Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 16 January 2024 – Friday, 26 January 2024
Wednesday, 21 February 2024 – Monday, 26 February 2024

Mercure Liverpool Atlantic Tower Hotel Chapel Street, Liverpool, Merseyside, L3 9RE (16 – 26 January 2024)

Physical and virtual (21 - 23 February 2024)

Virtual (26 February 2024)

Name of Registrant:	**Mohamed Ali El-Sheikh**
NMC PIN	90G0758E
Part(s) of the register:	Registered nurse Sub part 1 RN1: Adult nurse, level 1 (28 September 1993)
Relevant Location:	Liverpool
Type of case:	Misconduct
Panel members:	Konrad Chrzanowski (Chair, Lay member) Janet Fitzpatrick (Registrant member) David Anderson (Lay member)
Legal Assessor:	Nigel Ingram (16 – 19 January 2024) Fiona Moore (21 – 26 February 2024)
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter (16 – 26 January 2024); Represented by Matthew Kewley, Case Presenter (21 – 26 February 2024)
Mr El-Sheikh:	Present and supported by Mrs El-Sheikh and represented by Wafa Shah (Counsel), instructed by the Royal College of Nursing (RCN)

Facts proved by admission:	1(a), 1(b), 1(c) 2(a), 2(b), 2(c) 3, 4, 5(a), 5(b) 7, 13(a), 13(b), 14, 15(b), 15(c), 16, and 18 (misconduct denied in all admissions)
Facts proved:	8, 9, 10(a), 10(b), 11(a), 11(b), 12, 15(a), 17(a), 17(b), 17(c), and 19
Facts not proved:	6(a) 6(b), 20, 21(a), 21(b) 21(c), and 22
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (12 months) with review**
Interim order:	**Interim suspension order (18 months)**

Application for an adjournment – Day one

Ms Shah on your behalf made for an application for an adjournment until 11:00am on 17 January 2024. She submitted that the reason for the application to adjourn was in order to progress ongoing efforts between the parties to resolve this case without the need for a hearing.

The hearing resumed on Day three

The panel was made aware that Ms Shah had applied for an Agreed Removal (AgR) on your behalf and the application was refused. Further, Ms Shah told the panel that a Consensual Panel Determination had been discussed with the NMC, however they took the view that it may take further time and there is a risk that the panel might not agree to it. As such, it was preferable to proceed with the hearing as planned.

Details of charge (as read)

That you a registered nurse;

1. On 22 June 2016 did not record Patient D's saturations levels on their Observation Scores and Pain Assessment Chart at:

(a) 15.00.

(b) 16.00.

(c) 16.30.

(Admitted / not to misconduct)

2. On 22 June 2016 did not take Patient D's saturation observations at:

(a) 15.00.

(b) 16.00.

(c) 16.30.

(Admitted / not to misconduct)

3. On 22 June 2016 did not conduct observations on Patient D at 15 minute intervals between 15.00 and 16.30 hours. **(Admitted / not to misconduct)**

4. On 22 June 2016 having administered a second 2mg dose of Oxycodone to

Patient D at 16.05 did not record this on Patient D's EPMA chart. **(Admitted / not to misconduct)**

5. On 22 June 2016 did not seek a review from Doctor Lane prior to administering 2mg of Oxycodone to Patient D at:

(a) 15.40 and/or

(b) 16.05.

(Admitted / not to misconduct)

6. On 22 June 2016 breached confidentiality of Patient D by; **(Denied in its entirety)**

(a) Copying Patient D's clinical notes, and/or

(b) Taking them home.

7. On 10 November 2016 having emptied Patient C's catheter into a bottle did not immediately take it to the sluice room to be emptied. **(Admitted / not to misconduct)**

8. On 10 November 2016 failed to prevent air from getting into Patient C's catheter tube by not replacing the irrigation fluid. **(Denied)**

9. On 10 November 2016 failed to empty Patient C's urinary catheter bag when requested. **(Denied)**

10.On 10 November 2016 did not investigate why Patient C's monitor did not take blood pressure readings at: **(Denied)**

(a) 11.40.

(b) 11.50.

11.On 10 November 2016 inaccurately recorded in Patient C's perioperative booklet blood pressure readings at: **(Denied)**

(a) 11.40.

(b) 11.50.

12.Your actions in charge 11 were dishonest in that you were attempting to mislead others into believing that the monitor had recorded blood pressure readings when you knew that it had not. **(Denied)**

13.On 10 November 2016 did not take Patient C's blood pressure using the sphygmomanometer at: **(Admitted / not to misconduct)**

(a) 11.40.

(b) 11.50.

14.On 10 November 2016 did not complete Patient C's recovery care plan. **(Admitted / not to misconduct)**

15.On 6 August 2020 having been informed that there was an issue with Resident A's catheter did not:

(a) Assess whether the catheter was draining urine correctly, and/or **(Denied)**

(b) Conduct a bladder washout, and/or **(Admitted / not to misconduct)**

(c) Re-catheterise Resident A. **(Admitted / not to misconduct)**

16.On 6 August 2020 did not record the care provided on Resident A's PCS care notes. **(Admitted / not to misconduct)**

17.On 6 August 2020 having been informed that there was an issue with Resident B's catheter did not: **(Denied in its entirety)**

(a) Assess whether the catheter was draining urine correctly, and/or

(b) Conduct a bladder wash, and/or

(c) Re-catheterise Resident B.

18.On 6 August 2020 did not record the care provided on Resident B's PCS care notes. **(Admitted / not to misconduct)**

19.On 6 August 2020 handed over to Colleague 1 two residents that were deceased. **(Denied)**

20.On one or more occasions between July 2019 and September 2019 did not complete medication rounds in a timely manner. **(Denied)**

21.On or before 4 September 2020 made the following incorrect declarations to Priory Group: **(Denied in its entirety)**

(a) That your reason for leaving your employment with the Royal Liverpool and Broadgreen University Hospital was, "Contract terminated and I retired" or words to that effect.

(b) That your reason for leaving your employment with the Royal Liverpool

and Broadgreen University Hospital was, “Resignation” or words to the effect.

(c) That your employment ended with Alt Park Nursing Home in “September 2020”.

22.Your declarations in charge 21(a) and/or 21(b) and/or 21(c) were dishonest in that you were attempting to mislead the Priory Group about your employment history. **(Denied)**

In light of the above your fitness to practise is impaired by reason of your Misconduct.

Ms Shah’s request to redact parts of Ms 1’s and Witness 4’s witness statements – Day 5

Ms Shah read out and submitted the following and said that a written copy will be placed before the panel to be exhibited in due course:

‘Agreed The Facts

1. *Paragraph 7 of [Witness 4’s] statement and [Ms 1]/19 refers to a previous incident. This should be redacted.*
2. *All previous incidents (including the ones referred to by [Witness 4) reported against this Registrant are before the panel and are reflected by Charges 1-7 of the allegations on the Schedule of Charge. There are no other reported complaints against the Registrant.*
3. *The Registrant has no other fitness to practice referrals reported against him, no regulatory findings or allegations outstanding against him other than what is on the Schedule of Charges before the panel. He is otherwise of good character with an unblemished fitness to practice record.’*

The panel agreed to take this into consideration going forward.

Decisions and reasons on applications to admit hearsay evidence - Day 5

The panel heard applications made by Mr Malik, on behalf of the Nursing and Midwifery Council (NMC), under Rule 31 to adduce the following evidence as hearsay: Witness statements of Ms 1; evidence of Mr 2, Ms 3, Ms 4 and hearsay evidence in Witness 8's Statement. He made reference to relevant case law including *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and *El Karout v NMC* [2019] EWHC 28 (Admin).

Witness statement of Ms 1

Mr Malik submitted that Ms 1 was not present at this hearing and, whilst the NMC had made efforts to ensure her attendance, she was unable to attend today [PRIVATE].

He referred the panel to a letter from Dr 1 dated 20 December 2023, which states:

> *'I have recently reviewed [Ms 1] [PRIVATE].'*

The panel also had sight of an email from Ms 1 to the NMC dated 11 January 2024, which stated:

> *'[PRIVATE]*

The attached Statement of Fitness to Work dated 11 January 2024 indicated that Ms 1 [PRIVATE].

Mr Malik told the panel that due to Ms 1's [PRIVATE], the NMC did not feel it was appropriate to summon her as a witness.

He submitted that Ms 1 has signed her written statement on 21 January 2022, and it contains a statement of truth. He submitted that Ms 1 was a professional acting in the course of her employment at the relevant time and has no reason to fabricate her evidence. He submitted that Ms 1's evidence is highly relevant and although it was not provided during the course of the NMC's investigation, it was produced for the purpose of the local internal investigations.

Mr Malik submitted that Ms 1 has provided the relevant exhibits including your job description, contract of employment, and training record. He further submitted that Ms 1 had also interviewed you, Witness 4, Witness 7, Witness 6 during the local investigation interviews. He submitted that Ms 1's statement is relevant to provide further observations and is not the sole evidence in relation to the issues to which it relates. Further the statement is corroborated by other evidence, live evidence of witnesses and documentary evidence.

Mr Malik submitted there is a public interest in the issues being explored fully, which support the admission of this evidence into proceedings. He submitted that it is fair, just, and reasonable to admit Ms 1's witness statement and exhibits into evidence.

Witness statement of Mr 2

Mr Malik referred the panel to Mr 2's written and signed witness statement and corresponding exhibits.

He submitted that Mr 2's statement relates to Charge 6 and that it is not the sole evidence in relation to the charge. He submitted that Witness 7 was also present at the meeting which took place between you and Mr 2. He submitted that Witness 7 will be giving oral evidence at this hearing and Ms Shah will have an opportunity to cross-examine her.

Mr Malik submitted that the NMC have made attempts to secure Mr 2 to attend to give evidence. He referred the panel to correspondence exchanges between the NMC and Mr 2 indicating the efforts made by the NMC to have him attend the hearing to give evidence. He submitted that an email dated 16 January 2023 was not responded to; an email from Mr 2 to the NMC dated 14 February 2023 states *'My original statement is with RLH HR. I have nothing further to add to it'* and in response to an email from the NMC dated 9 March 2023 he states: *'This happened nearly seven years ago. I have nothing to add.'*

Evidence of Ms 3

Mr Malik referred the panel to Ms 3's written and signed witness statement dated 22 June 2016 and corresponding exhibits.

He submitted that Ms 3's statement and the corresponding exhibits relate to Charges 1, 2 5 and 6. He submitted it is not the sole evidence and her statement is corroborated by live evidence of other witnesses and documentary evidence.

