Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting

Friday, 14 March 2025 – Wednesday 19 March 2025

Virtual Meeting

Name of Registrant:	Mark Barry
NMC PIN:	89C0608E
Part(s) of the register:	RN1: Adult – Level 1 (17 December 1993) RN2: Adult – Level 2 (6 April 1993)
Relevant Location:	London
Type of case:	Misconduct/Lack of Competence/Health
Panel members:	Michelle McBreeze (Chair, Lay member) Susan Laycock (Lay member) Julia Briscoe (Registrant member)
Legal Assessor:	John Bassett
Hearings Coordinator:	John Kennedy
Facts proved:	Charges 1ai, 1aii, 1bi, 1bii, 1biii, 1ci, 1d, 1e, 1fi, 1fii, 1g, 1hi, 1hii, 1i(i)a, 1i(i)b, 1i(i)c, 1i(i)d, 1i(ii)a, 1i(ii)b, 1ji, 1jiii, 1jiv, 1k(i)a, 1k(i)b, 1k(ii)a, 1k(ii)b, 1k(ii)c, 1k(iv)a, 1k(iv)b, 1k(iv)c, 1k(v)a, 1k(v)b, 1k(vi), 1k(vii)a, 1k(vii)b, 1l(i)a, 1l(i)c, 1l(i)d, 1l(ii)a, 1l(iii)c, 1l(iv)b, 1l(iv)c, 1l(iv)d, 1l(iv)e, 1l(iv)f, 1l(v)a, 1l(v)b, 5, 6, and 7
Facts not proved:	Charges 1cii, 1jii, 1kiii, 1l(i)b, 1l(ii)b, 1l(iii)a, 1l(iii)b, 1l(iii)d, 1l(iii)e, 1l(iv)a, 1l(iv)g, 2, 3, and 4
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

At the start of this meeting, the panel was informed that the Notice of Meeting had been sent to Mr Barry's registered email address by secure email on 22 January 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually.

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

Details of charge

That you, a registered nurse:

1. Failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 7 nurse in that you:

a. On 28 December 2016:

i. Failed to arrange for Patient A to have an x-ray.

ii. Did not record that Patient A had osteopenia.

b. On 27 April 2017, in relation to Patient B:

i. Failed to arrange for Patient B to have an x-ray.

ii. Did not record a detailed history.

iii. Did not undertake an assessment of the scaphoid bone and/or the joints above and below the wrist, or alternatively undertook an assessment but failed to record it in the notes.

c. On 10 January 2018, in relation to Patient C:

i. Failed to record their vaccination and immunisation status.

ii. Advised to treat their injury as a sprain.

d. On or around 15 January 2018 failed to pack Patient D's wound appropriately.

e. On 21 February 2018 failed to send Patient E for an x-ray.

f. On 17 March 2020, in relation to Patient F:

i. Failed to conduct an initial assessment.

ii. Sent them away despite them having heart palpitations.

g. On 12 April 2020 used steri strips on Patient G's wound when it should have been sutured.

h. On 2 May 2020, in relation to Patient H:

i. Failed to get an interpreter.

ii. Failed to document the correct injury and/or take an adequate history.

i. On 18 January 2021:

i. In relation to Patient U:

a. Documented that a pedal pulse was present and/or recorded the capillary refill time when you had not tested for these.

b. Did not know where the navicular bone was.

c. Had forgotten the OTTOWA ankle rules.

d. Used another nurse's log in details for the iclip.

ii. On one or more occasion:

a. Had to be reminded to ask a patient to get on the couch for examination.

b. When examining a patient went straight to resisted movement without doing an active and passive range of movement first.

j. On 23 January 2021 in relation to Patient V:

i. Failed to record the administration of antibiotics and/or Revaxis.

ii. Did not provide safety net/worsening advice or provided it but did not record it.

iii. Had to be reminded to wash your hands and/or put gloves on following your previous patient.

iv. Were unaware of the NICE guidelines of management of the wound.

k. On 2 February 2021:

i. In relation to Patient I:

a. Recorded in the notes that you had conducted a Simmonds test when you had not and/or “Allergies NK” when the patient did have allergies.

b. Failed to assess the knee joint and/or toe joints.

ii. In relation to Patient J:

a. Had to be prompted in asking the questions required to assess a knee injury.

b. Had to be advised to review the x-ray systematically.

c. Failed to write detailed and/or specific notes.

iii. Tried to move Patient K’s ankle when it had a clear deformity.

iv. In relation to Patient L:

a. Required support with Patient Group Directive.

b. Recorded that the wound was on the proximal interphalangeal joint (PIPJ) when it was on the distal interphalangeal joint (DIPJ).

c. Required prompting and/or support to discuss the patient with the plastics team.

v. In relation to Patient M:

a. Incorrectly noted that the patient had bony tenderness over the lateral navicular bone.

b. Did not ask sufficient questions as to the mechanism of the foot injury.

vi. In relation to Patient N did not provide sufficient details in the notes as to special tests and/or the mechanism of the injury.

vii. In relation to Patient O:

a. Did not ask about any neurovascular symptoms and/or what the patient did in terms of sport.

b. Had to be prompted to carry out the Simmonds test properly.

l. On 5 February 2021:

i. In relation to Patient P:

a. Documented that the patient had a radial pulse present and/or a capillary refill time of less than 2 seconds when you had not performed the tests for these observations.

b. Did not ask and/or record what medications the patient was currently on.

c. Did not recognise the possible abscess around the wound.

d. Had to be prompted to complete an orthopaedic referral.

ii. In relation to Patient Q:

a. Recorded that there was no medial collateral ligament (MCL) or lateral collateral ligament (LCL) laxity without completing the stress test.

b. Incorrectly documented that the injury related to the proximal phalanx.

iii. In relation to Patient R:

a. Did not take full details of the mechanism of injury to the eye.

b. Had to be prompted to complete one or more Patient Group Directives.

c. Did not consider differential diagnoses.

d. Required support with the Moorfield referral.

e. Completed the wrong visual acuity.

iv. In relation to Patient S:

a. Did not ask sufficient questions to determine the severity of the head injury.

b. Had to be prompted to check the c-spine.

c. Suggested using steri strips on a full thickness wound.

d. Did not recognise the need to follow up with the Ear Nose and Throat Team.

e. Required full support and/or prompting with the Patient Group Directive Revaxis.

f. Did not use the correct equipment and/or technique for suturing.

g. Did not check for a nasal fracture.

v. In relation to Patient T:

a. Were unable to recall how to complete the specialist tests on the patient's shoulder.

b. Documented that the patient had restricted movement without completing the test.

