Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Friday, 23 May 2025
Tuesday, 27 May 2025

Virtual Meeting

Name of Registrant:	**Mark Gavienas**
NMC PIN:	01B0228S
Part(s) of the register:	Nursing, Sub part 1 RNA, Registered Nurse - Adult 2 February 2004
Relevant Location:	West Dunbartonshire
Type of case:	Misconduct
Panel members:	Louise Guss (Chair, Lay member) Purushotham Kamath (Registrant member) Jane Malcolm (Lay member)
Legal Assessor:	Suzanne Palmer (Friday, 23 May 2025) Nina Ellin KC (Tuesday, 27 May 2025)
Hearings Coordinator:	Amira Ahmed
Consensual Panel Determination:	Accepted (as amended)
Facts proved:	**All**
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mr Gavienas' representative by secure email on 19 May 2025. The panel noted that although this was less notice than was required by the Rules Mr Gavienas had agreed through his representatives to a shorter notice period.

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, date and the fact that this meeting was heard virtually.

In the light of all of the information available, the panel was satisfied that Mr Gavienas has been properly served with notice of this meeting in all the circumstances, and that it would be appropriate to proceed.

Details of charge

That you, a registered nurse:

1. Around 23 April 2019 attached patient A's bile bag to the jejunostomy port which was incorrect.

2. Around 29 April 2020 attached patient A's bile bag to the jejunostomy port which was incorrect.

3. On one or more occasions between November 2016 and December 2017 failed to administer the correct amount of feed for patient A.

4. On one or more occasions between November 2016 and February 2020 failed to provide adequate oral care to patient A.

5. On one or more occasions between November 2016 and May 2019 failed to provide adequate personal care to patient A.

6. On 30 April 2020 made an entry timed at 06:30 in patient A's nursing notes recording an incorrect temperature of 34.3 degrees Celsius.

7. Your action at 6 above was dishonest in that you knew you had not taken a reading of 34.3 degrees Celsius at any time during your shift.

8. Around 20 March 2016 caused patient A to be scalded.

9. Failed in your professional duty of candour in that you did not report the incident described in charge 8.

10. Around 16 May 2019 failed to safely transport patient A on a car journey in that you did not follow the risk assessment that indicated equipment should not be placed in the van with the patient.

11. In early 2020 covered patient A's tracheostomy with a conti-wipe.

12. Around 31 January 2019 you left Patient A unattended in the bath, when you were not supposed to

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

Consensual Panel Determination

At the outset of this meeting, the panel was made aware that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the Nursing and Midwifery Council (NMC) and Mr Gavienas.

The provisional agreement, which was put before the panel, sets out Mr Gavienas' full admissions to the facts alleged in the charges, that his actions amounted to misconduct, and that his fitness to practise is currently impaired by reason of that misconduct. It is further stated in the provisional agreement that the only appropriate sanction in this case would be a striking off order.

The panel has considered the provisional CPD agreement reached by the parties. The panel decided to amend the provisional agreement paragraph 24, specifically to change reference to relevant provisions of the NMC Code from sub-section 21 to sub-section 20 to accurately reflect the information before it. Both Mr Gavienas' representative and the NMC on 27 May 2025 agreed to the following amendment which is as follows:

~~*'21 Uphold your position as a registered nurse, midwife or nursing associate*~~*.*

20 Uphold the reputation of your profession at all times'

The amended provisional CPD agreement reads as follows:

1. *'Mr Mark Gavienas is content for his case to be dealt with by way of a CPD meeting. Mr Mark Gavienas understands that if the panel determines that a more severe sanction should be imposed, the panel will adjourn the matter for this provisional agreement to be considered at a CPD hearing.*
2. *The registrant now admits the following charges:*

That you, a registered nurse:

13. *Around 23 April 2019 attached patient A's bile bag to the jejunostomy port which was incorrect.*

14. *Around 29 April 2020 attached patient A's bile bag to the jejunostomy port which was incorrect.*

15. *On one or more occasions between November 2016 and December 2017 failed to administer the correct amount of feed for patient A.*

16. *On one or more occasions between November 2016 and February 2020 failed to provide adequate oral care to patient A.*

17. *On one or more occasions between November 2016 and May 2019 failed to provide adequate personal care to patient A.*

