Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 4 March 2024 – Friday, 15 March 2024
Wednesday, 20 March 2024 – Monday, 25 March 2024

Virtual Hearing

Name of Registrant:	**Roshin Mohammed Sherif**
NMC PIN	21I0104O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (September 2021)
Relevant Location:	Cumbria
Type of case:	Misconduct/Lack of competence
Panel members:	Dr Katharine Martyn (Chair, Registrant member) Hannah Harvey (Registrant member) James Carr (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Monsur Ali [4-8 March 2024] Vicky Green [11-14 March 2024] Margia Patwary [20 – 22 March 2024] Clara Federizo [25 March 2024]
Nursing and Midwifery Council:	Represented by Simon Gruchy, Case Presenter
Mr Sherif:	Not present and not represented in his absence
Facts proved:	Charges 1.a., 1.b., 1.c., 1.d., 1.e., 1.f., 1.g., 1.h., 1.i., 1.j., 1.k., 1.l., 2.a., 2.b., 2.c., 2.d., 3.a., 3.b., 3.c., 3.d., 3.e., 3.f., 4.c., 5.a., 5.b., 5.c., 5.d., 6.b., 8, 10 (in respect of charge 8)
Facts not proved:	Charges 4.a., 4.b., 6.a., 7.a., 9
Fitness to practise:	Impaired

Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Sherif was not in attendance and not represented at the hearing.

The electronic Notice of Hearing had been sent to his registered email address on 2 February 2024. The panel also had sight of the witness statement which was signed and dated and confirmed email correspondence. The panel considered that the Notice of Hearing provided details of the substantive hearing, the time, dates, and the nature of the hearing. It also contained information about Mr Sherif's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Mr Gruchy, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

In light of all of the information available, the panel was satisfied that Mr Sherif had been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Sherif

The panel next considered whether it should proceed in the absence of Mr Sherif. The panel had regard to Rule 21 and heard the submissions of Mr Gruchy who invited the panel to continue in the absence of Mr Sherif.

Mr Gruchy submitted that there is ample evidence before the panel which demonstrates that Mr Sherif is fully aware of this hearing but had voluntarily absented himself. He further submitted that there are a number of witnesses arranged to give evidence and it is in the interest of justice to proceed in the absence of Mr Sherif.

The panel decided to proceed in the absence of Mr Sherif. In reaching this decision, the panel has considered the submissions made by Mr Gruchy and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones (Anthony William) (No.2*) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment had been made by Mr Sherif;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- There are witnesses lined up to give evidence so any delay would cause unjustifiable inconvenience to them; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Sherif.

Details of charge

That you a registered nurse between 28 September 2021 and 11 March 2022, whilst working at the North Cumbria NHS Foundation Trust did not demonstrate the standards of knowledge, skill and/or judgement required of a Band 5 nurse to practice without supervision in one or more of the following areas:

1. In relation to Medicines management:

    a. In November 2021 drew up medication without clinical justification and/or supervision. **[Proved in relation to 'without clinical justification' and not proved in relation to 'without supervision']**

b. On 27 February 2022 was unable to recall information regarding the medication doxycycline. **[Proved]**

c. On 27 February 2022 were unable to obtain sodium chloride from Omnicell. **[Proved]**

d. On or around 3 March 2022 did not understand why stat medication was needed in addition to routine medication. **[Proved]**

e. On or around 3 March 2022 took 5mg of prednisolone out instead of 50mg out of the Omnicell. **[Proved]**

f. On or around 3 March 2022 attempted to obtain 375mg Carbocisteine instead of 750mg out of the Omnicell. **[Proved]**

g. On or around 3 March 2022 when informed that IV fluids were prescribed for a patient did not ensure that this was done. **[Proved]**

h. On or around 5 March 2022 didn't understand that you didn't need to give medication to a patient as they had self-medicated. **[Proved]**

i. On 7 March 2022 when administering a subcut injection did not administer the full dose as you removed the injection prematurely. **[Proved]**

j. On 9 March 2022 when asked to obtain Levothyroxine out of the Omnicell, typed 125mg into the 100mg Levothyroxine section. **[Proved]**

k. On 9 March 2022 on being required to administer 500mg of Ranolazine stated that you would administer 1 and half tablets of Ranolazine which is an excessive amount. **[Proved]**

l. On an unknown date attempted to draw up oral medication in the normal IV medication cannula which is incorrect. **[Proved]**

2. In relation to care planning and other documentation/clinical handover:

   a. On 5 March 2022 when documenting information for a patient in bed 5, documented information relating to other patients. **[Proved]**

   b. On 7 March 2022 relied on the handover provided to you at 7am when providing information to staff regarding the patient throughout the day without taking into account the patients changing circumstances. **[Proved]**

   c. On 9 March 2022 provided poor handover in that it was unclear. **[Proved]**

   d. Between 7 and 8 April 2022 were not clear in your documentation in that you:

      i. Did not complete the daily nursing care record – medicine and elderly care accurately for one or more patients. **[Proved]**

      ii. Did not sign and/or date the patient repositioning chart. **[Proved]**

3. In relation to Infection Control:

   a. On 3 March 2022 did not deal with a urine spill by a patient appropriately in that you did not ensure that it was cleared up straight away. **[Proved]**

   b. On 3 March 2022, did not wear your mask correctly in that it was below your nose. **[Proved]**

c. On one or more occasions did not wear the correct PPE and/or any PPE. **[Proved]**

d. On or around 5 March 2022 tried to attach fluids with no PPE on. **[Proved]**

e. On or around 5 March 2022 did not change your gloves between patients. **[Proved]**

f. On or around 5 March 2022, did not wear your mask correctly in that it was below your nose. **[Proved]**

4. In relation to Moving and Handling:

a. On 29 January 2022 did not assist with the moving and handling of a patient. **[Not proved]**

b. On 29 January 2022 when asked to sit a patient up in bed proceeded to remove a pillow as opposed to adjusting the bed. **[Not proved]**

c. On 27 February 2022 Were unable to correctly position an elderly patient so that she had her breakfast and call bell to hand. **[Proved]**

5. In relation to Communication:

a. On 7 March 2022 did not listen to what a patient told you in relation to their preference for taking medication. **[Proved]**

b. On an unknown date interrupted colleague 1 unnecessarily when they were setting up a palliative syringe driver for a patient. **[Proved]**

c. On 5 March 2022 whilst colleague 2 was attempting to put pads on a patient, tried to take the pads out of colleague 2 hands for no good reason. **[Proved]**

d. On or around 9 March 2022 proceeded to wash a female patient without asking them if they preferred a female to wash them. **[Proved]**

6. In relation to Escalation:

a. On 3 March 2022 on becoming aware that a patient had a high temperature did not escalate. **[Not proved]**

b. On 9 March 2022 did not escalate one or more of the following patients to a Doctor.

i. An unknown patient with a blood pressure reading of 235/91. **[Proved]**

ii. An unknown patient with a blood pressure reading of 90/42. **[Proved]**

7. In relation to IT issues:

a. On 29 January 2022 attempted to enter observations onto another colleagues Webv when you were supposed to enter them onto your own Webv. **[Not proved]**

8. Did not inform the Select Healthcare Group that you were subject to an NMC investigation. **[Proved]**

9. Did not inform the Select Healthcare Group that you were subject to an interim conditions of practice order imposed on 4 August 2022. **[Not proved]**

10. Your actions at charges 8 and /or 9 were dishonest in that you sought to conceal the fact you were subject to an NMC investigation and/or an interim conditions of practice order in order to continue employment with the Select Healthcare Group. **[Proved in respect of charge 8]**

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence in relation to charges 1 – 7 and misconduct in relation to charges 8 - 10.