2. Your actions at charge i(i)(a) were dishonest in that you knew that you had not checked for a pulse and/or recorded the refill time.

3. Your actions at charge k(i)(a) were dishonest in that you knew that you had not conducted a Simmonds test and/or that the patient did have allergies.

4. Your actions at charge l(i)(a) and/or l(ii)(a) and/or l(v)(b) were dishonest in that you knew that you had not conducted the requisite testing for those observations.

5. On one or more occasion attempted to and/or left a shift before the time that you were due to finish.

6. [PRIVATE]

7. [PRIVATE]

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence at charge 1; your misconduct at charges 2, 3, 4 and 5; and your health and/or any associated and/or consequential health condition at charges 6 and 7.

Schedule 1
[PRIVATE]

Background

The charges arose whilst Mr Barry was employed as a registered nurse by St Georges University Hospitals NHS Foundation Trust (the Trust) in a Band 7 Emergency Nurse Practitioner Role.

Concerns arose about Mr Barry's competence at working safely and effectively as a band 7 nurse, and his conduct. During the period of supervision and support offered by the Trust

in 2020 – 2021, concerns were raised about Mr Barry's [PRIVATE] and how these might impact his ability to practise as a registered nurse.

The panel noted that in some of the early documents Mr Barry is referred to by a different name. Having considered all the documents the panel is satisfied that it is the same person.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together, with the representations made by the NMC and from Mr Barry as part of the Trust's local investigation. The panel noted that Mr Barry had not made any direct submissions to the NMC concerns.

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

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

- Witness 1: Head of Nursing at the Emergency Department at the Trust
- Witness 2: Lead Emergency Practitioner at the Trust
- Witness 3: Specialist Doctor at the Trust working in the Urgent Treatment Centre, also involved in teaching emergency practitioners including nurses.

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

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

Charge 1a

1 Failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 7 nurse in that you:

a. On 28 December 2016:

i. Failed to arrange for Patient A to have an x-ray.

ii. Did not record that Patient A had osteopenia.

This charge is found proved

The panel considered these two subcharges together as they relate to the same patient and are substantially connected.

The panel had regard to the statement of Witness 1 which states that the Matron at the time of the incident had held a meeting with Mr Barry to discuss a complaint that had been made against him. This stated:

'After what [Patient A] felt was only a cursory examination of her hand, [Mr Barry] said that an x-ray wasn't necessary…

As [the Matron] said to [Mr Barry], [Patient A's] condition worsened overnight and she re-attended the next day when an x-ray of her hand was taken and a fracture seen.'

Later on in the letter the Matron states to Mr Barry:

'…your documentation, done at the time, does not have any record of her bone condition, which [Patient A] clearly stated to you as a concern for her attendance. This is a clear lack of record keeping for a nurse of your experience. You were not

able to give me any reason as to why you had not documented such a vital piece of information, or at least recognised that this condition would increase the risk of fracture.'

The panel considered this evidence from the Matron to be convincing and there is no suggestion Mr Barry challenged the matters set out in the charge. Therefore, the panel found both subcharges of 1a proved.

Charge 1b

b. On 27 April 2017, in relation to Patient B:
i. Failed to arrange for Patient B to have an x-ray.
ii. Did not record a detailed history.
iii. Did not undertake an assessment of the scaphoid bone and/or the joints
above and below the wrist, or alternatively undertook an assessment but failed to record it in the notes.

This charge is found proved

The panel had regard to the statement of Witness 1 which stated:

'Following a bicycle accident on 27 April 2017 [Patient B] attended, their hand was examined by [Mr Barry] but not X-rayed and discharged to say there was no fracture. Due to prolonged pain the patient went to her GP and the patient was referred for an X-ray on 21 July 2017 which showed a fracture of the Scaphoid bone that needed urgent attention.'

The panel also had sight of the medical notes Mr Barry made during his assessment of the patient. These did not include any notes of the patient's past medical history, social history (such as job or other relevant lifestyle factors), and nothing about the mechanism of the presenting injury. The notes also confirm Mr Barry did not arrange for an x-ray, nor does his written account dated 18 October 2017.

The panel therefore found that subcharges i and ii are proved.

The panel then considered sub charge iii and found it proved as regards the first clause. The panel had regard to the medical notes, Mr Barry's response to the complaint dated 18 October 2017, and the statement of Witness 1 and found that on the balance of probabilities it is more likely that Mr Barry did not carry out any assessment of the scaphoid bone or the joints above and below the wrist.

Charge 1ci

c. On 10 January 2018, in relation to Patient C:
    i. Failed to record their vaccination and immunisation status.

This charge is found proved

The panel had regard to the medical notes Mr Barry made during his assessment and noted that the section for recording vaccinations/immunisations was left blank. The panel noted that, especially with paediatric patients, it is standard nursing practice to check their vaccination status and to record this in the notes anytime a patient is presenting to accident and emergency.

The panel therefore considered that the absence of this record in the assessment notes is sufficient evidence to find this charge proved.

Charge 1cii

c. On 10 January 2018, in relation to Patient C:
    ii. Advised to treat their injury as a sprain.

