red and needs looking at . Have asked Rashan for pain relief . Awaiting a response

04/05/2021

17:18

Comfort Break - Early evening AGENCY CARER Status: OK

Constantly asking to go to the toilet . Reported to Rashan. I did a ketone test that was negative. Colleague C came to see […]. She carried out a urine test which was positive. Resident A expressed pain when walking . Asked Resident A to rest on the bed. Also asked Rashan for pain relief earlier. Resident A is waiting for pain relief.'

The panel considered an entry on the Nourish records on 4 May 2021 at 16:31 completed by another nurse, Colleague C, which stated that Resident A received pain relieving medication. It stated:

'Resident A complained of frequency urine and abdominal discomfort. Urinalysis showed evidence of infection. Nitrates and Protein++, blood trace and Glucose+++. Will contact the GP for antibodies. Paracetamol to settle.'

The panel took account of your oral evidence in which you expressed that you delegated the task of administering pain relief to Colleague C as you were attending to other residents that day as there were between 20-23 residents in the Home. It was satisfied that pain relieving medication was administered within 20 minutes after the first instance of the pain being mentioned.

Having regard to the evidence, the panel concluded that charge 4 was not proved. It finds that Resident A had received pain relieving medication from Colleague C whilst you were assisting other residents in the Home.

This charge is found NOT proved.

Charge 5

On one or more occasions between February and May 2021 did not ensure that a reason was documented in Resident A's notes to explain why Resident A's medication was omitted

This allegation in charge 5 originates from paragraph 204 of Witness 1's statement which stated:

> *'I consider that Mr Persand's initials are attributable to omissions of medication administration from February 2021 onwards. Resident A's blood sugar recordings are not consistently recorded on Resident A's MAR charts. I would state that this is because Resident A's blood sugar checks are completed more than the norm throughout the day and the MAR charts do not accommodate for this. I have not been provided with any separate blood sugar charts to review.'*

The panel noted that there was an issue in the EMAR system at the Home which led to safeguarding concerns being raised regarding the alleged omissions of medication and therefore the MAR charts were closely investigated, and discrepancies had been identified with multiple residents.

The panel had sight of a MAR chart dated 5 April 2021 which showed there to be omissions in the medication for Resident A. However, the panel considered the findings

of the Medicines Optimisation in Care Homes (MOCH) to be materially relevant. MOCH carried out an audit and produced evidence that a number of tablets were left in packaging and therefore medication could be proven to have been given to residents.

The panel also considered the oral evidence of Witness 3 who said that when he joined the Home there was a change from electronic records to a paper system. His evidence was supportive of your live evidence.

Witness 3's statement stated:

> *'Due to the numerous changes which had occurred at the Home in the time preceding Mr Persand taking up the position of Home Manager, I consider that he had much to do at the Home (as did I). For example, there were problems with a resident at the Home who did not receive their epilepsy medication, who suffered an epileptic fit and was admitted to hospital. Mr Persand subsequently changed the resident's pharmacy, returned to the use of paper Medication Administration Record ("MAR") charts and completed a medication log book in order to try and ensure that the Home would not be short of medication again…'*

The panel was satisfied that there were plausible reasons for why medication had been recorded as 'omitted' in the Home. Having regard to the evidence, it found charge 5 not proved.

This charge is found NOT proved.

Charge 7b

> Did not escalate Resident A's over-granulated PEG feed to the GP until 14 July 2021

This allegation in charge 7b originates from paragraph 151 of Witness 1's statement which stated:

> *'Mr Persand appears to have had responsibility regarding Resident A's PEG dressing, though Mr Persand did not identify the over-granulation of Resident A's*

at any early stage, and did not document this until July 2021. As Manager, Mr Persand is responsible for all clinical failings and/or lack of managerial oversight of the condition of Resident A's.'

The panel first considered your oral evidence in which you explained that you had accepted the role of Nurse Manager at the Home in May 2021 with some reluctance. You said you had concerns that you would not have sufficient support in the Home. The panel noted that you were employed as a Nurse Manager and not as the Registered Manager of the Home. It further noted that your role as Nurse Manager involved overall responsibility of between 20-23 residents in May 2021 when the Home was also facing significant organisational challenges including those arising from whistleblowing, safeguarding, a CQC inspection and a high turnover of staff.