Background

Mr Sherif was referred to the NMC by West Cumberland Hospital (the Hospital), North Cumbria Integrated Care NHS Foundation Trust (the Trust) on 14 July 2022. The referral relates to Mr Sherif who was formerly employed by the Trust as a Band 5 Staff Nurse. Mr Sherif first started working at the Trust on 28 June 2021 where he worked as a healthcare assistant until he received his NMC PIN in September 2021. Mr Sherif was one of the 197 international nurses recruited to the Trust due to vacancies.

Despite a thorough induction and preceptorship programme and being moved to areas for increased support and supervision, concerns were raised about Mr Sherif's ability to perform as a registered nurse in the Band 5 role as he was not able to demonstrate safe and effective practice.

The Trust stated that they provided Mr Sherif with pastoral support, clinical educator support and HR & Occupational Health support. Mr Sherif was also placed on an action plan for development.

At the beginning of Mr Sherif's employment in June 2021 he underwent additional training and undertook an Objective Structured Clinical Examination (OSCE) to gain his NMC PIN before being based in the Coronary Care Unit (CCU) in September 2021. After a short period, concerns were raised about Mr Sherif's capability to undertake the role and the

level of support required in addition to a lack of competence and confidence in performing core nursing skills.

Due to the level of support which Mr Sherif required and the small staffing ratio on CCU, it was felt that CCU were unable to support him, and it was agreed that Mr Sherif would be transferred to the Emergency Assessment Unit (EAU). This was because EAU had a higher staffing ratio and a clinical educator who could provide enhanced support and supervision.

Concerns were raised by multiple members of staff initially during the onboarding training, subsequently on arrival at CCU, on the EAU Ward and across the hospital. The concerns included:

- Inability to provide basic patient care;
- Inability to retain and apply information in that Mr Sherif had a poor recall of patient's conditions and plans;
- Inability to follow clear instructions;
- Inability to safely administer medication in that Mr Sherif attempted to administer nebulised solution intravenously, was unable to use the Omnicell (Smart medicines cabinet) effectively and on multiple occasions removed incorrect medications with similar spellings;
- Working outside scope of practice;
- Mr Sherif was unable to choose correct personal protective equipment (PPE) for the task and poor awareness of infection control issues for individual patients;
- Inability to use effective moving and handling techniques and risk assess situations in that there were several reports by portering staff, healthcare assistants (HCAs) and other departments about lack of understanding of safe use of hospital beds and basic control (steering etc) and safe transfer of patients;
- Inability to communicate effectively and share appropriate information in that there were multiple incidents of being unable to convey appropriate information to the correct person.

Increased support and supervision were provided for each of the above concerns. An action plan was created to support Mr Sherif. Further to the additional support on the EAU Ward, and as a result of the concerns, the clinical educator, Colleague 1, worked alongside Mr Sherif providing 1-1 support. In summary, enhanced support, additional direct supervision and study time was provided to Mr Sherif on EAU.

Throughout Mr Sherif's eight months on EAU, the above concerns and his inability to work independently without supervision, resulted in inefficiency in quality service delivery. A meeting was held with Mr Sherif to explore any underlying medical, psychological or language issues. The meeting did not identify any medical conditions or personal circumstance issues. Mr Sherif denied that he had any extra learning needs or requirements. Mr Sherif failed his final probationary review on 11 March 2022.

Mr Sherif's contract of employment was terminated by the Trust on 13 June 2022, after a final review hearing on 10 June 2022 held under the probationary policy. It was determined that despite the additional support provided, Mr Sherif was unable to carry out the basic tasks and achieve the competencies expected in the delivery of nursing care on the Ward. Mr Sherif did not work at the expected level of a band 5 staff nurse.

The Trust confirmed that no patients came to harm as a result of Mr Sherif's actions because he was supernumerary and supervised at all times.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case which included Mr Sherif’s response bundle. It also had regard to the submissions made by Mr Gruchy on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mr Sherif.

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

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

- Colleague 1: Employed by the Trust as a Clinical Educator at the Hospital.
- Colleague 2: Employed by the Trust as the Deputy Ward Manager of the Emergency Assessment Unit at the Hospital.
- Ms 3: Employed by the Trust as a Ward Manager at West Cumberland Hospital (the Hospital) at the time.
- Ms 4: Employed by the Trust as the Ward Manager of the Emergency Assessment Unit at the Hospital.
- Ms 5: Employed by the Trust as a Critical Care Outreach Sister at the Hospital.
- Ms 6: Employed by North Cumbria Integrated Care NHS Foundation Trust as the Clinical Recruitment Lead for Overseas Educated Nurses.

- Ms 7: Care Home Manager employed by Select Healthcare Group.

- Ms 8: Practice Development Facilitator: Deteriorating Patient and Clinical Nurse Editor at the Hospital.

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

Charge 1.a.

1. In relation to Medicines management:
    a. In November 2021 drew up medication without clinical justification and /or supervision.

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the oral and documentary evidence provided by Colleague 1.

The panel had sight of an email from Colleague 1 dated 18 November 2021 in which the following was stated:

> *'We discussed with him the very concerning incident regarding the saline nebuliser flush. He assured us that he was getting the flush out for somebody else (although he can't recall who) and that he had no intention of administering it himself. He says that as he was drawing it up he knew it was the incorrect preparation as there was too many ampoules. We made it very clear to him that we were disappointed and that this was a breach of our trust…'*

The panel also had sight of Colleague 1's witness statement, in particular, the following:

‘In November 2021, Mr Sherif was involved in a serious and very concerning incident involving a saline nebuliser flush. I discussed this incident with Mr Sherif during my meeting with him on 18 November 2021 []. My understanding of the incident was that a member of staff named [Ms 9] was in the clean utility room and Mr Sherif entered and asked if he could get a saline nebuliser flush from the Omnicell (electronic medicines cabinet). [Ms 9] allowed him to do this, but it took him a long time and he appeared to remove more than one item. As this was the case, [Ms 9] followed Mr Sherif and found that he was drawing up multiple ampoules into a syringe. [Ms 9] realised that this was normal saline for nebulisation. Mr Sherif had drawn up the incorrect saline. Initially, Mr Sherif was extremely defensive and stated he was unable to recall who had asked him to prepare the flush. However, Mr Sherif had firstly collected the incorrect saline, and secondly drawn up this medication. Mr Sherif was not competent to administer the medication as he had not had his medicines administration competency signed off. I was extremely worried that if [Ms 9] had not returned to Mr Sherif and observed what he was doing that he would have given the patient the incorrect medication.’

The panel had regard to Mr Sherif’s response in his bundle in which he acknowledged and apologised for the incident, and accepted that he should have checked the medication that he took from the drug cabinet.

The panel noted that from Colleague 1’s evidence, it appears that Mr Sherif was supervised by Ms 9 during the incident and it could therefore not find this charge proved based on the *‘supervision’* element of this charge.

The panel then went on to consider whether Mr Sherif drew up medication without clinical justification in November 2021. The panel found the oral evidence of Colleague 1 to be consistent with her contemporaneous email dated 18 November 2021 and her witness statement. The panel found her evidence to be credible and reliable in respect of this charge. The panel was satisfied that Mr Sherif drew up fluid into a syringe which should not have been and it heard evidence that if this fluid had been administered to a patient

then this could have caused serious harm. The panel therefore found that there was no clinical justification for drawing up this medication. Accordingly, the panel found this charge proved.

Charge 1.b.

1. In relation to Medicines management:

    b. On 27 February 2022 was unable to recall information regarding the medication doxycycline.

This charge is found proved.

In reaching this decision had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 1.