This charge is found not proved

The panel had regard to the assessment notes taken by Mr Barry which stated that there was swelling on the right ankle. The panel noted that two days after Mr Barry's examination it was reported that a fracture had been seen on the x-ray. While it is correct

that on 10 January 2018 as is shown in his note Mr Barry advised that the injury should be treated as a sprain the panel consider that the treatment Mr Barry advised would have been the same if he had treated the injury as a fracture. In these circumstances the panel did not consider that this charge has been proved on the balance of probabilities.

Therefore this subcharge is found not proved.

Charge 1d

d. On or around 15 January 2018 failed to pack Patient D's wound appropriately.

This charge is found proved

The panel considered the statement of Witness 1 which stated:

'There was a concern the [Mr Barry] had not managed [Patient D's] wound appropriately. When there is a cavity wound, if a wound is surgical they cut a big hole out which needs to be packed by putting dressing down in the wound to allow it to heal upwards. If this is not done skin forms across the top and leaves a hole underneath which is then at risk of infection. [Mr Barry] had not packed the wound and just put Aquacel over the top which is incorrect.'

The panel had sight of a contemporaneous account from the Practice Nurse, who received concerns from Patient D about the care they received which states that the wound was not properly packed. There is no reason to suggest that the Practice Nurse has not accurately described what they observed.

The panel therefore found that this charge is proved.

Charge 1e

e. On 21 February 2018 failed to send Patient E for an x-ray.

This charge is found proved

The panel had sight of the medical assessment notes Mr Barry made for Patient E and his reflection letter made after the event.

In the assessment notes there is no record of the patient being sent for an x-ray, which would have been recorded if this had been the case. Mr Barry also stated in his letter that he did not send the patient for an x-ray.

The panel therefore found that this charge is proved.

Charge 1f

f. On 17 March 2020, in relation to Patient F:
   i. Failed to conduct an initial assessment.
   ii. Sent them away despite them having heart palpitations.

This charge is found proved

The panel had regard to a DATIX which had been raised about this incident which stated:

> *'Patient presented to department said she was having palpitations feeling unwell. [Another nurse on shift] had asked her to book in and would help in a minute. When we went to call [Patient F] she was leaving. [Patient F] had been met by [Mr Barry], the patient told [Matron] she had said to [Mr Barry] she was having palpitations, had taken her medication felt unwell – [Mr Barry] advised we do not deal with that and to go elsewhere.'*

The panel had regard to the contemporaneous note completed by another nurse which described Patient F's presentation at the time. The panel noted that Witness 1 stated that there was no record of Mr Barry carrying out an assessment on this patient in order to determine whether it was something that they would treat or not.

The panel noted that Mr Barry, when questioned at a local investigation about this incident stated that the patient had decided to leave themselves but that this was not documented.

Witness 1 stated, and the panel accepted, that if a patient had decided to leave, the normal procedure would have been to make a note to record this, which was not done, and that in any event with a cardiac patient presenting an initial assessment should have been completed and documented which was not done in this incident.

The panel therefore found both subcharges in this charge proved on the balance of probabilities.

Charge 1g

> g. On 12 April 2020 used steri strips on Patient G's wound when it should have been sutured.

This charge is found proved

The panel had sight of the patient assessment notes made by Mr Barry which state that he used *'steri strip, cosmopore'* to treat the patient.

The panel noted that Witness 1 stated:

> *'[Mr Barry] administered steri strips and non-adherent dressing. The patient was then discharged. The patient then returned later that day at 22:19 due to bleeding from the wound. The dressing [Mr Barry] had applied was removed and the wound appeared to have jagged and deep edges that were not coming together. The use of the steri strips was not the most appropriate treatment. The wound should have been sutured.'*

The panel noted that in Mr Barry's local response he indicated he had no recollection of this patient.

The panel therefore found that this charge is proved.

Charge 1h

h. On 2 May 2020, in relation to Patient H:

i. Failed to get an interpreter.

ii. Failed to document the correct injury and/or take an adequate history.

This charge is found proved

The panel had regard to the statement of Witness 1 which said:

> *'[Doctor 1] saw a patient who had reattended the unit after seeing [Mr Barry] two weeks before on 2 May 2020. This patient had a dislocated shoulder but there were concerns that when he presented initially. This patient spoke very limited English, their first language was Portuguese and [Mr Barry] did not get an interpreter. [Mr Barry] did refer for an x-ray of the elbow which came back fine, [Mr Barry] also did not document the correct injury or take an adequate history. … The documentation was very poor and there were inaccuracies as he noted no cardiac history but the patient did have a cardiac history and also noted no allergies but they did. It might have been due to the language barrier however there is a process to obtain interpreters if required.'* [sic]

The panel had sight of the patient assessment notes and a DATIX which confirmed that Mr Barry did not obtain an interpreter to assist the patient, and that he failed to take a completed medical history, and document the correct presenting injury.

Therefore the panel found this charge proved. Regarding charge 1hii the panel found both limbs proved.

Charge 1i(i)

i. On 18 January 2021:

i. In relation to Patient U:

a. Documented that a pedal pulse was present and/or recorded the capillary refill time when you had not tested for these.

b. Did not know where the navicular bone was.

c. Had forgotten the OTTOWA ankle rules.

d. Used another nurse's log in details for the iclip.

This charge is found proved

In reaching this decision, the panel had sight of the handwritten skills assessment notes made at the time by Doctor 1 who was supervising Mr Barry during this assessment. Doctor 1's statement describe who they were present when Mr Barry made his assessment. The panel also had sight of the assessment notes made by Mr Barry.

The panel considered that the first sub charge is found proved only in respect to the allegation concerning the record of the pedal pulse. The patient records note that a pedal pulse was present; however, there is no record of a capillary refill time. The panel considered that in their witness statement and handwritten notes Doctor 1 states that they did not observe Mr Barry carrying out a pedal pulse test and therefore it has been recorded without the test being done by him.