He referred to an email sent from the NMC on 26 January 2023 asking Ms 3 to respond to their email of 16 January 2023; and to a letter from the NMC dated 14 February 2023, asking her, again, to engage in the process. There is another email from the NMC to Ms 3 dated 8 February 2023, which again garnered no response. He submitted that the NMC have made all reasonable efforts to get Ms 3 to attend the hearing however they have received no response from her. He submitted that it is fair and reasonable to admit her witness statement into evidence as it is in the public interest to do so.

Evidence of Ms 4

Mr Malik referred the panel to Ms 4's written and signed witness statement dated 19 August 2020.

He submitted her evidence relates to Charge 15 and notwithstanding you have admitted to Charges 15(b) and 15(c), her statement relates to charge 15(a) which you have denied. He submitted that Ms 4's statement is corroborated by live evidence of witnesses, and documentary evidence. He submitted that it is not the sole evidence relating to this charge.

Mr Malik submitted that several attempts have been made to secure Ms 4's attendance today. He submitted that the NMC sent correspondence to Ms 4 on 5 January 2023, 17 January 2023 and again on the 13 March 2023, all of which have garnered no response.

Mr Malik submitted there is a public interest in the issues being explored fully which

support the admission of this evidence into these proceedings.

Parts of Witness 8's statement in relation to Ms 5

The panel was referred to the relevant paragraphs 12, 13, 16, 33 and 38 of Witness 8's witness statement in which reference is made to a Ms 5, a care assistant. He submitted that the NMC had made a number of attempts to contact Ms 5. Letters were sent to her from the NMC on 5 January 2023 and 17 January 2023 notifying her of the upcoming hearing, and also a letter requesting that she engage with the process on 13 March 2023. She was asked to contact the NMC in relation to her giving a telephone witness statement to the NMC. He submitted that all reasonable efforts have been made by the NMC to secure her attendance, but to no avail.

Ms Shah's submissions to the hearsay applications

Ms Shah provided the panel with full written submissions in relation to the Witness statement of Ms 1; evidence of Mr 2, Ms 3, Ms 4 and the hearsay evidence in Witness 8's Statement and made brief oral submissions on each in turn.

Witness statement of Ms 1

Prior to her submissions, Ms Shah made a request that [PRIVATE] in relation to Ms 1 be marked as private retrospectively.

Mr Malik raised no objection to Ms Shah's request.

The panel heard and accepted the legal assessor's advice.

Having heard that there would be references to Ms 1's [PRIVATE], the panel agreed to hold parts of the hearing in private in order to preserve the confidential nature of those matters. The panel was satisfied that these considerations justified that course, and that this would outweigh any prejudice to the general principle of hearings being in public.

Ms Shah submitted that It is not accepted that the [PRIVATE] She submitted that it does not relate to the dates of this hearing and appears to be relevant until December 2023. She submitted that [PRIVATE]. Therefore, she submitted, there is no [PRIVATE] before this panel to show that Witness 8 is unable to attend the hearing by video link to give evidence for a short period of time during these sitting dates.

She submitted that Witness 8's evidence is demonstrably unreliable in parts, in particular the pertinent parts of paragraph 9 in her statement which you dispute. She submitted that it is not only the sole and decisive evidence in relation to Charge 13, but it also does not fall into the category of '*demonstrably reliable evidence'*. She submitted that It is not demonstrably reliable as reference to the machine being available or appropriate does not appear anywhere else in any witness statements from witnesses who were present, but furthermore the first reference to the machine is in a statement written over half a decade after the incident. As such it is unfair to admit this evidence without affording you an opportunity to cross-examine her.

Ms Shah further submitted that Ms 1's evidence is demonstrably unreliable, or certainly cannot be said to be demonstrably reliable, because Ms1 refers to a document, and alleges that something is within it, which is not there. She submitted that nowhere does it say that you acknowledge that your handwritten note contains patient-identifiable information. She submitted that that section of Ms 1's statement is very important and appears to be something that requires testing, questioning, and afforded an opportunity to cross-examined on it.

Ms Shah submitted that Ms 1's evidence also provides the sole and decisive evidence for charge 13 and that no other witness makes reference to this machinery. Further, Ms 1 makes a number of comments and conclusions about what should and should not have been done by you in the circumstances. She was not present at the recovery unit and it is submitted that she has made some of those conclusions based on inaccurate information.

Ms Shah submitted that paragraph 14 of Ms 1's statement contains anonymous hearsay evidence. She submitted that Ms 1 refers to an unknown, un-named anaesthetist therefore it is anonymous hearsay,

Ms Shah submitted that there is no charge about the appropriateness of giving codeine in light of any respiratory presentation. That is not something that has been explored during the evidence and does not form the basis of any disclosure because, quite simply, the charge said you ought to have a review from Dr 1 prior to the dose being administered.

She submitted that the panel heard from Witness 3 and his evidence was clear that a review is not required. So you would not be able to explore that point with Ms 1. Had this been a situation where there is specific medical evidence that specifically states Ms 1 cannot log on to a video link for an hour to answer questions, or a couple of hours, perhaps the panel might consider matters slightly differently, however there is no such evidence. She submitted that there are clear, identifiable areas that require cross examination in order for you to be able to fairly conduct your case and also for the panel to ask questions of Ms 1, which is another reason for requiring witnesses to attend.

Ms Shah submitted that in regulatory proceedings, it is not simply that you have a right to cross-examine, but the panel may also explore matters with witnesses, and in this case it cannot be done.

She invited the panel to deem Ms 1's evidence inadmissible.

Witness statement of Mr 2

Ms Shah submitted that it is not accepted that the NMC have taken all reasonable steps to secure the attendance of Mr 2. She submitted that there is no recent communication to Mr 2 that shows he is even aware of this hearing taking place. The only reference is to a previous hearing that did not take place for a number of reasons.

There is no documentation provided by the NMC to demonstrate that they have made Any attempt to secure Mr 2's attendance at this hearing, nor have the NMC sought to obtain a witness summons compelling him to attend and we have no information as to why he was deemed to be inappropriate for a witness summons. She submitted that it is particularly surprising that his response to the NMC's letters is '*I have nothing more to*

say...' .

She submitted that Mr 2 gives evidence in respect of Charge 6 and there is reference to what Mr 2 says in Witness 7's statement and this evidence is inadmissible and extends also to hearsay accounts from Witness 7 as to what Mr 2 said to her. She invited the panel to take this under consideration when deciding about the admissibility of Mr 2's evidence.

Ms Shah submitted that Mr 2's evidence is, in essence, evidence of a confession. She submitted nothing can be said to be more decisive evidence than the evidence of a confession and in particular, it is a confession in relation to Charge 6. Ms Shah invited the panel to consider that evidence of a confession should always be treated with care. In particular, when assessing whether to rely on a confession that is disputed by you in this case. She submitted that the panel may want to consider if it can rely on Mr 2's account of a confession and as to whether it was actually a confession.

Ms Shah submitted that you have been put in an unfair position where you cannot put your case to Mr 2 and cannot test the reliability of that alleged confession, which puts you at a significant disadvantage.

Ms Shah submitted that this is all the more reason that any evidence of the alleged confession should not be admitted as it would be unfair to do so.

Evidence of Ms 3

Ms Shah raised a number of objections to Ms 3's evidence. She referred to Ms 3's handwritten note. She submitted that it does not in fact, appear to relate to any of the charges before this panel. She submitted that it relates to whether or not oxycodone ought to have been given in the circumstances; it does not relate to whether or not a review was required by Dr 1, which is what you are actually charged with. She submitted that the panel could first of all look at page 18, read it, and decide whether it is relevant and therefore admissible.

She referred the panel to a typewritten statement on page 19, and the second is an interview on page 21. She submitted that this does not meet the test of fairness for the

following reasons; it is not demonstrably reliable, and it also references some form of confession, and it is decisive or very important evidence. She submitted that it is not demonstrably reliable as Ms 3 says that there was a confession made to falsify documentation, or that is what she appears to be saying to Witness 7. She submitted that this is not now a charge before this panel. She submitted that in Ms 3's local interview she changes the alleged confession to copying patient notes. She submitted that there is a clear inconsistency between Ms 3's two accounts of what she overheard. Ms Shah submitted that in and of itself, it means that it is not reliable.

Ms Shah submitted that Ms 3 is somebody that the NMC have not taken reasonable steps to secure her attendance. Ms Shah submitted that there is nothing to suggest that Ms 3 has been recently contacted, or any evidence as to why a witness summons has not been sought. Further, there is no evidence that the NMC have tried to trace her to see if the addresses they are writing to are correct or even check the NMC Register.

Ms Shah submitted that, in all the circumstances, it is unfair to admit Ms 3's evidence because it is important, decisive evidence and further, it is inconsistent and requires some exploring within the hearing.

Evidence of Ms 4

Ms Shah submitted that in respect of Ms 4, it is unfair to admit her evidence as it is the decisive evidence in respect of Charge 15. She submitted that the panel have not yet heard from any witnesses about any of the incidents that occurred in August 2020 and Ms 4 is the main witness. She further submitted that the NMC have not provided any good reason for Ms 4's non-attendance at this hearing. She further submitted that NMC have not provided evidence of any recent attempts to make Ms 4 aware of this hearing and there's no evidence of whether or not the NMC have considered a summons and why it might not be appropriate. She submitted that the NMC have not taken reasonable steps to secure Ms 4's attendance.

Ms Shah submitted that because Ms 4's evidence is so crucial to Charge 15, it would be unfair to admit it. Ms Shah also submitted that we do have a written statement, but it is not signed. She noted that Mr Malik referred to the statement as being *'electronically signed',* however we do not know that, and more importantly, it is not accompanied by a

statement of truth.

Ms Shah referred the panel to the principles in the case of *El Karout v NMC* [2019] EWHC 28 (Admin)*,* that in circumstances where panels do not have a signed document, a document taken in the context of a disciplinary, or challenged in some other way, that all points towards unfairness in admitting it. Ms Shah submitted that as it is decisive evidence that it is unfair to allow it where the NMC have not tried very hard to secure her attendance.

Parts of Witness 8's statement in relation to Ms 5

Ms Shah submitted that within Witness 8's written statement she makes reference to comments that she heard from someone called Ms 5. She referred the panel to Witness 9's written statement in which Ms 5 is mentioned however her original statement was destroyed in a flood. She submitted that the panel only have a comment related to Ms 5 which appears to have been said in a non-formal context, perhaps made during a break.

