Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 8 July 2025 – Friday, 18 July 2025
Wednesday, 18 March 2026 – Friday, 20 March 2026

Virtual Hearing

Name of Registrant:	Lee Steven Clavery
NMC PIN:	12E0632E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 10 September 2012
Relevant Location:	South Tyneside
Type of case:	Misconduct
Panel members:	Alan Greenwood (Chair, Registrant Member) Sally Thomas (Registrant Member) Karan Sheppard (Lay Member)
Legal Assessor:	Andrew Young (8 – 18 July 2025) Graeme Sampson (18 – 20 March 2026)
Hearings Coordinator:	Rene Aktar (8 – 18 July 2025) Margia Patwary (18 – 20 March 2026)
Nursing and Midwifery Council:	Represented by Vanessa Mistry, (8-14 July 2025 and 16-18 July 2025), Debbie Churaman (15 July 2025 only), and Rowena Wisniewska (18 – 20 March 2026), Case Presenters
Mr Clavery:	Present and unrepresented at the hearing
No case to answer:	Charges 3, 4, 5, 7a, 7b, 8, 14, 15 and 16
Facts proved by admission:	Charges 7c and 12b
Facts proved:	Charges 1b, 2, 9a, 9c, 10, 12, and 13

Facts not proved:	Charges 1a, 6, 9b, 9d, 11a, and 11b
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge

‘That you, a registered nurse:

1) Between Feb 2019 and March 2019

(a) Failed to update Patient A’s care plan

(b) Incorrectly stated to Person A that you had updated Patient A’s care plan when you had not

2. You conduct at Charge 1(b) was dishonest because you made this statement to Person A in order to conceal that you had not updated Patient A’s care plan.

3. During a nightshift on 15 and 16 March 2019:

(a) failed to administer Patient A’s prescribed medications

(b) incorrectly recorded on Patient A’s medication records that you had administered prescribed medication of:

(i) Clonazapem

(ii) Ferrous Fumarate,

(iii) Halopenidol

(iv) Hypromellose

(v) Lorazapam

(vi) Paracetemol

(vii) Olanzapine

(viii) Tetrabenzine

4. Your conduct at one or more of Charges 3(b)((i) – (viii) was dishonest in that:

(a)you knew that you had not administered Patient A’s medications

(b) you intended that someone reading Patient A’s medication records would believe that you had administered the medication.

5. During a nightshift on15 and 16 March 2019 failed to administer Patient A's PEG feed.

6.During a nightshift on 15 and 16 March 2019 failed to administer morphine sulfate to Patient B when they required it.

7.During a nightshift on 15 and 16 March 2019:

(a)failed to administer some or all of the prescribed medication as per Schedule 1

(b) incorrectly recorded that you had administered such medication

(c) failed to employ safe medication administration procedures

8. Your conduct at Charge 7(b) was dishonest in that:

(a) you knew that you had not administered the medication

(b) you intended that someone reading the electronic medication records would believe that you had administered the medication.

9. Between 23 and 24 March 2019

(a) failed to administer Patient A's prescribed medications

(b) failed to administer Patient A's PEG feed

(c) incorrectly recorded on Patient A's medication records that you had administered prescribed medication of:

(i) Calogen extra shots

(ii) Clonazepam

(iii) Haloperidol

(iv)Lorazepam

(v) Paracetemol

(vi) Tegretol

(vii) Tetrabenazine

(d) incorrectly recorded that you had administered Patient A's PEG feed

10. Your conduct at one or more of Charges 9(c)((i) – (vii) was dishonest in that:

(a)you knew that you had not administered Patient A's medications

(b) you intended that someone reading Patient A's medication records would believe that you had administered the medication.

11. Your conduct at Charge 9 (d) was dishonest in that:

(a) you knew that you had not administered Patient A's PEG feed

(b) you intended that someone reading Patient A's medication records would believe that you had administered the PEG feed.

12. On 25 March 2019 knowing that Person B was not fully trained to administer PEG feeds:

(a) failed to supervise Person B when they administered Patient A's PEG feed

(b) incorrectly recorded on Patient A's MAR chart that you administered Patient A's PEG feed

13. Your conduct at Charge 12(b) was dishonest in that:

(a) you knew that Person B had administered the PEG feed unsupervised

(b) you intended that someone reading Patient A's medication records would believe that you had administered the PEG feed.

14. On 25 March 2021

(a) failed to administer Patient A's prescribed medications

(b) failed to administer Patient A's PEG feed

(c) incorrectly recorded on Patient A's medication records that you had administered prescribed medication of:

(i) Clonazepam

(ii) Ferrous Fumarate

(iii) Lorazepam

(iv) Paracetemol

(v) Tegretol

(vi) Tetrabenazine

(d) incorrectly recorded that you had administered Patient A's PEG feed

15. Your conduct at one or more of Charges 14(c)((i) – (vii) was dishonest in that:
    (a) you knew that you had not administered Patient A's medications
    (b) you intended that someone reading Patient A's medication records would believe that you had administered the medication

16. Your conduct at Charge 14 (d) was dishonest in that:
    (a) you knew that you had not administered Patient A's PEG feed
    (b) you intended that someone reading Patient A's medication records would believe that you had administered the PEG feed

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Mistry, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charges 2, 3, 14, and 15.

It was submitted by Ms Mistry that the proposed amendment would provide clarity and more accurately reflect the evidence.

'That you, a registered nurse:

1) Between Feb 2019 and March 2019

    (a) Failed to update Patient A's care plan
    (b) Incorrectly stated to Person A that you had updated Patient A's care plan when you had not

2. ~~You~~ **Your** conduct at Charge 1(b) was dishonest because you made this statement to Person A in order to conceal that you had not updated Patient A's care plan.

3. During a nightshift on 15 and 16 March 2019:

(a) failed to administer Patient A's prescribed medications

(b) incorrectly recorded on Patient A's medication records that you had administered prescribed medication of:

(i) Clonazapem

(ii) Ferrous Fumarate,

(iii) Halopenidol

(iv) Hypromellose

(v) Lorazapam

(vi) ~~Paracetemol~~ **Paracetamol**

(vii) Olanzapine

(viii) Tetrabenzine

4. Your conduct at one or more of Charges 3(b)((i) – (viii) was dishonest in that:

(a) you knew that you had not administered Patient A's medications

(b) you intended that someone reading Patient A's medication records would believe that you had administered the medication.

5. During a nightshift on 15 and 16 March 2019 failed to administer Patient A's PEG feed.

6. During a nightshift on 15 and 16 March 2019 failed to administer morphine sulfate to Patient B when they required it.

7. During a nightshift on 15 and 16 March 2019:

(a) failed to administer some or all of the prescribed medication as per Schedule 1

(b) incorrectly recorded that you had administered such medication

(c) failed to employ safe medication administration procedures

8. Your conduct at Charge 7(b) was dishonest in that:

(a) you knew that you had not administered the medication

(b) you intended that someone reading the electronic medication records would believe that you had administered the medication.

9. Between 23 and 24 March 2019

(a) failed to administer Patient A's prescribed medications

(b) failed to administer Patient A's PEG feed

(c) incorrectly recorded on Patient A's medication records that you had administered prescribed medication of:

(i) Calogen extra shots

(ii) Clonazepam

(iii) Haloperidol

(iv) Lorazepam

(v) Paracetemol

(vi) Tegretol

(vii) Tetrabenazine

(d) incorrectly recorded that you had administered Patient A's PEG feed

10. Your conduct at one or more of Charges 9(c)((i) – (vii) was dishonest in that:

(a) you knew that you had not administered Patient A's medications

(b) you intended that someone reading Patient A's medication records would believe that you had administered the medication.

11. Your conduct at Charge 9 (d) was dishonest in that:

(a) you knew that you had not administered Patient A's PEG feed

(b) you intended that someone reading Patient A's medication records would believe that you had administered the PEG feed.