The panel noted that in the skills assessment notes Doctor 1 states that they needed to explain where the navicular bone was and what the OTTOWA rules were. The panel had no reason to doubt this account, and therefore found subcharges b and c proved.

The panel had sight of the patient record of the assessment and noted that Mr Barry's name does not appear as the electronic entry. The panel noted that the style of taking the notes, in block capitals, is what Doctor 1 states was Mr Barry's usual style at this time and that they saw him make the entries. Therefore the panel concluded that on the balance of probabilities it is likely that Mr Barry used another nurse's log in details to access the system and make this record.

The panel therefore finds all of charge 1i(i) proved.

Charge 1i(ii)

i. On 18 January 2021:

ii. On one or more occasion:

a. Had to be reminded to ask a patient to get on the couch for

examination.

b. When examining a patient went straight to resisted movement without doing an active and passive range of movement first.

This charge is found proved

The panel considered that Witness 3 stated:

> *'I had to remind [Mr Barry] on several occasions to tell the patient to get onto the couch, he had a tendency to bend forward and prod at the patient who was sat in a chair, from an ergonomic/manual handling perspective this was not good practice and could result in injury to [Mr Barry].*
>
> *When you have a joint injury you do active range of movement and passive range of movement, resisted movement and special tests. [Mr Barry] went straight to resisted movement.'*

The panel noted that there is nothing to doubt the credibility of Witness 3 on this therefore this charge is found proved in its entirety.

Charge 1j(i), (iii), and (iv)

j. On 23 January 2021 in relation to Patient V:

i. Failed to record the administration of antibiotics and/or Revaxis.

iii. Had to be reminded to wash your hands and/or put gloves on following your previous patient.

iv. Were unaware of the NICE guidelines of management of the wound.

These charges are found proved

The panel had regard to the patient notes made by Mr Barry of this assessment, the handwritten skills assessment of Doctor 1, and the accompanying witness statement of Witness 3.

The panel noted that in the patient records there is no mention of administering antibiotics or revaxis and therefore the panel finds the first subcharge proved on both clauses.

The panel noted that Witness 3 stated that Mr Barry had to be reminded to wash his hands and put gloves on when switching patients. Further Witness 3 also stated that Mr Barry was unaware of National Institute for Health and Care Excellence (NICE) guidelines and wanted to advise the patient to return if there was a sign of infection instead of following the guidelines and providing them with prophylactic antibiotics. There is no reason to doubt this evidence. The panel therefore found subcharges iii and iv proved.

Charge 1j(ii)

j. On 23 January 2021 in relation to Patient V:

ii. Did not provide safety net/worsening advice or provided it but did not record it.

This charge is found not proved

The panel considered that the patient notes stated:

'ADVICE BITE CARE'

The panel concluded that while this is unclear as to what exactly this advice involved and if it was a full safety net, it is indicative that some form of advice on wound care was provided by Mr Barry.

Therefore on the balance of probabilities the panel found this charge not proved.

Charge 1k(i)

k. On 2 February 2021:

i. In relation to Patient I:

a. Recorded in the notes that you had conducted a Simmonds test when you had not and/or “Allergies NK” when the patient did have allergies.
b. Failed to assess the knee joint and/or toe joints.

This charge is found proved

The panel had regard to the statement by Witness 2, the handwritten skills assessment report, and the patient notes.

The panel considered that for charge 1k(i)a this is found proved on both grounds. The panel noted that Witness 2 states that Mr Barry carried out a test on the patient while they were lying in a supine position, that is on their back. However, in order to carry out a Simmonds test a patient needs to be lying prone, that is on their front. Therefore, while there is evidence that Mr Barry carried out a test, it could not have been a Simmonds test as the patient was in the incorrect position for such a test.

The panel further noted that Witness 2 said to Mr Barry that the patient had allergies and that these need to be recorded in the patient records. Nevertheless Mr Barry did not record this and recorded *‘Allergies: NK’* in the patient record. When Witness 2 reviewed these noted shortly after the assessment as part of the supervision they had to make an addendum to record what allergies the patient had stated in the assessment.

In regards to charge 1k(i)b the panel noted that there is no record in the patient notes of an assessment of the knee and/or toe joints.

Therefore the panel found this charge proved in its entirety.

Charge 1k(ii)

k. On 2 February 2021:
ii. In relation to Patient J:
a. Had to be prompted in asking the questions required to assess a knee injury.

b. Had to be advised to review the x-ray systematically.
c. Failed to write detailed and/or specific notes.

This charge is found proved

The panel considered the patient notes of the assessment, the handwritten skills assessment, and the statement of Witness 2.

Witness 2 states that:

> *'[Mr Barry] needed prompting in asking the special questions that need to be asked when assessing a knee injury. This would include things like asking the patient if they have experience of the knee giving way/buckling this would indicate an unstable knee and potential ligament injury. …*
>
> *I also had to advise [Mr Barry] to examine the x-ray systematically, not just focus on the area of concern. …*
>
> *I noted that [Mr Barry's] noted required a bit more detail and to be more specific he noted "slight laxity LCL", the LCL is a ligament in the knee, I would expect him to note down how he had determined that.'*

The panel considered that this is similar to the notes made by Witness 2 at the time of the skills assessment and with what Mr Barry recorded in the patient notes.

Therefore the panel found this charge proved on the balance of probabilities.

Charge 1k(iii)

k. On 2 February 2021:
iii. Tried to move Patient K's ankle when it had a clear deformity.

This charge is found not proved

The panel only had information from the statement of Witness 2 on this charge.

While Witness 2 states that there was an occasion where Mr Barry attempted to move a patient's ankle despite it being clearly deformed there is no contemporaneous record, or patient notes to provide particular evidence of this.

Therefore the panel concluded that this charge due to the lack of additional evidence is found not proved.