18. *On 30 April 2020 made an entry timed at 06:30 in patient A's nursing notes recording an incorrect temperature of 34.3 degrees Celsius.*

19. *Your action at 6 above was dishonest in that you knew you had not taken a reading of 34.3 degrees Celsius at any time during your shift.*

20. *Around 20 March 2016 caused patient A to be scalded.*

21. *Failed in your professional duty of candour in that you did not report the incident described in charge 8.*

22. *Around 16 May 2019 failed to safely transport patient A on a car journey in that you did not follow the risk assessment that indicated equipment should not be placed in the van with the patient.*

23. *In early 2020 covered patient A's tracheostomy with a conti-wipe.*

24. *Around 31 January 2019 you left Patient A unattended in the bath, when you were not supposed to*

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

Background Facts:

3. *In January 2024 the registrant was the subject of a criminal case heard in the sheriff court in Scotland where he faced the common law charge of 'culpable and reckless conduct'. The case against him was found 'not proven' with the sheriff finding that his actions had been careless but not culpable and reckless. The matters complained of in the sheriff court covered the same matters now encompassed within this consensual panel determination. The standard of proof in the sheriff court is the criminal standard, a much higher standard than that required in NMC proceedings which is the civil standard.*

4. *The registrant first appeared on the register of nurses and midwives maintained by the NMC on 2 February 2004.*

5. *This is the first referral received by the NMC regarding the registrant. The referral was first received on 1 July 2020 from the Acting Nurse Team Leader within the Learning Disability Service of West Dunbartonshire Health and Social Care Partnership ('WDHSCP'). The registrant worked for ScotNursing, an agency commissioned by WDHSCP to provide nursing services to patients at home. WDHSCP were alerted by Patient A's mother that the registrant had been removed from working with Patient A, and this resulted in WDHSCP investigating the reasons behind the registrant's removal by ScotNursing. The registrant was suspended from further work with ScotNursing on 1 July 2020. The registrant was*

not interviewed as part of ScotNursing's internal investigation and made no formal admissions. The registrant's employment with ScotNursing was terminated on 28 July 2020. A disciplinary hearing did not take place.

6. *ScotNursing, an agency, provided 24-hour nursing care to Patient A since November 2010. [PRIVATE]. A core team of 4 nurses worked back-to-back, one was on day shift and one was on nightshift with a 3 on 3 off rota. Carers also provided care, one for part of the day and another overnight.*

7. *The registrant worked as an agency nurse for ScotNursing and was employed as one of the nurses who provided care to Patient A from around early 2016 until around mid-2020.*

8. *The NMC received a duplicate referral in relation to these concerns from both ScotNursing and West Dunbartonshire HSCP.*

9. *The parties agree the following facts in relation to the specific charges:*

<u>Charges 1 & 2</u>

10. *On 29 April 2020, after giving Patient A an immersion bath, the registrant had wrongly connected the feeding tube to the port for the bile bag and vice versa. He was therefore administering the feed, water and medication through the wrong portal. There was a high risk of Patient A vomiting and potentially aspirating the feed, which could have resulted in suffocation. According to the fluid chart, and evidence from colleagues, there were at least 7 occasions over the day when administering medication and water that the registrant should have checked the tube. If he had done so he could have recognised and corrected his error. During investigations it was also identified that the same error was made by the registrant on 23rd April 2019.*

Charge 3

11. *Between 3 November 2016 and 22 December 2017, it was discovered that as one of the nurses responsible for the care of Patient A and also for ensuring documentation was completed fully, accurately and correctly, the registrant had not been administering the correct amount of feed to Patient A This issue was discovered by one of the other nurses responsible for the care of Patient A who would regularly start a night shift after the registrant's shift had ended. The registrant was resetting the memory of the pump used to administer the bag of feed each day. This meant that the memory on the pump used to feed Patient A had regularly been cleared by the registrant instead of him leaving this to be done by the night shift nurse who would normally record an accurate overall feed balance at midnight each night. However, there were occasions when the pump memory had not been cleared by the registrant and showed for example, one occasion when 715 mls of feed had been given instead of the required 1400 mls, and another occasion when 1119 mls had been given instead of the required 1400 mls.*

