Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Friday, 26 September 2025 – Thursday 2 October 2025

Virtual Meeting

Name of Registrant:	**Andrew Graham Burgess**
NMC PIN:	80E0285E
Part(s) of the register:	Adult Nursing – Sub Part 1 (1 June 2016)
Relevant Location:	Suffolk
Type of case:	Misconduct and Conviction
Panel members:	Suzy Ashworth (Chair, lay member) Jennifer Anne Childs (Registrant member) Dino Rovaretti (Lay member)
Legal Assessor:	Gerard Coll
Hearings Coordinator:	Fionnuala Contier-Lawrie
Facts proved:	Charges 1, 2, 4, 5, 6, 8a, 8b, 9a, 9b, 11a, 11c, 12a, 12b, 12c, 15, 16, 17b, 18
Facts partially proved:	13a (with exception of incidents C and N from Schedule 3); and 13b (with the exception of C and N of Schedule 3)
Facts not proved:	Charges 3a, 3b, 7a, 7b, 10, 11b, 11d, 14, 17a
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 Burgess' registered email address by secure email on 4 August 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, 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 Burgess 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 charges

That you, a registered nurse whilst working as the registered manager of Priory Paddocks Nursing Home ('the Home'):

1. On 2 April 2021 received a Caution for possessing 0.4g of amphetamine, a controlled Class B drug contrary to section 5(1) of the Misuse of Drugs Act 1971.

2. In relation to charge 1, failed to notify the NMC of your caution as soon as you became aware of it.

3. Your conduct as specified in charge 2 was dishonesty in that:

a) you knew you had a duty to disclose your caution to the NMC as soon as you became aware of it.

b) you deliberately failed to do so.

4. On or around 25 July 2021, failed to safeguard residents in that you were responsible for 1.23 grams of methylamphetamine, a controlled Class A drug found in the Home within access of residents.

5. On 18 January 2022, at Suffolk Magistrates Court were convicted of possession of 1.23 grams of methylamphetamine, a controlled Class A drug contrary to section 5(1) and 5(2) of the Misuse of Drugs Act 1971.

6. In relation to charge 5, failed to notify the NMC that you had been charged with and/or convicted of a criminal offence as soon as you became aware of it.

7. Your conduct as specified in charge 6 was dishonest in that:

a) you knew you had a duty to disclose your charge and/or conviction to the NMC as soon as you became aware of them;

b) you deliberately failed to do so

AND in light of the above, your fitness to practise is impaired by reason of your caution at charge 1 and your conviction at charge 5 and/or your misconduct at charge 2, 3, 4, 6, 7

8. On 13 February 2018 in relation to Colleague A
   a. shouted at them.
   b. slammed one or more pots of medication on their desk.

9. Between September and December 2021 on one or more occasions:

   a. shouted at one or more members of staff.
   b. Shouted at a resident's family member.

10. In around November or December 2021 in relation to Resident B, shouted at them for touching your paperwork.

11. Between 1 January 2021 and 31 January 2022, on one or more occasions in relation to one or more residents:

a. did not ensure that medicines were administered in a timely manner or at all.
b. left medication in pots in residents' rooms during medication rounds.
c. potted medications for more than one resident at the same time.
d. On or around 15 February 2021, did not administer and/or sign for medication for one or more residents, as set out in Schedule 2

12. Between 26 October 2021 and 31 January 2022, did not ensure that adequate record keeping was being maintained in that you:

a. did not ensure care plans contained sufficient information to accurately reflect the care and/or treatment and/or needs of one or more residents.
b. did not ensure that risk assessments were in place or up to date for one or more residents.
c. did not ensure that there were Personal Emergency Evacuation Plans ('PEEPs') in place for one or more residents.

13. On one or more occasions between 1 November 2020 and 30 November 2021, did not take sufficient and/or any action in respect of safeguarding "incidents as set out in Schedule 3 in that you:

a. did not ensure that the safeguarding incidents were reported to the Local and/or CQC in a timely manner or at all.
b. did not take any and/or sufficient action following the safeguarding incidents.

14. On one or more occasions between 17 October 2021 and 24 November 2021 failed to safeguard one or more staff members from harm in respect of a safeguarding incidents as set out in Schedule 4.

15. Between 1 September 2021 and 31 December 2021, on one or more occasions emptied the sharps bins into industrial bins outside the Home.

16.Having been made aware of breaches of regulations as specified in Schedule 1 following a CQC inspection on 26 October 2021 and 8 November 2021, failed to ensure compliance with one or more of the said regulations at the time of the subsequent CQC inspection in January 2022.

17.On one or more occasions between 1 September 2019 and 31 December 2021, attended work when you were unfit to do so in that:

a. you appeared to be under the influence of a substance.
b. your speech was slurred and/or you were unable to speak properly.

18. Between 6 September 2022 and 21 February 2024, failed to co-operate with an NMC investigation into [PRIVATE].

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

Schedule 1

a) Regulation 13 HSCA (Regulated Activities) Regulations 2014; Safeguarding service users from abuse and improper treatment.

b) Regulation 12 HSCA (Regulated Activities) Regulations 2014; Safe care and treatment.

c) Regulation 18 HSCA (Regulated Activities) Regulations 2014; Staffing.

d) Regulation 17 HSCA (Regulated Activities) Regulations 2014; Good governance.