The panel had sight of an email from Colleague 1 to Colleague 2 dated 27 February 2022 in which the following is stated:

> *'When administering lunchtime medication (under my supervision) he was unable to recall the information about doxycycline that I had gone through with him the week before.'*

The panel also had regard to Colleague 1's witness statement, in which the following was stated:

> *'On 27 February 2022, Mr Sherif was unable to recall information about a medication named doxycycline.'*

The panel also heard oral evidence from Colleague 1 which it found to be consistent with the email dated 27 February 2022 and her witness statement. The panel found the

evidence of Colleague 1 to be credible and reliable in respect of this charge. The panel was satisfied that it was more likely than not that Mr Sherif was unable to recall information about a medication named doxycycline on 27 February 2022. Accordingly, the panel found this charged proved.

Charge 1.c.

1. In relation to Medicines management:
    c. On 27 February 2022 were unable to obtain sodium chloride from Omnicell.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 1.

The panel had sight of an email from Colleague 1 to Colleague 2 dated 27 February 2022 in which the following was stated:

> *'He then went into the wrong patient's room and took several minutes to work out which medication was for which of his patients (He had two). He was unable to obtain a sodium chloride flush from the Omnicell as he could not recall the name.'*

The panel had regard to Colleague 1's witness statement in which the following was stated:

> *'On this same shift on 27 February 2022, Mr Sherif was unable to obtain a sodium chloride flush from the Omnicell as he could not recall the name of the medication. I would expect that sodium chloride flush would be given universally and that he would be familiar with this drug. Mr Sherif was unable to type the name of the drug into the Omnicell.'*

The panel also heard oral evidence from Colleague 1. The panel found that Colleague 1's oral evidence was consistent with her email dated 27 February 2022 and her witness statement. The panel was of the view that Colleague 1's evidence was credible and reliable in respect of this charge. The panel found that it was more likely than not that Mr Sherif was unable to obtain sodium chloride from Omnicell on 27 February 2022. The panel therefore found this charge proved.

Charge 1.d.

1. In relation to Medicines management:

    d. On or around 3 March 2022 did not understand why stat medication was needed in addition to routine medication.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. The panel had particular regard to the evidence of Colleague 2.

The panel had sight of an email from Colleague 2 to Colleague 1 dated 3 March 2022 in which the following was stated:

> *'On morning drug round, Roshin (under my supervision) found it quite hard to understand the need to check the stat dose, even when highlighted to Roshin he struggled to understand that we needed to give stat medication as well as routine medications.'*

The panel also had sight of Colleague 2's witness statement in which she stated the following:

‘On numerous occasions, Mr Sherif struggled to understand what a stat dose was and why it was prescribed. This was despite the fact that I had explained to Mr Sherif on every shift about the importance of a stat dose.’

The panel heard oral evidence from Colleague 2 which was consistent with what she had stated in the email dated 3 March 2022 and in her witness statement. The panel found the evidence of Colleague 2 to be credible and reliable in respect of this charge. The panel determined that it was more likely than not that Mr Sherif did not understand why stat medication was needed in addition to routine medication on, or around, 3 March 2022. Accordingly, the panel found this charge proved.

Charge 1.e.

1. In relation to Medicines management:

    e. On or around 3 March 2022 took 5mg of prednisolone out instead of 50mg out of the Omnicell.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 3 March 2022 in which the following was stated:

‘He also made a few errors when getting medications out of the Omni cell, he took 5mg of prednisolone out instead of 50mg despite me explaining how we would take it out beforehand.’

The panel also had sight of Colleague 2's witness statement in which she stated the following:

> *'Mr Sherif also struggled to use the Omnicell (electronic drugs cabinet). The Omnicell is a very simple machine. It is necessary to type the patient's name in and the drug name. The Omnicell will then light up a certain cupboard and this is where you are to remove the drug from… Mr Sherif would struggled[sic] to use the Omnicell and would often have forced entries where he would pull at a cupboard door which was not flashing or would miss the flashing light indicating to him which medication was required. On 3 March 2022, Mr Sheriff made a few errors when getting medications out of the Omnicell. Mr Sherif took out 5mg of prednisolone instead of 50mg despite me explaining to him what should be taken out beforehand.'*

The panel heard oral evidence from Colleague 2 which was consistent with her email dated 3 March 2022 and her witness statement. The panel found Colleague 2's evidence in respect of this charge to be credible and reliable. The panel determined that it was more likely than not that on or around 3 March 2022 took 5mg of prednisolone out instead of 50mg out of the Omnicell. The panel therefore found this charge proved.

Charge 1.f.

1. In relation to Medicines management:

    f. On or around 3 March 2022 attempted to obtain 375mg Carbocisteine instead of 750mg out of the Omnicell.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 3 March 2022 in which the following was stated:

> *'On 3 March 2022, Mr Sheriff made a few errors when getting medications out of the Omnicell… Another error he made was getting 375mg Carbocistene instead of 750mg despite it saying 2 tablets of 375mg.'*

The panel also had sight of Colleague 2's witness statement in which she stated the following:

> *'Another error which Mr Sherif made was getting 375mg of Carbocistene out instead of 750mg.'*

The panel heard oral evidence from Colleague 2 which was consistent with her email dated 3 March 2022 and her witness statement. The panel found Colleague 2's evidence in respect of this charge to be credible and reliable. The panel determined that it was more likely than not that on or around or around 3 March 2022 attempted to obtain 375mg Carbocisteine instead of 750mg out of the Omnicell. The panel therefore found this charge proved.

Charge 1.g.

1. In relation to Medicines management:

    g. On or around 3 March 2022 when informed that IV fluids were prescribed for a patient did not ensure that this was done.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent from Colleague 2 to Colleague 1 on 3 March 2022 in which she stated the following:

> *'He was also informed of some iv fluids were prescribed for a patient and he didn't inform anyone to put them up.'*

The panel also heard oral evidence from Colleague 2 who stated that one of the doctors came to inform her that they had prescribed fluids for a patient that Mr Sherif was looking after. Colleague 2 told the panel that Mr Sherif did not ensure that the patient received these IV fluids. The panel found the evidence of Colleague 2 to be consistent, credible and reliable in respect of this charge. The panel was therefore satisfied that it was more likely than not that on or around 3 March 2022, when informed that IV fluids were prescribed for a patient did not ensure that this was done. Accordingly, the panel found this charge proved.

Charge 1.h.

1. In relation to Medicines management:

    h. On or around 5 March 2022 didn't understand that you didn't need to give medication to a patient as they had self-medicated.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 5 March 2022 in which she stated the following:

‘Again meds rounds were very disorganised and really struggled to understand we didn’t need to give a patient her meds as she had self-medicated and he wanted to get the meds out again.’

The panel also had sight of Colleague 2’s witness statement in which she stated the following:

‘Mr Sherif could also not understand that some patients on EAU were able to self-medicate. On 5 March 2022, Me Sherif could not understand why we didn’t need to give a patient her medications. This was because the patient had self-medicated. Mr Sherif wanted to get the medications out of the Omnicell again and give them to the patient to administer. Mr Sherif could not understand that the patient had already received their necessary medication.’

The panel heard oral evidence from Colleague 2 which was consistent with her email dated 5 March 2022 and her witness statement. The panel found Colleague 2’s evidence in respect of this charge to be credible and reliable. The panel determined that it was more likely than not that on or around 5 March 2022 didn’t understand that you didn’t need to give medication to a patient as they had self-medicated. The panel therefore found this charge proved.

Charge 1.i.

1. In relation to Medicines management:

    i. On 7 March 2022 when administering a subcut injection did not administer the full dose as you removed the injection prematurely.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 1.