Ms Shah referred the panel to the relevant paragraphs in Witness 8's statement. She submitted that some of those paragraphs appear to be anonymous hearsay, but others directly refer Ms 5. She submitted that the panel ought not to admit it under the principle in *White v Nursing and Midwifery Council and Turner v Nursing and Midwifery Council [2014] EWHC 520 (Admin)*, which is that it would be inconceivable to think of circumstances where anonymous hearsay would be fair to admit.

She submitted that those parts of those paragraphs that refer directly to Ms 5 ought not to be admitted because the principles in *El Karout* apply. She submitted that it is not evidence given in a formal context and appears to have occurred during a break, in an informal chat. She submitted that it is the sort of evidence that ought not to be admitted in a hearsay capacity.

Ms Shah submitted that there is no statement or signature accompanying Witness 8's written statement. Further, there is no evidence of her having been questioned on what she says in her statement and there is no signed statement of truth accompanying her statement. She submitted that the parts of Witness 8's statement referring to Ms 5

is not reliable evidence, but is evidence in respect of Charge 15, which is in dispute.

Ms Shah submitted that there has not been any real attempt by the NMC to obtain a statement from Ms 5 and as such, it is entirely unfair to admit those parts of Witness 8's statement. She submitted that Ms 5 appears to be uncontactable, however there is no statement from an NMC case officer, for example, saying the NMC have written to the Health and Care Professions Council (HCPC) to contact her as her regulator. Ms Shah further submitted that the NMC also have access to people who can track people down and there has been no attempt to do that and certainly no recent attempt to tell Ms 5 about these hearing dates or to ask her to attend.

In conclusion, Ms Shah submitted that, in all the circumstances, it is entirely unfair to admit all the above-mentioned evidence that the NMC seeks to rely on.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. She referred the panel to relevant case law which included *Thorneycroft, Bonhoeffer V GMC* [2011] EWHC 1585 (Admin) and *Ogbonna v NMC* [2010] EWCA Civ 216. She also referred to Rule 31 which 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.

Panel decision and reasons on hearsay applications

Decision and reasons on application to admit the witness statement of Ms 1 as hearsay evidence

Overall, the panel was of the view that the NMC has failed to make any serious attempts to engage with the above-named witnesses in these applications to secure their attendance at this hearing. It appeared to the panel on the basis of the information before it that communication from the NMC to these witnesses had stopped in March 2023.

The panel considered the application in regard to Ms 1. The panel noted that Ms 1's statement had been prepared in anticipation of being used in these proceedings and

contained the paragraph, ‘This statement … is true to the best of my information, knowledge and belief’ and signed by her.

The panel considered whether you would be disadvantaged by the change in the NMC’s position of moving from reliance upon the live testimony of Ms 1 to that of a written statement and thus allowing hearsay testimony into evidence.

The panel took account of the [PRIVATE] reasons put forward for Ms 1’s non-attendance at this hearing. It had sight of her latest [PRIVATE] 11 January 2024 and noted that it was current and [PRIVATE].

The panel was of the view that the NMC’s reasons for not seeking to compel Ms 1 to attend were fair and reasonable particularly as Ms 1 [PRIVATE] Ms 1 cannot attend the hearing and not appear via video link.

The panel determined that the [PRIVATE] appearing before a panel as a witness. It determined that it is reasonable to accept her non-attendance [PRIVATE] and it would not be fair to compel her to attend the hearing. The panel was content that there are [PRIVATE] for Ms 1 not to attend the hearing.

The panel acknowledged that Dr 1’s letter on 20 December 2023 did not specifically mention her participation at a hearing, however the panel determined that it would be reasonable to assume that it would be inappropriate for her to attend given that she has been [PRIVATE].

The panel considered Ms 1’s witness statement in relation to Charge 6. Ms 1 states that you acknowledged in the investigation interview that your hand-written note contained patient identifiable information, whereas in the investigation interview notes accompanying her statement this comment that Ms 1 attributes to you does not appear anywhere in the interview.

The panel was of the view that there is no identifiable patient information contained in these two above-mentioned documents, however it determined that whilst there is some inconsistency between the two documents, they are not contradictory. The panel was of

the view that this could potentially be explained away by the passage of time between the local investigation which occurred in 2016 and her signed written statement in 2022.

The panel had regard to the provisions of Rule 31 which empowers the panel to admit in evidence any material so long as it is fair and relevant. The panel, having read the statement and considered the circumstances in which it was being offered in evidence, was satisfied that it is fair and relevant to admit into evidence as hearsay evidence the written statement of Ms 1. The panel would give appropriate weight to the evidence once it had heard and evaluated all of the evidence before it at the fact-finding stage of these proceedings.

Decision and reasons on application to admit the Witness statement of Mr 2 (as hearsay evidence

The panel considered the application in regard to Mr 2.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Mr 2 to that of a written statement and thus allowing hearsay testimony into evidence.

The panel was of the view that Mr 2 never indicated that he was not going to give evidence only that he had nothing further to add. The panel noted that the last contact from the NMC with Mr 2 was in March 2023. The panel was of the view that it has been asked to admit his evidence without the NMC attempting to secure his attendance. In an email dated 14 February 2023 to Mr 2, the NMC stated that they could obtain a summons to compel him to attend, however there is nothing before the panel to show that the NMC acted on this.

The panel was of the view that no good reason has been provided for Mr 2's non-attendance and the last date that the NMC had engaged with him was in March 2023. At no stage did Mr 2 state that he was unprepared or unwilling to attend the hearing, he merely said that he had nothing further to add.

The panel was of the view that there is nothing in the timeline to show that he was even

aware that this hearing was taking place.

The panel took into account the lack of recent correspondence from the NMC to Mr 2, however given the potential corroborating statement of Witness 7, the public protection obligations are such that the panel has decided to admit Mr 2's statement into evidence. The panel would give what it considered appropriate weight to this evidence once it had heard and evaluated all of the evidence before it at the fact-finding stage of these proceedings.

The panel was of the view that Mr 2's evidence can be corroborated by and was broadly consistent with Witness 7's evidence, who the panel will have the opportunity to hear give evidence in person and can be questioned as to the veracity of the claims made in Mr 2' statement. As such, Mr 2's evidence is not the sole and decisive evidence and his statement was made within a few days of these events.

The panel determined that the evidence which the NMC seek to rely on is consistent and contemporaneous with the events and Mr 2's written statement and investigative interview notes and can be corroborated by Witness 7.

In light of the above the panel decided to admit Mr 2's statement as hearsay evidence.

Decision and reasons on application to admit the witness statements of Ms 3 as hearsay evidence

The panel considered the application in regard to Ms 3. The panel noted that Ms 3's statements had been signed by her and the typed statement dated 22 June 2016 states *'I believe that the facts stated in this witness statement are true'.*

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms 3 to that of a written statements and thus allowing hearsay testimony into evidence.

The panel was of the view that there is no evidence to show that the NMC have taken steps to secure Ms 3's attendance at this hearing and the panel has been asked to admit her evidence without the NMC having attempted to secure her attendance. The panel noted that Ms 3's interview notes were not signed and the last contact from the NMC with her was in an email dated 14 February 2023.

The panel has decided to exclude Ms 3's statements and accept Ms Shah's submissions. The NMC have offered no explanation as to why Ms 4 has not been called and there is nothing before the panel to show any attempts to contact her since February 2023. Bearing in mind that Ms 3 is a registered nurse the panel would have expected the NMC to make stronger attempts to secure her attendance.

Ms Shah raised in her submissions the inconsistencies and that you will be deprived of the opportunity to challenge the evidence put forward by Ms 3. The panel agrees that Ms 3's handwritten statement dated 22 June 2016 only provides why the patient was given a second dose of oxynorm. The panel was of the view that Ms 3's evidence does not appear to relate to any of the charges before it.

The panel has decided not to admit this evidence and accepts the submissions made by Ms Shah.

In these circumstances the panel refused the application.

Decision and reasons on application to admit the witness statement of Ms 4 as hearsay evidence

The panel considered the application in regard to Ms 4. The panel noted that Ms 4's statement did not contain the paragraph, 'This statement … is true to the best of my information, knowledge and belief' nor was it physically signed by her.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms 4 to that of a written statement and thus allowing hearsay testimony into evidence.

The panel was of the view that there is no evidence to show that the NMC have taken steps to secure Ms 4 as a witness to attend this hearing and the panel has been asked to admit her evidence without the NMC having attempted to secure her attendance. The panel noted the last contact from the NMC with her was in an email dated 14 February 2023.

The panel determined that it is unfair to admit Ms 4's evidence for the following reasons: It is decisive evidence in respect of Charge 15 which is denied; There is no good reason before the panel for Ms 4's non-attendance; The NMC have made no recent attempts to contact her and not sought to summons her as a witness. The panel therefore determined the NMC have not taken all reasonable steps to secure Ms 4's attendance and as such there is no realistic means by which to test her evidence without cross-examination. Further, Ms 4's statement is not signed nor is it accompanied by a statement of truth. As such, it cannot therefore be said it is demonstrably reliable.

Therefore the panel has determined to exclude Ms 4's evidence and refused the application.

Decision and reasons on application to admit Parts of Witness 8's statement in relation to Ms 5 as hearsay evidence

The panel considered the application in regard to Witness 8 in relation to Ms 5. The panel noted that Witness 8's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'I believe that the facts stated in this witness statement are true...'* and signed by her.

The panel considered whether you would be disadvantaged by relying on the parts of Witness 8's statement as it relates to Ms 5 and allowing those parts of her statement as hearsay evidence.

The panel was of the view that it was going to hear from Witness 8 as a live witness therefore anything contestable could be challenged by way of cross-examination. The

panel determined that as she will be giving live evidence any issues you have with her evidence can be addressed at the time of her giving her live evidence.

The panel therefore dismissed the application in its entirety and refused the application.

Background

You were referred to the NMC on 5 January 2021 by the registered manager at Alt Park Nursing Home (Home 1). The charges arose whilst you were employed at Home 1.

The facts as alleged by the NMC are:

In July 2019, you commenced your employment as a registered nurse at Home 1, working mainly on night shifts. Home 1 provides residential and nursing care for up to 35 residents with dementia, cognitive impairment, physical and mental health care needs.

Staff at Home 1 raised concerns soon after you started working there, regarding the length of time it was taking you to complete the medication rounds. Supportive measures were put into place, and you were offered additional training.

During the night shift on 5 August 2020, carers raised concerns to you about two residents who had urinary catheters in place. The catheters had not drained urine all night, and one of the residents was in significant pain. You did not respond to the concerns raised, or document anything for these two residents.

During the handover on the morning of 6 August, you handed over details of two residents that had been deceased for some time.