The panel considered the GP records of Resident A dated 18 February 2021, before you became the Nurse Manager in the Home in May 2021. The GP records show that the GP was aware of the granuloma, and it was being treated. The GP record dated 18 February 2021 stated:

'…Stoma site granuloma and we have been asked to prescribe 1% corticosteroid non adh foam dressing sufficient for 1 10 day course…'

The panel noted numerous entries on the Nourish record system and GP records across May and one in June 2021 in respect of the condition of Resident A's PEG.

The panel took account of the entry on the Nourish record system on 11 July 2021 at 10:36 completed by another staff member which stated:

'Phone call from Dietician for update of Resident A's PEG tube Reported that ,the PEG tube is still in place,has not been removed yet,and looks loke infected,with discharge coming out. GP has been informed yestarday,wound swab has been sent-we are waiting for the out comes and future treatment. Dietician will call us again for update and fututе plan in a month time' [sic]

The panel also considered the entry on the Nourish record system on 12 July 2021 at 11:42 completed by another staff member which stated:

> *'Reported to the GP that Resident A has over granulated PEG site. - GP requested a picture of the PEG site to be sent to her and a swab to be taken and sent it to the lab. 2) Reported that Resident A is more agitated/aggressive lately and asked if risperidone can be increased. - GP has to check with other specialists about this and will get back to us. GP also referred Resident A to Mental team to have a review. (awaiting for the appointment letter). GP also requested to do a urine dipstick and send results to her.'*

Having considered all the evidence, the panel concluded that the over-granulated PEG feed had been raised as a matter of concern by Resident A's GP from February 2021, well before you became the Nurse Manager of the Home. The presence of a number of entries on the GP and Nourish records confirm that the over-granulated PEG feed was being managed by other staff members including the GP and Specialist PEG Nurse .

This charge is found NOT proved.

Charge 7c

> Did not ensure that Resident A received a diabetic review between 24 May 2021 and her admission to hospital on 16 July 2021 which was required before the PEG feed could be removed

The panel was satisfied that the principal responsibility of this belonged to the diabetic team and saw evidence of this on an entry on the Nourish records completed by Colleague A on 8 June 2021 at 07:37 which stated:

> *'…This morning Blood sugar 19.2mmol/l. Blood taken as advised by the surgery for Diabetic review…'*

The panel also had sight of the GP records dated 11 June 2021 which showed a letter from East Sussex Healthcare NHS Trust Diabetes & Endocrinology and an entry on the GP records on 21 June 2021 which stated that Resident A was seen by a dietician.

Having considered the evidence, the panel determined that you were under no obligation and/or duty to arrange a diabetic review, but in any event there is evidence that Resident A was reviewed by the diabetic team.

This charge is found NOT proved.

Charge 7d

> Failed to notify AACC or ensure that AACC was notified of Resident A's admission to hospital on 16 July 2021

The panel took account of your oral evidence in which you explained that when you accepted the role as Nurse Manager you had discussions with the director regarding the scope of your responsibilities. You said that it was your understanding that, as you were not a Registered Manager, your responsibilities did not include contracts and financial matters.

The panel noted the NMC's assertion that it was your obligation to notify and deal with the AACC. However, it heard no evidence from the NMC as to the extent of your role and responsibilities.

Having considered all the evidence, the panel found your actions in line with the agreed process.

This charge was found NOT proved.

Charge 7e

> Did not contact AACC to discuss the hospital's request that the home provide 1:1 care for Resident A during her admission

Consequently, the panel found 7e is not proved for the same reasons as 7d.

This charge was found NOT proved.

Charge 7f

On one or more occasions did not ensure that Resident A received timely treatment for headlice

The panel identified a number of entries on the Nourish records completed by other staff nurses at the Home regarding Resident A's headlice.