Charge 1k(iv)

k. On 2 February 2021:

iv. In relation to Patient L:

a. Required support with Patient Group Directive.

b. Recorded that the wound was on the proximal interphalangeal joint (PIPJ) when it was on the distal interphalangeal joint (DIPJ).

c. Required prompting and/or support to discuss the patient with the plastics team.

This charge is found proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel noted that Witness 2 states:

'in [patient notes] I highlighted that [Mr Barry] needed full support with a [Patient Group Directive]. These are select medications for certain presentations that if you are a non-medical independent prescriber but have done the relevant training, PGD, you can provide. In this case it was a PGD Revaxis which is a tetanus injection. I showed [Mr Barry] how to do this and he said that he'd never prescribed it in that way before.

…

Reding [Mr Barry's] reflections he stated that "from this assessment of this finger wound I learned the need for follow up by plastics due to tendon damage. I learned that further care required for this injury." Given his experience I would have expected him to already know this…'

The panel also noted that in the patient notes Mr Barry recorded the injury as being a PIPJ. However, in the addendum provided by Witness 2 who was supervising Mr Barry it is recorded as instead being a DIPJ injury. Witness 2 makes note of this in the skills assessment that Mr Barry had incorrectly diagnosed the injury.

The panel therefore found that all these subcharges are proved.

Charge 1k(v)

k. On 2 February 2021:

v. In relation to Patient M:

a. Incorrectly noted that the patient had bony tenderness over the lateral navicular bone.

b. Did not ask sufficient questions as to the mechanism of the foot injury.

This charge is found proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel noted that in the patient notes the presenting history recorded by Mr Barry as to the mechanism of the foot injury is significantly shorter than that recorded by Witness 2 who was supervising this assessment. The panel considered that in the skills assessment report Witness 2 stated that Mr Barry did not ask sufficient questions, which contributed to incorrectly noting the bony tenderness over the lateral navicular bone.

The panel therefore found this charge proved.

Charge 1k(vi)

k. on 2 February 2021:

vi. In relation to Patient N did not provide sufficient details in the notes as to special tests and/or the mechanism of the injury.

This charge is found proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel noted that in the patient notes there is a lack of detail as to the mechanism of injury and what special tests were carried out by Mr Barry. Witness 2 states that this was a recurring theme in Mr Barry's assessments of patients and that he needed prompting to ask questions and reminding to include this in his noted.

The panel therefore found that this charge is proved.

Charge 1k(vii)

k. On 2 February 2021:

vii. In relation to Patient O:

a. Did not ask about any neurovascular symptoms and/or what the patient did in terms of sport.

b. Had to be prompted to carry out the Simmonds test properly.

This charge is found proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel noted that in the skills assessment Witness 2 notes that they had to remind Mr Barry to ask about any neurovascular symptoms and on how to carry out the Simmonds test properly.

The panel bore in mind its earlier findings about Mr Barry's ability to carry out a Simmonds test.

The panel noted that the skills assessment is consistent with the account given in Witness 2's statement to the NMC.

The panel therefore found this charge proved.

Charge 1l(i)a, c, and d

l. On 5 February 2021:

i. In relation to Patient P:

a. Documented that the patient had a radial pulse present and/or a capillary refill time of less than 2 seconds when you had not performed the tests for these observations.

c. Did not recognise the possible abscess around the wound.

d. Had to be prompted to complete an orthopaedic referral.

This charge is found proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel noted that Witness 2 stated they did not see Mr Barry complete a radial pulse test or a capillary refill time during the assessment. Further in the skills assessment they state that they needed to prompt Mr Barry to complete an orthopaedic referral as he did not recognise the possible abscess around the wound.

The panel therefore found charges 1l(i) a, c, and d proved.

Charge 1l(i)b

l. On 5 February 2021:

i. In relation to Patient P:

b. Did not ask and/or record what medications the patient was currently on.

This charge is found not proved

The panel had sight of the patient assessment notes and while the medications the patient was on were not recorded in the correct place, this information was included within the presenting case history.

Therefore the panel found this charge not proved.

Charge 1l(ii)a

ii. In relation to Patient Q:

a. Recorded that there was no medial collateral ligament (MCL) or lateral collateral ligament (LCL) laxity without completing the stress test.

This charge is found proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel noted that Witness 2 stated:

'For the stress test you have to physically do the test…. [Mr Barry] documented the tests had been completed but I had not seen this.'

The panel considered that this is the same as recorded in the skills assessment notes which were contemporaneous and the summary of the shift.

The panel had no information to question the veracity of this statement.

Therefore the panel found this charge proved.

Charge 1l(ii)b

ii. In relation to Patient Q:

b. Incorrectly documented that the injury related to the proximal phalanx.

This charge is found not proved

The panel had regard to the patient notes which Mr Barry made which state:

'… proximal distal phalanx right big toe'

The panel considered that this therefore recorded both the proximal and the distal phalanx and therefore finds this charge not proved.

Charge 1l(iii) a and b

iii. In relation to Patient R:

a. Did not take full details of the mechanism of injury to the eye.

b. Had to be prompted to complete one or more Patient Group Directives.

This charge is found not proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel considered that in the notes made by Witness 2 as an addendum to the patient records made by Mr Barry there is very little additional details provided as to the mechanism of the injury to the eye. Therefore the panel determined that there is insufficient evidence that Mr Barry did not take full details.

Further the panel noted that in their statement Witness 2 did not state any particular PGD that Mr Barry failed to complete and that the evidence is unclear as to what he either did or failed to do in this regards.

Therefore the panel found both these subcharges not proved.

Charge 1l(iii) c

iii. In relation to Patient R:

c. Did not consider differential diagnoses.

This charge is found proved

The panel considered that Witness 2 stated:

'[Mr Barry] considered abrasion but no other differentials, this related to the type of injury to the eye and is part of the history taking.'

The panel noted that this is consistent with the skills assessment carried out at the time of the incident and indicative that Mr Barry did not give any consideration to differential diagnoses.