12. On 25 March 2019 knowing that Person B was not fully trained to administer PEG feeds:

(a) failed to supervise Person B when they administered Patient A's PEG feed

(b) incorrectly recorded on Patient A's MAR chart that you administered Patient A's PEG feed

13. Your conduct at Charge 12(b) was dishonest in that:

(a) you knew that Person B had administered the PEG feed unsupervised

(b) you intended that someone reading Patient A's medication records would believe that you had administered the PEG feed.

14. On 25 March ~~2021~~ **2019**

(a) failed to administer Patient A's prescribed medications

(b) failed to administer Patient A's PEG feed

(c) incorrectly recorded on Patient A's medication records that you had administered prescribed medication of:

(i) Clonazepam

(ii) Ferrous Fumarate

(iii) Lorazepam

(iv) Paracetemol

(v) Tegretol

(vi) Tetrabenazine

(d) incorrectly recorded that you had administered Patient A's PEG feed

15. Your conduct at one or more of Charges 14(c)((i) – ~~(vii)~~ **(vi)** was dishonest in that:

(a) you knew that you had not administered Patient A's medications

(b) you intended that someone reading Patient A's medication records would believe that you had administered the medication

16. Your conduct at Charge 14 (d) was dishonest in that:

(a) you knew that you had not administered Patient A's PEG feed

(b) you intended that someone reading Patient A's medication records would believe that you had administered the PEG feed

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

The panel heard submissions from you. You did not oppose the application.

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

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

Background

The regulatory concerns are as follows:

1. Poor record keeping - in that you:
    a. Failed to update Patient A's care plan when asked to do so and then stated that it had been completed.
    b. Inaccurately recorded that you had administered medication to Patient A and other residents when you had not; and
    c. Inaccurately recorded that you had administered PEG feeds to Patient A when you had not.

2. Dishonesty associated with regulatory concern 1 - in that you intended to create a misleading impression that you had undertaken those tasks when you had not.

3. Poor medications practice - in that you:
    a. Failed to administer medication to residents in line with their MAR charts.

b. Failed to administer PRN Oramorph to Patient B when this was requested.
c. Delivered medication inappropriately by potting it for several residents at the same time.
d. Left Care Assistant (Witness 6) to administer Patient A's PEG feed alone when:
    (i) Witness 6 was not signed off as competent to undertake PEG feeds; and
    (ii) Two members of staff were required to administer Patient A's PEG feed.

Your name was first entered on to the NMC register in 2012. You were referred to the NMC on 10 April 2019 by Witness 1. At the time of the concerns raised in the referral, you were employed as the Deputy Manager for the Home and you started working at the Home in February/March 2019, when your period of employment was approximately five weeks.

Witness 1 in her statement detailed your role and responsibilities as Deputy Manager at the Home. She explained that the Home caters for residents with a variety of medical conditions including Dementia, Huntington's Disease, Parkinson's Disease, Multiple Sclerosis, and that some residents require Percutaneous Endoscopic Gastronomy (PEG) feeding. Witness 1 confirmed that you had an induction at the Home and that she completed your final assessment and sign off.

You were working a night duty shift at the Home on 15/16 March 2019, alongside Witness 3, Witness 5 and Witness 7. In their statements, Witnesses 3, 5, and 7 confirmed that they were caring for the resident who required 1:1 care in turn in 1-hour sessions. You were expected to administer medication to the resident during the night shift and his PEG feed would be administered before the end of the night shift but Witnesses 3, 5, and 7 did not see you administer any medication or PEG feed to Patient A at any time during the night shift. Witness 1 explained that you had nonetheless signed the MAR chart to confirm administration of a number of medications for Patient A when in fact you had administered

none of them. You did not sign to document administration of Patient A's PEG feed at any point on 15 or 16 March 2019.

During the same night shift of 15 and 16 March 2019, you also failed to administer morphine sulphate to Patient B when they required it.

Witness 4 said she was working day shifts at the Home on either 23 or 24 March 2019, and that you were the nurse in charge. She confirms she was caring for Patient A, who is meant to receive his PEG feeds at 07:00, 11:00, 13:00 and 19:00 and various medications throughout the day shift. Witness 4 says she was with Patient A between 13:30 and 19:30 and that during this time you failed to administer any medication or PEG feeds to Patient A but documented in the care notes that you had done so.

On 25 March 2019, it is alleged that you failed to supervise Witness 6 when administering PEG feeds to Patient A. In his statement, Witness 6 confirmed that he had not been signed off as competent to carry out this procedure and that he therefore had to be supervised while doing so. It is further alleged that you failed to administer Patient A's medications or his PEG feed on the same day but incorrectly recorded in his records that you had done so.

Decision and reasons on application to admit hearsay evidence of Ms 1

The panel heard an application made by Ms Mistry under Rule 31(1) to admit the local witness statement of Ms 1 dated 28 March 2019 into evidence.

Ms Mistry invited the panel to consider the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). Ms Mistry invited the panel to consider 'Exhibit TM/23' where Ms 1's local witness statement is reproduced.

Ms Mistry submitted that Ms 1's witness statement is not the only evidence in support of this allegation as it is also referred to in the witness statement of Witness 1. She submitted

that the panel could attach as much or little weight to this as it felt appropriate as it is not the sole or decisive evidence in support of this charge.

Ms Mistry submitted that when looking at the factors and whether there were any suggestions that Ms 1 would fabricate her allegation, the NMC would submit that Ms 1 gave a truthful account.

Ms Mistry appreciated the impact of adverse findings on your career.

You submitted that the panel should not admit Ms 1's local witness statement on the basis that it would be unfair to you to do so. Ms 1's witness statement was the only evidence in support of this allegation, and it was inconsistent with the evidence of Witness 6 who denied in cross examination that Ms 1 had been present when he was administering a PEG feed to Patient A.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is '*fair and relevant*', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He referred the panel to the guidance in the case of *Thorneycroft.* He advised the panel that the evidence of Ms 1 was the sole or decisive evidence in support of this allegation as the evidence of Witness 1 consisted only of a hearsay statement of what Witness 1 had been told by Ms 1.

The panel considered the facts, the submissions and the relevant case law with care.
The panel gave careful regard to the application in relation to the exhibits of Ms 1 into evidence. The panel exercised the guidance in *Thorneycroft* and took into account although that there is no suggestion of fabrication or inconsistencies in the evidence of Ms 1, her evidence is in fact the sole and decisive evidence in relation to the charge.
The panel also took into consideration that the evidence included a significant piece of evidence which was multiple hearsay. The panel also concluded that there was not a

satisfactory explanation for the absence of the two witnesses who featured in Ms 1's evidence.

Taking those matters into account, the panel concluded that it would not be fair to you to admit Ms 1's local witness statement. Having determined that it would not be fair to admit Ms 1's witness statement into evidence, the panel decided to reject this application.

Decision and reasons on application to admit hearsay evidence of Witness 7

The panel heard an application made by Ms Mistry under Rule 31(1) to admit the witness statement of Witness 7 into evidence. She submitted that Witness 7 provided evidence in relation to charges 3, 4, 5 and 6.

Ms Mistry submitted that Witness 7's evidence was not the sole and decisive evidence in support of these charges. She submitted that both Witness 3 and 5 present evidence in respect of the same charges. Ms Mistry submitted that there is no reason for Witness 7 to fabricate her allegations against you.

Ms Mistry appreciated the adverse findings on your career and the impact on your career. However, she submitted that the evidence that Witness 7 gives in her witness statement relates to serious allegations being made.

Ms Mistry submitted that the NMC have made significant efforts through numerous voicemails and emails over the last week and before to try and get her to attend. She invited the panel to accept the hearsay application of Witness 7.

You submitted that Witness 7's statement is the sole and decisive evidence in this regard. You submitted that Witness 3 and 5 both confirmed this in their cross examination and that the only reason they both believed Patient A was still due medication was because this was something that was told to them directly by Witness 7.