Schedule 2

a) Resident C

b) Resident D

c) Resident E

d) Resident F

e) Resident G

f) Resident H

g) Resident I

Schedule 3

a) 22/11/20 – Resident A found in bed in another resident's room.

b) 23/11/20 – Resident A witnessed grabbing another resident's breast.

c) 26/04/21 – Resident A found inappropriately touching another resident's breasts.

d) 27/05/21 – Resident A found in another resident's room touching them in a sexual manner

e) 29/05/21 – Resident A witnessed trying to fondle and kiss another resident.

f) 29/05/21 – Resident A found in another resident's room.

g) 18/06/21 – Resident A witnessed behaving sexually inappropriately with another resident in their room.

h) 01/07/21 – Resident A witnessed behaving sexually inappropriately with another resident in their room.

i) 21/07/21 – Resident A found acting sexually inappropriately in another resident's room.

j) 13/10/21 – Resident A found in the hall with their trousers down and another resident holding Resident A's penis.

k) 15/10/21 – Resident A found performing sexually inappropriate behaviour in another resident's room.

l) 16/10/21 – Resident A found kneeling on the floor in front of another resident, inappropriately touching the other resident's groin/crotch area and breasts.

m) 16/10/21 – Resident A found in another resident's room with his night shirt up around his waist in front of the other resident.

n) 18/11/21 – Resident A found in another resident's room standing over the other resident who was sitting in a chair, with Resident A's trousers around his knees.

o) 28/11/21 – Resident A found in the dining room touching another resident's breasts and groin/crotch area.

Schedule 4

a) 17/10/21 – Resident A touched Staff member A's testicles.

b) 24/11/21 – Resident A touched Staff member B's breast and Staff member C's bottom

Background

Charges 1-7:

On 30 November 2021 the NMC received a referral from Suffolk Police. The referral stated that Mr Burgess owns and runs the Home.

The referral stated that Mr Burgess was subject to a police investigation for Drugs – Possession of Class A after it was alleged that he had taken Class A drugs into the Home.

Mr Burgess admitted to possession of Class A drugs during a voluntary interview on 5 August 2021 but denied that he took the drugs into the Home and suggested that they must have been planted there.

Mr Burgess submitted a self-referral to the NMC on 04 February 2022 in which he disclosed a previous police caution for possession of a Class B drug. In this self-referral he stated that he had no knowledge of this being placed on his Disclosure and Barring Service (DBS) which is why he had not disclosed it to the NMC before.

Charges 8-18:

On 15 March 2022 the NMC received a referral from the Care Quality Commission (CQC).

At the material times, Mr Burgess was the Registered Manager and part owner of the Home.

The CQC inspected the Home after receiving anonymous concerns in September 2021 that:

- Mr Burgess had been displaying increasingly erratic behaviour at work, including being unprofessional when dealing with staff and occasionally some residents; shouting and swearing on a daily basis and there were concerns about substance abuse.

- Mr Burgess was not completing the morning medication round in a timely manner, typically not finishing until at least 11:00 when it ought to be completed between 06:00 and 08:30, which placed the lunchtime medications out of sync, and medications were being found abandoned in pots in rooms.

- Mr Burgess was frequently late for most of his shifts at the Home, leaving the day nurse to stay well over their allotted shift and after administering night time medications would frequently sleep in a spare room leaving two carers to manage the Home's 30 residents.

The CQC Inspection on 26 October and 8 November 2021 found that there had been a significant deterioration in service provision at the Home since the previous inspection and that it was inadequate on the criteria of safe and well-led, with serious concerns about care planning, protection of residents from risk and abuse, administration of medicine and governance and audit.

At a subsequent inspection in January 2022 following further concerns being raised about lack of improvement, the CQC inspected and again concluded that there hadn't been sufficient improvements and the Home was still rated Inadequate.

Mr Burgess applied to cease being the Registered Manager of the Home in January 2022.

The CQC raised a safeguarding alert about Mr Burgess following the inspections in relation to a number of incidents they found documented in residents' behaviour charts which hadn't been reported to safeguarding by Mr Burgess and where there was no evidence any actions had been taken to protect the residents involved from further harm.

Decision and reasons on facts

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

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:

- Colleague A: Past Medications Manager, Priory Paddocks (''The Home'')
- Witness 1: Deputy Manager, Priory Paddocks (''The Home'')
- Witness 2: Clinical Lead, Priory Paddocks (''The Home'')
- Witness 3: Safeguarding Consultant/ Adult Safeguarding Social Worker, Suffolk County Council
- Witness 4: Inspector, Care Quality Commission (CQC)
- Witness 5: Case Coordinator, Nursing and Midwifery Council (NMC)

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1)

'On 2 April 2021 received a Caution for possessing 0.4g of amphetamine, a controlled Class B drug contrary to section 5(1) of the Misuse of Drugs Act 1971.

This charge is found proved.

In reaching this decision, the panel took into account the Simple Adult Caution record dated 2 April 2021 and Mr Burgess' response to the Nurse, Midwife, Nursing Associate Context Form dated 25 March 2022.

The panel considered the Simple Adult Caution whereby Mr Burgess signed to acknowledge he had been formally Cautioned for possessing 0.4g of amphetamine.

The panel also considered the context form dated 25 March 2022, which states:

> '*I received a caution in April 2020 for possession of a class B drug'*

The panel noted that Mr Burgess does not contest receiving this caution.

The panel found the charge proved.

Charge 2)

> *'In relation to charge 1, failed to notify the NMC of your caution as soon as you became aware of it.*

This charge is found proved.

In reaching this decision, the panel took into account the Simple Adult Caution record, an email exchange between Mr Burgess and the NMC and Mr Burgess' response to the Nurse, Midwife, Nursing Associate Context Form dated 25 March 2022.

The panel considered the Simple Adult Caution form which shows Mr Burgess had signed the caution form on 2 April 2022, proving he was aware of it since this date.

The panel was satisfied that under the Code 23.2 Mr Burgess had a duty to report any caution to the NMC as soon as he could.

The panel noted that there is an onus on Mr Burgess to be up to date with the Code as a registered Nurse, which would entail knowing that he has a duty to disclose any caution or

convictions to the NMC. The panel further noted that nurses must revalidate every 3 years and therefore there is an expectation that Mr Burgess would also be aware of the relevant sections of the Code on this basis.