The panel had sight of an email sent by Colleague 1 to Colleague 2 on 8 March 2022 in which the following was stated:

> *'I couldn't stay to email you last night after my shift, so I'm just sending you yesterday's observations from my personal email today…*
>
> *We had an issue first thing with the administration of a subcut injection where the needle was removed before the full dose had been given.'*

The panel also had sight of Colleague 1's witness statement in which she stated the following:

> *'On 7 March 2022, I was supervising Mr Sherif with the administration of a subcut injection. Mr Sherif had been deemed competent up until that point in administering a subcut injection. These injections are given to reduce the risk of blood clots. Mr Sherif was keen to give the injection and as I had observed him doing it before, I told him that I would supervise him doing this. Mr Sherif put the needle into the patient and pressed down so that the medication was being administered. However, before the full treatment dose had been given, Mr Sherif removed the needle, and the rest of the medication was squirted on the floor. The patient in question was aware that he had not received the full dose and became concerned. The patient was very disappointed. I was not aware of how much medication had been administered and therefore the error was difficult to rectify. I had to discuss the incident with the patient's consultant and pharmacy. On the balance of risk, it was decided that the patient should receive an extra dose of the medication.'*

The panel also heard oral evidence from Colleague 1 which was consistent with her email dated 8 March 2022 and her witness statement. The panel found Colleague 1's evidence

in respect of this charge to be credible and reliable. The panel determined that it was more likely than not that on 7 March 2022 when administering a subcut injection Mr Sherif did not administer the full dose as he removed the injection prematurely. Accordingly, the panel found this charge proved.

Charge 1.j.

1. In relation to Medicines management:

    j. On 9 March 2022 when asked to obtain Levothyroxine out of the Omnicell, typed 125mg into the 100mg Levothyroxine section.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 9 March 2022 in which she stated the following:

> *'Again on meds round I[sic] he had to get levothyroxine 125mg and he typed 125mg into the 100mg levothyroxine section, and when questioned he said he would have to split the pill, despite there being a 25mg tablet.'*

The panel also had sight of Colleague 2's witness statement in which she stated the following:

> *'Moreover, on 9 March 2022, I had asked Mr Sherif to get 125mg of Levothyroxine out of the Omnicell. Mr Sherif typed 125mg into the 100mg Levothyroxine section of the Omnicell.'*

The panel heard oral evidence from Colleague 2 which was consistent with her email dated 9 March 2022 and her witness statement. The panel found Colleague 2's evidence in respect of this charge to be credible and reliable. The panel determined that it was more likely than not that on 9 March 2022 when asked to obtain Levothyroxine out of the Omnicell, Mr Sherif typed 125mg into the 100mg Levothyroxine section. The panel therefore found this charge proved.

Charge 1.k.

1. In relation to Medicines management:

    k. On 9 March 2022 on being required to administer 500mg of Ranolazine stated that you would administer 1 and half tablets of Ranolazine which is an excessive amount.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. The panel had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 9 March 2022 in which the following was stated:

> *'Another issue we had with ranolazine 500mg MR was prescribed, but in the Omnicell 375mg, to which he stated he would get a tablet and a half out the Omnicell, explained this would mean overdosing the patient.'*

The panel also had sight of Colleague 2's witness statement in which she stated the following:

‘Mr Sherif was required to administer 500mg of Ranolazine which was prescribed to a patient. However, in the Omnicell, the tablets of Ranolazine were 375mg. Mr Sherif stated that he would give the patient 1 and a half tablets of the 375mg Ranolazine. This would have led to an overdose to the patient. Mr Sherif had not recognised this.’

The panel heard oral evidence from Colleague 2 which was consistent with her email dated 9 March 2022 and her witness statement. The panel found Colleague 2’s evidence in respect of this charge to be credible and reliable. The panel determined that it was more likely than not that on 9 March 2022 on being required to administer 500mg of Ranolazine stated that you would administer 1 and half tablets of Ranolazine which is an excessive amount. Accordingly, the panel found this charge proved.

Charge 1.l.

1. In relation to Medicines management:

    l. On an unknown date attempted to draw up oral medication in the normal IV medication cannula which is incorrect.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 1.

The panel had sight of Colleague 1’s witness statement in which she stated the following:

‘During one shift, I asked Mr Sherif to prepare IV medication for a patient and have them ready to give. I told Mr Sherif that he needed to prepare oral medication which should be drawn up in the 'oral medication' syringe. We have different syringes for IV medication through a cannula and IV medication which is taken orally. Mr Sherif

attempted to draw up the oral medication in the 'normal IV medication cannula' syringe and not the designated oral syringe. When I told Mr Sherif that this was extremely dangerous and that we could not do this, he could not understand why I was concerned. This mistake is extremely serious as if medications are drawn up in the incorrect syringes, there is a chance that they will become mixed up. This is the reason as to why we have separate syringes for oral medication and medication which is given through a cannula. As a result of this incident and Mr Sherif's lack of understanding and insight, I asked him to re-do his medicine management mandatory online training.'

The panel also heard oral evidence from Colleague 1 on this point and it found her evidence to be consistent, credible and reliable. The panel was therefore satisfied that it was more likely than not that Mr Sherif attempted to draw up oral medication in the normal IV medication cannula which is incorrect. Accordingly, the panel found this charge proved.

Charge 2.a.

2. In relation to care planning and other documentation/clinical handover:

    a. On 5 March 2022 when documenting information for a patient in bed 5, documented information relating to other patients.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 on 5 March 2022 in which she stated the following:

‘We again have had very poor documentation practices today, while documenting about bed 5 he incorrectly documented information about the other patients he was looking after in her file.’

In her oral evidence Colleague 2 told the panel about Mr Sherif’s poor documentation. The panel found the evidence of Colleague 2 to be consistent, credible and reliable in respect of this charge. The panel was satisfied that in view of the contemporaneous record and the evidence of Colleague 2, it was more likely than not that on 5 March 2022 when documenting information for a patient in bed 5, Mr Sherif documented information relating to other patients. Accordingly, the panel found this charge proved.

Charge 2.b.

2. In relation to care planning and other documentation/clinical handover:

    b. On 7 March 2022 relied on the handover provided to you at 7am when providing information to staff regarding the patient throughout the day without taking into account the patients changing circumstances.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 1.

The panel had sight of an email sent by Colleague 1 to Colleague 2 on 8 March 2022 in which the following was stated:

‘As with every shift, my main frustration has been his reliance on his printed handover (from 7am!) and not on what he was told by other staff, information on WebV and his knowledge of the patient. By relying on his handover he mistakenly informed CIC staff that his patient was in DKA and was unable to appropriately deal

with an enquiry from a specialist from another hospital – insisting that the patient wasn't on EAU as they weren't on his sheet. He seems unable to process what he is being told when patients are moved into his beds from elsewhere on the ward and attempted to re-admit patients that had previously been in the side rooms despite being informed.'

The panel also had sight of Colleague 1's witness statement in which she stated the following.

'It was extremely frustrating that Mr Sherif would rely on his printed handover which had been given to him at 07:00 and not what he had been told by other staff, information on WebV and his own knowledge of the patient. On 7 March 2022 [], Mr Sherif relied on the handover given to him at 07:00 to provide information to other staff members and hospitals. By relying on this handover, Mr Sherif mistakenly informed CIC staff that his patient was in DKA and was unable to appropriately deal with an enquiry from a specialist from another hospital. Mr Sherif insisted that the patient was not on EAU as they were not on his sheet. In reality, the patient had been admitted on to EAU during the shift. Mr Sherif was clearly unable to profess what he was being told when patients are moved into his beds from elsewhere on the ward and attempted to re-admit patients that had previously been is the side rooms despite being informed.'

The panel also heard oral evidence from Colleague 1 which was consistent with her email and witness statement. The panel found the evidence of Colleague 1 to be credible and reliable in respect of this charge. The panel was satisfied that it was more likely than not that on 7 March 2022 Mr Sherif relied on the handover provided to him at 7am when providing information to staff regarding the patient throughout the day without taking into account the patient's changing circumstances. The panel therefore found this charge proved.