The panel first considered the entry on the Nourish records completed by another staff member on 13 June 2021 at 22:18 which stated:

'Resident A said she is having itching on her head. When I have look I founds some headlices removed them using the headlice comb. Better to apply the medicine for headlice again…' [sic]

Later that evening a further entry was completed by another staff member at 23:07 which stated:

'Assisted Resident A with sculp treatment and shampooed and conditioned her hair.'

The panel therefore concluded that Resident A's headlice was found and treated within 40 minutes on 13 June 2021.

On 23 June 2021 at the Nourish records completed by another staff nurse at 17:41 it stated:

'Resident A has attended dermatology clinic and medically escorted by care staff Tom. Clinic has prescribed special shampoo. Prescription has been handed by care staff Tom to the home manager to be sorted out tomorrow.'

The panel also considered the GP records and found that on 23 June 2021 a Clinical Letter Community Dermatology Clinic Dermatology was attached.

On 12 July 2021 at 14:23 it stated:

‘Reported by care satff that Resident A has head lice, NOK brought in an over the counter treatment spray to use. Bottle treatment is being kept in her room.’

On 14 July 2021 at 12:41 it stated:

‘Deliced Resident A’s hair she has nits again.’

The panel accepted your oral evidence that the responsibilities regarding Resident A’s headlice were delegated by you to other staff nurses as you were a Nurse Manager at the time, attending to other residents.

This charge was found NOT proved.

Charge 7g

Failed to ensure that Resident A received adequate PEG care from staff at Ersham House Nursing Home

The panel took account of your oral evidence in which you explained that in your role as Nurse Manager you wanted to ensure that staff nurses were performing physical assessments of PEG. You said that you thought this was happening however when you looked at the Nourish records it appeared that there was a failure to adequately record that these physical assessments of PEG took place. You said that following this you conducted an audit to ensure that Resident A was receiving PEG care and it was being recorded.

The panel had sight of the minutes of the Management Meeting dated 23 June 2021 at 14:00 where you raised your concerns recording PEG care on the Nourish system.

Having heard the evidence, the panel was satisfied that you took steps as the Nurse Manager of the Home to ensure that Resident A received adequate PEG care from staff members and that this was accurately reflected in the Nourish records.

This charge is found NOT proved.

Charge 7h

> Failed to ensure that Resident A received adequate wound care from staff at Ersham House Nursing Home

The panel first considered that it had evidence that there was a multi-disciplinary approach to the wound care of Resident A. It saw evidence that the podiatrist was seeing Resident A's wound every week, and she was being monitored every four weeks by the diabetic foot clinic. The nurses had instructions regarding wound care as part of Resident A's care plan and Resident A's GP was aware of this.

The panel also heard evidence from Witness 8 who said that there were no concerns regarding Resident A's wound care until 1 July 2021 and there were only two occasions when Resident A was critical. However, the podiatrist addressed the wounds on other occasions.

The panel found two entries on the Nourish system. On 1 July 2021 at 10:41, completed by other staff nurse, it stated:

> *'Visited by podiatris today,dressing has been changed, bythem, as she is under their care for the food. Next reviwe is next Friday. No changes or conserns were reported to me by podiatrist.'* [sic]

On 8 July 2021 at 12:39, completed by other staff nurse, it stated:

> *'…HEELS rf MACERATEED WITH CENTRE NERCROSIS REDRESSED WITH tAGERDERM OFF LOADED WITH 10MM SCFDONUT SOFT AND K BAND LF HEEL DOING WELL LIGHT CALLUS AND SMAL SPILT NO EXUDATE SEEN RE DRESSED WITH nA SG AND SOFT KBAND…'*

Finally, the panel considered that given no specific concerns were escalated to you as Nurse Manager of the Home regarding Resident A's wound, their case was managed by the podiatrist.

This charge was found NOT proved.