The panel had regard to Mr Burgess' email from 4 February 2022 in which he disclosed his caution he received the previous year.

The panel also considered the Nurse, Midwife, Nursing Associate Context Form dated 25 March 2022 which states:

> *'I received a caution in April 2020 for possession of a class B drug… . I did eventually notify the NMC, you did hear about this firstly from me, though I was slow in my duty to inform you.'*

The panel noted that the evidence provided clearly shows Mr Burgess was aware of the caution well before he informed the NMC and therefore found the charge proved on this basis.

Charge 3a)

> *Your conduct as specified in charge 2 was dishonesty in that:*
>
> a) *you knew you had a duty to disclose your caution to the NMC as soon as you became aware of it.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the Police report dated 14 August 2021 and an email from Mr Burgess to the NMC dated 4 February 2022.

The panel considered the Police interview document, dated 05 August 2021 which states:

‘I asked if he had reported the matter to CQC, he stated no, I asked if he had disclosed his caution for Posession in March for Crystal Meth he said no, he was waiting for a DBS check to show it first.’

The panel then considered the email from Mr Burgess to the NMC which stated:

‘I have no knowledge of this being placed on my DBS which explains my not having disclosed this caution to you yet.’

The panel noted that the evidence provided showed Mr Burgess’ subjective belief that he only needed to disclose a caution when it appeared on a DBS check. The panel accepted that this was likely to have been Mr Burgess’ belief at the time, even though it was incorrect.

The panel found that there was insufficient evidence to show that Mr Burgess knew that he had a duty to disclose the caution to the NMC. The panel determined that although this was erroneous, it was not dishonest. On this basis, the fact was found not proved.

Charge 3b)

Your conduct as specified in charge 2 was dishonesty in that:

b) you deliberately failed to do so.

This charge is found NOT proved.

In reaching this decision, the panel took into account Mr Burgess’ email to the NMC dated 04 February 2022 which confirms that Mr Burgess made a deliberate decision not to disclose the caution to the NMC as he felt he had no duty to do so as it was not on his DBS check.

The panel noted that the evidence indicates that Mr Burgess made a choice not to disclose his caution on the basis that he misled himself that he did not need to, however the duty in

the Code to disclose, remained regardless of his own self-deception. The choice not to do so represents a failure to fulfil his duty to his regulator.

On this basis, the panel was satisfied that there was a deliberate failure to inform the NMC of the caution, however it did not believe the conduct reached the threshold required to establish dishonest motive for the reasons set out under 3a) above.

The panel accordingly finds this charge not proved.

Charge 4)

> *On or around 25 July 2021, failed to safeguard residents in that you were responsible for 1.23 grams of methylamphetamine, a controlled Class A drug found in the Home within access of residents.*

This charge is found proved.

In reaching this decision, the panel took into account the Memorandum of conviction and the witness statement of Colleague A.

The panel was satisfied that as registered manager of the Home Mr Burgess had a duty to safeguard the residents from harm.

The panel considered the witness statement of Colleague A who explained the circumstances in which she discovered the Class A drugs.

> *'I found the pouch on a table underneath some aprons which was situated just outside one of the resident's bedroom, I do not recall which door number it was. It was the one next to the dining room. There was a risk to residents as they could have accessed the substance as we have residents who walk around, they could have swallowed the plastic bag or its contents or both. This is one of the things I was upset about, that the residents were at risk.'*

In all the circumstances, the panel found that Mr Burgess had failed to safeguard residents with regard to the Class A substance.

The panel found this charge proved.

Charge 5)

> *On 18 January 2022, at Suffolk Magistrates Court were convicted of possession of 1.23 grams of methylamphetamine, a controlled Class A drug contrary to section 5(1) and 5(2) of the Misuse of Drugs Act 1971.*

This charge is found proved.

In reaching this decision, the panel took into account the Police report dated 14 August 2021, the Memorandum of conviction and Mr Burgess' email to the NMC dated 13 May 2022.

The panel recognised that the essence of a plea of guilty to such a charge was an acknowledgment of control of the substance. Mr Burgess therefore accepted that he had control of the substance at the relevant time.

The panel considered the police report and memorandum of conviction which both confirmed that Mr Burgess was convicted on the 18 January 2022 for possession of 1.23 grams of methylamphetamine.

The panel also considered the email from Mr Burgess sent to the NMC on 13 May 2022 which stated:

> *'I pleaded guilty to possession of Methamphetamine as the bag that it was found in was formally in my possession.'*

The panel was satisfied that the Memorandum of conviction in itself was sufficient to find this charge proved.

The panel therefore found this charge proved.

Charge 6)

In relation to charge 5, failed to notify the NMC that you had been charged with and/or convicted of a criminal offence as soon as you became aware of it

This charge is found proved.

In reaching this decision, the panel took into account the email from Mr Burgess to the NMC dated 4 February 2022 and the Memorandum of Conviction.

The panel considered the email Mr Burgess sent to the NMC on 4 February 2022 which stated:

'I hereby wish to inform you that on Tuesday 18th January 2022 I pleaded guilty, as advised by my lawyer to the charge of the possession of a class A substance, methamphetamine'

The panel noted that Memorandum of Conviction states the date of conviction as 18 January 2022 and that the above email was the first time Mr Burgess informed the NMC that he had had been convicted, which was 3 weeks after the conviction.

The panel found that there was no evidence to show that Mr Burgess had informed the NMC of his initial charge, however it was satisfied that Mr Burgess had the obligation to inform the NMC of any charges as stated in the Code 23.2. The panel was satisfied that it was likely that Mr Burgess failed to inform the NMC of his charge and conviction.

The panel therefore found this charge proved.