You submitted that Witness 7's statement is not a reliable source of evidence, as other staff's testimonies showed the clinical documentation that was recorded at the time of the event, which greatly differed from what had been alleged within their statements. You referenced 'Exhibit TM/25' where Witness 7 described the patient as 'settled and sleeping' and therefore contradicts what was written in their statement.

You said that although Witness 7 made claims that you had not given this medication, she had completed a fluid balance chart using the information from any clinical records which would have been documented.

You said that if Witness 7 was in attendance, then you would have had the opportunity to cross examine her and challenge her on the timings of the two patients in question. Also, it was your case that you had a conversation with Witness 7 during the night shift, when you agreed to take over care of Patient A from her so that you could administer medication and a PEG feed to him and unless Witness 7 was called to give oral evidence you would not be able to put this case to the witness.

The panel heard and accepted the advice of the legal assessor, which he gave both orally and in writing. In his advice, he drew a distinction between Witness 7's evidence in relation to Patient A and Witness 7's evidence in relation to Patient B. In relation to Patient A, the legal assessor advised that Witness 7's evidence was decisive, as without that evidence the NMC could not establish continuity of evidence in the sense of there being witnesses who gave first hand evidence that you had not administered either medication or PEG feed to Patient A at any time during the night shift. However, in relation to Patient B, Witness 7's evidence was not decisive because it was corroborated by the evidence of Witnesses 3 and 5. Accordingly, the legal assessor recommended that the panel should admit the witness statement of Witness 7 but only insofar as it referred to Patient B and to Charge 6 of the Charges.

The panel considered the facts, the submissions and the relevant case law with care.

The panel gave careful regard to the application in relation to the statement of Witness 7. This evidence goes to the charges and that there is no suggestion of fabrication or inconsistencies in the evidence of Witness 7.

The panel next considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 7 to that of a written statement and exhibits and it decided that you would be disadvantaged as you would be unable to put your case to Witness 7 in cross examination.

The panel decided to admit the evidence relating to Patient B (in relation to charge 6) and not the evidence relating to Patient A. The panel decided that the charge talks about how Schedule 1 comes into question (in relation to charge 7). The panel determined it would exclude the evidence of Witness 7 when in relation to Patient A and admit the evidence when in relation to Patient B. The panel considered that in respect of the controlled drug required for Patient B, the absence of any record of the drug being administered by you and the counter signatures required in each case provided support for this hearsay evidence.

In these circumstances, the panel was of the view that it would be fair and relevant to admit into evidence the written statement Witness 7 but only insofar as it related to Patient B, as advised by the legal assessor.

Decision and reasons on application of no case to answer

In accordance with Rule 24(7) of the Rules, at the close of the NMC case, the panel heard submissions, both on your application and of its own volition as to whether you had a case to answer in relation to some of the charges. The submissions related to all of the charges, apart from charges 2, 6 and 9 to 11.

As regards charge 1, you denied that you had told Witness 1 that you had updated Patient A's care plan. In support of your submission on this charge, you relied on an answer

Witness 1 had given in cross examination when she admitted she could not remember whether you had told her that you could not produce the updated care plan, but that answer related specifically to a conversation between them on 23 March 2023 and did not amount to a denial by you that you had completed the care plan. The panel identified a passage in Witness 1's evidence in which she clearly stated that you had told her that you had done it. Further, Witness 1 repeated the allegation that you told her that you had completed the care plan at the investigation meeting held on 29 March 2023, so Witness 1 stood by her evidence on this issue and there was therefore a case to answer.

In relation to charges 3 to 5, having refused to admit the hearsay evidence of Witness 7 as to what she had observed during the night shift of 15/16 March 2019, as one of the three carers who were looking after Patient A on a 1:1 basis throughout the night, the panel accepted the advice of the legal assessor that there was a break in the continuity of the evidence as to whether you had administered medication and a PEG feed to Patient A at some point during the night. This meant that it could not be proved, on a balance of probabilities, that you had not carried out these tasks, so there was no case to answer in respect of these three charges. An additional difficulty for the NMC in relation to charge 5 was that the PEG feeds were a daytime task, not a task for the night shift according to Patient A's MAR sheet, apart from the 7am PEG fee in relation to which there was evidence that this PEG feed was often performed by the day shift.

In relation to charges 7 and 8, the panel accepted the advice of the legal assessor that, on the evidence of the NMC's own witness, Witness 1 stated, in paragraph 31 of her witness statement, there were two possible explanations for the fact that medication was recorded as having been administered to different residents at the same time by you. One explanation being that the medication had not been administered and that you had falsely recorded that it had been. But, the other explanation being that you had pre-potted the medication at the same time and had in fact then administered it. Witness 1 did not suggest that she was able to exclude the second explanation as possibly the true one, or even to contend that it was less likely than the first explanation to be true, so you had no case to answer in respect of charges 7 and 8.

In relation to charge 12, you contended that you were unaware that Witness 6 had to be supervised for the administration of a PEG feed for Patient A on 25 March 2019, so you were not guilty of a failure to supervise him because you did not know that it was your duty to do so. However, Ms Mistry submitted that you ought to have been aware of the requirement for a carer to be supervised three times administering a PEG feed successfully before the carer was allowed to carry out the procedure without supervision.

The panel accepted the NMC's submission on this charge and in addition it noted that you recorded this PEG feed as having been administered by you and not by Witness 6, which the panel concluded was further evidence that you were aware of the fact that you should have supervised Witness 6 in respect of this PEG feed. Therefore, the panel found that you have a case to answer on charge 12.

Finally, in respect of charges 14, 15, and 16, the panel having refused the NMC's application for permission to rely on the evidence of Ms 1, determined that there is no direct evidence in support of these charges and therefore you have no case to answer.

In reaching its decision, the panel made an initial assessment of all the evidence that was been presented to it by the NMC at this stage. The panel appreciated that its consideration was directed to considering solely whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel was of the view that, taking account of all the evidence before it that has been adduced by the NMC, there was not a realistic prospect that it could find the facts in relation charges 3, 4, 5, 7a, 7b, 8, 14, 15 and 16 proved and accordingly finds that there is no case to answer in respect of these charges.

Decision and reasons on facts

At the outset of the hearing, the panel heard from you who informed the panel that you made full admissions to charge 7c and to charge 12(b), the latter admission on the basis that you should have recorded the fact that you had delegated the actual administration of the PEG feed to someone else.

The panel therefore finds charge 7c proved in its entirety and charge 12(b) proved, by way of your admissions.

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

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

- Witness 1: Healthcare Assistant at Gateshead Health NHS Foundation Trust
- Witness 2: Occupational Health Nurse at AkzoNobel
- Witness 3: Healthcare Assistant for South Tyneside and Sunderland NHS Foundation Trust

- Witness 4: Care Assistant at Garden Hill Nurse Home
- Witness 5: Care Assistant at Garden Hill Nursing Home
- Witness 6: Senior Care Assistant at Garden Hill Nursing Home

The panel also heard evidence from you under affirmation.

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

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

Charge 1(a)

1) Between Feb 2019 and March 2019
   (a) Failed to update Patient A's care plan

This charge is found not proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1, alongside all of the documentary evidence put before it, and also your own oral and written evidence, including your email evidence of 14 July 2025 which you submitted as your evidence in chief at the hearing (Exhibit LC/01).

The panel took into account Witness 1's oral evidence where she stated that you had a duty to update Patient A's care plan as a nurse looking after Patient A and also being in

charge to that extent. The panel noted that Witness 1 was the manager at the time, that she had clearly asked you to update Patient A's care plan and you do not dispute that you agreed to do so. You also do not dispute that you did not in fact update Patient A's care plan.

The panel accepted the advice of the legal assessor that, in order to find that you failed to update Patient A's care plan, the panel must be satisfied that not only did you not update the care plan but that you were in breach of a legal or professional duty to carry out that task.