The panel therefore found this charge proved.

Charge 1l(iii)d and e

iii. In relation to Patient R:

d. Required support with the Moorfield referral.

e. Completed the wrong visual acuity.

This charge is found not proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel noted that in the patient notes Mr Barry indicated that a referral to Moorfield was made, and advised the patient to contact them if needed.

Further, the panel noted that while the visual acuity noted by Mr Barry was different to the visual acuity noted by Witness 2, it is unclear whether this is because the test was carried out twice. The panel noted that it is possible for the same person to score differently on the same test if taken at different times. Additionally, the panel was unsure if the patient had been administered any medication which would alleviate their pain and improve their visual acuity which could explain the differences in results.

Therefore the panel found on the balance of probabilities these subcharges are not proved.

Charge 1l(iv) a

iv. In relation to Patient S:

a. Did not ask sufficient questions to determine the severity of the head injury.

This charge is found not proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel considered that there is no information as to what further questions Mr Barry would have been expected to ask of the patient who presented with this injury. Further Witness 2 stated they cannot recall any specifics about what Mr Barry may not have asked.

Therefore the panel concluded that on the balance of probabilities there is insufficient evidence to find this charge proved.

Charge 1l(iv)b, c, d, e, and f

iv. In relation to Patient S:

b. Had to be prompted to check the c-spine.

c. Suggested using steri strips on a full thickness wound.

d. Did not recognise the need to follow up with the Ear Nose and Throat Team.

e. Required full support and/or prompting with the Patient Group Directive Revaxis.

f. Did not use the correct equipment and/or technique for suturing.

This charge is found proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel noted that Witness 2 stated:

'I had to prompt [Mr Barry] to check the c-spine to check for any neck injury which linked t note that he didn't discuss if CT imaging was needed'

Upon the assessment of the wound it was determined this patient had a full thickness wound and [Mr Barry] suggested using steristrips, this is not appropriate as the steristrips would not close the wound and it would not have healed. It would have been more appropriate to us staples or sutures.

…

[Mr Barry] did not recognise the need to discuss a follow up with the Ear Nose and Throat team.'

Again [Mr Barry required full support and prompting with the PGD Revaxis which is a tetanus injection. He had to be prompted again to complete the second stage of sign off.

…

I was also concerned about [Mr Barry's] suturing… he went to use a 4.0 so I advised him to use a 5.0.'

The panel noted that this confirmed with what was recorded in the patient notes and in the handwritten skills assessments.

Therefore on the balance of probabilities the panel found these subcharges proved.

Charge 1l(iv)g

iv. In relation to Patient S:

g. Did not check for a nasal fracture.

This charge is found not proved

The panel noted that this was not recorded as a concern as part of the skills assessment, and in the shift summary is only noted in connection with prescribing antibiotics not in checking for a nasal fracture as a stand alone test.

Therefore the panel considered that there is insufficient evidence to find this charge proved.

Charge 1l(v)

v. In relation to Patient T:

a. Were unable to recall how to complete the specialist tests on the patient's shoulder.

b. Documented that the patient had restricted movement without completing the test.

This charge is found proved

The panel had sight of the patient notes, the handwritten skills assessment, and the statement of Witness 2 in regards to this incident.

The panel noted that in the skills assessment it is recorded that Mr Barry needed prompting to be reminded what specialist tests were required. Further in Witness 2's statement they state that they cannot recall seeing Mr Barry perform these tests; however, there is a record in the patient notes.

The panel concluded that given Mr Barry did not recall how to complete the tests independently and that Witness 2 was present during the full assessment it is more likely than not that Mr Barry has merely recorded the tests as completed without having done them

Therefore this charge is found proved.

Charge 2

2. Your actions at charge i(i)(a) were dishonest in that you knew that you had not checked for a pulse and/or recorded the refill time.

This charge is found not proved

In considering this charge the panel had regard to the test of dishonesty as set out in *Ivey v Genting Casino (Ltd)* [20077] UKSC 67.

The panel had regard to its findings at charge 1 and that Mr Barry was under a period of supervision when completing patient assessments at the time of the incident, and that he would have been aware that his patient notes would be checked by a senior nurse.

The panel considered that the evidence available presents Mr Barry as having failed in a number of the required competencies of a band 7 nurse and that it is within the context of lack of competency that he has made these mistakes. This included in his record keeping which was consistently found to have errors and to have missed important factors. The panel had no information from Mr Barry as to his intentions or subjective state of mind at the time of making the record. In their statement, Doctor 1, stated that Mr Barry would type up his notes while they saw other patients. In these circumstances, the panel cannot rule out the possibility that Mr Barry included the reference to the pedal pulse having seen Doctor 1 carry out the test in their assessment of the patient.

Therefore, the panel concluded that there was insufficient evidence to consider the first aspect of the test set out in *Ivey* and that, therefore, the NMC has failed to prove this charge on the balance of probabilities.

This charge is therefore found not proved.

Charge 3

> 3. Your actions at charge k(i)(a) were dishonest in that you knew that you had not conducted a Simmonds test and/or that the patient did have allergies.

This charge is found not proved

The panel had regard to the test of dishonesty as set out in the case of *Ivey*.

In regards to the first clause the panel had regard to its findings that Mr Barry had carried out a test on the patient but it was not a Simmonds test. Given the panel's numerous findings regarding his lack of competence and one witness' description that his competence was at the level of an '*advanced beginner'* rather than a senior nurse of 22 years, it cannot rule out the possibility that Mr Barry had been under the impression that it was a Simmonds test that he performed. The panel therefore considered that the NMC has failed to prove on the balance of probabilities that Mr Barry was dishonest.

In regards to the second clause the panel considered that the evidence was unclear as to when the supervisor found out the patient had allergies and told Mr Barry this. The panel considered that if this was done after Mr Barry had written his notes then it would not have been dishonest on his part as from his assessment the patient did not have allergies. Mr Barry reached this conclusion based on his lack of competence but not dishonesty.