Charges 7a and b)

Your conduct as specified in charge 6 was dishonest in that:

a) *you knew you had a duty to disclose your charge and/or conviction to the NMC as soon as you became aware of them;*

b) *you deliberately failed to do so*

These charges are found NOT proved.

In reaching this decision, the panel took into account Mr Burgess' email to the NMC dated 4 February 2022 and the Police interview document, dated 5 August 2021.

The panel considered the email from Mr Burgess to the NMC dated 4 February 2022 which stated:

> *'I hereby wish to inform you that on Tuesday 18th January 2022 I pleaded guilty, as advised by my lawyer to the charge of the possession of a class A substance, methamphetamine…I have no knowledge of this being placed on my DBS which explains my not having disclosed this caution to you yet'*

The panel noted that there was no evidence that Mr Burgess knew he had to disclose a charge or conviction to the NMC as soon as he was aware of it. The panel determined that the evidence indicated that he misled himself that he did not need to disclose anything to the authorities until it was revealed on a DBS check. However the panel noted that the duty in the Code to disclose, remained regardless of his own self-deception. The choice not to do so represents a failure to fulfil his duty to the NMC.

The panel was satisfied that Mr Burgess deliberately failed to inform the NMC promptly of his charge and conviction. However, the panel noted that there was no evidence to show that Mr Burgess knew it was his duty to inform his regulator. The panel found that the conduct did not reach the threshold required to establish a dishonest state of mind.

These charges are therefore found not proved.

Charges 8a and 8b)

On 13 February 2018 in relation to Colleague A:

a) shouted at them.

b) slammed one or more pots of medication on their desk.

These charges are found proved.

In reaching this decision, the panel took into account the witness statement of Colleague A and Colleague A's letter to Mr Burgess.

Colleague A stated in their witness statement:

> *'I recall an occasion whereby Andrew had asked me to sign in a resident's medication following their admission to the Home. I was busy, so I informed Andrew that I could not sign in the resident's medication at that point. Andrew then started to bang the medication on the table and shouted at me. The handy man at the Home was present during the incident, Andrew did not know this at the time as the handy-man was kneeling down fixing an object. When the handy man stood up, Andrew stopped shouting and banged the medication on the table and left.'*

The panel considered the contemporaneous note made by Colleague A headed: 'Statement re Tuesday 13th February 2018' which stated:

> *'I asked which job he would like me to prioritise and he immediately became extremely aggressive and pulled each item of medication out of the carrier bag and slammed them on my desk whilst shouting at me that he didn't care about my work load.'*

The panel considered Colleague A's evidence to be a plausible and credible recollection which was supported by a contemporaneous note of events which gave wider context to the charge. The panel noted that Colleague A was *'very upset'* by the incident and that they had reported receiving a note of *'apology'* from Mr Burgess in which he had partially

blamed her for the incident. The panel also identified nothing in the evidence provided which could be construed as a response by Mr Burgess relating to this charge.

The panel therefore accepted Colleague A's evidence as plausible and as a result found that on the balance of probabilities, Charges 8a and 8b are found proved.

Charge 9a)

Between September and December 2021 on one or more occasions:

a) Shouted at one or more members of staff.

This charge is found proved.

In reaching this decision, the panel firstly considered the witness statement of Witness 1 dated 16 December 2022 which stated the following:

'I did witness him shout at the admin staff in the office, shout at the nurses, shout at a resident once and a relative of a resident."
...
'[PRIVATE] *worked in the office. I witnessed him shout at them on number of occasions.'*
...
'In relation to the Nurses, Andrew would always shout instead of talk. I can't remember specifics but he would belittle and shout at them.'

The panel also considered the witness statement of Colleague A dated 14 October 2022 which stated:

'There were times where Andrew would shout and raise his voice at staff. I do not recall specific dates but I had written various letters to Andrew about his actions and communication towards myself and sometimes the other staff'

The panel considered the supplementary witness statement of Colleague A dated 18 November 2022:

'Sometimes Andrew would have a short temper and shout at the staff. I do not recall why he would shout at the staff, sometimes he just would. I am unable to recall any specific incidents which I could refer to, it seemed to happen fairly often within the last couple of years before my retirement.'

The panel took into account the witness statement of Witness 2 dated 23 November 2022:

'I think quite a few people had concerns about Andrew's behaviour. Everyone can get annoyed at times but Andrew would snap at staff by shouting at them…I do not recall specific dates or arguments, I just remember he would shout at staff and sometimes he would shout at me'

The panel then considered the witness statement of Witness 3 dated 15 December 2022 which stated:

'Staff did say his moods were up and down. He would shout. There was a previous safeguarding referral regarding Andrew shouting at a relative. I did not witness these incidents myself'

The panel noted that all three of the witnesses reported witnessing or experiencing Mr Burgess shouting at staff. The panel noted that Witness 1's account referred directly to the timeframe in the charge and that although Colleague A and Witness 3's evidence did not provide specific dates, they provided corroboration and general context behind the charge. The panel found that the accounts provided were all very similar and therefore it found the evidence credible and plausible.

The panel identified nothing in the evidence provided which could be construed as a response by Mr Burgess to this charge.

The panel accepted Witness 1's evidence and the contextual corroborating evidence.

The panel therefore found this fact proved.

Charge 9b)

Between September and December 2021 on one or more occasions:

b) Shouted at a resident's family member.

This charge is found proved.

In reaching this decision the panel considered the witness statement of Witness 1 which stated:

'I did witness him shout at the admin staff in the office, shout at the nurses, shout at a resident once and a relative of a resident.'

...

'In relation to the family member, they had arrived at the Home and knocked to come in and was waiting for staff to let them in. No one arrived to let them in so she called the phone. Andrew answered and shouted at her for ringing the phone as they were clearly busy'

The panel noted in relation to the above evidence, that although the events stated by Witness 1 were not dated, it must have fallen within the relevant time frame as this is when Witness 1 was employed at the Home.