Charge 2.c.

2. In relation to care planning and other documentation/clinical handover:

    c. On 9 March 2022 provided poor handover in that it was unclear.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 9 March 2022 in which the following was stated:

> *'Handover was very poor today, as there were no spare handovers and he hadn't had time to practice his handover prior, the nursing[sic] taking over was very confused about what each patient was getting treat[sic] for as he kept mixing patients up.'*

The panel also had sight of Colleague 2's witness statement in which she stated the following:

> *'On 9 March 2022, Mr Sherif attempted to handover his patients. However, his handover was very poor and the nurse taking over was extremely confused. This was because Mr Sherif kept mixing the patients up.'*

The panel heard oral evidence from Colleague 2 which was consistent with her email and witness statement. The panel found the evidence of Colleague 2 to be credible and reliable in respect of this charge. The panel was satisfied that it was more likely than not that on 9 March 2022 provided poor handover in that it was unclear. Accordingly, the panel found this charge proved.

Charge 2.d.

2. In relation to care planning and other documentation/clinical handover:
    d. Between 7 and 8 April 2022 were not clear in your documentation in that you:

        i. Did not complete the daily nursing care record – medicine and elderly care accurately for one or more patients.
        ii. Did not sign and/or date the patient repositioning chart.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of some handwritten notes made by Colleague 2 on 8 April 2022 in which she stated the following:

> *'very disorganised today work on being more organised and prepared when being with patients.'*

The panel also had sight of the daily nursing care record and the repositioning chart for the period of 7-8 April 2022.

The panel had regard to the witness statement of Colleague 2 in which she gave a number of examples of Mr Sherif not being clear in his documentation between 7-8 April 2022. In her evidence Colleague 2 provided examples of when Mr Sherif did not complete the daily nursing care record – medicine and elderly care and did not sign and/or date the repositioning chart:

'The patient to which this document relates [] was a complex patient with complex daily care need. The Registrant's notes about Patient [] remained very generic and lacked the level of detail to be expected in relation to a patient with complex needs. This was typical of the Registrant's inability to differentiate between a patient that needed detailed care planning and that did not.

On pages 422 and 423 of the bundle is another example of a 'Daily Nursing Care Record – Medecine and Elderly Care' dated 07/04/2022 completed by the Registrant. On this document the Registrant has again failed to complete the top of the document correctly. Furthermore, there is a crossed-through a note. This is not good practice. The correct approach is to put a single strike through the error rather than scribble over it, and write 'error' and sign and date.'

The panel found the evidence of Colleague 2 to be consistent, credible and reliable. Having regard to all of the evidence before it, the panel was satisfied that it was more likely than not that between 7 and 8 April 2022 Mr Sherif was not clear in his documentation in that her did not complete the daily nursing care record – medicine and elderly care accurately for one or more patients and did not sign and/or date the patient repositioning chart. The panel therefore found this charge proved.

Charge 3.a.

3. In relation to Infection Control:

    a. On 3 March 2022 did not deal with a urine spill by a patient appropriately in that you did not ensure that it was cleared up straight away.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 4 March 2022 in which the following was stated:

> *'One other issue highlighted today was, Roshin had spilled some urine on the floor of a high risk falls patient and left the spill to go for a break and for me to ask a domestic to clean it up, I explained that you don't walk away from a spill and we should clean it up and make the area safe before skin[sic] the domestic to mop the floor. He stated he didn't leave the patient but when re-entering the patients room the spill was still on the floor.'*

The panel also had sight of Colleague 2's witness statement. The panel heard oral evidence from Colleague 2 which was consistent with her email and witness statement. The panel found Colleague 2 to be credible and reliable. The panel was satisfied that it was more likely than not that on 3 March 2022 Mr Sherif did not deal with a urine spill by a patient appropriately in that he did not ensure that it was cleared up straight away. The panel therefore found this charge proved.

Charge 3.b.

3. In relation to Infection Control:

    b. On 3 March 2022, did not wear your mask correctly in that it was below your nose.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email from Colleague 2 to Colleague 1 dated 3 March 2022 in which the following is stated:

> *'PPE – Still no masks over his nose despite me asking multiple time,'*

The panel also had sight of Colleague 2's witness statement in which she stated the following:

> *'Again, on this shift, Mr Sherif's mask was below his nose. When I challenged Mr Sherif on this, he stated that it was a one-off occasions[sic].'*

The panel heard oral evidence from Colleague 2 which was consistent with her email and witness statement. The panel found the evidence of Colleague 2 to be credible and reliable in respect of this charge. The panel found that it was more likely than not that Mr Sherif did not wear his mask correctly in that it was below his nose. Accordingly, the panel found this charge proved.

Charge 3.c.

3. In relation to Infection Control:

    c. On one or more occasions did not wear the correct PPE and/or any PPE.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email from Colleague 2 to Colleague 1 dated 5 March 2022 in which the following is stated:

‘He again walked around with gloves on, and even walked between patients with the same gloves on. Again his mask was below his nose.’

The panel also had sight of Colleague 2’s witness statement in which she stated the following:

‘Mr Sherif did not have any understanding about the importance of infection control or wearing PPE…

On 5 March 2022, I witnessed Mr Sherif walk between patients with the same gloves on in contravention of the Trust’s Infection Prevention & Control: Standard Precautions Policy.’

The panel heard evidence from Colleague 2 who told the panel that on numerous occasions Mr Sherif did not wear the correct or any PPE. The panel found the evidence of Colleague 2 to be consistent, credible and reliable in respect of this charge. The panel determined that it was more likely than not that Mr Sherif did not wear the correct PPE and/or any PPE on one or more occasions. The panel therefore found this charge proved.

Charge 3.d.

3. In relation to Infection Control:

    d. On or around 5 March 2022 tried to attach fluids with no PPE on.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 5 March 2022:

‘He then tried to attach fluids with no PPE on.’

The panel also had sight of Colleague 2’s witness statement in which she stated the following:

‘on 5 March 2022, I had to ask Mr Sherif to wear his mask correctly, so that it covered his nose. Mr Sherif’s IV technique was very poor. For example, when mixing up an IV, he would often do this in the correct tray but then touch the vials or the base of the needle with no gloves on even though he had already sterilised the tray.’

The panel heard oral evidence from Colleague 2 which was consistent with her email and witness statement. The panel found the evidence of Colleague 2 to be consistent, credible and reliable in respect of this charge. The panel was satisfied that it was more likely than not that Mr Sherif tried to attach IV fluids without wearing PPE on 5 March 2022. The panel therefore found this charge proved.

Charge 3.e.

3. In relation to Infection Control:

    e. On or around 5 March 2022 did not change your gloves between patients.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 5 March 2022:

‘He has again walked around with gloves on, and even walked between patients with the same gloves on.’

The panel also had sight of Colleague 2’s witness statement in which she stated the following:

‘Mr Sherif would also wander around EAU with a pair of gloves on.’

The panel heard oral evidence from Colleague 2 which was consistent with her email and witness statement. The panel found the evidence of Colleague 2 to be consistent, credible and reliable in respect of this charge. The panel was satisfied that it was more likely than not that Mr Sherif did not change gloves between patients on or around 5 March 2022. Accordingly, the panel found this charge proved.

Charge 3.f.

3. In relation to Infection Control:

    f. On or around 5 March 2022, did not wear your mask correctly in that it was below your nose.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 5 March 2022:

‘Again his mask was below his nose.’