Charge 7i

Failed to ensure staff understanding of podiatry instructions

The panel first considered Witness 8's statement which made references to the podiatrist instructions, it stated:

> *'Podiatry therefore visited the Home and provided advice in a mixture of written and verbal advice. I initially could not find evidence of this matter, but I now note that Podiatry did document in the notes to the nursing staff of the Home on a few occasions, which I have referenced in my witness statement. The care staff of the Home would not have been involved in Resident A's dressings but the nursing staff were eventually asked to share care with the Podiatrist and to reapply dressings as needed/instructed. All communication made to district nursing staff is always contained in email via writing. Communication made to the Home would have also been verbal and written on their electronic note keeping system….*
>
> *…The instructions provided to the Home by Podiatry were to ensure that Resident A had their shoes on and to try and encourage Resident A not to walk, but rest. I cannot see any documentary evidence that the Home was asked to be involved in dressing changes, until much later on in Resident A's treatment (following the Safeguarding meeting which I discuss in further detail below…'*

The panel also took account of Witness 3's oral evidence during cross examination in which he said that the podiatry instructions in the care plan were ambiguous.

The panel then considered a number of entries on the Nourish system completed by staff nurses at the Home relating to Resident A's podiatry care.

On 29 June 2021 at 18:36 it stated:

> *'Resident A's top dressing on her feet been changed , given yellow line . She kept her shoes in today…'*

On 8 July 2021 at 14:51 it stated:

> *'Resident A was very active today Refused to rest her legs in her room. Around 19.50 become very tired, she did not eat her supper, fluid given as ;200 ml of orange juise,200ml of milk and some biscuits .Obs don.- Seen by podiatrist -see the report ,dressing done by podiatrist ,no any conserns reported to me .'*

These entries show that Resident A's needs were being attended to by other nurses and care staff.

The panel took account of your oral evidence in which you said that you were advised that the podiatrists would provide wound care to Resident A, if the dressing had to be changed then silver nitrate had to be used and to call the podiatrist hotline if there were any questions.

Having considered the evidence, the panel took the view that there was strong evidence to establish that the staff nurses in the Home had a good understanding of podiatry instructions.

The charge is found NOT proved.

Charge 7j

> Failed to ensure that Resident A received prescribed antibiotics in a timely manner

This allegation in charge 7j originates from paragraph 21 of Witness 2's statement which stated:

> *'Podiatry requested that the Home was to arrange for a collection of the antibiotics, however, there was a three to four day period whereby Resident A did not receive their antibiotics. This was identified as a failing, highlighted due to Resident A attending a foot clinic on 25 June 2021, in which it was established that Resident A's antibiotics had not yet been arranged. This concern was*

highlighted by the Podiatry Service as part of the information gathering stage, and a specific member of care staff was not mentioned.'

The panel considered Resident A's GP records and found a prescription of antibiotics. It identified an entry on the Nourish records on 25 June 2021 at 12:30 completed by a staff nurse which stated:

'…Her right heel however does have a slight infection in so anti biotics have been prescribed for 10-14 days. Which we collected before leaving the hospital.'

The panel considered there to be no evidence to suggest that Resident A did not receive antibiotics in a timely manner.

This charge was found NOT proved.

Charge 8

On 21 October 2021 you:

a) Demanded that Witness 6 cover a night shift at Prideaux Manor Nursing Home
b) Were verbally aggressive towards Witness 6
c) Said that you would dismiss staff and employ other nurses if Witness 6 did not do the night shift or words to that effect

Charge 9

Your conduct at charge 8 above was:

a) intended to intimidate Witness 6 into covering the shift
b) Amounted to bullying and/or harassing behaviour.

The panel considered charges 8 and 9 collectively. It had been presented with two conflicting accounts of what happened from you and Witness 6. It did not have enough evidence to determine which one is most likely to have happened, nor did it have any evidence of bullying and harassing. The panel took account the inconsistencies in

evidence of Witness 6 and Witness 5, and as such, the panel determined that the NMC have not discharged the burden of proof.

These charges were found NOT proved.

Charge 11

> Your conduct at charge 10 above was dishonest in that you deliberately provided information on your job application form and CV which you knew was incorrect

The panel noted your admissions to charges 10 (a) and 10 (b). It also noted your evidence was that you were aware of the false nature of those statements.

As regards charge 10(a) on your job application form that you had previously been employed as a Band 6 staff nurse at Tunbridge Wells Hospital when you a had not You had been employed as a Band 5 nurse. That assertion was untrue, and you knew it at the time. Your reasoning was that you had been acting as a Band 6 nurse and therefore you could be regarded as such.

