Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
4 – 5 November 2021
9 – 12 November 2021
22 – 25 November 2021
25 April 2022
27 – 28 April 2022

Virtual Hearing

Name of registrant:	**Patience Ndidamaka Ibe**
NMC PIN:	07F2369E
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nursing (November 2007)
Area of registered address:	Reading
Type of case:	Misconduct
Panel members:	Avril O'Meara (Chair, Lay member) Shorai Dzirambe (Registrant member) James Kellock (Lay member)
Legal Assessor:	Michael Bell
Hearings Coordinator:	Dilay Bekteshi
Nursing and Midwifery Council:	Represented by Callum Munday, Case Presenter
Ms Ibe:	Present and represented by Krystal Peters of the Independent Democratic Union
Facts proved by way of admission:	6), 7), 8), 9), 10), 12)
Facts proved:	1), 2), 3c), 4b), 4c) i) ii), 5), 11) partially, 13)
Facts not proved:	3a), 3b), 4a), 4c) iii), 11) partially
Fitness to practise:	Impaired

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

Details of charge [as amended]

That you, a registered nurse;

1) On 18 or 19 November 2017 handled an unknown patient roughly whilst taking blood pressure in that you grabbed her arm. **[FOUND PROVED]**

2) On 18 or 19 November 2017 failed to gain consent from an unknown patient before taking blood pressure. **[FOUND PROVED]**

3) Between 2 February 2018 and 4 February 2018 failed to promptly follow a doctor's instructions to;

    a) Administer Oxygen to Patient C; **[NOT PROVED]**

    b) Start an electrocardiogram for Patient C; **[NOT PROVED]**

    c) Start a syringe driver for Patient C. **[FOUND PROVED]**

4) On 11 April 2019;

    a) Failed to respond immediately on hearing concerns that Patient X was experiencing breathing difficulties; **[NOT PROVED]**

    b) Failed to identify the cause of Patient X's breathing difficulties; **[FOUND PROVED]**

    c) Did not remove a lantern drain correctly from Patient Z in that you;

        i) Caused pain to patient Z; **[FOUND PROVED]**

ii) Did not de-vac the drain; **[FOUND PROVED]**

iii) Did not to use aseptic technique. **[FOUND NOT PROVED]**

5) Between 15 May 2019 and 4 July 2019 failed to inform KCare Nursing Agency that you were subject to an interim Conditions of Practice Order. **[FOUND PROVED]**

6) Between 15 May 2019 and 4 July 2019 failed to inform the NMC of your employment with KCare Nursing Agency. **[PROVED BY WAY OF ADMISSION]**

7) On or before 15 May 2019 failed to inform Spire Dunedin Hospital that you were subject to an Interim Conditions of Practice Order. **[PROVED BY WAY OF ADMISSION]**

8) On or before 21 May 2019 failed to inform West Berkshire Community Hospital that you were subject to an Interim Conditions of Practice Order. **[PROVED BY WAY OF ADMISSION]**

9) On or before 23 May 2019 failed to inform Wokingham Hospital that you were subject to an Interim Conditions of Practice Order. **[PROVED BY WAY OF ADMISSION]**

10) On or before 6 June 2019 failed to inform St Marks Hospital that you were subject to an Interim Conditions of Practice Order. **[PROVED BY WAY OF ADMISSION]**

11) Were dishonest in that your actions in charges 5, 6, 7, 8, 9 and/or 10 were intended to conceal the fact that you were subject to an Interim Conditions of Practice Order. **[PARTIALLY FOUND PROVED]**

12) On 5 July provided to a Committee of the Nursing and Midwifery Council a statement signed 5 July 2019 stating that due to the short nature of your employment you were

unable to provide a report from your employer. **[PROVED BY WAY OF ADMISSION]**

13) Were dishonest as you knew your statement in charge 12 to be untrue because you had not informed KCare Nursing Agency of NMC proceedings. **[FOUND PROVED]**

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

Decision and reasons on application to amend charges 6 and 11

At the outset of the hearing, Mr Munday on behalf of the Nursing and Midwifery Council (NMC) made an application to amend charges 6 and 11 under Rule 28 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). He invited the panel to amend Charge 6 to include the year '2019'. It was submitted by Mr Munday that the proposed amendment would provide clarity and more accurately reflect the evidence. Mr Munday further told the panel that the charges set out in Charge 11 are incorrect. He invited the panel to amend the numbered charges in Charge 11 to 5, 6, 7, 8, 9 and 10. He submitted there would be no injustice to either party by the proposed amendments being allowed.