You were suspended on 6 August 2020 whilst a local investigation was undertaken. A disciplinary meeting was held on 25 August 2020 which you did not attend. Your employment with Home 1 was terminated following the disciplinary meeting.

Following your dismissal, you were employed by Vancouver House Nursing Home (Home 2) commencing 9 November 2020. Home 2 provided care for up to 32 residents with complex needs.

The NMC informed Witness 1, the registered manager at Home 2 by email on 25 January 2021 that you were under investigation into your fitness to practise, following the referral from Home 1.

Witness 1 then reviewed your recruitment documents and discovered anomalies in the information you provided, including your reason for leaving your previous employment and references you provided. A probationary review meeting was held on 29 January 2021 following which your employment was terminated during your probationary period due to your dishonesty.

In the course of the NMC investigation, it was identified that you had previously worked at the Royal Liverpool and Broadgreen University NHS Trust ('the Trust'). On contacting the Trust, it was discovered that you had been dismissed from your employment with them on 27 March 2017, following incidents on 22 June and 10 November 2016. Following the incidents on 22 June 2016, you were moved to a different department and a 'Poor Performance Action Plan' was developed.

Following an internal investigation a disciplinary hearing was held, and you were dismissed.

The regulatory concerns identified and investigated by the NMC are as follows:

1. Failing to assess, monitor and act upon concerns relating to residents, catheter care and medication management.

2. Failing to keep clear and accurate records.

3. Concerns relating to medication administration.

4. Employment related dishonesty.

Decision and reasons on facts

At the outset of the hearing, Ms Shah informed the panel that you have made admissions to the following charges however you deny misconduct in all admitted charges: 1(a); 1(b); 1(c); 2(a); 2(b); 2(c); 3; 4; 5(a); 5(b); 7; 13(a);13(b); 14; 15(b); 15(c); 16; and 18.

The panel therefore finds charge 1(a); 1(b); 1(c); 2(a); 2(b); 2(c); 3; 4; 5(a); 5(b); 7; 13(a);13(b); 14; 15(b); 15(c); 16; and 18 proved in their entirety, 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, including all of the written submissions made by Mr Malik on behalf of the NMC and those made by Ms Shah on your behalf.

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. It bore in mind the advice that it received that the seriousness of the allegation or its inherent improbability may mean that the facts should be examined more critically before the panel concludes that the allegation has indeed been established on the balance of probabilities.

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

- Witness 1: Registered Manager for Home 1, at the relevant time

- Witness 2: Senior Unit Manager at the Hospital [PRIVATE], at the relevant time

- Witness 3: Speciality trainee [PRIVATE] at the Trust, at the relevant time
- Witness 4: Matron [PRIVATE] at the Hospital, at the relevant time
- Witness 5: Unit manager at the hospital, at the relevant time
- Witness 6: Senior Recovery Practitioner [PRIVATE], at the relevant time
- Witness 7: Recovery Ward Manager at the Unit, at the relevant time
- Witness 8: Registered nurse at Home 2, at the relevant time
- Witness 9: Registered nurse at Home 2, at the relevant time

The panel also heard evidence from you under oath.

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

Charge 6

That you a registered nurse;

On 22 June 2016 breached confidentiality of Patient D by;

(a) Copying Patient D’s clinical notes, and/or
(b) Taking them home

This charge is found NOT proved.

In reaching this decision, the panel considered the accounts in the respective written statements of Ms 1 and Mr 2 and Witness 7's written and oral evidence. In Ms 1's statement she outlined that it was not normal practice for a staff nurse to photocopy notes and it is never acceptable to take patient notes home. In Witness 7's statement she stated that when you were asked by Mr 2 whether you had photocopied patient information, you told him yes it was in your bag in your house. The panel was of the view that both Ms 1 and Witness 7's respective evidence correlated with each other.

The panel considered that during the hearing it was the first time you have mentioned that what you said to Mr 2 was not true and that you were only trying to protect yourself in case of any future investigation against you. The panel took into account your contradictory accounts both in your written and oral evidence in relation to the number of photocopies you made. In the local interview with Ms 1 you said you made two copies, however, the printer usage sheet clearly shows six copies were made. In your oral evidence you suggested you made one photocopy of the handwritten patient notes then at other times in oral evidence you said you made two copies and at other times four or five copies. The panel considered that you also gave further inconsistent accounts during the interview on the day of the event to Mr 2 in the presence of Witness 7, that you had removed the patient details from the copies you made.

The panel found Witness 7 to be a credible witness and had no reason to not tell the truth, and her witness statement and oral evidence are corroborated by Mr 2, albeit his evidence is hearsay and therefore there is no opportunity to test his evidence as he was not called as a witness. However, his evidence was consistent with the Witness 7's. The panel considered that Witness 7's local investigation statement dated 9 July 2016 and her interview notes dated 26 August 2016 to be consistent with each other and with the oral evidence she gave at the hearing.

In relation to this charge, the panel found you to be inconsistent in your oral evidence which changed on a number of occasions depending on the questioner and it is inconsistent with earlier statements you provided. The panel determined that your

evidence in relation to the number of copies made was inconsistent throughout which undermined your credibility.

The panel took the view that despite the inconsistencies in your evidence, the NMC have failed to provide sufficient evidence to prove that you had breached the confidentiality of Patient D as they have not provided any documentary evidence to prove it. Whilst there is evidence that you copied Patient D's clinical notes and on the balance of probabilities took them home, there is no evidence of a breach of confidentiality in the actual notes provided to the panel. The only documentary evidence before the panel are the handwritten notes you admit you made but these clearly do not show patient identifiable information.

The panel therefore found on the balance of probabilities that the NMC's case is not made out in relation to the charge and finds this charge not proved.

Charge 8

> That you a registered nurse;
>
> 8. On 10 November 2016 failed to prevent air from getting into Patient C's catheter tube by not replacing the irrigation fluid.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 2. It also had regard to her local statement of events dated 10 November 2016, which states:

> *'I noted the patient's catheter bag was full of blood stained fluid and there was a 2 litre bottle full of blood stain fluid at the bed side near the catheter bag. I then went closer to the bed side and notice the irrigation fluid had ran through and there was air in the catheter tubing...'*

Ms Shah in her submissions made mention of the working relationship between you and Witness 2. She said that Witness 2 bullied you and was looking to find fault in your work and had made a passing comment to you, that you were writing your memoirs in relation to how long you took to undertake your work. Witness 2 admitted that she said this to you however she told the panel that it was just a passing comment that she would say to anyone.

The panel considered Witness 2 was consistent in both her oral evidence and under cross-examination in relation to her initial internal interview and her NMC witness statement. The panel found her to be a credible witness with no reason to not tell the truth.

The panel determined that it has no evidence before it to show who changed the catheter bag however the panel preferred the evidence of Witness 2 that there was air in the system. Whilst no harm came to Patient C, Witness 2 states that:

> *'I also noticed that the irrigation fluid had run through and there was air in the catheter tubing. I asked the Registrant to empty the urinary catheter bag and take the full bottle to the sluice to empty. I explained how important it was to make sure the irrigation fluid didn't run out as this could lead to clotting off.'*
>
> *...*
>
> *'At this point, I was trying to get the air out of the tubing and reinitiate the flow of the bladder irrigation in order to prevent the Patient from clotting off'*
>
> *...*
>
> *'I intervened at the right time but there was the potential for harm if the patient had clotted off as a result of a delay in the irrigation fluid flowing into the patient.'*

While the panel has not heard from Ms 6 who was present at the time, the panel preferred Witness 2’s account of events.

The panel therefore determined on the balance of probabilities that this charge is found proved.

Charge 9

That you a registered nurse;

On 10 November 2016 failed to empty Patient C’s urinary catheter bag when requested.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 2.

In her witness statement Witness 2 states:

[Mr El-Sheikh] just tutted at me and raised his eyebrows when I asked him to empty the bag and bottle. I don't remember if I asked him why he had not done so and why he had not replaced the bag of irrigation fluid. He proceeded to take the full bottle to the sluice but did not empty the urinary catheter bag as requested.

Witness 2 then asked Ms 6 to empty the catheter bag which she did.

‘[Ms 6] came back from the sluice to the Patient's bedside and told the Registrant there was excess 300ml in the catheter measurement. This was so he knew what to document on the fluid balance chart. She then asked if she could help him with anything else. He replied 'I don't need help from anyone.'

The panel considered your written statement in which you disagreed that the bag was full of blood-stained liquid, and claimed you had emptied it and there was no need to again.

In your oral evidence you denied that Witness 2 asked you to empty the catheter bag as you had already done it. However, the panel determined that Witness 2's statement provided to the NMC is consistent with her initial statement in the investigation six years prior and oral evidence she gave to the panel, in that she asked you to empty the catheter bag and you did not do so, therefore she got another colleague to do so. The panel preferred Witness 2's evidence as it was consistent throughout.

The panel also had regard to Witness 6's handwritten document dated 10 November 2016 in which she states that Ms 6 emptied the catheter bag. This corroborates the evidence of Witness 2.

The panel therefore determined on the balance of probabilities that this charge is found proved.

Charge 10

> That you a registered nurse;
>
> On 10 November 2016 did not investigate why Patient C's monitor did not take blood pressure readings at:
> (a) 11.40.
> (b) 11.50.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account your written statement provided during the course of this hearing and your oral evidence. It also had sight of the Observation scores and pain assessment chart for the patient dated 10 November 2016.

The panel considered your oral evidence to be contradictory, insofar as you said that the machine *'beeped'* twice and the 11.40am and 11.50am readings were done. However, in your statement you stated that you did investigate why the machine was not taking readings and found that the patient needed to straighten his arm.

> *'I found that there was a hole in the machine's tubing and that the patient needed to straighten their arm. Once the patient straightened their arm, I was able to get a reading. I maintain the readings I recorded for the blood pressure were readings I obtained from the monitor'.*

The panel found this explanation to be implausible in that if you had found a hole in the tubing you would and should have remedied the matter by using an alternative monitor or changing the tube. It also contradicts your oral evidence where you state that you did not find a hole in the tubing and that it was Witness 6 who did. However, the panel noted that Witness 6 makes no mention finding a hole in the tubing in her evidence, she says that she just changed the cable and was able to get an accurate blood pressure reading.

The panel acknowledges that there were slight differences in the evidence of Witness 2 and Witness 6. Witness 2 said:

> *'The blood pressure tubing to the cuff had a slight kink in it which I removed. I then initiated the monitor to take a reading at 12:02 which it did with no problem.'*

The panel also noted in Witness 6's written local statement dated 10 November 2016, she notes that she replaced the cable with the cable from bedspace 4 and then the monitor worked correctly.