As regards charge 10(b), your statement as to the length of your employment at Prideaux Manor Nursing Home from February 2021 ‘until present’ was untrue. You asserted you had been employed for nine months when in fact you had only been employed for 25 days. The panel noted your evidence that this was a one of a number of *‘careless’* errors made in your application form and CV at the time due to [PRIVATE] and your intention was not to deceive.

However the panel noted your admission that you had read and signed the declaration on your job application form, which stated:

> *‘I declare that to the best of my knowledge and belief, the information given is true. I understand that employment will be considered subject to the particulars being correct. I further understand and accept that if any of the information given in this document is incorrect or untrue, that the Proprietors reserve the right to terminate my employment with them immediately.’*

In determining whether your actions were dishonest the panel had regard to the test set out in *Ivey v Genting Casinos* [2017] UKSC 67. There was no doubt that you committed the acts alleged in charges 10(a) and 10(b). You knew what you had stated was untrue and you made them having read and signed the Declaration.

Applying the test of whether your conduct was honest or dishonest by the (objective) standards of ordinary decent people. The panel had no doubt that your actions were and would be viewed as dishonest.

Accordingly, the panel find his charge proved.

The hearing resumed on Monday 21 July 2025

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

At the outset of the hearing, Ms Collins made an application for parts of the hearing to be held in private [PRIVATE]. This application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

[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.

[PRIVATE]

In respect to the Conduct and Competence Committee's decision dated December 2016, the panel considered that this was a public hearing, and it is a public document that is available on the NMC website. It therefore determined that any references made to this document in the hearing would not need to be held in private.

[PRIVATE]

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired.

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, does the panel go onto decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

[PRIVATE]

[PRIVATE]

Submissions on misconduct and impairment

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

Ms Kirwan 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, midwives and nursing associates (2015) (the Code) in making its decision.

Ms Kirwan identified the specific, relevant standards where your actions amounted to misconduct.

Ms Kirwan submitted that you made untrue assertions in your job application, the first being that you stated that you were a substantive Band 6 nurse when in actual fact you were a Band 5 nurse and the second being that your employment at Prideaux Manor was for a period of only 25 days long and not as stated by you for nine months. She submitted that you provided this information dishonestly and your actions were made deceptively for your personal gain i.e. to secure a job. She submitted that giving false and untrue information in this setting poses a direct risk of harm to patients in your future employment. She submitted that your actions indicate deep seated attitudinal concerns.

Ms Kirwan submitted that, in all of the circumstances of the case, your actions and the charges proved are a departure from good professional practice and are sufficiently serious to constitute serious misconduct.

Ms Kirwan moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and uphold proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). In paragraph 76 of *CHRE v NMC and Grant*, 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.’*

Ms Kirwan submitted that all four limbs of *Grant* are engaged. In relation to the first limb, Ms Kirwan submitted patients could have been put at risk of harm by your actions as you were posing as a more experienced and more qualified individual than you actually were at the time.

In relation to the second and third limbs, Ms Kirwan submitted that your actions have brought the nursing profession into disrepute, and you have breached fundamental tenets of the nursing profession by failing to promote professionalism and trust and acting in a thoroughly dishonest manner.

Ms Kirwan submitted that registered professionals occupy a position of trust in society. She submitted that the public expects nurses to provide safe and effective care and conduct themselves in a way that promotes trust and confidence. She submitted that the conduct in this case undermines the public's trust and confidence in the profession and could result in patients, and members of the public, being deterred from seeking nursing assistance when needed.

In relation to the fourth limb, Ms Kirwan submitted that the NMC considers there to be a continuing risk to both public protection and the wider public interest due to your actions which directly link to dishonesty. Ms Kirwan further submitted that your actions indicate attitudinal issues which are more difficult to put right and therefore there is a risk of repetition and a risk of significant harm to patients in the future should you be permitted to practise as a nurse again.