The panel also noted that the family member in question *'did not want to deal with him following this'* which showed the impact of his actions.

The panel next considered the witness statement of Witness 3 dated 15 December 2022 which stated:

'There was a previous safeguarding referral regarding Andrew shouting at a relative.'

The panel accepted the evidence provided. The panel found that it was more likely than not that Mr Burgess had shouted at a relative and therefore the charge was found proved.

Charge 10)

> *In around November or December 2021 in relation to Resident B, shouted at them for touching your paperwork.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 dated 16 December 2022 which described the event whereby Mr Burgess had his paper work on the dining room table and a resident moved a bit of the paper and Mr Burgess shouted at them for touching his papers, saying things such as *"can't you just wait!"* and *"you have no patience!".*

The panel noted that Witness 1 had witnessed this incident directly and has given a clear summary of events. The panel also noted that *'the resident appeared to be shocked'* and found it extremely concerning that this would be the case in an establishment where residents with dementia are being looked after.

The panel noted that it found no reason to disbelieve the accounts of Witness 1 and that it would seem more likely than not that this event occurred. However, it was unable to ascertain that Resident B was the resident who touched the paperwork. On this basis the panel found this charge not proved.

Charge 11a)

> *Between 1 January 2021 and 31 January 2022, on one or more occasions in relation to one or more residents:*
>
> a) *did not ensure that medicines were administered in a timely manner or at all.*

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2, the witness statement of Colleague A and their supplementary witness statement, the witness statement of Witness 3 and the witness statement of Witness 4.

The panel first considered the witness statement of Witness 2, dated 23 November 2022 which reported occasions whereby Mr Burgess had not administered medications in a timely manner and did not report that he had not done so, which could have resulted in harm to the patients involved. The panel noted that there was no date specified for these events, however, Witness 2 estimated them to have taken place in early-mid 2021.

The panel next considered the witness statement of Colleague A dated 14 October 2022 which stated:

> '*I had concerns about Andrew failing to administer medications on time… there was an occasion whereby Registered Nurse, [PRIVATE], informed me that Andrew had failed to administer medications to the residents on time during a night shift.'*

The panel also considered the supplementary witness statement of Colleague A dated 18 November 2022 which the panel found corroborated the evidence of Witness 2 in that Colleague A had submitted a document in their evidence which detailed the shortfalls in Mr Burgess' medication administration.

The panel next considered the witness statement of Witness 4 dated 30 August 2022 which stated:

> *'I was informed by an anonymous whistle-blower that morning medications were due to take place between 06:30-08:00 however when Andrew was on duty he was not finishing these until 11:00am which then put the lunchtime medications out of sync.'*

The panel noted that Witness 4 confirmed in their statement that *'the overall registered persons is responsible for ensuring correct medications practice'* and that as Mr Burgess

was the registered manager at the time of the events, he was responsible for ensuring the safe administration of medication.

The panel considered the witness statement of Witness 3 dated 15 December 2022 which reported that there was an anonymous safeguarding referral through the CQC regarding Mr Burgess' behaviour, including in relation to poor medication practice.

The panel noted that the evidence provided by Witness 2 and Colleague A both relate to specific concerns which the panel found to be corroborated by Witness 4's evidence of the CQC's inspection and Witness 3's evidence of the safeguarding referral. The panel therefore found this fact proved.

Charge 11b)

> *Between 1 January 2021 and 31 January 2022, on one or more occasions in relation to one or more residents:*
>
> *b) left medication in pots in residents' rooms during medication rounds.*

This charge is found NOT proved.

In coming to this decision, the panel considered the witness statement of Colleague A and the witness statement of Witness 4.

The panel noted that the statement of Colleague A reported only a *'vague recollection'* of such an incident and did not give a timeframe. Witness 4's statement shows they did not witness any specific events relating to the charge and that they were merely informed of the concerns.

The panel found that there was insufficient evidence to find on balance of probabilities that the events happened during the time frame in the charge.

The panel therefore found this charge not proved.

Charge 11c)

Between 1 January 2021 and 31 January 2022, on one or more occasions in relation to one or more residents:

c) potted medications for more than one resident at the same time.

This charge is found proved.

In making this decision, the panel considered the witness statement of Witness 1 which stated:

'I had concerns about the way Andrew would administer medications… I witnessed Andrew pot several residents medication all at once and administer rather than as standard one resident and give then move on to next resident. The risk potential being he could have given the wrong medication to the wrong resident.'

The panel found this to be a credible statement in that it was a direct account of witnessing the relevant concerns, within the time frame as this took place when Witness 1 worked at the Home. The panel found that this evidence was corroborated by others' more general concerns over Mr Burgess' medication administration, including concerns by CQC in their inspection.

The panel therefore found the evidence to be plausible and that on the balance of probabilities, this fact was found proved.

Charge 11d)

Between 1 January 2021 and 31 January 2022, on one or more occasions in relation to one or more residents:

d) On or around 15 February 2021, did not administer and/or sign for medication for one or more residents, as set out in Schedule 2

This charge is found NOT proved.

The panel considered the supplementary witness statement of Colleague A which outlined that on 15 February 2021, it was reported by Witness 2 that some of the 8am medication had not been signed for or given by the night nurse (Mr Burgess). The panel noted that although this was contemporaneous evidence, there was a lack of evidence to correlate this incident with the residents set out in Schedule 2 within the charge.

The panel therefore found this fact not proved.

Charge 12a)

> *Between 26 October 2021 and 31 January 2022, did not ensure that adequate record keeping was being maintained in that you:*
>
> > *a) did not ensure care plans contained sufficient information to accurately reflect the care and/or treatment and/or needs of one or more residents.*

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 4, Witness statement of Witness 3 and the CQC report.