You said in evidence that you first saw the readings on the screen and then they disappeared and you could not get them back. You said that you saw an arterial reading and from that you could work out the blood pressure reading by doing a mathematical calculation. The panel found this to be implausible.

The panel found your evidence to be inconsistent in relation to this matter and found Witness 2 and Witness 6's evidence to be reliable. The panel therefore was satisfied that you did not investigate why Patient C's monitor did not take blood pressure readings at 11.40 and 11.50.

The panel determined on the balance of probabilities that this charge is found proved.

Charge 11

> That you a registered nurse;
>
> On 10 November 2016 inaccurately recorded in Patient C's perioperative booklet blood pressure readings at:
> (a) 11.40.
> (b) 11.50.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account your written statement provided during the course of this hearing and your oral evidence.

The panel had regard to Witness 2's local statement of events dated 10 November 2016, in which she states: *'I asked him again why he had recorded the patients BP reading when it hadn't been taken'.* It also had sight of Witness 2's local investigation interview dated 16 November 2016 in which she states: *'There was definitely nothing recorded on the monitor at either 11:40 or 11:50'.*

The panel took account of Ms 6's handwritten statement dated 10 November 2016 in which she states '*I'd noticed on the monitor that the patients [sic] blood pressure had not been recording...'*

The panel had regard to Witness 2's witness statement:

> *'I went to document my reading on the Patients paper chart in the perioperative booklet but then noticed that the Registrant had documented blood pressure readings for 11:40 and 11:50 even though there were no readings displayed on the monitor.'*
>
> *...*
>
> *'I could see from the Patient's vital signs at 11:33 that he was stable. He was sitting up in bed talking to me and I had been with him sorting out the bladdder [sic] irrigation for enough time to visually assess this. No harm had come to the Patient as a result of the initial assessment not being completed and no harm had come to the Patient as a result of the Registrant falsifying his blood pressure readings because the Patient was stable. However, if the patient wasn't stable, there is the potential that something important could have been missed by the Registrant falsifying the blood pressures and not completing the initial assessment.'*

The panel noted Witness 4 says in her witness statement that you gave her a different explanation for the blood pressure reading, you told her that you had taken the first and third blood pressure reading and that the second figure was an average of both readings.

On the basis that Charge 10 has been found proved in its entirety, it therefore follows that any recording on the chart must be an inaccurate recording, based on the evidence of Witness 2 and Witness 6 who both state that when they looked at the monitor the only one reading was at 11.33 and that 11.40 and 11.50 had not been recorded.

The panel found your evidence to be inconsistent throughout in relation to this charge. Consequently, the panel preferred the evidence of Witness 2 and Witness 6.

The panel therefore finds this charge found proved in its entirety.

Charge 12

> That you a registered nurse;
>
> Your actions in charge 11 were dishonest in that you were attempting to mislead others into believing that the monitor had recorded blood pressure readings when you knew that it had not.

This charge is found proved in its entirety.

In reaching this decision, the panel applied the legal test for dishonesty in *Ivey v Genting Casinos* (UK) Ltd 2017 UKSC 67

The panel determined that your motive was that you needed to complete the patient's paperwork and medical records which are important to the patient's care history. The panel was of the view that you understood how important post-operative readings are and given the length of your experience as a registered nurse you would be well aware of this. In your statement you say that you took those readings and the machine just did not record all of the readings or that they did not remain on the machine. Yet in your oral evidence you said the patient kept wriggling around and that was the reason the machine did not record the patient's blood pressure. The panel noted that there was no reference to this in the patient notes.

The panel noted that you kept referring to an arterial pressure reading at the corner of screen. The panel do not accept that you used this to calculate the diastolic and systolic blood pressure and there is no evidence to show that you did so.

The panel does not accept that you believed at the time what you were doing was accurately recording the patient's blood pressure. The panel has found both Charges 10 and 11 proved in their entirety; that the machine was not working accurately and you failed to investigate those failings yet went on to record those blood pressure recordings at 11.40 and11.50. The panel is satisfied that on the balance of probabilities those recordings were made in order to complete a medical chart and in so doing, you were acting dishonestly in that you were attempting to mislead others into believing that the monitor had recorded blood pressure readings when you knew it had not.

The panel determined that ordinary decent people would regard this as dishonest. Therefore, the panel find this charge proved.

Charge 15(a)

> That you a registered nurse;
>
> On 6 August 2020 having been informed that there was an issue with Resident A's catheter did not: (a) Assess whether the catheter was draining urine correctly, and/or ...

This charge is found proved

In reaching this decision, the panel took into account Witness 8's witness statement dated 12 November 2021, which states:

> *'I questioned the Registrant about resident A having a settled night because I had been informed by [Ms 5] that resident A had been in discomfort throughout the night. I asked the Registrant if he had performed a bladder washout on the resident's catheter. He said "no." I asked whether he had passed 30ml of urine per hour. This is because you never fully empty your bladder and basic nurse training on catheter care is that the catheter should be draining at least 30ml of urine per hour. During your training to become a nurse, all nurses receive basic training for catheter care and therefore I expect the Registrant to be aware of this from his training. The Registrant said he had given the resident his medication for*

his kidneys but I replied that this was not going to solve the pain and discomfort Resident A was in.'

and her local statement made on 6 August 2020 states:

> *'Nurse in charge [Mr El-Sheikh] began hand over, when speaking about RES A he stated he had a settled night however his catheter had not passed much urine in the night but had felt his abdomen and it felt empty. I asked [Mr El-Sheikh] had he performed a bladder wash out he stated no. I asked if had re catheterised RES A he also stated no. I asked if he knew how much urine was in the catheter at this present time his reply was no. I expressed major concerns to [Mr El-Sheikh] that it was not acceptable due to the previous problems which had occurred in his past medical history and he is already under urology. [Mr El-Sheikh] then stated he had given him his medication for his kidneys. I expressed major concerns and he had not acted on passing the minimal of around 30 mls per hour and with no disrespect the medication was not going to solve the pain and him being in retention. I expressed my own concerns as he had not acted on the pain and discomfort RES A was in and as I a registered nurse I felt he had not complied with the NMC guidelines and acted on RES A best interest; especially when the staff was raising concerns throughout the shift'.*

The panel also had regard to Resident A's Care notes and Catheter Care Policy and Procedure for Home 1,

The panel noted that you had catheterisation training the year before this incident.

In Resident A's care notes the panel noted that he had been pain all night and had not passed much urine and that it had been reported to you. Further the care note records show that: *'at 23.09 passed 100mls and was unhappy; 00.12 catheter fluid not passed...given a drink...back in 10 mins; 04.30 pain not slept; 06.37 did not need catheter emptied'.*

In your oral evidence you told the panel that one of the reasons for Resident A not passing urine was because he had diarrhoea, however the panel noted that this was not

mentioned before by you at any stage prior to the hearing nor was it recorded in the notes. You told the panel that Resident A's leg was up 45 degrees and you had put his leg down, yet there is nothing in the care notes to show that this was done You did not mention this at handover to Witness 8 neither did you mention it on the phone with Witness 9.

In Witness 8's oral evidence she told the panel that she has no reason not to be truthful about these events. You told the panel in your oral evidence that you felt Resident A's abdomen yet there is no record to show that you did so. The panel was of the view that had you checked Resident A's abdomen you would have discovered that his bladder was full, distended and sore which is what Witness 8 found when she took over the shift. As a consequence, she re-catheterised Resident A and 750mls of urine was drained from his bladder.

You stated in your statement that you were informed of an issue, assessed the catheter, and established it was not draining correctly.

> *'I deny the allegation. I was informed that there was an issue, and I assessed the catheter and established that it not draining correctly. On assessment I also saw that the catheter was attached to the patient's leg which was higher than his head. This would have made it impossible for the catheter to fill with urine. I then placed the catheter lower and it drained'..*

The panel noted however that reference to the catheter bag being higher than Resident A's head is not mentioned in the patient's notes nor in the handover to Witness 8 in the morning of 6 August 2020. You appear to only have mentioned it in your written statement this week and this has not been referred to previously.

Resident A's care notes at 04.27 states that the catheter bag did not need to be emptied. You said that Resident A's bladder was empty, however Witness 8 when starting her shift found the resident to have a full, distended and sore abdomen, which

suggests that you did not assess the resident nor whether the catheter was draining urine correctly.

Whilst the panel accept that you may have moved the catheter bag, there is no record of this or to show that you went back to check it again. When Witness 8 assessed the resident at the beginning of her shift, she re-catheterised him and drained 750mls out of his bladder. The panel determined that you may have done an assessment of sorts but did not record this in the resident's care notes, or tell Witness 8 at handover. Nor did you go into any detail when telephoned by Witness 9. Therefore, the panel determined it could not have been draining urine correctly.

The panel determined that you did not go back and check if any urine was draining from the resident. Had you done so there would not have been 750mls of urine two hours later.

The panel took into consideration your written statement however reference to the catheter bag being higher than Resident A's head has only been brought to the panel's attention during this hearing.

The panel determined that it is clear from the catheter policy of Home 1 that an assessment of the resident should have included the following process:

> *'Document the catheter blockage history*
>
> *Undertake a full assessment of the need for catheter maintenance solutions If a catheter becomes blocked, it is imperative to respond in a timely manner due to the discomfort caused to the Residents as well as the risk of damage to their bladder and kidneys.*
>
> *In the event of a blocked catheter, trained staff should: Review the activity and mobility of the Residents (check for catheter position, catheter kinking, etc.) and remedy accordingly Review and monitor the Residents' diet and fluid intake as well as considering constipation as a factor'*

The panel determined that you failed to comply with this policy. Consequently, the panel finds that on the balance of probabilities, it is more likely than not that you did fail to assess whether the catheter was draining urine correctly.

The panel therefore finds this charge proved.

Charge 17

> That you a registered nurse;
>
> On 6 August 2020 having been informed that there was an issue with Resident B's catheter did not:
> (a) Assess whether the catheter was draining urine correctly, and/or
> (b) Conduct a bladder wash, and/or
> (c) Re-catheterise Resident B.

This charge is found proved in its entirety

In reaching this decision, the panel took into account Witness 8 and Witness 9's respective witness statements and oral evidence.

In Witness 8's local statement she says that she asked you if you had any issues with Resident B and you said that you had no issues. You deny that anyone informed you that Resident B's catheter had not been draining during the night.

The panel took into account Resident B's care notes which shows an entry stating that the catheter did not need to be emptied and that he had a night bag on. You did not inform Witness 8 that Resident B had not passed urine all night and there was no record that you had checked Resident B. Witness 8 says in her statement that she had been told by a colleague when she arrived on duty that there was concern that Resident B's catheter was only draining small amounts of urine during the night.