Ms Kirwan invited the panel to find impairment on the ground of public protection. She submitted that dishonesty is difficult to remediate. She submitted that the conduct in this case was serious and over a period of time, it was not an isolated incident of dishonesty. She submitted that there are two elements of dishonesty, two separate documents with two pieces of false information. She submitted that the supervision records before the panel today do not address dishonesty but rather discuss what honesty and integrity mean rather than looking at any specific situations. She submitted that dishonesty is a much harder issue to remedy, and you have limited insight into your dishonesty as you have maintained throughout your oral evidence that your actions were not intentionally dishonest.

She invited the panel to find that your misconduct breached the fundamental tenets of the nursing profession, brought its reputation to disrepute and a finding of impairment is also necessary for the protection of the public.

Ms Kirwan invited the panel to find impairment on the ground of public interest. She submitted that your actions are deplorable and amount to serious misconduct. You have brought the nursing profession into disrepute and served to undermine public confidence and trust in the profession. She submitted that your conduct raises fundamental questions about his integrity and trustworthiness as a registered professional and seriously undermines public trust in nurses, midwives and nursing associates.

[PRIVATE]

Ms Collins told the panel that you have accepted that honesty is a fundamental tenet of the profession and you acknowledged the serious nature of the allegations in your reflective statement. She submitted that there is no prior history in relation to dishonesty matters.

[PRIVATE]

Ms Collins submitted that at the time of completing your CV application, you did not realise the error you had made. She submitted that during this hearing, you have not sought to blame any other person for your actions or accuse any witnesses of being dishonest. She reminded the panel that you have made full admissions to charges 10a and 10b which is indicative of your insight. She referred the panel to your updated reflective piece, the positive references from your previous employers and the supervision reports where you discussed the importance of candour, honesty and integrity as a requirement for nurses with your supervisor who is aware of the charges you face today.

In respect of dishonest behaviour putting patients at risk, Ms Collins submitted that you were a registered manager of a care home between 2018 and 2019, and you had direct evidence of your qualifications and experience in that role within the application form. She submitted that the panel heard evidence from Witness 4 who explained that there

was a rigorous job process to determine the successful candidate and therefore it is not possible that you were able to put any patients at risk by submitting a job application form.

Ms Collins invited the panel to consider the context of the allegations, that this was a rushed application as a result of a very difficult working environment at the end of 2021. She submitted that you accept that your actions may appear dishonest however you deny that you were intentionally dishonest. Ms Collins submitted that you appreciate that you should have double checked your application form to ensure that your CV was up to date and accurate and in future you intend to ensure the information is correct before submitting the job application.

Ms Collins invited the panel to consider all the information it has before it today including the positive references from employers, testimonials, supervision records which are contemporaneous, your reflective piece and your oral evidence when making its decision on misconduct and impairment today.

The panel accepted the advice of the legal assessor.

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 also had regard to the NMC's guidance on misconduct (FTP-2a) and the guidance on seriousness, with particular regard to dishonesty (FTP-3). The panel also bore in mind the context in which these charges arose, pursuant to the guidance.

The panel considered the 'Introduction' section of the Code, which outlined:

> '*The values and principles set out in the Code can be applied in a range of different practice settings, but they are not negotiable or discretionary*.'

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

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…

The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct. The panel determined that honesty is a fundamental tenet of nursing, and your dishonest conduct was deliberate in that you entered the incorrect information on your job application in order to secure a job role. The first being that you stated that you were a substantive Band 6 nurse when in actual fact you were a Band 5 nurse and secondly, you wrote on your CV that you had been employed at Prideaux Manor for nine months when in fact you were only employed for 25 days.

The panel considered your oral evidence in which you accepted that your actions could be viewed as misleading but that you still deny that your actions were dishonest.

For the reasons above, the panel concluded that your actions amounted to misconduct.

Decision and reasons on impairment

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

The panel were aware that there is no statutory guidance on what constitutes impairment. However, it was guided by NMC Guidance and the leading Case of *Grant.*

In paragraph 76 of *CHRE v NMC and Grant*, 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 determined limb (a) was not engaged as your actions did not relate to your clinical skills and did not put patients at unwarranted risk of harm.

It determined however that limbs (b), (c) and (d) were engaged in this case.