Charge 4

12. *Between November 2016 and February 2020, the registrant was found not to have been providing adequate oral care to Patient A in that he was not ensuring that Patient A's teeth were brushed while he was on shift and that Vaseline was placed on Patient A's lips periodically throughout the day. Following numerous dates of care expected to be provided by the registrant throughout the relevant period, colleagues found Patient A's mouth, lips and tongue were coated and cracked and his teeth were dry and coated.*

Charge 5

13. *Between November 2016 and May 2019, it was discovered that as one of the nurses responsible for the care of Patient A and also for ensuring documentation was completed fully, accurately and correctly, there were numerous occasions when the registrant failed to provide personal care. [PRIVATE]. The registrant also often failed to wash the patient which was noted due to the poor condition the patient was frequently found in by staff on shift after the registrant. There was a specific issue in May 2019 demonstrating poor personal care where it was discovered by another nurse that following an away day annual trip for Patient A the registrant had not washed Patient A and changed his incontinence pad. This resulted in a red welt forming on Patient A's leg.*

Charge 6

14. *On 30 April 2020 during handover the registrant stated that when he came on shift Patient A had been hypothermic, his temperature had been 34.3 degrees Celsius, and he had been cold to touch. He stated that he had warmed the patient up with blankets and his temperature rose to normal limits. The registrant didn't mention any other vital signs being outside normal range or that Patient A had any other symptoms or signs of hypothermia. The registrant didn't mention that he had taken any other temperature readings. The temperature probe that had a memory reading of the last 10 temperatures taken was checked and there was no reading of 34.3 degrees Celsius or any other readings taken during the registrant's shift. The registrant recorded a temperature of 34.3 degrees Celsius at 06:30 in Patient A's nursing notes.*

Charge 7

15. *The Registrant knew that he had not taken any reading from the patient measuring 34.3 degrees Celsius at any time during his shift. The registrant therefore knew that when he recorded a temperature of 34.3 degrees Celsius in the patent's nursing*

notes that this was a dishonest act and furthermore would wholly mislead any reader of the patient's nursing notes.

Charge 8

16. *An incident occurred around 20 March 2016 whereby Patient A sustained a large surface scald to the skin. The registrant was the nurse on shift working with Patient A at the relevant time. The registrant spilt some hot water over Patient A. The registrant did not report this incident and ScotNursing only became aware of it during the investigation in 2020 into the care of the patient. No record of the incident having been reported was ever found by ScotNursing. The scald covered a large area of Patient A's side and arm.*

Charge 9

17. *The registrant accepts that he had a professional responsibility to report the incident described at Charge 8, that is that he was under a duty to report that his action caused actual harm to the patient in that the patient had been scalded. He should have reported this serious incident to the nursing agency responsible for Patient A, ScotNursing and Medical Services, by way of a telephone call to their offices so that the call handler could record the incident and the call report to be then passed on to the Nursing Directorship. The registrant acknowledges that no record was ever found of his having reported this serious incident to ScotNursing and Medical Services, and that he failed in his professional duty of candour.*

Charge 10

18. *[PRIVATE]. Patient A requires a substantial amount of equipment that needs to be transported in a separate vehicle to allow for adequate space in the van in case of an emergency. There was a specific risk assessment in place for this activity. Around 16 May 2019, the registrant and a colleague were the nurses caring for the*

registrant and were responsible for bringing him home. Despite confirming that he had read the risk assessment, the registrant decided that he was not willing to take all the equipment in his car on the return journey. This meant that the only other way to transport the equipment was in the back of the van. The registrant was reminded about the risk assessment which clearly states that no equipment should be placed in the back of the van. Despite this, the registrant left [PRIVATE] without taking steps to transport the equipment and the equipment therefore had to be loaded up in the back of the van which dangerously limited the space for Patient A in the event of an emergency.

Charge 11

19. *In early 2020 during a shift, the registrant was attending to Patient A's tracheostomy. The registrant had a conti-wipe in his hand, and he used this to cover the tracheostomy opening by way of trying to clean around it by making Patient A cough. This was dangerous because it had the effect of preventing the patient from breathing properly. When asked about this, his response was [PRIVATE]. However, it was noted that Patient A's face had gone a purplish colour, and he looked distressed.*

Charge 12

20. *Sometime around 31 January 2019 a carer for Patient A saw the registrant sat on a chair, on his mobile phone, with his back to the bathroom where Patient A was in the bath unattended. [PRIVATE]. Patient A could easily slip down into the water and drown due to water entering his tracheostomy and straight into his lungs. Leaving the patient unattended in this way was an extremely dangerous act by the registrant with the potential for an immediate risk to life for the patient.*