Therefore, the panel concluded that given this lack of information it is unclear to what degree Mr Barry knew of the patient's allergies when completing his notes and therefore finds this charge not proved.

Charge 4

> 4. Your actions at charge I(i)(a) and/or I(ii)(a) and/or I(v)(b) were dishonest in that you knew that you had not conducted the requisite testing for those observations.

This charge is found not proved

The panel had regard to the test for dishonesty as set out in the case of *Ivey*.

The panel considered that these incidents occurred within the context of ongoing serious concerns of Mr Barry's competence. It noted that his supervisor had recorded that Mr Barry would often include clinical terms in his notes that the supervisor had mentioned without fully understanding the meaning behind them; however, there was no suggestion this was dishonest but rather an attempt by Mr Barry to be seen as competent.

In regards to charge 1I(i)a the panel considered that the evidence is unclear as to the timing of the observations and when the patient notes were completed. In light of this the panel considered that the NMC has not proved to the standard that Mr Barry's actions were dishonest.

In regards to charge 1I(ii)a the panel considered that Mr Barry's notes indicate that he did carry out some examination of the patient's knee. Again, given the panel's numerous findings regarding his lack of competence and one witness' description that his competence was at the level of an '*advanced beginner'* rather than a senior nurse of 22

years, it cannot rule out the possibility that Mr Barry believed that he had carried out a sufficient examination to determine that there was no MCL or LCL laxity in the patient's knee. The panel therefore considered that the NMC has failed to prove on the balance of probabilities that Mr Barry was dishonest in making this record.

In regards to charge 1l(v)b the panel considered that there is a lack of information regarding what the precise test was that Mr Barry is alleged to have dishonestly signed for. Therefore given this lack of information and the overall context of his lack of competence the panel considered that any incorrect entry is more likely to have been due to Mr Barry's incompetence rather than dishonesty.

Therefore, the panel found this charge not proved.

Charge 5

> 5. On one or more occasion attempted to and/or left a shift before the time that you were due to finish.

This charge is found proved

In considering this charge the panel had regard to the informal warning letter dated 25 January 2017, and the complaints of other Trust staff as to Mr Barry's attendance at work.

The panel noted that this states Mr Barry left the Trust early leaving the unit understaffed on multiple occasions and that following an investigation his manager issued a warning to him regarding this. Further the panel noted that Mr Barry left on one occasion as he thought he was due time off in lieu but that he had not arranged and agreed this with the managers at the Trust.

Therefore the panel found this charge proved.

Charge 6

> 6. [PRIVAATE]

This charge is found proved

[PRIVATE]

The panel therefore found this charge proved.

Charge 7

7. [PRIVATE]

This charge is found proved

The panel considered [PRIVATE] The panel further bore in mind its findings at charge 6 above.

Therefore, on the balance of probabilities the panel found this charge proved.

Fitness to practise

Misconduct

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved at charge 5 amount to misconduct and, if so, whether Mr Barry's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Representations on misconduct and impairment

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

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

The NMC identified the specific, relevant standards where Mr Barry's actions amounted to misconduct.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Mr Barry's fitness to practise impaired on the grounds that his conduct placed patients at risk of harm should they have attended the clinic when there was not an emergency nurse practitioner available.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Calheam v GMC* [2007] EWHC

2606 (Admin), *R (on the application of Cohen) v GMC* [2008] EWHC 581 (Admin) and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

When determining whether the facts found at charge 5 proved amount to misconduct, the panel had regard to the terms of the Code.

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

> *'8.5 work with colleagues to preserve the safety of those receiving care*
>
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people*
>
> *20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*
>
> *25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mr Barry's actions of leaving a shift early on multiple occasions is a significant departure from the expected standards of conduct that amount to misconduct.

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

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 3 March 2025, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

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

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

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

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

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

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

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

d) ...'

The panel finds that patients were put at risk of harm as a result of Mr Barry's misconduct in leaving his shift early without there being appropriate cover in place. Mr Barry's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that it had no information from Mr Barry as to his insight, remediation, or any efforts to strengthen his practice. Therefore, the panel is unable to determine if the misconduct has been addressed or is something that Mr Barry is seeking to address.

As a result, the panel is of the view that there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

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

Having regard to all of the above, the panel was satisfied that Mr Barry's fitness to practise is currently impaired on the grounds of misconduct.

Lack of Competence

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts it found proved at charge 1 amount to a lack of competence and, if so, whether Mr Barry's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Representations on lack of competence and impairment

The NMC has defined a lack of competence as:

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

The NMC invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of the Code in making its decision.

The NMC identified the specific, relevant standards where Mr Barry's actions amounted to a lack of competence. A lack of competency needs to be assessed using a three stage process:

- Is there evidence that Mr Barry was made aware of the issues around their competence?
- Is there evidence that they were given the opportunity to improve?
- Is there evidence of further assessment?

The NMC invited the panel to find that the facts found proved show that Mr Barry's competence at the time was below the standard expected of a band 7 registered nurse.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant*.

The NMC invited the panel to find Mr Barry's fitness to practise impaired on the grounds that the actions in charge 1 represent a fair sample of his work over a prolonged period of time and demonstrate consistent areas of concern.

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

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

'1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
2.1 work in partnership with people to make sure you deliver care effectively

6 Always practise in line with the best available evidence
To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

6.2 maintain the knowledge and skills you need for safe and effective practice

8.2 maintain effective communication with colleagues

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

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

10.3 complete records accurately …, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

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

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

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

The panel bore in mind, when reaching its decision, that Mr Barry should be judged by the standards of the reasonable average band 7 registered nurse and not by any higher or more demanding standard. The panel considered that the information before it represents a fair sample of Mr Barry's work over a number of years, and during a period when he was given multiple opportunities by the Trust for support and improvement. However, despite this there is little evidence that Mr Barry addressed the concerns and was able to demonstrate he could work safely and effectively as a band 7 registered nurse.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mr Barry's practice was below the standard that one would expect of the average registered nurse acting in Mr Barry's role.