The panel also had sight of Colleague 2's witness statement in which she stated the following:

> *'Mr Sherif did not have any understanding about the importance of infection control or wearing PPE. Mr Sherif would often not wear his face mask correctly and would wear it under his nose despite me asking him numerous times.*
>
> *Again on this shift Mr Sherif's mask was below his nose. When I challenged Mr Sherif on this, he stated that it was one off occasions. This was not true and throughout the whole shift on 5 March, I had to ask Mr Sherif to wear his mask correctly, so that it covered his nose.'*

The panel heard oral evidence from Colleague 2 which it found to be consistent with her email and witness statement. The panel found the evidence of Colleague 2 to credible and reliable in respect of this charge. The panel was satisfied that Mr Sherif did not wear his mask correctly in that it was below his nose on or around 5 March 2022. The panel therefore found this charge proved.

Charge 4.a.

4. In relation to Moving and Handling:

    a. On 29 January 2022 did not assist with the moving and handling of a patient.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. Having assessed all of the evidence before it, the panel found that the only evidence provided was hearsay and that there was no direct evidence to support this charge and the NMC had not discharged its evidential burden. The panel therefore found this charge not proved.

Charge 4.b.

4. In relation to Moving and Handling:

    b. On 29 January 2022 when asked to sit a patient up in bed proceeded to remove a pillow as opposed to adjusting the bed.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. Having assessed all of the evidence before it, the panel found that the only evidence provided was hearsay and that there was no direct evidence to support this charge and the NMC had not discharged its evidential burden. The panel therefore found this charge not proved.

Charge 4.c.

4. In relation to Moving and Handling:

    c. On 27 February 2022 Were unable to correctly position an elderly patient so that she had her breakfast and call bell to hand.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 1.

The panel had sight of an email sent by Colleague 1 to Colleague 2 on 27 February 2022 in which she stated the following:

‘I was unsatisfied with his ability to correctly position one of his elderly patients so that she was sat up and had her breakfast and call bell to hand.’

The panel also had sight of Colleague 1’s witness statement in which she stated the following:

‘On 27 February 2022 [], I was concerned and unsatisfied with Mr Sherif's ability to correctly position an elderly patient so that was set up and had her breakfast and call bell to hand.’

The panel heard oral evidence from Colleague 1 which was consistent with her email and witness statement. The panel found the evidence of Colleague 1 to be credible and reliable. The panel was satisfied that it was more likely than not that on 27 February 2022 Mr Sherif was unable to correctly position an elderly patient so that she had her breakfast and call bell to hand. Accordingly, the panel found this charge proved.

Charge 5.a.

5. In relation to Communication:

    a. On 7 March 2022 did not listen to what a patient told you in relation to their preference for taking medication.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 1.

The panel had sight of an email from Colleague 1 to Colleague 2 date 8 March 2022 in which the following was stated:

‘He failed to listen to what a patient was telling him about the way he prefers to take his medication left the patient very frustrated.’

The panel also had sight of Colleague 1’s witness statement in which she stated the following:

‘On 7 March 2022 [ ], Mr Sherif failed to listen to what a patient was telling him about the way in which he prefers to take his medication. As Mr Sherif was extremely dismissive, the patient became very frustrated.’

The panel also heard oral evidence from Colleague 1 which was consistent with her email and witness statement. The panel found the evidence of Colleague 1 to be credible and reliable in respect of this charge. The panel was satisfied that on 7 March 2022 Mr Sherif did not listen to what a patient told him in relation to their preference for taking medication. The panel therefore found this charge proved.

Charge 5.b.

5. In relation to Communication:

    b. On an unknown date interrupted colleague 1 unnecessarily when they were setting up a palliative syringe driver for a patient.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 1.

The panel had sight of Colleague 1’s witness statement in which she stated the following:

‘Mr Sherif was also unable to understand any social cues. On one occasion, I was setting up a palliative patient's syringe driver and speaking to the family members present. During this very sensitive time for the patient and their family members, Mr Sherif entered the room and started to tap me on the shoulder and stated that he wanted to administer medications. This was not an emergency and I should not have been interrupted.’

The panel heard oral evidence from Colleague 1 which was consistent with her witness statement. The panel found the evidence of Colleague 1 to be credible and reliable in respect of this charge. The panel was satisfied that it was more likely than not that an unknown date Mr Sherif interrupted Colleague 1 unnecessarily when she was setting up a palliative syringe driver for a patient. Accordingly, the panel found this charge proved.

Charge 5.c.

5. In relation to Communication:

    c. On 5 March 2022 whilst colleague 2 was attempting to put pads on a patient, tried to take the pads out of colleague 2 hands for no good reason.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email from Colleague 2 to Colleague 1 dated 5 March 2022 in which she stated the following:

‘We sadly had an arrest on the ward this morning and while I was trying to put pads on the patient and attach them to the defib he was trying to take them out of my hand.’

The panel also had sight of Colleague 2's witness statement in which she stated the following:

> *'Whilst I was attempting to put pads on to the patient and attach them to the defibrillator, Mr Sherif was trying to take them out of my hands.'*

The panel heard oral evidence from Colleague 2 which was consistent with her witness statement. The panel found the evidence of Colleague 2 to be credible and reliable in respect of this charge. The panel was satisfied that it was more likely than not that on 5 March 2022 whilst Colleague 2 was attempting to put pads on a patient, Mr Sherif tried to take the pads out of colleague 2 hands for no good reason. The panel therefore found this charge proved.

Charge 5.d.

5. In relation to Communication:

    d. On or around 9 March 2022 proceeded to wash a female patient without asking them if they preferred a female to wash them.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague 2.

The panel had sight of an email sent by Colleague 2 to Colleague 1 on 9 March 2022 in which she stated the following:

> *'Again one patient was very frustrated with roshin for not listening to her, and when she wanted help with a wash he just began and she was very upset that a man was*

washing her, I explained to him that older ladies may prefer a female and we have to ask them.'

The panel also had sight of Colleague 2's witness statement in which she stated the following:

'On 9 March 2022, a further patient complained about Mr Sherif's communication. The patient stated that Mr Sherif did not listen to her and when she wanted help with a wash he just began. She was very upset about this as she did not want a man to wash her.'

The panel heard oral evidence from Colleague 2 which was consistent with her email and witness statement. The panel found the evidence of Colleague 2 to be credible and reliable in respect of this charge. The panel was satisfied that it was more likely than not that on or around 9 March 2022 Mr Sherif proceeded to wash a female patient without asking them if they preferred a female to wash them. Accordingly, the panel found this charge proved.

Charge 6.a.

6. In relation to Escalation:

    a. On 3 March 2022 on becoming aware that a patient had a high temperature did not escalate.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. Having assessed all of the evidence before it, the panel found that the only evidence provided was hearsay and that there was no direct evidence to support this charge and the NMC

had not discharged its evidential burden. The panel therefore found this charge not proved.

Charge 6.b.

b. On 9 March 2022 did not escalate one or more of the following patients to a Doctor.

i. An unknown patient with a blood pressure reading of 235/91.
ii. An unknown patient with a blood pressure reading of 90/42.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. The panel had particular regard to the evidence of Colleague 2.

The panel had sight of an email from Colleague 2 to Colleague 1 date 9 March 2022 in which the following was stated:

'He done observations on his 3 patients and despite having someone with a BP of 235/91 and someone with a BP of 90/42 he didn't escalate this.'

The panel also had sight of Colleague 2's witness statement in which she stated the following:

'Despite the fact that he had one patient with a high blood pressure of 235/91 and another patient with a low blood pressure of 90/42, he did not escalate this.'

The panel heard oral evidence from Colleague 2 which was consistent with her email and witness statement. The panel found the evidence of Colleague 2 to be credible and reliable in respect of this charge. The panel was satisfied that it was more likely than not

that on 9 March 2022 Mr Sherif did not escalate patients with blood pressure readings of 235/91 and 90/42. The panel therefore found both limbs of this charge proved.

Charge 7.a.