The panel first considered the witness statement of Witness 4 dated 30 August 2022 which included:

> *'The registered persons are responsible for ensuring patient records are maintained and up to standard.'*
>
> *...*
>
> *'During the inspection we reviewed seven resident's records. I noted that not all care records were always complete and accurate. For example care plans*

were not person centred and did not have enough detail to guide staff on how their specific needs and preference were to be met.'

The panel had sight of the CQC report which confirmed care plans were not accurate or person centred.

The panel also considered the witness statement of Witness 3 which stated:

'From reviewing residents care plans I determined that they were not fit for purpose'

The panel accepted the evidence and found this charge proved.

Charge 12b)

Between 26 October 2021 and 31 January 2022, did not ensure that adequate record keeping was being maintained in that you:

b) did not ensure that risk assessments were in place or up to date for one or more residents.

This charge is found proved.

The panel considered the witness statement of Witness 1, Witness 3 and Witness 4 when coming to this decision.

The panel first considered the witness statement of Witness 3, dated 15 December 2022. Witness 3 reported that when reviewing residents care plans, they found that very few had any risk assessments in them at all, including choking risk assessments and weight trackers. Witness 3 also stated that Mr Burgess did not understand the need to complete a risk assessment if bedrails were being used.

The panel considered the witness statement of Witness 4, dated 30 August 2022 whereby Witness 4 had noted that Mr Burgess records did not always have risk assessments.

Witness 4's statement also specified that Mr Burgess would be responsible for ensuring risk assessments were up to date.

The panel considered the evidence of Witness 1 dated 16 December 2022 which stated:

> *'The NMC asked me about risk assessments, when I started at the Home there were no risk assessments in place. I had gone onto a risk assessment website to make some risk assessments for bed rails and lap belts on wheelchairs. I asked Andrew if we could subscribe to the site to get the risk assessments and he said he didn't want to pay out money for it, he said he would make a template and give it to me which never happened. Nothing was risk assessed. He said that everyday you risk assess, you would do it in your head and there was no need to document it.'*

The panel found that as well as the Home Manager, two outside agencies considered that there was significant failings short of expectations in this respect and accepted the evidence presented.

The panel therefore found this charge proved.

Charge 12c)

> *Between 26 October 2021 and 31 January 2022, did not ensure that adequate record keeping was being maintained in that you:*
>
> *c) did not ensure that there were Personal Emergency Evacuation Plans ('PEEPs') in place for one or more residents*

This charge is found proved.

In making this decision, the panel considered the witness statement of Witness 4, the CQC report and the witness statement of Witness 3.

The panel first considered the witness statement of Witness 4, dated 30 August 2022 which reported that there were no Personal Evacuation Plans in place for any resident and that Mr Burgess did not know these were needed.

The panel noted that the CQC report also demonstrated that there were no personal evacuation plans for people using the service.

The panel considered the witness statement of Witness 3, dated 15 December 2022 which reported that Mr Burgess had apparently taken home the documentation on personal emergency evacuation plans to *'tidy up',* but they never reappeared.

The panel accepted this evidence and found this charge proved.

Charge 13a)

> *On one or more occasions between 1 November 2020 and 30 November 2021, did not take sufficient and/or any action in respect of safeguarding "incidents as set out in Schedule 3 in that you:*
>
> > *a) did not ensure that the safeguarding incidents were reported to the Local Authority and/or CQC in a timely manner or at all.*

This charge is found partly proved.

In reaching this decision, the panel took into account the witness statement of Witness 3, the witness statement of Witness 1 and related incident reports.

The panel considered the witness statement of Witness 3, dated 15 December 2022, which stated:

> *'Another safeguarding referral was made by the CQC on 28 October 2021 which raised concerns about incidents where a Resident of the Home had sexually assaulted other residents. These had not been referred to Safeguarding.'*

The panel also considered the witness statement of Witness 1 whereby they stated:

> *'There was an issue with one of the male residents sexually assaulting other female residents. I had to put safeguarding referrals in myself as Andrew said that he did not believe it was a safeguarding issue and repeatedly said it was two consenting adults even though all residents involved had dementia and could not consent.'*

The panel found Witness 3's evidence to be credible and reliable as they were a safeguarding professional from an outside investigating agency and therefore, the panel accepted this evidence. The panel noted that the evidence provided by Witness 1 supported this.

The panel considered the internal notes and incident reports of the incidents occurring at the Home, and, in the absence of any correlation information provided by the NMC, could identify all incidents set out in Schedule 3, except incidents C and N.

The panel found that there was no evidence to show Mr Burgess had reported any of the noted safeguarding incidents the panel identified on Schedule 3.

This charge is found proved with exception of incidents C and N from Schedule 3.

Charge 13b)

> *On one or more occasions between 1 November 2020 and 30 November 2021, did not take sufficient and/or any action in respect of safeguarding "incidents as set out in Schedule 3 in that you:*
>
> > *b) did not take any and/or sufficient action following the safeguarding incidents.*

This charge is found partly proved.

In coming to this decision, the panel considered the witness statement of Witness 3, the witness statement of Witness 1 and Witness 2.

The panel first considered the witness statement of Witness 3 which referenced events which happened following the initial safeguarding incidents:

> *'I came into work the following Monday and found there had been another incident of sexual assault at the Home over the weekend. Andrew had not completed the risk assessment or done anything to mitigate this.'*

The panel noted that Witness 3 had stated in their witness statement that neither Mr Burgess nor the staff demonstrated an understanding of mental capacity and deprivation of liberty in relation to sexual assault.

The panel considered the witness statement of Witness 1 which reported that they had made necessary safeguarding referrals themself as Mr Burgess did not believe the incidents to give rise to safeguarding concerns.