In all the circumstances, the panel determined that Mr Barry's performance demonstrated a lack of competence.

Decision and reasons on impairment

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

The panel finds that patients were put at risk and were caused physical and emotional harm as a result of Mr Barry's lack of competence. The panel considered that multiple patients had to return to the Trust to seek further care and treatment as a result of Mr Barry's lack of competence. This caused actual harm to the patients involved and additionally resulted in an increase in the number of patients presenting for care on any shift which would be likely to cause further delays in patients obtaining the care needed.

Mr Barry's lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mr Barry demonstrated no significant improvement or strengthening of his practice over the years he was given increased supervision and support from the Trust. The panel had no information from Mr Barry as to his insight or remediation, and no examples of any further training he has carried out. Therefore the panel is of the view that there is a risk of repetition.

In light of this the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that, in this case, a finding of impairment on public interest grounds was required. The panel determined that a reasonable member of the public would expect to be treated by an emergency nurse practitioner who had the appropriate level of competence in the role and would be shocked if a finding of impairment was not made in this case.

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

Health

Having announced its findings on the facts, the panel then considered whether, on the basis of facts 6 and 7, found proved, Mr Barry's fitness to practise is currently impaired by reason of Mr Barry's [PRIVATE].. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession and in the NMC as a regulatory body. 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.

Representations on impairment

In reaching its decision, the panel considered all the documentary evidence adduced in this case together with the representations made by the NMC. It referred to Rule 31(5) as follows:

> *'**31.**— (5) In determining whether a registrant's fitness to practise is impaired by reason of physical or mental health, the Fitness to Practise Committee may take into account, amongst other matters—*
>
> *(a) a refusal by the registrant to submit to medical examination;*
>
> *(b) the registrant's current physical or mental condition;*
>
> *(c) any continuing or episodic condition suffered by the registrant; and*
>
> *(d) a condition suffered by the registrant which, although currently in remission, may be expected to cause a recurrence of the impairment of the practitioner's fitness to practise.'*

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

Decision and reasons on impairment on [PRIVATE]

The panel was aware that in order to find Mr Barry's fitness to practise impaired by reason of his [PRIVATE], it must first establish whether Mr Barry's has a [PRIVATE] that goes to the issue of his fitness to practise. If it does not, then there can be no subsequent finding

of impairment of fitness to practise. If it does, the panel should go on to consider whether by reason of those [PRIVATE] Mr Barry's fitness to practise is impaired.

In reaching its decision, the panel considered [PRIVATE]

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 3 March 2025, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

The panel was not in possession of any evidence from Mr Barry. The panel was otherwise unable to determine Mr Barry's insight and understanding of [PRIVATE].

On the basis of the [PRIVATE] before it, and in the absence of anything to undermine that evidence, the panel determined Mr Barry's fitness to practise is currently impaired by reason [PRIVATE].

This finding is made to protect the public from harm which might be caused by Mr Barry practising without restriction [PRIVATE], which would involve a breach of a fundamental tenet of the profession and result in his bringing the nursing profession into disrepute, albeit that this could be involuntary on his part.

Additionally, the finding is made having regard to the need to uphold proper professional standards and public confidence in the profession, which would be undermined if a finding of current impairment was not made at this time.

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 Mr Barry's registration has been suspended.

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 22 January 2025, the NMC had advised Mr Barry that it would seek the imposition of a striking-off order if it found Mr Barry's fitness to practise currently impaired.

Decision and reasons on sanction

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

The panel had regard to the fact that it did not have the power to make a striking-off order in respect of the proven charges relating to Mr Barry's lack of competence and [PRIVATE].

The panel took into account the following aggravating features:

- A failure to demonstrate a meaningful level of insight, remorse, and remediation
- Lack of competence in basic nursing skills such as, record keeping, assessing, and triaging patient.
- Actual harm caused due to misdiagnosis
- Some attitudinal issues
- Persistent lack of competence despite being provided support

The panel also took into account the following mitigating features:

- Personal mitigation including [PRIVATE].

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Barry's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Barry's misconduct and lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Barry's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*

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

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel considered that while the impairment found is something that could be addressed through further training and conditions it had no information from Mr Barry that he would be willing or able to comply with any conditions. Further the panel noted the already long period of supervision and support the Trust provided Mr Barry to address his lack of competence and that this did not lead to significant improvements.

Furthermore, the panel concluded that the placing of conditions on Mr Barry's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The panel considered that Mr Barry's impairments arising from his lack of competence and his [PRIVATE] were so extensive and serious that only the most serious sanction available to the panel would be appropriate.

It did go on to consider whether a striking-off order would be proportionate but, given that a striking-off order would only be available on the impairment found in respect of charge 5 considered that in that case a striking-off order would be disproportionate.

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 will inevitably cause Mr Barry. However, this is outweighed by the public interest in this case.

The panel considered that this 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 making this decision, the panel carefully considered the submissions of the NMC in relation to the sanction being sought in this case. However, the panel considered that given the impairment found a striking-off order is either not available or inappropriate in this case.

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.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Attendance at future review
- Information regarding any employment undertaken whether voluntary or paid, including testimonials
- Evidence of professional development and evidence of further training
- Information of any [PRIVATE]
- Indication of any future intentions regarding his returning to nursing

This will be confirmed to Mr Barry in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period or should Mr Barry appeal the determination of that appeal, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Barry's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that an interim suspension order of 18 months is necessary on the grounds of public protection and otherwise in the public interest to cover any potential appeal period.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months as being necessary on the grounds of public protection and otherwise in the public interest to cover any potential appeal period.

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

That concludes this determination.