In this case, the obvious source of that duty was the request from Witness 1, who was the Home Manager and your own line manager, to carry out a task that was within your normal range of duties and no doubt also within your job description. However, the evidence of Witness 1 is that she asked you to complete the care plan within a week but that, because she knew the care plan would be complex in Patient A's case, she told you that if you needed more time to complete it '*this wouldn't be a problem'.*

It is unclear from Witness 1's evidence exactly when this conversation took place but, as Witness 1 states that you told her that you had completed the care plan 'the following Friday' which could not have been the same day as the investigatory meeting, which was held on 29 March 2019, which was also a Friday, it seems likely that the first discussion about the care plan took place between Friday 15 March and Friday 22 March 2019, but whatever the exact date, the panel was satisfied that not enough time had elapsed for the conclusion to be drawn that you had failed to complete Patient A's care plan.

Accordingly, the panel finds Charge 1(a) not proved.

Charge 1(b)

1)Between Feb 2019 and March 2019

(b) Incorrectly stated to Person A that you had updated Patient A's care plan when you had not

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1, alongside all of the documentary evidence put before it and your own oral and written evidence.

The panel took into account the 'Minutes of Investigatory Meeting' dated 29 March 2019 which took place between you and Witness 1. It stated (in part):

> *"[Witness 1]: Lee this is an investigatory meeting, we had a meeting last Wednesday and I said at that time to draw a line under things and start again. Nothings changed. You told me Patient A's care plan was completed, and it wasn't, I found out when I asked [PRIVATE] to check it over, and she said it was nowhere near being completed.*
>
> *LC: Staffing is a big part of why it has not been done.*
> *…*
> *[Mr 1's] Pnt a's care plan you said you done and you hadn't*
> *…*
> *LC: I'm trying to put things right as I find them. I've only been here 5 weeks and still don't know all the residents. We have none of our night shift nurses left and don't feel you get supported."*

The panel also considered exhibits "TM/6" and "TM/27".

The panel also took into account the written statement of Witness 1 where she stated:

> *"Another issue I experienced with Lee whilst he was working with us involved his completion of care plans. At Garden Hill, the Care Practitioner and Registered Nurse complete the clinical sections of each of the residents' care plans. They also*

ensure that all the documentation relating to medication is up-to-date. At a minimum, every resident should have each of their care plans reviewed and updated every 4 weeks

...

The following Friday, I asked Lee how he was getting on with the care plan. I asked if he needed any help or input from me and Lee told me that he had completed the care plan."

The panel found that Witness 1 was a credible witness in relation to this charge as her oral evidence from the meeting in 2019 corroborated the information that was provided.

Your evidence, both in your email statement dated 14 July 2025 that was your evidence in chief at the hearing and in your oral evidence, is that you at no time told Witness 1 that you had completed Patient A's care plan and that you had in fact repeatedly told her that you had been unable to do so because of understaffing issues which meant that you did not have time to attend to the task of updating Patient A's care plan.

In support of your version of events, you rely on the non-verbatim minutes of the investigatory meeting held on 29 March 2019, where you were recorded as saying that staffing was *'a big part of why it has not been done'*. However, you made this comment in response to Witness 1's opening statement at the meeting in which she stated that you had told her that Patient A's care plan had been completed but that she had found out that this was untrue when she asked another member of staff to check the care plan. The panel found it significant that you did not dispute Witness 1's claim that you had wrongly told her that you had completed the care plan but instead gave an explanation for not having done so, which did not answer the point that you had made an earlier untrue statement to Witness 1. Later in the meeting Mr 1 repeated the allegation that you said you had done Patient A's care plan when in fact you had not done so and again you did not dispute this allegation.

The panel determined that Witness 1's evidence in relation to this charge was credible and it does not accept your version of events. The panel did not agree that the minutes of the investigatory meeting assist your case, because Witness 1 raised the issue of your untrue statement about Patient A's care plan at the start of the meeting on the basis that it was, in her mind, one of the most important issues to be discussed and it was raised again later in the meeting by Mr 1 but you at no point disputed that you had made this false statement to Witness 1.

The panel therefore found charge 1(b) proved.

Charge 2

2. Your conduct at Charge 1(b) was dishonest because you made this statement to Person A in order to conceal that you had not updated Patient A's care plan.

This charge is found proved.

In relation to Charge 2, the panel finds that you made the false statement that you had updated Patient A's care plan in order to conceal from Witness 1 that you had not done so. The panel accepted the advice of the legal assessor that, in order to find that your conduct was dishonest, it has to consider whether your conduct in this regard would be considered dishonest by ordinary decent people, and the panel is satisfied that it would be so regarded by ordinary decent people. Therefore, the panel finds charge 2 proved.

Charge 6

6. During a nightshift on 15 and 16 March 2019 failed to administer morphine sulfate to Patient B when they required it.

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Witnesses 3 and 7, alongside all of the documentary evidence put before it and also your own oral and written evidence.

The panel took into account exhibit 'TM/17' where it stated:

> *"[Witness 3] (care assistant) wrote on 15 March 2019 23:20…Patient B in bed comfortable."*

The panel considered the care notes in exhibit 'TM/18' which stated the various time stamps written by Witness 7, alongside 6 entries from that night shift none of which stated that Patient B was in pain. The panel also noted that Witness 7 in her witness statement, stated:

> *"I don't think Lee administered any medication at all during the night (15 / 16 March 2019). I didn't personally see him giving any of the residents their medication."*

The panel took into account exhibit 'TM/18' and where it indicated that you had never administered morphine sulfate before to Patient B that month. The panel also took into account that this was later passed onto another nurse the next day and was confirmed in Witness 3's oral evidence.

The panel noted that this was confirmed by Witnesses 3 and 5 when cross examined in their oral evidence. The panel took into account that no morphine sulfate was given to Patient B until late in the evening of the following day. The panel noted that none of the care notes written by the witnesses suggested that Patient B was in need of the medication and no reference to Witness 7's account was made in the other witness' oral evidence.

Your evidence was that you were never made aware that Patient B was in need of morphine sulfate during the course of this shift.

The panel concluded that there was insufficient evidence to suggest that Patient B required the medication and that you did not therefore fail to provide it during this shift.

The panel therefore found this charge NOT proved.

Charge 9(a)

9. Between 23 and 24 March 2019
(a) failed to administer Patient A's prescribed medications

This charge is found proved.

In reaching this decision, the panel took into account the written evidence of Witness 4 and 7, alongside all of the documentary evidence put before it and also your own oral and written evidence.

The panel also took into account Witness 4's written statement where she stated:

> *"I recall another incident which occurred on either 23 or 24 March 2019. That day, I was working a day shift (07:30am to 07:30pm) and Lee was working the same shift. At 01:30pm, I took over 1:1 care for Patient A's. On dayshift, 1:1 care is carried out in 6 hour shifts so I was allocated the 1:1 between 01:30pm and 07:30pm. I recall sitting in Patient A's room when Lee popped his head around the door and said he was running late with the medication round. Lee said he would be back as soon as he could. Lee did not administer Patient A's medication at that time and he did not return to Patient A's room whilst I was there that day."*

Witness 4 gave a similar account of the incident in her local statement, which she made on 28 March 2019 and in which she added that it was about 5.30pm when you entered Patient A's room and said that you were running late and would be back to administer Patient A's medication but that you never did so.

The panel considered very carefully your account of this incident in which you deny that Witness 4 was undertaking the 1:1 care of Patient A during the day shift in question and maintain that this was being done by an agency nurse on your insistence. You also relied on a note of a telephone conversation which took place on 2 November 2019, between the NMC case officer and Ms 2, who was the clinical standards inspector for the owners of the Home and who investigated the allegations made against you in March 2019.