The panel also considered the witness statement of Witness 2, dated 23 November 2022 which stated that they were aware of the safeguarding concerns relating to one of the residents who would be sexually inappropriate towards staff and other residents and that Mr Burgess did not manage this well or make any timely risk assessment.

The panel noted that Witness 1's evidence showed that Mr Burgess actively prevented them from taking action to prevent incidents from occurring as he did not believe the issue to be a safeguarding concern.

Again, due to the NMC's omission to provide evidence of correlation between the noted incidents and Schedule 3, the panel was unable to identify incidents C and N in the evidence provided.

The panel found this charge proved, with the exception of C and N of Schedule 3.

Charge 14)

> *On one or more occasions between 17 October 2021 and 24 November*

2021 failed to safeguard one or more staff members from harm in respect of a safeguarding incidents as set out in Schedule 4.

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 and the relevant reports.

The panel noted that the witness statement of Witness 1 shows clear incident reports which reference the correct dates in the charge, however the panel found that there is no evidence to show that a risk assessment would have stopped any of the incidents from happening, or that any harm occurred.

The panel therefore found this fact not proved.

Charge 15)

Between 1 September 2021 and 31 December 2021, on one or more occasions emptied the sharps bins into industrial bins outside the Home.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 which stated:

'Around November time 2021 not long before I left I saw a massive industrial bin out the back of the building, Andrew would take the sharps bins and empty the bins into these industrial bins in the shed with no lid on so sharps were exposed. I asked Andrew what was going on and he responded that he would not be paying for a contractor to come and collect the sharps as it was a waste of money. He would not listen to me. Used, exposed needles were a risk as anyone could prick themselves on them which could cause bleeding or infection. I do not know how he was disposing of the industrial bins. I saw hundreds, if not thousands of needles in this bin.'

The panel found that the statement provided was a clear and direct explanation of something they had witnessed. The panel noted that this was unlikely to be a misunderstanding and found that it was more likely than not that it happened.

The panel therefore found this charge proved.

Charge 16)

> *Having been made aware of breaches of regulations as specified in Schedule 1 following a CQC inspection on 26 October 2021 and 8 November 2021, failed to ensure compliance with one or more of the said regulations at the time of the subsequent CQC inspection in January 2022.*

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 4 and the related reports.

The panel had sight of the CQC report dated 15 February 2022 , completed by Witness 4 after an inspection in January 2022 which stated:

> ‘At this inspection we found that the service continued to be in breach of regulations’

The panel found that based on the evidence in the CQC report, it was evident there had been insufficient improvement in the Home and therefore found this fact proved.

Charge 17a)

> *On one or more occasions between 1 September 2019 and 31 December 2021, attended work when you were unfit to do so in that:*
>
> *a) you appeared to be under the influence of a substance.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Colleague A and their supplementary statement and the witness statement of Witness 1.

The panel considered the witness statement of Colleague A, dated 14 October 2022 which outlined that they had concerns about Mr Burgess appearing as if he was under the influence of alcohol whilst on shift at the Home. Colleague A reported that Mr Burgess was unable to speak properly and that his speech was slurred. The panel noted that in this case there were no specific dates mentioned.

The panel also considered the supplementary witness statement of Colleague A dated 18 November 2022 whereby Colleague A stated that they estimated that these concerns began approximately a year or so prior to their retirement in September 2021 and that they assumed that his slurred speech may have been as a result of pain medication for an operation he had undergone.

The panel considered the witness statement of Witness 1 dated 16 December 2022, whereby they report seeing Mr Burgess showing erratic behaviour, he was becoming unkempt and dishevelled which they described as *'a tell-tale sign of someone experiencing highs and lows'*.

The panel noted that Witness 1 had a history of working in drug and alcohol services and did not state that they felt Mr Burgess was under the influence of a substance. The panel found that objectively it was likely that Colleague A had made an assumption of some form of substance use as this was not his usual behaviour. The panel therefore found that there was insufficient evidence to show that Mr Burgess objectively appeared under the influence of a substance as stated in the charge and therefore found this charge not proved.

Charge 17b)

On one or more occasions between 1 September 2019 and 31 December

2021, attended work when you were unfit to do so in that:

b) your speech was slurred and/or you were unable to speak properly.

This charge is found proved.

The panel considered the witness statement of Colleague A which stated:

'There have been multiple occasions where Andrew was unable to speak properly and his speech would be slurred.'

The panel also referenced the supplementary statement of Colleague A, dated 18 November 2022 which reiterates their report of Mr Burgess slurring his words.

The panel found Colleague A's evidence to be reliable and accepted it. The panel found that Mr Burgess being unable to speak properly would impact his ability to communicate properly and therefore his fitness for work. The panel found this fact proved on this basis.

Charge 18)

Between 6 September 2022 and 21 February 2024, failed to co-operate with an NMC investigation into your [PRIVATE].

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 5 and related reports.

The panel had sight of correspondence between Witness 5 and Mr Burgess as well as a report which states:

'He explained that he does not want to [PRIVATE].

The panel accepted this evidence as fact that Mr Burgess did not co-operate with NMC investigation [PRIVATE] and therefore found this fact proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Burgess' 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 Burgess' 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 Burgess' actions amounted to misconduct and considered the following provisions of the Code had been breached in this case in relation to charges 2 and 6:

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times…

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

23 Cooperate with all investigations and audits

To achieve this, you must:

23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)

The NMC submitted that in relation to charge 4, the following provisions of the Code had been breached in this case:

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.4 keep to the laws of the country in which you are practising

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

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

With regard to charges 1 and 5, the NMC submitted the following parts of the code had been breached:

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times…

20.4 keep to the laws of the country in which you are practising.