7. In relation to IT issues:

    a. On 29 January 2022 attempted to enter observations onto another colleagues Webv when you were supposed to enter them onto your own Webv.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. Having assessed all of the evidence before it, the panel found that the only evidence provided was hearsay and that there was no direct evidence to support this charge and the NMC had not discharged its evidential burden. The panel therefore found this charge not proved.

Charge 8.

8. Did not inform the Select Healthcare Group that you were subject to an NMC investigation.

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 7.

The panel had sight of an email sent by the NMC to Mr Sherif dated 15 July 2022 in which he was informed that a referral had been received and that he was subject to an

investigation. On 17 July 2022, Mr Sheriff replied to the NMC to acknowledge receipt of the email dated 15 July 2022 and stated in his response to the question of whether he had, or was in the process of applying for any nursing roles:

> *'I have applied for a job in a couple of nursing homes . When I applied , I let them know about my termination from the service and the related proceedings . As my previous employer did not provide a reference to the places where I had applied , I could not get a job. I had not asked for any favourable references without withholding any facts , but pleaded for any reference.'*

The panel had sight of Ms 7's witness statement in which she stated the following:

> *'The Registrant was employed by Select Healthcare Group as a Registered General Nurse between 20th July 2022 and 12th August 2022, and was working as a supernumerary carer to familiarise themselves with the residents and their routines…*
>
> *Select Healthcare Group was unaware of any allegation being investigated by the NMC.'*

The panel also heard oral evidence from Ms 7 who stated that Mr Sherif did not inform Select Healthcare Group about the NMC investigation which was consistent with her witness statement. The panel found the evidence of Ms 7 to be credible and reliable in respect of this charge. The panel was satisfied that Mr Sherif was aware of the NMC investigation and did not inform Select Healthcare Group about this. The panel therefore found this charge proved.

Charge 9.

9. Did not inform the Select Healthcare Group that you were subject to an interim conditions of practice order imposed on 4 August 2022.

This charge is found not proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 7 and Ms 8.

The panel had regard to the witness statement of Ms 7 in which she stated the following:

> *'Select Healthcare Group was unaware of…, or that the Registrant was subject to an Interim Order, as this was not declared by the registrant.'*

The panel heard evidence that Select Healthcare Group became aware of the NMC investigation when Mr Sherif had requested to take time off work to attend his interim order hearing on 4 August 2022. The panel had sight of Mr Sherif's bundle, and email to the NMC, dated 4 October 2022 in which he stated that *'after the nmc hearing. My nursing home dismissed me saying that they do not have the facilities for the supervised practice.'*

The panel was therefore satisfied that Select Healthcare Group was aware of the interim order hearing and the subsequent interim order that was imposed. The panel had not satisfied that the NMC had discharged its evidential burden in respect of this charge and therefore found it not proved.

Charge 10.

> 10. Your actions at charges 8 and /or 9 were dishonest in that you sought to conceal the fact you were subject to an NMC investigation and/or an interim conditions of practice order in order to continue employment with the Select Healthcare Group.

This charge is found proved in respect of charge 8.

In reaching this decision the panel had regard to all of the evidence before it.

On 17 July 2022, Mr Sheriff replied to the NMC to acknowledge receipt of the email dated 15 July 2022 and stated in his response to the question of whether he had, or was in the process of applying for any nursing roles:

> *'I have applied for a job in a couple of nursing homes . When I applied , I let them know about my termination from the service and the related proceedings . As my previous employer did not provide a reference to the places where I had applied , I could not get a job. I had not asked for any favourable references without withholding any facts , but pleaded for any reference.'*

The panel had sight of an email sent by Mr Sherif to the NMC dated 27 July 2022 in which he stated the following:

> *'When I applied to that post, I had disclosed everything including my profession related issues in the West Cumberland Hospital and its final outcome. At present I am working as part of orientation as a Staff Nurse. For that for the initial two weeks, I have been posted as a Health care assistant. I have informed them about the Interim Order Hearing'*

Having found that Mr Sherif had not informed his employer about being subject to an NMC investigation, prior to commencing employment on 20 July 2022, the panel determined that his responses to the NMC in these emails were dishonest. The panel was satisfied that Mr Sherif's intention by not informing his employer about the NMC investigation was to conceal it from his employer. The panel was also satisfied that this intention on Mr Sherif's part would be regarded as dishonest by the objective standards of ordinary, decent people. The panel therefore found this charge proved.

Fitness to practise

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

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

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

Submissions on lack of competence, misconduct and impairment

The NMC has defined a lack of competence as:

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

Mr Gruchy submitted that the facts found proved show that Mr Sherif's competence at the time was below the standard expected of a Band 5 registered nurse. He identified the specific, relevant standards where Mr Sherif's actions amounted to a lack of competence.

Moving onto misconduct, Mr Gruchy also identified that dishonesty is capable of being classified as being misconduct of a serious nature. Dishonesty falls short of the

requirements of the Code, and could cause risk to the public and undermine professional standards and public confidence in the profession. He submitted that it had not resulted in any harm but that does not detract from the seriousness of breaking his duty of candour.

Mr Gruchy submitted that Mr Sherif's misconduct in charges 8 and 10 was unacceptable in that his actions were capable of putting patients at risk of harm. He submitted that Mr Sherif was provided with high quality support and supervision and therefore there is a high risk that he is unable to practise safely unrestricted.

Mr Gruchy submitted that Mr Sherif's actions breached the Code and fell short of expected standards of a Band 5 Nurse. With regard to misconduct, he referred to the case of *Nandi* in which it was held that, to amount to misconduct, the conduct in question must be such as would be viewed as '*deplorable'* by fellow registered nurses.

Mr Gruchy submitted that Mr Sherif's insight is limited and referred the panel to Mr Sherif's response bundle. He submitted that Mr Sherif did not address charges 8 and 10, where the panel heard during live evidence that his actions could have caused patients serious harm. He submitted that there is no evidence of insight or remediation on Mr Sherif's part and that his fitness to practise is therefore impaired by reason of his lack of competence, and misconduct. He further submitted that Mr Sherif's practise needs to be restricted as the concerns raised are wide-ranging and serious.

In light of this, Mr Gruchy invited the panel to make a finding of impairment on the ground of public protection and also in the wider public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council (No 2) [2000] 1 A.C. 311, Nandi v General Medical Council [2004] EWHC 2317 (Admin), CHRE v NMC Grant [2011] EWHC 927 (Admin), Holton v GMC [2006] EWHC 2960 (Admin) and Calhaem v GMC [2007] EWHC 2606 (Admin).* In the last case, the Court held that lack of competence connoted an unacceptably low standard of professional performance which,

save in exceptional circumstances, had been demonstrated by reference to a fair sample of the practitioner's work.

The panel also had regard to the NMC guidance entitled 'Making decisions on dishonesty charges' (reference DMA-8) dated 27 February 2024.

Decision and reasons on lack of competence and misconduct

When determining whether the facts found proved amount to lack of competence and/or misconduct, the panel had regard to the terms of the Code.

Collectively, the panel found that the deficiencies in Mr Sherif's practice in the areas identified in charges 1 to 6 showed that he lacked the key skills that were required of a band 5 nurse, that these were not limited to isolated incidents and occurred over a period of time when, without continued support and supervision, there was a real risk of potential harm to patients.

The panel bore in mind, when reaching its decision on lack of competence, Mr Sherif should be judged by the standards of employment of an average band 5 nurse and not by any higher or demanding standard. The panel noted that the serious concerns had been raised during the initial "*onboarding*" and e-learning processes. They persisted notwithstanding close support and supervision over a period of 8 months. The panel determined that this demonstrated an unacceptably low standard of professional performance.