Witness 8 states:

'...I performed a successful bladder washout. Resident B's urine continue to drain and he was monitored throughout my shift.'

This is confirmed in Resident B's care notes and corroborated in Witness 8's local statement.

The panel determined that you also failed to comply with Catheter Care policy of Home 1.

The panel therefore finds this charge proved in its entirety.

Charge 19

That you a registered nurse;

On 6 August 2020 handed over to Colleague 1 two residents that were deceased.

This charge is found proved

In reaching this decision, the panel took into account the respective witness statements and oral evidence of Witness 8 and Witness 9

The panel considered your oral evidence that you handed over to Witness 8, however when questioned by the panel you said it was a mistake. You said that you mentioned the deceased one at a time. When asked why you mentioned them at all, you said it was in your mind and that you had no notes. You refuted Witness 8's evidence that you handed over these two deceased residents to her.

The panel took into consideration your statement where you admit to mentioning the two deceased residents but denied handing them over to Witness 8. You also deny telling Witness 9 that you had handed them over to Witness 8.

In Witness 8's written witness statement, she says:

> *'He said the residents names, I can only remember initials of the residents, possibly – and –He said they had had settled nights. I interrupted him when he said the first deceased residents name and I told him they were deceased. I can't remember his response. When he read the second name out who was also deceased. I said something like "Are you joking? That's the second deceased resided [sic] you've handed over". Again I can't remember his response.'*

In Witness 9's written witness statement, she says:

> *'I asked the Registrant why had he handed over deceased residents. He did not give a reason for this. He said that it was just a mistake...'*

Witness 9 went on to explain that if the residents are deceased they would be taken off the Primary Care Support (PCS) sheet.

The panel considered your evidence to be vague and inconsistent, for example, in your statement provided at the hearing you stated that:

> *'I deny that I handed over two residents who were deceased, I mentioned them at handover as they were on my list, I explicitly said they were dead and deny that I told [Witness 9] that I made a mistake in handing them over'*

You were unable to provide the panel with a plausible or logical explanation as to why you would mention two patients who had been deceased for some time.

The panel considered Witness 8 and Witness 9 to be reliable and credible witnesses whose evidence in this matter was consistent throughout.

The panel therefore finds that on the balance of probabilities that this charge is proved.

Charge 20

> That you a registered nurse;
>
> On one or more occasions between July 2019 and September 2019 did not complete medication rounds in a timely manner.

This charge is found NOT proved

In reaching this decision, the panel took into account Witness 9's witness statement and oral evidence.

The panel was of the view that there is no documentary evidence from the NMC, or any policy to show that the medication rounds had to be done within a specific or approximate period of time.

The panel determined this charge to be unspecific. There was no documentary evidence in the form of warnings or reports before the panel to show you were not being timely with medication rounds.

The panel found no evidence upon which it could find this charge proved. Witness 8 spoke to this charge in her oral evidence, however was unable to provide any specific examples of times or dates when these events occurred.

The panel therefore finds this charge not proved.

Charge 21

That you a registered nurse;

On or before 4 September 2020 made the following incorrect declarations to Priory Group:
(a) That your reason for leaving your employment with the Royal Liverpool and Broadgreen University Hospital was, “Contract terminated and I retired” or words to that effect.
(b) That your reason for leaving your employment with the Royal Liverpool and Broadgreen University Hospital was, “Resignation” or words to the effect.
(c) That your employment ended with Alt Park Nursing Home in “September 2020”.

This charge is found NOT proved in its entirety

In reaching this decision, the panel took into account the witness statement and oral evidence of Witness 1. The panel also had sight of your curriculum vitae and your Priory Group application form.

The panel considered your Priory Group application form. It was mindful that this charge refers to events on or before 4 September 2020. The panel examined the application form and could find only one reference to a date on or before 4 September 2020 and that was a note which mentions the date 25 August 2020 which is a copy of your P45 record. The panel could find no reference or declaration made by you to the Priory Group dated on or before 4 September 2020.

The panel also considered the oral evidence and witness statement of Witness 1. The panel was of the view that there is no reference to any interaction with the Priory group before 4 September 2020. The panel noted the Priory Group’s Interview Framework of your interview that took place at 12:00 noon on 4 September 2020. However, this still

does not provide any evidence to show any incorrect declarations on or around 4 September 2020.

The panel therefore could find no evidence upon which to find this charge not proved. Consequently, the panel finds this charge not proved.

Charge 22

> That you a registered nurse;
>
> Your declarations in charge 21(a) and/or 21(b) and/or 21(c) were dishonest in that you were attempting to mislead the Priory Group about your employment history.

This charge is found NOT proved in its entirety

On the basis that Charge 21 is found not proved in its entirety, it follows that the panel also finds this charge not proved.

The hearing resumed on Wednesday 21 February 2024

Fitness to practise

Having reached its determination on the facts of this case, the panel 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 ability to practise kindly, safely and professionally.

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

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

You gave further evidence under oath. Ms Shah and the panel asked you questions to which you responded.

Submissions on misconduct

Mr Kewley provided the panel with full written submissions, which included the following:

> *'4. The panel may be assisted by the following case law and guidance:*
>
> *a. In Roylance v General Medical Council (no.2) [2000] 1 A.C 311, Lord Clyde held that:*
> *'misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'*
>
> *b. Subsequent case law has confirmed that misconduct must be sufficiently 'serious' (see, for example, Mr Justice Elias in Remedy v General Medical Council [2010] EWHC 1245 (Admin) at paragraph [37]).*
>
> *c. In Calhaem v General Medical Council [2007] EWHC 2606 (Admin), Mr Justice Jackson provided the following guidance in relation to misconduct: '[39] From this review of the authorities, I derive five principles which are relevant to the present case:*

(1) Mere negligence does not constitute "misconduct" within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "misconduct".

(2) A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as "misconduct".

(3) "Deficient professional performance" within the meaning of 35C(2)(b) is conceptually separate both from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work. (emphasis added)

(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "deficient professional performance".

(5) It is neither necessary nor appropriate to extend the interpretation of "deficient professional performance" in order to encompass matters which constitute "misconduct".'

5. In determining whether any of the facts amount to misconduct the panel may be assisted by reference to 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates' (effective 31 March 2015): 1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
6.2 maintain the knowledge and skills you need for safe and effective practice
10 keep clear and accurate records relevant to your practice
10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
20 uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times

6. The facts in this case engage different aspects of the Registrant's nursing practice from record keeping to catheter care across two separate places of employment. The panel will note that there appears to be repetition of similar issues across the two places of employment. The assessment of seriousness is a matter for the panel alone,...'

Mr Kewley then provided detailed submissions on certain charges that the panel took into consideration whilst making its decision on misconduct.

Ms Shah provided the panel with full written submissions, which included:

1. *'At the outset of proceedings, the majority of the factual charges were admitted by Mr El Sheikh. There were no admissions regarding misconduct. The panel have found the following additional charges proved: 8, 9, 10(a), 10(b), 11(a), 11(b), 12, 15(a), 17(a), 17(b), 17(c), and 19. The panel has now come to conclusions on the circumstances of the facts. At this stage, the panel is tasked with establishing whether the admitted facts amount to misconduct and whether Mr El Shiekh's fitness to practise is currently impaired.*

2. *Having heard all of the evidence in the case, and in light of the panel's findings of fact, it is admitted, on behalf of Mr El Sheikh, his conduct in relation to the charges found proved by the panel (apart from those he admitted) amount to misconduct. The panel is invited to find that his fitness to practise is not currently impaired.'*

Ms Shah set out appropriate case law and further stated:

16. *'It is for the panel to assess the nature and seriousness of the misconduct, however serious misconduct is admitted. Mr El Sheikh has always been*

apologetic for his failings as demonstrated by the panel during his evidence today and his evidence earlier (despite raising contextual matters in mitigation).

17. *The panel should note that nothing within these submissions is intended to detract from El Sheikh's own professional accountability. Many of the allegations it is submitted do not amount to misconduct. Some of the evidence heard by the panel from the witnesses demonstrates that many charges represent genuine errors contributed by the circumstances in which Mr El Sheikh found himself rather than wilful or reckless omissions.'*

Ms Shah then went on to provide detailed submissions on many of the charges which the panel took into consideration in making its decision.

Decision and reasons on misconduct

The panel had regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives 2015 (the Code) in making its decisions.

The panel heard and accepted the advice of the legal assessor, which included reference to: NMC guidance FTP-2a on Misconduct and DMA-1 on Impairment, as well as reference to a number of relevant judgments. These included: *Roylance v General Medical Council (no.2)* [2000] 1 AC 311; *Meadow v. General Medical Council* [2007] 1 All ER 1); *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin)).

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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 breaches of the Code.
Specifically:

‘1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

2.6 recognise when people are anxious or in distress and respond compassionately and politely

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

To achieve this, you must:
10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

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

10.3 complete records accurately and without any falsification, ...

11.1 only delegate tasks and duties that are within the other person’s scope of competence, making sure that they fully understand your instructions

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, ...'

The panel acknowledges that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the Charges found proved individually and made the following decisions:

1(a), 1(b), 1(c)

1. On 22 June 2016 did not record Patient D's saturations levels on their Observation Scores and Pain Assessment Chart at: (a) 15.00. (b) 16.00. (c) 16.30

The panel was of the view that you were responsible for the patient and you admitted to not taking Patient D's observations. You said that Witness 7 had taken the chart to photocopy it so you could not record the saturation levels. In her evidence the witness said she took the chart after the time when the saturation levels were due to be recorded. The panel was therefore of the view not recording them put the patient at significant risk of harm. The panel was of the view that saturation levels are a fundamental part of nursing care for patients in the immediate post-operative phase and failure to record could impact or inform future treatment and therefore are important aspects of care. The panel therefore decided that your failings in respect of the entirety of this charge amount to misconduct.

2(a), 2(b), 2(c)

> *2. On 22 June 2016 did not take Patient D's saturation observations at: (a) 15.00. (b) 16.00. (c) 16.30*

The panel considered that by your own admission you did not take Patient D's saturation observations and that you recognise that it was a failure on your part. The panel was of the view that you were the lead nurse for Patient D and that it was your responsibility to ensure that the saturation readings were taken, notwithstanding that Witness 7 came to help you. As outlined above, knowledge of saturation levels are a vital part of initial assessments. Notwithstanding your claim to have been busy doing other important tasks, you did not complete these observations at any time during the 90 minute period of time in question. The panel therefore decided, that your failings in respect of this charge amount to misconduct.