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

The NMC submitted that in relation to charges 8,9,11 and 12, the following parts of the Code were breached:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.5 work with colleagues to preserve the safety of those receiving care

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to a

The NMC further submitted that in relation to charges 13a)-b),15 and 16, the following parts of the Code were breached:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognise diversity and individual choice

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.5 respect, support and document a person's right to accept or refuse care and treatment

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

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.4 work with colleagues to evaluate the quality of your work and that of the Team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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

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

10.5 take all steps to make sure that records are kept securely

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

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.4 keep to the laws of the country in which you are practising

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

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 NMC submitted that the following parts of the Code were breached in relation to charges 17 and 18:

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to
20.9 maintain the level of [PRIVATE] you need to carry out your professional role

23 Cooperate with all investigations and audits

To achieve this, you must:

23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise

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 Burgess' fitness to practise impaired by reason of his caution at charge1, conviction at charge 5 and misconduct in respect of all other charges found proved.

The NMC submitted that Mr Burgess' fitness to practise is impaired on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the guidance in the case of Nandi and considered whether fellow professionals would consider Mr Burgess' conduct to have been deplorable. The panel observed that three fellow staff members, two senior personnel from outside professional agencies had given statements to the NMC regarding Mr Burgess' behaviour which contained criticisms of his actions. The panel also observed that the police had been involved. The panel was satisfied that by reasonable standards, Mr Burgess' professional conduct had been deplorable.

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

1 Treat people as individuals and uphold their dignity
To achieve this, you must:

1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively
1.3 avoid making assumptions and recognise diversity and individual choice
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns
To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.5 respect, support and document a person's right to accept or refuse care and treatment

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

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages
3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues
8.4 work with colleagues to evaluate the quality of your work and that of the team
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
10.5 take all steps to make sure that records are kept securely

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

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.
14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so
16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse
17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

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

To achieve this, you must:

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.4 keep to the laws of the country in which you are practising

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

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 Burgess' actions as represented by the charges found proved fell 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 Burgess' fitness to practise is currently impaired.

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

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

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/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*

The panel was satisfied that Mr Burgess' conduct breached limbs a, b and c of the *Grant* test.

The panel found that residents and their families and members of staff were put at risk of physical and emotional harm as a result of Mr Burgess' misconduct. The panel bore in mind that the Home housed vulnerable elderly residents, many of whom had dementia.

The risk of physical harm also extended to the public with Mr Burgess' method of *'sharps'* disposal. The panel found that Mr Burgess' treatment of patients and staff and his failure to appropriately manage the Home had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel noted that Mr Burgess' conviction for possessing Class A drugs and bringing them into the residential home was in itself a serious breach of the Code and encompassed all three limbs of the *Grant* test.

Regarding insight, the panel found that although there were a number of potential opportunities for remediation early on, Mr Burgess has shown very little insight and continued to act in a way which b
rings the reputation of the nursing profession into disrepute. The panel has not had sight of any reflection, remediation, education or strengthened practice that addresses the risks that Mr Burgess created. His refusal to cooperate with the NMC investigation [PRIVATE] is also indicative of a lack of insight on his behalf.

The panel found further evidence of lack of insight whereby Mr Burgess often deflected the blame as seen in his email to the NMC dated 13 May 2022 which states:

> *'The assumption is that our poor targeted inspection from CQC was caused by me taking drugs and ever since I have been scrutinised and observations have been subjected to confirmation bias. No one seems willing to listen.'*
> ...
> *'The problems at my Nursing Home were being caused by the lack of available staff'*
> ...
> '*No allowances have been made for the 30 wonderful years during which time we enjoyed a great reputation and had consistently good inspection reports. No allowances either for the huge burden placed on us by the pandemic. No resident caught Covid 19 until March this year - our hard work kept our residents safe.'*

The panel acknowledged Mr Burgess' submissions, however the panel have a duty to protect the public going forwards and reports of good historic practice cannot mitigate current poor practice.

The panel noted that Mr Burgess is currently retired, however it considered that the risk still remains due to Mr Burgess' lack of insight and remediation.

The panel therefore decided that a finding of impairment of fitness to practice is necessary on the grounds of public protection.

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

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

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Burgess off the register. The effect of this order is that the NMC register will show that Mr Burgess has been struck-off the register.

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 4 August 2025, the NMC had advised Mr Burgess that it would seek the imposition of a strike off order if it found Mr Burgess' fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mr Burgess' 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 sanction guidance. The decision on sanction is a matter for the panel independently exercising its own judgement.
The panel took into account the following aggravating features:

- Criminal offending which put patients receiving care, their families, staff and the general public at a serious risk of suffering harm.
- Pattern of criminal offending – two occasions of possessing illicit drugs, over a period of time.
- Pattern of misconduct over a period of time
- Repeated nature of failings
- Lack of insight and/or cooperation with the NMC's investigation.
- Deep-seated attitudinal issue, difficult to remediate.

The panel also took into account the following mitigating features:

- Difficult personal circumstances.

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 Burgess' 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 Burgess' 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 Burgess' 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. The panel also considered the fact that Mr Burgess has since retired and as a result, is not currently working and has shown no willingness to engage with conditions. The wide-ranging misconduct identified in this case included matters that cannot be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Burgess' registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel found that these factors were not apparent in Mr Burgess' case.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the

fundamental tenets of the profession evidenced by Mr Burgess' actions is fundamentally incompatible with Mr Burgess 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? (Yes)*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register? (No)*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards? (Yes)*

Mr Burgess' 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 to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

Interim order

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

Representations on interim order

The panel took account of the representations made by the NMC that submitted an Interim Suspension Order of 18 months is necessary for the protection of the public and is otherwise in the public interest.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months.

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

This will be confirmed to Mr Burgess in writing.

That concludes this determination.