With regard to the second and third limbs, your misconduct has breached the fundamental tenets of the nursing profession and therefore it has brought its reputation into disrepute. The panel determined that it is a fundamental tenet of nursing for a registrant to be open and honest, and to act with integrity. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find that your misconduct was a breach of a fundamental tenet of the profession.

With regard to the fourth limb, the panel had found that you had been dishonest on your job application/CV. It took account of your reflective piece stating that you would be more careful in the future and acknowledged according to your oral evidence that you have some developing insight. The panel noted that you said during your oral evidence that your actions were not an intentional act, but you understand how it appears to the public or an employer. However, despite the panel's determination of the facts found proved, you still do not accept that you had acted dishonestly. As a result, the panel is not satisfied that your insight is sufficiently well developed and therefore finds you would be at risk of repeating this behaviour in the future.

With regard to future risk, the panel next considered the comments of Silber J in *Cohen v General Medical Council* [2008] EWHC 581 (Admin) namely (*i) whether the concerns*

are easily remediable; (ii) whether they have in fact been remedied; and (iii) whether they are highly unlikely to be repeated.

The panel was not satisfied that the dishonesty in this case is capable of being easily addressed and has not been. The panel took into account your reflective piece which showed some developing insight. You also said in oral evidence that you would check details on your job application form before submitting it in the future. It also considered the supervision notes from your most recent employer where you were practising under conditions and where you discussed honesty and integrity with your supervisor. It took the view that these were general discussions rather than specifically how you would address the dishonesty identified where you were able to draw on actual situations that related specifically to the duty of candour or honesty and integrity. It determined that, in light of these circumstances, the concerns in this case would be difficult to remediate.

Regarding insight, the panel was concerned to learn that although you accept during your oral evidence that your actions could appear misleading, you continue to deny that your dishonesty was deliberate. It reminded itself of the NMC guidance (reference: SAN-2) on *'Cases involving dishonesty'* and determined that you had deliberately breached the professional duty of candour by submitting incorrect information in a job application in order to secure a job role.

The panel further noted that you had read and signed the declaration on your job application form, which stated:

> *'I declare that to the best of my knowledge and belief, the information given is true. I understand that employment will be considered subject to the particulars being correct. I further understand and accept that if any of the information given in this document is incorrect or untrue, that the Proprietors reserve the right to terminate my employment with them immediately.'*

The panel was satisfied that there is a risk of repetition, given your lack of sufficient insight and remediation.

The panel determined that the misconduct in this case did not relate to your clinical skills and therefore concluded that a finding of impairment is not necessary on the ground of public protection.

The panel then considered whether a finding of impairment was necessary in the wider public interest.

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

The panel gave consideration to the NMC guidance on Impairment: What factors are relevant when deciding whether a professional's fitness to practise is impaired?:

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

The panel determined that a finding of impairment on the ground of public interest is necessary. It concluded that submitting false information on a job application form and CV whilst declaring that it is true when it is not needs to be taken seriously and a lack of full insight into your dishonesty remains.

Having found misconduct, the panel determined that not to make a finding of impairment would significantly undermine the public's trust and confidence in the nursing profession. It is also necessary to mark the seriousness of the misconduct and to uphold proper standards and conduct for members of the nursing profession.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that you have been suspended from 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 Kirwan informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a striking off order if the panel found your fitness to practise currently impaired. She submitted that a striking-off order is the only order that would maintain public confidence in the profession and uphold the proper standards. She submitted that a striking-off order is proportionate to the findings in respect of the charges and the subsequent decision in respect of impairment and misconduct.

Ms Kirwan outlined the aggravating and mitigating features in this case. She submitted that the alternative sanctions the panel has the power to consider would not sufficiently protect the public as your dishonest behaviour in this case indicates deep seated personality issues or an attitudinal problem. She further submitted that your misconduct involved being dishonest in a job application form/CV for personal gain, in that you wished to secure a job role by stating that you had more experience than you actually had. This raises fundamental questions about your professionalism and the basic tenets of integrity and trust. She submitted that the panel has limited evidence of remediation or insight from you as you do not accept that you acted dishonestly and therefore you remain a risk to public safety.