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

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must*

1.2 *make sure you deliver the fundamentals of care effectively*
1.4 *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

6 Always practise in line with the best available evidence
To achieve this, you must:
6.2 *maintain the knowledge and skills you need for safe and effective practice*

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*
13.2 *make a timely referral to another practitioner when any action, care or treatment is required*
13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*

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

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.3 *keep to and promote recommended practice in relation to controlling and preventing infection'*

The panel also found proved charges relating to dishonesty, namely charges 8 and 10, where Mr Sherif had intentionally misled his employers by withholding that he was subject to an NMC investigation. The panel considered that Mr Sherif had multiple opportunities to disclose this information as he was aware of the regulatory concerns under investigation

by the NMC following his dismissal from his employment prior to engaging in a recruitment process with Select Healthcare Group. The panel concluded that Mr Sherif would have been expected to disclose the circumstances of the referral to the NMC. Mr Sherif's actions within the charges found proved fall far below the standards expected of a registered nurse and would be considered deplorable by other members of the profession. Mr Sherif's dishonesty was particularly serious in that it would have enabled him to work as a registered nurse without any supervision, with consequential risk of severe harm to his patients. Therefore, the panel noted that by not disclosing this information was alone serious enough to amount to misconduct. Further, the panel noted that Mr Sherif had ample opportunity to rectify this but continued to withhold such information.

The panel found that there were serious breaches of the Code in particular the following provisions:

> ***'20 Uphold the reputation of your profession at all times***
> *To achieve this, you must:*
> ***20.1*** *keep to and uphold the standards and values set out in the Code*
> ***20.2*** *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'*

Consequently, the panel found that the facts found proved amount to serious misconduct due to Mr Sherif's actions surrounding dishonesty.

In all the circumstances, the panel determined that Mr Sherif's performance and conduct demonstrated a lack of competence and misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel found that Mr Sherif's conduct 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. The panel determined that all four limbs of the *Shipman* test are engaged.

The panel finds that patients were put at risk of harm as a result of Mr Sherif's lack of competence. Mr Sherif's lack of competence breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel noted that the matters found proved were in respect of a number of patients, in two different clinical areas and had occurred over a period of time, and therefore were not isolated incidents. The panel also noted that Mr Sherif's lack of competence had been identified at an early stage in his employment and that this lack of competence was not remediated despite extensive and extended training, support and supervision.

The panel went on to consider whether Mr Sherif remained liable to act in a way that would put patients at risk of harm, would bring the profession into disrepute and breach the fundamental tenets of the profession in the future. In doing so, the panel considered whether there was any evidence of insight, remorse and remediation.
Regarding insight on lack of competence and misconduct, the panel considered Mr Sherif provided no evidence that he had developing insight. The panel has not been able to ascertain his current level of insight and therefore it was unable, with confidence to accept that Mr Sherif had demonstrated any insight into his lack of competence and misconduct or that he had considered the impact on patients, colleagues, the reputation on the

profession and the wider public interest. The panel also noted that Mr Sherif sought to blame others/lack of support for his difficulties.

In relation to remorse, the panel noted that there was no evidence available to it, including any comments or reflection from Mr Sherif. He has not engaged with this hearing and consequently the panel has not had the benefit of hearing from him.

The panel had no evidence before it that Mr Sherif had addressed the regulatory concerns and the charges found proved. It was of the view that Mr Sherif had not demonstrated any remediation or strengthening of practice. Therefore, the panel determined that Mr Sherif has not yet been able to demonstrate what he should do if he finds himself in similar situations, and he had not satisfied it that the risk of repetition was anything other than high.

The panel therefore determined that there is a high risk of repetition. The panel decided that a finding of impairment is necessary on the grounds of public protection.

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.

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

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

Sanction

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

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

Submissions on sanction

Mr Gruchy submitted that the appropriate sanction in Mr Sherif's case is that of a strike-off. He outlined several aggravating and mitigating factors.

Mr Gruchy referred to the NMC's SG and submitted that Mr Sherif's misconduct breached the level of trust and professionalism expected of a registered nurse and in the circumstances of this case only a striking-off order would protect the public and address the public interest. He submitted that there were no conditions which would address the risk to the public in this case.

Mr Gruchy submitted that a suspension order would not be sufficient to address the public protection and public interest concerns arising in this case. It was not an isolated or single incident, but had taken place over a period of time. The misconduct may indicate a personality or attitudinal problem and in the absence of insight, remorse or remediation there was a risk of repetition. For these reasons he submitted that a suspension order would not be sufficient. Mr Gruchy reminded the panel that a striking off order is not currently available in respect of the finding of lack of competence. However, a striking off order may be made in respect of the finding of misconduct.

Mr Gruchy submitted that a striking off order is therefore the only sanction which would protect the public and address the public interest.

Decision and reasons on sanction

Having found Mr Sherif's fitness to practise currently impaired on the grounds of both lack of competence and misconduct, 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:

- No insight into failings
- Widespread incompetence in basic and fundamental aspects of care and documentation over an extended period of eight months
- Despite continuous and close support provided, there was no evidence of improvement
- High risk of harm to patients presented by Mr Sherif's deficiencies was only mitigated by constant supervision
- Mr Sherif's inability and unwillingness to learn, and tendency to blame others for his shortcomings
- Mr Sherif's actions on being dismissed from the Trust and in seeking new employment involved dishonesty which was high on the scale of seriousness

The panel also took into account the following mitigating feature:

- Internationally trained nurse, unfamiliar with practice in the UK

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

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

The panel next considered whether placing conditions of practice on Mr Sherif's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel noted that Mr Sherif had received support over an extensive period time, similar to that of any conditions of practice order that could be imposed. As such, the panel concluded that a conditions of practice order would be ineffective to address the lack of competence.

Further, the misconduct identified in this case was attitudinal in nature and not something that can be addressed through retraining.

Furthermore, the panel bore in mind that Mr Sherif had previously been subject to an interim conditions of practice order, with which he had failed to engage. Therefore, the panel could not be assured that he would be willing or able to comply with a substantive conditions of practice order.

Finally, the panel concluded that the placing of conditions on Mr Sherif's registration would not adequately address the seriousness of the dishonesty in this case and would not protect the public or uphold public confidence in the profession.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *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 has found no insight or remorse, and a consequent risk of repetition. It has found that the misconduct may reflect an attitudinal problem. Further, the misconduct was particularly serious as it could have resulted in serious harm to patients had Mr Sherif succeeded in working as a registered nurse without supervision. In addition, the lack of competence took place over a substantive period of time.

The conduct, as highlighted by the facts found proved, were a significant departure from the standards expected of a registered nurse. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Mr Sherif's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Sherif's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Mr Sherif has not been present at this hearing and has not provided any information to demonstrate that he has developed any insight or remorse into his misconduct. Nor has he demonstrated to the panel in writing or in person, that he has sought to remediate his failings or strengthen his practice. In addition, the panel has had no information to indicate that Mr Sherif has done anything at all to remediate his misconduct. Taking account of the SG, the panel could not be satisfied that anything less than a striking-off order would keep the public protected and address the public interest in Mr Sherif's case.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Sherif's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Mr Sherif in writing.

Decision and reasons on interim order

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

The panel took account of the submissions made by Mr Gruchy, that an interim suspension order was necessary in light of the panel's earlier findings.

The panel accepted the advice of the legal assessor.

In reaching the decision to impose an interim order, the panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order. The panel was satisfied that an interim order is necessary for the protection of the public as there is sufficient reason to be believe that the public would be at risk of harm. The panel was satisfied that an interim order is also necessary in the public interest, to uphold the confidence in the nursing profession, as well as in Mr Sherif's own interest.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. It also considered that to do so would be inconsistent with its earlier findings. The panel therefore imposed an interim suspension order for a period of 18 months to allow time for any potential appeal.

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

That concludes this determination.