It is your case that you did administer Patient A's medications to him on the shift in question and that you correctly recorded that administration on Patient A's MAR sheet. However, the panel noted that, although Ms 2's evidence supports your account the document refers to no date insofar as she states that Patient A was being cared for by an agency carer not by Witness 4 (there is no date given but a time stated from 16:00 onwards). According to Ms 2, the agency carer reported that you did not enter Patient A's room at all during the medication round and that as a result Patient A did not receive his medication during that shift. In other words, this evidence on which you rely does not in fact support your case on important matters but supports the NMC.

The panel took into account that when other witnesses were cross examined about the incident on 23/24 March 2019, they all stated that this was a topic of discussion amongst the staff and was alarming enough to be reported to management. The panel noted that other staff encouraged Witness 4 to report this to the manager, who then asked her to make a statement within a few days of the events.

The panel accepted the contemporaneous evidence of Witness 4 as the local statement was created nearer the time as well as Witness 4 having full recollection of this in her oral evidence. The panel decided that there was sufficient evidence to prove that you failed to administer Patient A's prescribed medications.

The panel therefore found this charge proved.

Charge 9(b)

9. Between 23 and 24 March 2019

(b) failed to administer Patient A's PEG feed

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 4, alongside all of the documentary evidence put before it.

The panel took into account Witness 4's written statement where she stated:

> *"I believe Patient A would have been due a PEG feed about 07:00pm. I was still carrying out the 1:1 at that time and Lee did not return to Patient A's room at all. Accordingly, Patient A received neither his medication nor his PEG feed that night…. It is normally recorded on the computer system what time Patient A's PEG feed is administered so I would expect his records to show if Lee did administer his feed that evening."*

However, in her oral evidence, Witness 4 resiled somewhat from her written account as she said that the feed was administered to Patient A, but she was not sure whether she gave it or that it was given by you.

The panel decided that on the balance of probabilities, there was evidence to prove that the feed was given to Patient A.

The panel therefore found this charge NOT proved.

Charge 9(c)

9. Between 23 and 24 March 2019

(c) incorrectly recorded on Patient A's medication records that you had administered prescribed medication of:

(i) Calogen extra shots
(ii) Clonazepam
(iii) Haloperidol
(iv) Lorazepam
(v) Paracetemol
(vi) Tegretol
(vii) Tetrabenazine

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 4, alongside all of the documentary evidence put before it and your oral and written evidence.

The panel took into account Witness 4's written statement where she stated:

> *"I recall another incident which occurred on either 23 or 24 March 2019. That day, I was working a day shift (07:30am to 07:30pm) and Lee was working the same shift. At 01:30pm, I took over 1:1 care for Patient A's. On dayshift, 1:1 care is carried out in 6 hour shifts so I was allocated the 1:1 between 01:30pm and 07:30pm. I recall sitting in Patient A's room when Lee popped his head around the door and said he was running late with the medication round. Lee said he would be back as soon as he could. Lee did not administer Patient A's medication at that time and he did not return to Patient A's room whilst I was there that day."*

The panel took into account that there were entries on the MAR chart for 23 or 24 March 2019 which indicated that you had administered medication.

The panel decided that there was sufficient evidence to prove that you had incorrectly recorded on Patient A's medication records that you had administered a number of prescribed medications.

The panel therefore found this charge proved.

Charge 9(d)

9. Between 23 and 24 March 2019
    (d) incorrectly recorded that you had administered Patient A's PEG feed

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 4 that the feed was given although she was not sure whether it was given by her or by you. Accordingly, it was not proved that the record was incorrect.

The panel therefore found this charge NOT proved.

Charge 10

10. Your conduct at one or more of Charges 9(c)((i) – (vii) was dishonest in that:
    (a) you knew that you had not administered Patient A's medications
    (b) you intended that someone reading Patient A's medication records would believe that you had administered the medication.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence presented in relation to charges 9(c)(i) - (vii).

The panel decided that there was sufficient evidence to prove that you knew that you had not administered Patient A's medications and that you intended that someone reading Patient A's medication records would believe that you had administered the medication. The panel then asked itself whether your conduct in this respect would be regarded as dishonest by ordinary decent people and concluded that it would be so regarded.

The panel determined that you were dishonest in relation to this charge.

The panel therefore found this charge proved.

Charges 11(a) and (b)

11. Your conduct at Charge 9 (d) was dishonest in that:
    (a) you knew that you had not administered Patient A's PEG feed
    (b) you intended that someone reading Patient A's medication records would believe that you had administered the PEG feed.

These charges are found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Witness 4, that the feed was given to Patient A and that she was not sure whether it was given by her or by you. Accordingly, the evidence did not prove that the entry recorded in relation to the feed was incorrect.

In those circumstances, the issue of dishonesty did not arise

The panel therefore found this charge not proved.

Charge 12

12. On 25 March 2019 knowing that Person B was not fully trained to administer PEG feeds:

(a) failed to supervise Person B when they administered Patient A's PEG feed

(b) incorrectly recorded on Patient A's MAR chart that you administered Patient A's PEG feed

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 and 6, alongside all of the documentary evidence put before it and your own oral and written evidence.

The panel took into account Witness 5's written statement where he stated:

> *"I was setting up the equipment and the feed for Patient A when Lee came into Patient A's room. Lee said he didn't need to supervise me as he'd observed me completing the procedure the day before. Lee told me he'd sign me off as competent. As he was talking, Lee's phone began to ring and he walked off. This was only the second time I had completed a PEG feed at Garden Hill, and I had not had my competencies signed off. Consequently, I should not have been left unsupervised."*

The panel took into account that there is clear evidence and no dispute that Witness 6 was observed by you administering the feed to Patient A the day before. On the day of question had come in the room to observe him and Witness 6 was expecting to be observed by you, but you did not in fact remain in order to observe him.

The panel also took into account Witness 1's local statement, which supported Witness 6's statement that you did not supervise Witness 6 when required to do so. This was further clarified by Witness 6 in his oral evidence that he needed to be supervised as he was not fully trained at the time.

You said in evidence that you did not know that Witness 6 required supervision on three occasions before he could carry out the feed unsupervised.

However, the panel concluded that on the balance of probabilities, you did know that Witness 6 was not fully trained and required supervision. The panel took into account in that regard the evidence that you and Witness 6 discussed the issue of his supervision at the time. Moreover, there was evidence that you had come to him in order to observe him. The panel concluded that you left because your phone rang and you did not then return to supervise him. Witness 6 in his oral evidence and written statement clearly expressed his anxiety when considering carrying out the feed alone being unsupervised. He considered that he himself was insufficiently trained or observed to do it on his own. This was of such concern to Witness 6 that he approached the Home Manager (Witness 1) to report this and made a local statement on the same day, 25 March 2019.

In his local statement, made on the day of the incident, Witness 6 confirmed that you came into Patient A's room to observe him carrying out the PEG feed but that you then left the room leaving Witness 6 unsupervised when your phone rang.

The panel also took into account that you incorrectly recorded on Patient A's MAR chart that it was you who had administered Patient A's PEG feed when you were clearly aware that it was Witness 6 who had done it without supervision and you made no mention of this on the record.

The panel applied weight to Witness 6's evidence and found that there was sufficient evidence to prove that you failed to supervise Witness 6 knowing that Witness 6 was not fully trained to administer PEG feeds.

The panel therefore found this charge proved.

Charge 13

13. Your conduct at Charge 12(b) was dishonest in that:
    (a) you knew that Person B had administered the PEG feed unsupervised
    (b) you intended that someone reading Patient A's medication records would believe that you had administered the PEG feed.

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 6 and you, alongside all of the documentary evidence put before it and your own oral and written evidence.

The panel took into account your explanation of the usual practice at the Home where you explained that Witness 6 carried out the feed and then you signed for him as he would not have access to the computer, but that you would normally make it clear by adding a supplementary note in the patient's MAR chart that the signature was that of the supervisor and not that of the care assistant who had actually carried out the task.

The panel noted that you accepted that this was what you understood to be the practice and that you did not complete this on the day as you were distressed following a personal phone call. The panel also noted that you admitted that you had incorrectly recorded on Patient A's MAR chart that you had administered Patient A's PEG feed.