> *3. On 22 June 2016 did not conduct observations on Patient D at 15 minute intervals between 15.00 and 16.30 hours.*

You admitted to not taking observations in Charge 2 and said that Witness 7 took the paperwork and that you could have written them down elsewhere. The panel had regard to Witness 7's written statement in which she states that if a patient has a low respiratory rate, she would have expected the nurse to perform observations every 15 minutes and at a minimum every 30 minutes.

The panel took note of the fact that you had 2 patients to look after in recovery. However this was not unusual and observations were still required to be conducted for both patients.

The panel was of the view you had sufficient time to conduct the observations on Patient D at 15 minute intervals. The panel noted your admission to not conducting Patient D's observations at 15 minute intervals for over an hour and a half and you said the reason for this is because you were busy. The panel accept that you were busy, however it was of the view that there was sufficient time to conduct these important observations over the relevant period of time. The panel determined that irrespective of

how busy you were it is not acceptable that you failed in your duty of care to Patient D in a post-operative setting.

As a consequence, the panel therefore decided that your failings in respect of Charge 3 amount to misconduct.

> *4. On 22 June 2016 having administered a second 2mg dose of Oxycodone to Patient D at 16.05 did not record this on Patient D's EPMA chart*

The panel had regard to the Medication Administration Profile for the Hospital and noted that you did not record the second 2mg dose of Oxycodone on the Electronic Prescribing and Medicines Administration (ePMA) chart as you ought to have done. The panel noted that you said you recorded it on the perioperative booklet, however it was of the view that it should be recorded on the ePMA chart which is timestamped and the prime place for recording drug administration. The panel considered that by you not recording the administered medication, other colleagues taking over from you might not be aware that the drug had been administered and could have potentially given more oxycodone to Patient D than was prescribed. The panel noted that you said that you had administered the second dose of oxycodone at 16.05. Oxycodone can cause respiratory depression and patients respiration rate was already inconsistent and at times low. Giving an extra dose and not recording it could have put the patient at risk of harm if an unsuspecting colleague had given a third dose. The panel therefore decided, that your failure in respect of this charge amounts to misconduct.

> *5. On 22 June 2016 did not seek a review from Doctor Lane prior to administering 2mg of Oxycodone to Patient D at: (a) 15.40 and/or (b) 16.05.*

The panel took account of Dr 1's evidence. It determined that it is clear that you did not need to seek a review from Dr 1 prior to administering 2mg of Oxycodone to Patient D at these times. The panel therefore decided, that your action in respect of this charge does not amount to misconduct.

7. On 10 November 2016 having emptied Patient C's catheter into a bottle did not immediately take it to the sluice room to be emptied

The panel noted that there was no evidence to show how long the bottle had been sat on the floor ready to be taken to the sluice, and Witness 2 said in evidence that you were engaged in writing up notes at the time. The panel noted your admission and determined that it was unreasonable to expect you to take it immediately to the sluice as there may have been greater priorities at the time. The panel therefore decided, that your action in respect of this charge does not amount to misconduct.

8. On 10 November 2016 failed to prevent air from getting into Patient C's catheter tube by not replacing the irrigation fluid.

The panel had regard to Witness 2's witness statement and oral evidence. The panel accepted Witness 2's evidence that she noticed that irrigation fluid had run through and there was air in the catheter tubing and that she tried to get the air out of the tubing to reinitiate the flow of the bladder irrigation in order to prevent Patient C from *'clotting off'.* The panel was of the view that because air got into the catheter tube there was a risk of the patient suffering serious harm and could have needed to be re-catheterised. The panel determined this to be a potentially serious matter for the patient and therefore decided that your failings in respect of this charge amount to misconduct.

9. On 10 November 2016 failed to empty Patient C's urinary catheter bag when requested

The panel was of the view that a full catheter bag attached to a catheter has potential to cause the patient harm to them in that a full bag would prevent the bladder from draining further, potentially causing pain, clotting and blockage. The panel therefore determined that your failings in respect of this charge amount to misconduct.

10.On 10 November 2016 did not investigate why Patient C's monitor did not take blood pressure readings at: (a) 11.40. (b) 11.50

11.On 10 November 2016 inaccurately recorded in Patient C's perioperative booklet blood pressure readings at: (a) 11.40. (b) 11.50.

12. Your actions in charge 11 were dishonest in that you were attempting to mislead others into believing that the monitor had recorded blood pressure readings when you knew that it had not.

The panel considered the seriousness of not taking accurate blood pressure readings of a post-operative patient. The panel determined that this could have put the patient at risk of serious harm because a patient's blood pressure can change very quickly post operatively. Blood pressure is a key indicator of their post-operative condition and would alert staff to signs of bleeding and shock as well as other key parameters.

The panel determined that you misled colleagues into believing that the monitor had correctly recorded blood pressure readings, thereby potentially putting patients at risk because the blood pressure readings were inaccurate. The panel was of the view that this was dishonesty in a clinical setting and falsification of clinical records potentially puts patients at risk, by providing an incomplete record of the patient's condition and care.

The panel therefore determined that your action in respect of Charges 10, 11 and 12 amounts to misconduct.

13. On 10 November 2016 did not take Patient C's blood pressure using the sphygmomanometer at: (a) 11.40. (b) 11.50.

The panel considered that the first reference to the sphygmomanometer in this case occurs some five years after the incident during the internal investigation. The panel was of the view that there is no evidence to show that there was a manual sphygmomanometer available to you in the department, nor did any of the other witnesses say this should have been done. The panel determined that your failing in respect of this charge does not amount to misconduct.

14. On 10 November 2016 did not complete Patient C's recovery care plan.

The panel was of the view that a recovery care plan sets out the framework for how a patient is to be cared for and that it is fundamental to everything done from the moment a patient arrives on the ward. The panel determined that it is a baseline document for a patient coming out of theatre post operatively and is not something that should be completed retrospectively. The panel decided it was reasonable to have the initial recovery care plan completed comfortably with a 29 minute time span. The panel therefore decided that your failing in respect of this charge amounts to misconduct.

> *15. On 6 August 2020 having been informed that there was an issue with Resident A's catheter did not: ...(a) Assess whether the catheter was draining urine correctly, and/or (b) Conduct a bladder washout, and/or (c) Re-catheterise Resident A.*

The panel considered the evidence which shows that the patient needed to be re-catheterised and 750ml was subsequently drained from his bladder by the nurse who took over from your night shift. The panel saw evidence from the Patient Care Records that the patient had been in discomfort, in pain and had been crying out. The panel determined that because you did not assess the patient and take the appropriate actions, you could have put at serious risk of harm. The panel took into account your evidence that you felt that it was not safe to carry out a bladder washout or re-catheterisation and that you said you did not have the correct experience for those procedures. However, the panel determined that if that were the case a General Practitioner (GP) should have been called or arrangements made to transfer the patient to hospital. You did not do either of those things and so the panel determined that your failings in respect of this charge amount to misconduct.

.

> *16. On 6 August 2020 did not record the care provided on Resident A's PCS care notes*

The panel had sight of Resident A's Person Centred Care Notes. There is no entry made by you on this patient nor anything to suggest that you looked at this patient. Whilst the panel accepts that you were not confident using the iPad technology and delegated note taking to HCA's, the panel was of the view that you were responsible to

ensure that the care provided was properly recorded and you should have checked what the HCA had written and to check that the notes were comprehensive enough. The panel determined that the notes in the record included insufficient detail of a full patient assessment and you failed to set out the rationale for the patient's care during your shift. The panel therefore decided, that your failing in respect of this charge amounts to misconduct.

> *17. On 6 August 2020 having been informed that there was an issue with Resident B's catheter did not: (a) Assess whether the catheter was draining urine correctly, and/or (b) Conduct a bladder wash, and/or (c) Re-catheterise Resident B.*

The panel had regard to the patient care notes which show that you were advised of potential catheter issues. The panel heard evidence from Witness 8 that she conducted a bladder wash out and some 500ml was drained from the patient. The panel determined that based on the information you received you should have complied with the Catheter Care Policy of Home 1. You failed to comply with the Policy and as a consequence, the patient suffered unnecessary discomfort and pain. Therefore, the panel determined that your failings in respect of this charge amount to misconduct.

> ***18**.On 6 August 2020 did not record the care provided on Resident B's PCS care notes.*

The panel had sight of Resident B's Person Centred Care Notes. There is no entry made by you on this patient nor anything to suggest that you looked at this patient. Whilst the panel accepts that you were not confident using the iPad technology and delegated note taking to HCA's, the panel was of the view that you were responsible to ensure that the care provided was properly recorded and you should have checked what the HCA had written and to check that the notes were comprehensive enough. The panel determined that the notes in the record included insufficient detail of a full patient assessment and you failed to set out the rationale for the patient's care during your shift. The panel therefore decided, that your failing in respect of this charge amounts to misconduct.

19. On 6 August 2020 handed over to Colleague 1 two residents that were deceased

The panel considered that you were a permanent member of staff who ought to have known those patients had passed away some time ago. You handed them over which shows that you were not checking on them to know how they were during the course of your shift. The panel had regard to Witness 8's written witness statement where she stated that you should have known they were deceased because you were responsible for all the residents as the nurse in charge of the shift. Notwithstanding the above, the panel noted that your actions in relation to this charge did not place residents at risk of harm.

The panel does not find that this amounts to misconduct.

The panel concluded that your actions as set out above with respect to Charges: 1(a); 1(b); 1(c); 2(a); 2(b); 2(c); 3; 4; 8; 9; 10(a); 10(b); 11(a); 11(b); 12; 14; 15(a); 15(b); 15(c); 16; 17(a); 17(b); 17(c) and 18, did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Submissions on impairment

Mr Kewley provided the panel with written submissions on impairment. He addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The submission also included reference to the legal authorities in *Kimmance v General Medical Council* [2016] EWHC 1808 (Admin), *Cohen* and *Grant.* Mr Kewley submitted that all four limbs of *Grant* are engaged in this case. He also advised the panel that a finding of dishonesty is considered difficult to remediate. He concluded that a finding of current impairment is ultimately a matters for the panel's own judgement.

Ms Shah also provided the panel with written submissions on impairment. In summary, she submitted:

‘33. It is submitted the Registrant’s fitness to practice is not currently impaired for the following reasons:

(i) The panel have heard the Registrant has no other fitness to practice referrals or findings against him despite practicing for 3 decades;

(ii) The Registrant had engaged with the NMC process and clearly respects and understands its importance to promote patient safety.

(iii) The Registrant has exhibited remorse and insight in respect of his failures.