Misconduct

21. *In the case of Roylance v General Medical Council (No.2) [2000] 1 AC 311, Lord Clyde stated that:*

> *'misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by the medical practitioner in the particular circumstances'.*

22. *There is a wide-ranging pattern of clinical failings, over a long period of time, one episode of which resulted in significant harm to Patient A. In addition, there is an allegation of dishonesty, and a breach of the duty of candour, both of which call into question the registrant's honesty and integrity.*

23. *The registrant accepts all the charges and agrees that the facts admitted are serious enough to amount to misconduct.*

24. *The parties agree that the registrant's actions fell significantly short of the standards expected of a registered nurse, and that his actions amounted to a breach of the Code. The parties agree that the following sections of the Code are engaged in this case:*

Prioritise people

1 Treat people as individuals and uphold their dignity.

3 Make sure that people's physical, social and psychological needs are assessed and responded to.

4 Act in the best interests of people at all times.

Practise effectively

6 Always practise in line with the best available evidence.

10 Keep clear and accurate records relevant to your practice.

Preserve safety

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place.

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

Promote professionalism and Trust

20 Uphold the reputation of your profession at all times.

Impairment

25. *The registrant admits that his fitness to practise is impaired by reason of misconduct.*

26. *The parties have considered the questions formulated by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of CHRE v Grant & NMC [2011] EWHC 927 (Admin) ('Grant') by Cox J. The parties agree that the relevant questions are:*

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 practice 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?*

27. *The registrant's actions put Patient A, a very vulnerable patient, at considerable risk of harm. His conduct on more than one occasion resulted in harm.*

28. *The registrant's conduct was repeated and, on each occasion, placed a vulnerable patient at risk of harm. The conduct was repeated over a long period of time and his conduct was further compounded by his dishonesty and lack of candour. This brings into question the registrant's professionalism and his ability to practice safely.*

29. *The parties have also considered the comments of Cox J in Grant at paragraph 74:*

"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."

30. *The parties agree that the Registrant continues to present a risk to members of the public and that there remains the risk of repetition. The reputation of the nursing profession would also be damaged if the Registrant were to be permitted to practise. Members of the public trust nurses to care for them, in particular care for the very vulnerable. The public would therefore expect nurses to provide adequate care and to conduct and act with honesty, integrity and adherence to the code of conduct. The public and indeed other members of the profession would find the registrant's conduct in relation to Patient A abhorrent.*

31. *The parties agree that the registrant's failings relate to clinical errors as well as to professionalism and trustworthiness as a nurse and, considering his failings, the registrant accepts that a finding of current impairment is necessary on public protection grounds and to declare and uphold proper professional standards.*

32. *The registrant has not provided any evidence of insight or remediation.*

33. *In Cohen v GMC [2007] EWHC 581 (Admin), the court set out three matters which it described as being 'highly relevant' to the determination of the question of current impairment:*

    1. *Whether the conduct that led to the charge(s) is easily remediable*
    2. *Whether it has been remedied*
    3. *Whether it is highly unlikely to be repeated*

34. *The three questions set out in Cohen (above) can be answered as follows:*

    1. *The regulatory concerns in this case are potentially capable of remediation by way undertaking training sessions to address the clinical concerns. However, the registrant's willingness to act dishonestly, and to breach the*

duty of candour, are much more difficult to remediate and point towards attitudinal issues.

2. *There is no evidence that steps have been taken to address the clinical concerns in this case.*

3. *At present, there is insufficient evidence to be able to say that the conduct is unlikely to be repeated should the registrant find himself in the care of patients.*

35. *For the reasons above, the parties agree that the registrant's fitness to practise is currently impaired, on the grounds of public protection and the wider public interest.*

Sanction

36. *The appropriate sanction in this case is a Striking Off Order.*

37. *The aggravating features of the case are as follows:*

- *Actual patient harm*
- *Breach of the duty of candour*
- *Dishonesty*
- *Wide ranging clinical failings in the care of a vulnerable patient*

38. *The mitigating feature of the case is as follows:*

- *Acceptance of charges*

39. *There are repeated failings in caring for a very vulnerable patient which resulted in harm. These failings are compounded by dishonesty and a breach of the duty of candour; these are attitudinal issues and are not easily remediable. There is no*

evidence of insight or remediation, and the overall conduct is incompatible with remaining on the Register.