The panel rejected and concluded the explanation you provided and concluded that you signed the MAR chart in your own name as you knew that Witness 6 was not fully trained, that he needed to be supervised and that he had actually not been supervised. Also, as a care assistant, he did not have access to the electronic records of the Home so he could not record the PEG feed in his own name. The panel was also satisfied that you intended that someone reading Patient A's medication records would believe that you, and not Witness 7, had administered Patient A's PEG feed.

Having made these findings of fact, the panel went on to consider whether your actions in this regard would be considered dishonest by the standards of ordinary decent people, and it concluded that they would be regarded as dishonest by such people.

Accordingly, the panel found Charge 13 proved.

Interim order

The NMC made an application for an interim order. The panel considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interest.

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

Submissions on interim order

The panel took account of the submissions made by Ms Mistry. She submitted that an interim suspension order is required in this case on the grounds of public protection and otherwise in the public interest. Ms Mistry submitted that having found that some of the charges relating to dishonesty has been found proved, there is now a risk associated with you being able to practise without any restrictions.

Ms Mistry submitted that the codes 1.2, 8.2, 8.3, 8.6, 10.3, 10.4, 11.1, 11.2, 11.3, and 18.4, 20.1, 20.1, 20.2, 20.3, 20.4, 20.5, and 21 are engaged. She submitted that there is an attitudinal concern that may be continued in the future if you were allowed to practice without any restrictions.

You opposed the submissions from Ms Mistry. You said that an interim order was not required. You submitted that you have had an unblemished career with no concerns with your practice for the last six and a half years.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel took into account the positive and excellent character references that were provided by your employer and colleagues, in particular Dr 1, Chief Medical Officer of your current employer. The panel took into account that you had left your previous role and are now working in an environment that does not always require an NMC PIN. The panel noted that you are a nurse who has worked with an unblemished career for the past six and a half years without any restrictions. The panel also noted that your current references state that in your current employment you have shown yourself to be a person of integrity.

The panel considered that there was minimal risk to the public and therefore there are no public protection grounds for imposing an interim order. In those circumstances it would be rare to impose an interim order on public interest grounds alone. The panel therefore decided that it would not be necessary or proportionate to impose an interim order.
The panel decided that an interim order was not required.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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, your fitness to practise is currently impaired as a result of that misconduct.

Evidence on misconduct

Following the resumption of the hearing, the panel proceeded to hear evidence called on your behalf. You indicated that you did not intend to give evidence yourself but instead relied on witness evidence addressing your current practice, insight and remediation since the events giving rise to the charges.

The panel first heard from Witness 8, a Specialist Occupational Health Nurse with BP North Sea. Witness 8 gave evidence under affirmation. She explained that she has responsibility for oversight of the contracted offshore medical services, including ensuring that appropriate clinical governance systems are in place and that offshore medics are suitably qualified, trained and supported. She told the panel that she has regular oversight of clinical practice, including reviewing consultation records and monitoring standards across the service.

Witness 8 confirmed that she has known you since 2021 and has had ongoing professional oversight of your work since you became an offshore medic working within the BP contract. She explained that the offshore medic role is a highly autonomous position, where the medic is the sole clinical practitioner on the asset and is responsible for delivering primary and emergency care to a large offshore population, as well as undertaking additional occupational health and industrial hygiene duties.

In her evidence, Witness 8 stated that she has had no concerns regarding your clinical competence or practice at any time. She described the level of responsibility placed on offshore medics as significant and emphasised that a high level of trust is required, given the remote nature of the role and the absence of immediate supervision. She told the panel that she sets a high standard for those working in such roles and would not tolerate poor performance. She explained that where concerns arise in relation to offshore medics, action is taken, including removal from post if necessary.

Witness 8 told the panel that she has received consistently positive feedback regarding your practice from offshore personnel and that she has not received any complaints or concerns from patients or colleagues. She confirmed that she has visibility of your clinical consultations and has not identified any issues of concern. She also confirmed that you have been open and transparent with her regarding these proceedings from the outset and that she has had no concerns regarding your honesty or integrity. She further told the panel that she acted as a registered nurse and a confirmer for your revalidation and that during that process you had discussed and reflected on this case.

Witness 8 further explained that the offshore medic role extends beyond clinical care and includes responsibilities relating to occupational health and industrial hygiene, such as monitoring environmental risks and contributing to the prevention of ill health. She confirmed that you have undertaken these responsibilities appropriately and that there have been no concerns regarding your performance in these areas. She also confirmed that you have undertaken additional training relevant to the role. She further stated that you had been commended for your treatment and care a recent cardiac patient who needed an emergency treatment and extraction.

The panel then heard from Witness 9, Chief Medical Officer at TAC Healthcare and your employer. Witness 9 gave evidence under affirmation. He explained that he has had regular professional contact with you over a number of years, including reviewing your clinical consultations and maintaining frequent communication whilst you are offshore. He

described the offshore medic role as one involving sole clinical responsibility for a large number of individuals in a remote and challenging environment, requiring a high degree of competence, independence and professionalism.

Witness 9 told the panel that he has had no concerns regarding your clinical practice, honesty or integrity at any time. He explained that your work is subject to regular audit and scrutiny as part of the organisation's clinical governance processes, and that no concerns have been identified through those processes. He further stated that you are held in high regard by colleagues and that feedback regarding your performance has been consistently positive.

Witness 9 confirmed that you had disclosed these proceedings to your employer at an early stage and that you have been open about them. He also confirmed that, despite knowledge of these proceedings, there have been no restrictions placed on your practice.

Witness 9 provided an example of a recent complex cardiac case which you managed offshore in difficult circumstances, including adverse weather conditions which impacted evacuation. He explained that the case required a high level of clinical decision-making and coordination, and that your management of the situation was of such a standard that a recognition award was requested by the client. He described this as evidence of your competence and professionalism in practice.

Submissions on misconduct

Following the conclusion of the evidence, Ms Wisniewska made submissions on behalf of the NMC.

Ms Wisniewska reminded the panel that it is an experienced panel and would be familiar with the *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2015) (the Code), which sets out the professional standards of practice and behaviour expected of registrants. She submitted that the principles and

values within the Code are not negotiable, and that where a registrant falls short of those standards, such conduct may amount to serious professional misconduct.

Ms Wisniewska referred the panel to Article 22 of the Nursing and Midwifery Order 2001 and submitted that misconduct is one of the statutory grounds upon which a finding of impairment may be based. She reminded the panel that at this stage there is no burden or standard of proof and that the decision is a matter of the panel's own professional judgment.

In relation to misconduct, Ms Wisniewska referred the panel to the case of *Roylance v General Medical Council (No.2)* [2001], submitting that misconduct involves an act or omission which falls short of what would be proper in the circumstances. She further referred to *Nandi v GMC* [2004] EWHC 2317 (Admin), submitting that the conduct must be serious and that seriousness should be given proper weight.

Ms Wisniewska submitted that the panel must consider when poor practice, measured against the standards set out in the Code, becomes serious professional misconduct. She submitted that this case involved conduct which went beyond mere error and amounted to serious professional misconduct.

Ms Wisniewska then took the panel through the charges found proved and submitted that each of those charges represented breaches of the Code. She submitted that you failed to deliver fundamental aspects of care, failed to administer medication appropriately, failed to maintain accurate records, and failed to supervise appropriately. She submitted that these failings created a risk of harm to patients.

Ms Wisniewska further submitted that there were three findings of dishonesty, namely charges 2, 10 and 13. She submitted that dishonesty is a serious concern and demonstrates an attitudinal failing.

Ms Wisniewska submitted that, taken together, the conduct found proved demonstrated breaches of the fundamental tenets of the profession, namely prioritising people, practising effectively, preserving safety, and promoting professionalism and trust.

Ms Wisniewska invited the panel to find that your conduct, both individually and cumulatively, amounted to serious professional misconduct.