Ms Kirwan submitted that allowing you to continue practising would undermine public confidence in the profession and the NMC as regulator. She asked the panel to consider a striking-off order to mark the importance of protecting the public and to maintain public confidence in the profession.

Ms Collins submitted that a caution order is the only appropriate sanction as the panel wish to mark the behaviour as unacceptable and it decided that there is no risk to the

public or patients, meaning that this case is at the lower end of the spectrum of fitness to practise. She submitted that a caution order can last up to five years, and it addresses the risk of repetition in relation to dishonesty as it would show up on your registration.

Ms Collins submitted that a conditions of practice order does not apply to these circumstances as the panel have made the decision that there are no public protection concerns that relate to your clinical practice.

Ms Collins submitted that if the panel does not agree with the caution order, then she invited it to consider a short suspension order as this would mark the behaviour and is more proportionate to the matter than a striking off order as sought by the NMC.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found that your fitness to practise is currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel bore 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 NMC's guidance on 'Considering sanctions for serious cases' (SAN-2). In examining the factors in 'Cases involving dishonesty', the panel noted that findings of dishonesty will always be serious but that there is a spectrum of levels of dishonesty. It had regard to the serious factors in the SG which include:

- *'deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to people receiving care*
- *misuse of power*
- *vulnerable victims*
- *personal financial gain from a breach of trust*

- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception'*

The panel determined that none of the above factors were engaged and went onto consider the factors for dishonest conduct that is generally less serious, these include:

- *'one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *incidents outside professional practice'*

The panel determined that the first three points were relevant, but the fourth point was not relevant. The panel considered this to be a one-off incident, as your CV was attached to your job application dated 2 November 2021. The panel accepts that this may have been spontaneous conduct on your part in light of the context of you leaving Prideaux Manor in a stressful situation and requiring another job.

The panel took into account the following aggravating features:

- Dishonesty is always serious
- Insufficient insight

The panel took into account the following mitigating features:

- The misconduct did not involve patient harm
- The misconduct was an isolated incident

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 interest concerns raised, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour*

was unacceptable and must not happen again.' The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified; notably your denial of the fact of dishonesty having been found proved by it. The panel therefore decided that it would not be in the public interest to impose a caution order as there needs to be public acknowledgment that this type of honesty is unacceptable.

The panel next considered whether placing a conditions of practice order on your registration would be a sufficient and appropriate response. The panel determined that. given that there are no public protection concerns in this case, conditions would not be appropriate or workable in the circumstances.

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 acknowledged that this was a single instance of misconduct and there has been no repetition of dishonesty and in light of its earlier findings, it was satisfied that there are no deep-seated attitudinal issues. Moreover, it also took into account the supervision notes over a period of 12 months. It further noted that you have some developing insight but that this is not fully developed. Finally, the panel was satisfied that in this case; the misconduct was not fundamentally incompatible with remaining on the register.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation, the panel concluded that it would be disproportionate and unduly punitive.

The panel noted that the NMC maintained its original sanction bid of a striking-off order. The panel determined that a striking-off order was not necessary and would be disproportionate. It determined that a suspension order would be sufficient in marking the seriousness of the misconduct in this case and sufficient to protect the public interest.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order could cause you. However, this is outweighed by the public interest in this case.

The panel considered that this suspension order is 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.

In deciding the appropriate length of the suspension order, the panel carefully balanced the public interest against the impact a suspension order would have on you. The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

The panel then considered whether a review of the suspension order was required.

The panel bore in mind that it found your fitness to practise impaired only on the grounds of public interest. In these circumstances, in accordance with Article 29 (8A) of the Order, the panel has exercised its discretionary power and determined that a review of the substantive order is not necessary.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is

necessary for the protection of the public, is otherwise in the public interest or in your own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Kirwan. She submitted that an interim suspension order for a period of 18 months is in the public interest. She also submitted that the length of the interim suspension order should cover any potential period of appeal.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

In light of its decision that your fitness to practise is impaired on public interest grounds alone, the panel determined that it was not necessary to impose an interim order. The panel found there were no ongoing risks to the public.

If no appeal is made, the substantive suspension order will take effect 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.