40. *The guidance on Striking-Off Orders (Reference: SAN-3e Last Updated 30/08/2024) requires the Panel to consider the following key issues:*

- *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*

- *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not struck off from the register?*

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

41. *The parties agree that the Registrant's conduct raises fundamental questions about his professionalism and significantly impacts public confidence in the profession. Nurses hold a position of trust and confidence, and he has failed to uphold the reputation of the profession. A striking-off order is the only sanction to protect patients from harm and to main professional standards.*

42. *The parties agree that no order, or any other order available to the Panel would not be appropriate given the specific facts and circumstances of this case.*

Referrer's comments

43. *The referrer replied by email on 29 April 2025 and has indicated that they have no objection to the NMC dealing with the referral in the way that it deems to be appropriate.*

Interim Order

44. *An interim order is required in this case. The interim order is necessary for the protection of the public and is otherwise in the public interest for the reasons given above. The interim order should be for a period of 18 months in the event that the registrant seeks to appeal the panel's decision. The interim order should take the form of an interim suspension order.'*

Here ends the provisional CPD agreement between the NMC and Mr Gavienas. The provisional CPD agreement was signed by Mr Gavienas on 12 May 2025 and the NMC on 16 May 2025. The panel's proposed amendment was agreed by the NMC and Mr Gavienas on 27 May 2025.

Decision and reasons on the CPD

The panel decided to accept the CPD (as amended).

The panel heard and accepted the legal assessor's advice. She referred the panel to the 'NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. She reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Mr Gavienas. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

Decision and reasons on the facts

The panel noted that Mr Gavienas admitted the facts of the charges. Accordingly, the panel was satisfied that the charges are found proved by way of Mr Gavienas' admissions as set out in the signed provisional CPD agreement.

Decision and reasons on misconduct and impairment

The panel then went on to consider whether Mr Gavienas' fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Mr Gavienas, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of misconduct the panel determined that Mr Gavienas' actions did fall significantly short of the standards expected of a registered nurse. The panel endorsed paragraphs 21 to 24 of the provisional CPD agreement in respect of misconduct.

The panel then considered whether Mr Gavienas' fitness to practise is currently impaired by reason of misconduct. In coming to its decision, the panel had regard to the NMC Guidance 'Impairment DMA-1', last updated on 03 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 determined that Mr Gavienas' fitness to practise is currently impaired on the on the grounds of both public protection and the wider public interest. In this respect the panel endorsed paragraphs 25 to 35 of the provisional CPD agreement.

Decision and reasons on sanction

Having found Mr Gavienas' fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not

intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features as set out in the provisional CPD agreement:

- Actual patient harm
- Breach of the duty of candour
- Dishonesty
- Wide ranging clinical failings in the care of a vulnerable patient

The panel also took into account the following mitigating features as set out in the provisional CPD agreement:

- Acceptance of charges

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 Gavienas' 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 Gavienas' misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Gavienas' registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on Mr Gavienas' 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 determined that Mr Gavienas' conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Gavienas' actions cannot adequately be addressed by a suspension order and is fundamentally incompatible with remaining on the register.

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

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

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

The panel determined that Mr Gavienas' actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Gavienas' actions were serious and to allow him to continue

practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel agreed with the CPD in particular paragraphs 36 to 42 which outline that the only appropriate and proportionate sanction is that of a striking-off order. The panel gave careful regard to the matters it identified, in particular the circumstances set out in paragraph 39 of the provisional CPD agreement and the need to protect patients from harm and maintain professional standards. Bearing in mind the effect of Mr Gavienas' actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of a striking off order would be sufficient in this case.

The panel considered that this order was necessary to protect the public from the risk of harm. The panel determined that it was also necessary to uphold standards, mark the seriousness of the misconduct, maintain public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel noted that the referrers were consulted and had no objection to the NMC dealing with the case in the way they deemed appropriate.

Decision and reasons on interim order

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 Gavienas' own interest.

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

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interests. 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 agreed, for the reasons set out in relation to the substantive sanction, that an interim conditions of practice order would not be appropriate or proportionate in this case. The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.