Your submissions

At the outset, you acknowledged that although you had denied some of the charges at the earlier stage of the hearing, facts had now been found proved against you. You said that this was the position reached by the panel and that you had since had approximately eight months to reflect on those findings. You stated that you were able to address the panel to the best of your ability, noting that you were not represented.

You acknowledged the breaches of the Code identified by the NMC and said that you understood the impact those breaches had on your ability to remain a professional registered nurse. You also stated that you understood how the public would perceive the facts found proved against you. You acknowledged the impact of those matters on patient safety and offered an apology for your failings.

You told the panel that you had made early admissions to some of the charges and that you had fully engaged with the process throughout. You submitted that the events found proved represented an isolated period in your career. You explained that you had worked in healthcare for 22 years, initially as a medic in the British Army, then as a registered nurse, and currently as an offshore medic. You stated that the only concerns ever raised about your practice arose during a three-week period of employment at the care home to which these proceedings relate.

You said that there had been contextual factors at play during that period, which you had sought to explain at the earlier hearing. You stated that you did not rely on those factors

as an excuse or seek to deflect responsibility for your own actions, and that you had been open and honest about your failings. You reiterated that you had made early admissions to some of the charges.

You told the panel that you had revalidated three times since the events in question and submitted that you continue to use those events as a source of reflection to shape your current practice. You addressed the submission made by Ms Wisniewska that you had a deep-seated attitudinal problem and stated that the incidents had occurred approximately 2,555 days ago, around seven years previously. You said that during that period you had worked without restriction on your practice, including during the COVID-19 pandemic, in accident and emergency departments, on medical wards, and as a sole practitioner offshore.

You submitted that throughout that time you had received positive feedback and commendations in respect of your practice. You acknowledged that you made poor clinical decisions during the period in question and accepted that those decisions resulted in breaches of the Code and had an impact on patient care. You stated that you did not seek to deny that.

You also submitted that during that period you had demonstrated aspects of good practice, including advocating for patient safety, raising safeguarding concerns, and raising concerns about the standard of care within the care home. You said that despite this, you accepted that your practice fell short during that time and acknowledged the impact that had on public confidence.

You stated that you continue to reflect on the events and use them to inform your current practice. You referred the panel to the evidence of your witnesses and to your current role as a sole practitioner working in a remote offshore environment. You described managing a recent cardiac emergency on an offshore asset in challenging conditions, including adverse weather and distance from land, and explained that you took further steps to

ensure the patient received appropriate follow-up care even after they had left your immediate responsibility.

You told the panel that you have worked for seven years without restriction and that no concerns have been raised about your practice during that time. You submitted that all concerns relating to your practice arise solely from the three-week period in question. You questioned how, in light of your subsequent practice, it could be said that you present a current risk or that you have a deep-seated attitudinal problem.

You stated that you have undertaken further training, including retraining as an offshore medic, which you described as a demanding course covering areas such as documentation and medication management. You said that you completed that course within the top ten percent of the cohort and that you have since completed refresher training on multiple occasions. You submitted that you have taken all steps available to you to strengthen your practice and have remained fully engaged throughout.

You acknowledged again that the failings found proved had the potential to place patients at risk and stated that you were grateful that no harm had ultimately occurred. You also raised concerns about the length of the proceedings, noting that they had taken seven years, and referred to difficulties you had experienced in accessing certain information and recalling details during the process.

You concluded by stating that you are not the same nurse you were seven years ago and that you believe you have demonstrated insight, remediation and safe practice over a sustained period.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance* and *CHRE v NMC and Grant* [2011] EWHC 927 (Admin).

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

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

> *'**1 Treat people as individuals and uphold their dignity To achieve this, you must:***
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***8 Work co-operatively To achieve this, you must:***
> *8.2 maintain effective communication with colleagues*
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
> *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***
> *10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.'*
>
> ***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.***
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***

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

20.2 act with honesty and integrity at all times.'

The panel considered the charges found proved, namely charges 1b, 2, 7c, 9a, 9c, 10, 12a, 12b and 13, and the extent to which those charges demonstrated departures from the standards expected of a registered nurse.

In relation to charge 1b, the panel considered that your actions demonstrated a failure to communicate effectively and work cooperatively with colleagues, which had the potential to impact patient safety.

In relation to charges 7c, 9a and 9c, the panel considered that your actions involved failures in medication administration and record keeping. The panel noted that you failed to administer prescribed medication and inaccurately recorded that medication had been administered. The panel considered that such conduct had the potential to place patients at risk of harm.

In relation to charges 12a and 12b, the panel considered that your actions involved a failure to appropriately supervise a colleague and an inaccurate recording of a peg feed. The panel considered that this created a risk of harm and demonstrated a failure to uphold safe standards of practice.

In relation to charges 2, 10 and 13, the panel gave particular weight to the findings of dishonesty. The panel considered that recording information which was not accurate, particularly in clinical records, had the potential to mislead other healthcare professionals and place patients at risk of harm.

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 your conduct involved serious failings in fundamental areas of nursing practice, including medication administration, record keeping, supervision and honesty. The panel further noted that the patient involved was vulnerable and required a high level of care.

The panel considered your conduct both individually and cumulatively. It concluded that the repeated nature of the failings, together with the findings of dishonesty in a clinical context, represented a serious departure from the standards expected of a registered nurse.

The panel found that your actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

The panel noted that both witnesses had direct and ongoing professional oversight of your practice and that their evidence was consistent. The panel further noted that both witnesses described your role as highly autonomous and subject to ongoing scrutiny through clinical governance processes. Both witnesses confirmed that, over a sustained period since the events in question, you have practised safely and effectively and have demonstrated honesty and integrity in your professional role.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered each limb of this test. The panel found that your misconduct had in the past put a patient at risk of harm, in that you failed to administer prescribed medication and inaccurately recorded that it had been administered. The panel further found that your misconduct breached fundamental tenets of the profession, including the requirement to practise safely, maintain accurate records, and act with honesty and integrity. The panel also found that your conduct brought the profession into disrepute, particularly in light of the repeated findings of dishonesty in a clinical context.

In relation to dishonesty, the panel gave significant weight to the findings in charges 2, 10 and 13. The panel considered that these findings demonstrated that you had acted dishonestly and that this was serious, particularly as it related to clinical records and had the potential to mislead other healthcare professionals involved in patient care.

Regarding insight, the panel considered that you had engaged with the process and had made some admissions. The panel noted that you had demonstrated insight into aspects of your clinical failings, including the impact of your actions on patient safety. The panel also had regard to your submissions that you continue to reflect on these events and use them to inform your current practice.

The panel took into account the positive evidence of your current practice. In particular, the panel noted the evidence of Witness 8 and Witness 9, both of whom described you as a competent and trusted practitioner working in a highly autonomous role. The panel noted that you have worked without restriction for a significant period of time and that no concerns have been raised about your practice during that time. The panel accepted that you have demonstrated safe and effective practice over a sustained period.

The panel also considered the remediation you have undertaken, including further training and revalidation. The panel acknowledged your submissions that the conduct occurred during a limited period of your career and that you have since demonstrated improvement.

The panel nevertheless remained concerned about the findings of dishonesty. The panel considered that there was limited evidence of reflection specifically addressing the dishonest aspects of your conduct. The panel noted that dishonesty is inherently difficult to remediate and that this remained a significant concern.

The panel considered whether your fitness to practise is impaired on the grounds of public protection. The panel noted that this was a complex issue, particularly in light of the passage of time and the evidence of your subsequent good practice. The panel had regard to the positive evidence of your current practice and the absence of concerns over a sustained period.

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

The panel determined that a finding of impairment on public protection grounds is required in this case, given the seriousness of the misconduct, in particular the repeated dishonesty within a clinical context. This was not withstanding the clear and obvious progress that you had made in progressing during your career since these events have occurred. In the event the panel also found that a finding of impairment on public interest grounds will also be required on the grounds of the dishonesty found. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made.