(iv) He has been able to explain to the panel what the risks were to patients and also the impact of his failures, including dishonesty, on the nursing profession as a whole.

(v) The Registrant was bullied for his age by Margaret Balmer (she herself acknowledged she made comments about writing his memoirs). Further Miss Fitzpatrick was quick to jump to the conclusion and gather evidence of falsification of records (which were never proceeded with as they were misguided but did form the basis of her initial complaint against the Registrant). This created an emotionally distressing situation for the Registrant and can explain the stress and nervousness he felt when working.

Public interest

34. It is submitted that in light of the Registrant’s long history of unblemished service, the insight he has shown and his apology, an informed member of the public would not expect a finding of impairment in this case.’

Decision and reasons on impairment

The panel took account of both parties written submissions when considering whether your fitness to practise is currently impaired. The panel considered Article 3(4) of the Nursing and Midwifery Order 2001 and accepted the advice of the legal assessor.

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.'*

Taking into account its findings on facts and all of the evidence adduced in this case, the panel determined that all four limbs in the above test are engaged. The panel then went on to consider whether your fitness to practise is impaired at the current time.

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 considered the *Cohen* test:

> *'a. whether the misconduct is capable of remediation;*
> *b. whether it has been remediate; and*
> *c. whether the misconduct is highly unlikely to be repeated.'*

and the NMC guidance on impairment in regulatory proceedings, that is *'can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

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

Regarding insight, the panel acknowledged that you made some early admissions, apologised and expressed remorse during the hearing in your oral evidence at the facts and misconduct stages. You also provided a brief reflective piece. However, the panel was of the view that your insight was limited, for example, whilst telling the panel you accepted responsibility for your actions, you also frequently deflected blame onto

colleagues and your working environment. The panel was of the view that your insight was not sufficiently developed to address the regulatory concerns found proved.

The panel finds that your misconduct put the well-being of patients at significant risk of harm. It noted the number of past incidents that put patients at risk of harm, and on one occasion of actual harm where a patient was in pain and discomfort. The panel finds that your failings in relation to these incidents occurred over a number of years while working for two separate employers at three different locations. The panel therefore was of the view there is a significant risk of repetition of a similar kind occurring in the future.

The panel considered whether your misconduct in relation to your clinical practice is capable of being remediated. The panel was of the view that the clinical failings identified can be remediated with appropriate training, clinical supervision and full engagement by you. The panel bore in mind that dishonesty is particularly difficult to remediate. However, it noted that the dishonesty found proved in this case relates to a single act and considered it to be potentially remediable.

The panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. In terms of training, in evidence you told the panel that you had last undertaken any training in 2021 when you were employed in a nursing home setting. Since then you said that you have a nursing journal subscription and had read articles on children with high temperatures and female genital mutilation (FGM). You said that you had completed some online training as well as the mandatory training in your last substantive role. This included communication, drug administration, conflict resolution and equality and diversity. The panel was not provided with any independent evidence of any training or other activity undertaken to strengthen your practice.

The panel acknowledged the difficulties you have had in demonstrating strengthened practice as you have not practised as a nurse for some time. Nevertheless, the panel had no evidence before it to show that you can practice kindly, safely and professionally as a nurse at the current time. Therefore, there is a high risk of repetition based on insufficient evidence of insight and strengthened practice.

On the basis of all the information before it, the panel decided that there is a risk to patients if you were allowed to practise without restriction. The panel heard evidence from colleagues from different work places who raised concerns about your practice and the safety of patients in your care. Repeated failings were found proved over a long period of time and at various work sites, many of which did or could have resulted in harm to patients and you have shown limited insight into these failings. The panel therefore determined that a finding of current impairment on public protection grounds is necessary.

The panel was of the view that your misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. Further, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months with review. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Submissions on sanction

Mr Kewley provided the panel with written submissions.

The panel were informed that the NMC had given you advance notice of its sanction position, which is a suspension order for 12 months with review, if it found your fitness to practise currently impaired.

Mr Kewley submitted that the following aggravating factors are met in this case:

- *'Dishonesty linked to the Registrant's clinical practice*
- *Registrant's lack of insight (and subsequent 'high' risk of repetition);*
- *Pattern of misconduct occurring over a long period;*
- *Misconduct which put patients at risk of suffering harm (and one instance of actual harm as identified by the panel)'*

Mr Kewley referred to the NMC Guidance: FTP-3*: 'how we determine seriousness'.* He outlined relevant examples in the sub-section '*serious concerns which are more difficult to put right,'*. These included cases involving falsifying records, failing to prioritise people, practise effectively and promote professionalism and trust.

Mr Kewley submitted that making no order or imposing a caution order would be insufficient to protect the public and would fail to address the risk of repetition that has been identified.

He submitted that a conditions of practice order would not be appropriate as the charges raise concerns about fundamental areas of your nursing practice which have not yet been addressed. The concerns also arose across separate places of employment and span a wide range of dates. Also, there has been very little by way of insight and remediation. He submitted that the risk of repetition has been identified as '*high'* and in these circumstances, the panel may wish to consider whether the concerns can in fact be managed with a conditions of practice order in circumstances where you have not remediated the concerns. He further submitted that the dishonesty allegation elevates the seriousness of this case beyond that which can be properly addressed through conditions of practice.

Mr Kewley submitted that in these circumstances the panel is invited to impose a suspension order, in order to protect the public and maintain public confidence in the nursing profession. He submitted that a period of 12 months with review will mark the unacceptability of acting dishonestly in respect of the falsification of a patient record. If the panel does impose a suspension order, he submitted that the panel may wish to give an indication as to the material a future reviewing panel may find useful when the order is reviewed.

The panel also considered Ms Shah's oral submissions. She also referred the panel to the SG and reminded the panel when considering the purpose of imposing a sanction that sanctions are not to be punitive, but are there solely to protect the public interest and the reputation of the profession.

Ms Shah submitted in mitigation, that you have given 30 years of service to the nursing profession without any regulatory incident. She submitted that you have engaged with these proceeding despite obvious difficulties and it has not been easy for you, but nonetheless you have prioritised engaging with the NMC over other matters in your life. She submitted that you have exhibited remorse which is a valid mitigating feature.

Ms Shah noted that the panel have taken the view that your misconduct is in fact remediable in circumstances where there is adequate training, supervision and oversight. In these circumstances and in light of the comments in the panel's decision, she submitted that the panel may wish to consider that in this particular case, it would be far better to impose a conditions of practice order. She submitted that conditions of practice would allow you to seek work in an environment where someone could monitor those conditions, and any other conditions the panel wish to formulate that would guard against any risk to the public.

Ms Shah invited the panel to consider the following conditions:

- You must not to be the only nurse on shift.
- You must not to work our own.
- You must work in a substantive position with one employer and not through an agency.

- You must not be the nurse in charge of any shift.
- You must meet with a line manager, mentor or supervisor on a fortnightly basis.
- You must provide any further reviewing panel with an appraisal of your standard of practice in respect of taking observations, record keeping and patient care.

Ms Shah submitted that a conditions of practice order would be a more appropriate outcome in this case, as suspension would not achieve the purpose of allowing you a proper opportunity to remediate. She invited the panel to consider the public interest in the safe return to practice of a good nurse.

Ms Shah submitted that any order more restrictive than a suspension order would be disproportionate and would not meet the objectives of the SG.

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:

- Lack of insight into failings
- A pattern of misconduct over a period of time and at various sites
- Conduct which put patients at risk of suffering harm
- Actual harm to one resident
- Dishonesty

The panel also took into account the following mitigating features:

- You apologised at the final stages of the hearing
- Your nursing career has spanned 30 years with no previous regulatory findings

- You engaged in the fitness to practise process [PRIVATE] and difficulties in participation

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the charges found proved. 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 is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *...*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges found proved in this case. Further, the panel considered the wide-ranging charges which included clinical failings in caregiving in different areas of your practice and at a number of locations. The panel further concluded that the level of support and oversight needed would be difficult to achieve and would not be practical in these circumstances.

Furthermore, the panel concluded that placing of conditions on your practice would not adequately address the dishonesty found proved in this case and would not adequately protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. However, the panel was of the view that the misconduct evidenced in some areas of your practice did present a risk to patient safety if you were allowed to practise even with conditions.

Whilst the panel acknowledges that a suspension may have a punitive effect, protection of patients was paramount and outweighed any punitive effect the decision may have on you.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be a disproportionately harsh sanction. Further, the panel was of the view the dishonesty found proved in this case was a one-off event and have determined that it is potentially remediable.

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

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

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

The panel determined that a suspension order for a period of 12 months with review was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by:

- Your attendance at a hearing
- Evidence of appropriate training linked to the charges found proved
- A comprehensive reflective piece setting out how your actions potentially affected patients and colleagues and what you have subsequently learned from your actions

- Testimonials and character references from line managers, supervisors and senior colleagues

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Kewley. He submitted that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest. He invited the panel to impose an interim suspension order for a period of 18 months for the reasons stated in the panel's findings on the substantive sanction.

Ms Shah opposed the interim order application.

Ms Shah submitted that the test for an interim order is that it is necessary on the grounds of public protection, is otherwise necessary on the public interest grounds or in your own interest, the latter not being engaged in this case. She submitted that although the panel have found proved a number of allegations above and beyond those you have admitted, the last of these incidents occurred some time ago, and over the course of the intervening period you have been subject to interim conditions of practice. She submitted that it is not necessary to suspend you for 28 days as there has not been any reoccurrence whilst you have been subject to an interim conditions of practice order, as opposed to an interim suspension order.

In relation to public interest, Ms Shah submitted that an informed member of public would question why an interim suspension order was necessary when there has been no reoccurrence of these incidents during the interim conditions of practice order.

Ms Shah requested that the panel consider proportionality when exercising their decision at this stage. She submitted that in the absence of any reoccurrence since the last incident, it is clear that an interim suspension order is not necessary in this case.

When questioned by the panel Ms Shah confirmed that whilst you have been subject to an interim conditions of practice order, although you were employed for a short period of time after these events, you have not practiced as a nurse since 2021.

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

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 noted that save only for a brief period of time, you have not practised as a nurse since 2021, and as such it would not be practical nor would it protect the public to impose an interim conditions of practice order in this case. The panel was of the view that members of the public would question why it had imposed an interim conditions of practice order when it had decided that the appropriate sanction in this case was a suspension order.

The panel considered an appropriate length of time that the interim suspension order should be in force. It noted that the NMC has no control over the appeal process and any shorter period of time may lead to a further panel having to extend the interim suspension order. Therefore, the panel made an interim suspension order for a period of 18 months.

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

This will be confirmed to you in writing.

That concludes this determination.