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

Sanction

The panel considered this case very carefully and decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Ms Wisniewska reminded the panel that it had found that your actions fell significantly short of the conduct and standards expected of a nurse, amounted to misconduct, and breached the fundamental tenets of the profession. She submitted that the panel had also found your fitness to practise impaired on the grounds of both public protection and public interest.

Ms Wisniewska highlighted that the panel remained concerned about the findings of dishonesty and had identified limited evidence of reflection specifically addressing the dishonest aspects of your conduct. She submitted that dishonesty is inherently difficult to remediate and therefore remains an ongoing and significant concern.

Ms Wisniewska then invited the panel to consider the NMC Sanctions Guidance and to first identify the aggravating and mitigating factors.

In relation to aggravating factors, Ms Wisniewska submitted that there were three findings of dishonesty, and that this was not a single isolated incident but involved multiple instances. She further submitted that the panel had identified limited evidence of reflection

in respect of the dishonesty, and that this remained a concern. Finally, she submitted that your misconduct had placed patients at risk of harm.

In relation to mitigating factors, Ms Wisniewska submitted that the panel had taken into account that you had engaged with the process and made some admissions. She noted that the panel had found that you had demonstrated insight into aspects of your clinical failings, including the impact of your actions on patient safety. She also referred to your evidence that you continue to reflect on these events and use them to inform your current practice.

Ms Wisniewska further referred to the positive evidence regarding your current practice, including the evidence of Witness 8 and Witness 9, who described you as a competent and trusted practitioner working in a highly autonomous role. She also noted that the panel had taken into account the remediation you had undertaken, including further training and revalidation, and had acknowledged your position that the conduct occurred during a limited period of your career and that you had since demonstrated improvement.

Turning to sanction, Ms Wisniewska submitted that no further action would be inappropriate given the findings of misconduct and breaches of the Code. She submitted that a caution order would also be insufficient, as in the NMC's submission there remains a risk, particularly in relation to the dishonesty which had not been fully remediated, and that further action is required to protect the public and maintain confidence in the profession.

In relation to conditions of practice, Ms Wisniewska submitted that this would not be appropriate, as the concerns relate to dishonesty, which is attitudinal in nature and not something that can be addressed through conditions. She further submitted that conditions would not adequately address public interest concerns.

In relation to suspension, Ms Wisniewska submitted that this would also not be appropriate. She referred to the guidance which indicates that suspension may be

appropriate where there is no evidence of deep-seated attitudinal concerns or significant risk of repetition. However, she submitted that in this case the dishonesty remains unremediated and there is a risk of repetition, and therefore suspension would not be sufficient.

Ms Wisniewska submitted that the appropriate and proportionate sanction in this case is a striking-off order. She submitted that the dishonesty raises fundamental questions about your professionalism, that public confidence in the profession could not be maintained if you were not removed from the register, and that striking off is the only sanction sufficient to protect the public and maintain professional standards. She invited the panel to take a holistic view of the case and to conclude that striking off is the appropriate outcome.

Your submissions

You began by emphasising that the events in question occurred seven years ago, and that since that time no concerns have been raised about your practice. You stated that, over that period, you have received only positive feedback and commendations, and that this was supported by the evidence of the witnesses you had called.

You submitted that there is no evidence to suggest that you pose an ongoing risk. You referred to the fact that you have worked for a significant period without restriction, including in highly responsible and autonomous roles, and that no concerns have arisen during that time.

In relation to dishonesty, you stated that you understand the importance of honesty within the nursing profession and its status as a fundamental tenet of the Code. You said that you had made early admissions and that you have reflected on the matters found proved. However, you maintained your account of events and stated that you were not willing to say that you had been deliberately dishonest, notwithstanding the panel's findings.

You emphasised your professional background, including your service as a combat medic in the army and your work in challenging environments, including during the COVID-19 pandemic. You stated that your actions during this three-week period were not reflective of the type of nurse you are and that the conduct in question was not representative of your wider career.

You also referred to the circumstances at the time of the events, including the environment in which you were working, and stated that you had made poor clinical decisions under pressure. You acknowledged those failings but maintained that you had learned from them and had used them to inform your current practice.

You highlighted that the NMC had not imposed any restrictions on your practice throughout the investigation or following the findings, and that you had continued to practise safely during that time. You also referred to recent examples of your practice, including managing a serious medical emergency offshore, to demonstrate your competence and professionalism.

You submitted that you have done everything asked of you, have engaged fully with the process, and have demonstrated through your practice that you are not a risk to the public. You invited the panel to take into account the entirety of your career, your remediation, and the passage of time, and to conclude that the most severe sanction would not be appropriate.

Decision and reasons on sanction

Having found your 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:

- Three findings of dishonesty, which the panel considered amounted to a course of conduct.

The panel also took into account the following mitigating features:

- Engagement with the process.
- Developing insight
- Positive evidence of current practice over several years, including strong evidence from witnesses and testimonials.
- Continued safe practice without restriction.
- Remediation, including training and revalidation.
- The misconduct occurred during a three week period seven years ago.
- Challenging working environment at the time.

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 your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 your registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, workable and measurable. The panel determined that it would be possible to formulate appropriate and practical conditions to address the concerns identified in this case, particularly in relation to accurate record keeping and professional standards.

In reaching this decision, the panel had regard to the significant mitigating factors. In particular, the panel noted the length of time since the events, that you have practised without restriction for seven years, and the strong and consistent evidence of your current practice, including positive testimonials describing you as a competent and trusted practitioner. The panel were impressed by witnesses Witness 8 and Witness 9. The panel considered this evidence to be very significant. The panel also took into account that you have undertaken remediation, including training and revalidation, and have demonstrated improvement in your practice. It considered that the misconduct occurred during a limited period and was not reflective of your overall career. The panel accepted that you would be willing to comply with conditions of practice.

The panel considered whether a suspension order would be appropriate but concluded that this would be disproportionate. It noted that you have demonstrated safe and effective practice over a sustained period and that a suspension order would prevent you from practising despite the positive evidence of your current competence. The panel took into account that there was a risk you would lose your current employment in which you have served with distinction.

The panel then considered whether a striking-off order would be appropriate but concluded that it would be disproportionate bearing in mind the NMC guidance that such an order should not be imposed where there is an alternative sanction which is sufficient. The panel had regard to the significant mitigating factors, including the passage of time, your subsequent good practice, and the evidence that the misconduct was not

representative of your overall career. The panel considered that removing you from the register would not be justified in the circumstances.

The panel was satisfied that a conditions of practice order would provide appropriate safeguards to address the concerns identified, whilst allowing you to continue to practise. The panel considered that such an order would adequately address the public interest by marking the seriousness of the misconduct, in particular the findings of dishonesty, and by upholding proper professional standards.

In making this decision, the panel carefully considered the submissions of Ms Wisniewska on behalf of the NMC, who invited the panel to impose a striking-off order. However, the panel did not consider that such a sanction would be proportionate in the circumstances, given the significant evidence of remediation, your continued safe practice, and the strong testimonial evidence before it. The panel therefore rejected the NMC's submission.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is a conditions of practice order.

Having regard to the matters it identified, the panel concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must only work for a single employer.

2. Provide a reflective practice profile on:
   - Honesty, Integrity and Candour
   - Record keeping
   - Administering medication
   - The impact of patient care the profession and public confidence and feedback from line manager.

3. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

4. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any employers you apply to for work (at the time of application).
   c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

5. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

6. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Evidence of continued professional development, including documentary evidence of completion of relevant training.
- A reflective piece addressing the misconduct, in particular the findings of dishonesty, and how this has informed your current practice.
- Testimonials from a line manager or supervisor addressing your current work, including your record keeping and adherence to professional standards.

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own

interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Wisniewska. She invited the panel to impose an interim conditions of practice order for a period of 18 months.

You did not oppose the application.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.