Ms Peters, on your behalf, did not oppose this application.

Original Charge

6) Between 15 May and 4 July failed to inform the NMC of your employment with KCare Nursing Agency.

…

11) Were dishonest in that your actions in charges 7, 8, 9, 10, 11 and/or 12 were intended to conceal the fact that you were subject to an Interim Conditions of Practice Order.

Proposed Charge

6) Between 15 May **2019** and 4 July **2019** failed to inform the NMC of your employment with KCare Nursing Agency.

…

11) Were dishonest in that your actions in charges ~~7, 8, 9, 10, 11 and/or 12~~ **5, 6, 7, 8, 9 and/or 10** were intended to conceal the fact that you were subject to an Interim Conditions of Practice Order.

The panel accepted the advice of the legal assessor that Rule 28 states:

> *'**28.—** (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—*
>
> *(a) the charge set out in the notice of hearing; or*
>
> *(b) the facts set out in the charge, on which the allegation is based,*
>
> *unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.*
>
> *(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.'*

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments to Charges 6 and 11, as applied for, to ensure clarity and accuracy.

Decision and reasons on application for hearing to be held in private

At the outset of the hearing, Ms Peters made a request that this case be held partly in private on the basis that proper exploration of your case involves health and personal family matters. The application was made pursuant to Rule 19 of the the Rules.

Mr Munday did not oppose this application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference to your health and personal family matters, the panel determined that your interests in that regard outweighed the public interest in proceeding in public. It therefore determined to hold those parts of the hearing that related to your health and personal circumstances in private.

Decision and reasons on application to amend charge 3

During the course of witness evidence, Mr Munday made an application under Rule 28 to amend the wording of Charge 3). He told the panel that there are differences in the written and oral evidence as to whether or not the incident happened on 3 February 2018 or 4 February 2018. He told the panel that the witnesses agree that the incident happened on a weekend, but it is not clear on which date this occurred. He therefore invited the panel to change the wording of Charge 3) to 'Between 2 February 2018 and 4 February 2018 failed to promptly follow a doctor's instructions to…' He submitted that there is no dispute that the incident in Charge 3) occurred and that it occurred around that time period.

Ms Peters did not oppose this application.

Original Charge

3) On 3 February 2018 failed to promptly follow a doctor's instructions to;

Proposed Charge

3) ~~On 3 February 2018~~ **Between 2 February 2018 and 4 February 2018** failed to promptly follow a doctor's instructions to;

The panel accepted the advice of the legal assessor. He referred the panel to the statutory framework for substantive hearings and Rule 28 of the Rules.

The panel noted that under Rule 28 of the Rules, whilst there is no express power, there is an inherent power for the panel to amend the charges during a hearing.

The panel was satisfied at this stage of the proceeding that no unfairness or injustice would be occasioned to you by the proposed amendment being allowed. The panel

decided to allow the amendment, as applied for, to provide clarity and reflect the NMC witness statements.

Background

The NMC received a referral into your nursing practice on 12 December 2018 from Hampshire Hospitals NHS Foundation Trust (the Trust), where you were employed as a Band 5 Staff Nurse from 4 September 2017 to 3 October 2018. From September 2017 to February 2018, you worked on an acute respiratory ward.

Between November 2017 and February 2018 there were a number of concerns raised about your practice which are reflected in charges 1 – 3. On 19 February 2018, you were suspended from the Trust over allegations relating to unsafe nursing practice including a failure to promptly follow doctor's instructions and your rough handling of a patient. Following an investigation into these incidents, you resigned from your post on 3 October 2018.

An interim order was sought and imposed on 22 January 2019 by an NMC Committee panel. The interim conditions of practice order imposed on you included a supervision requirement and a requirement to tell any employer about the conditions, and also to inform the NMC when you took up new employment. At this time, you were working for ID Medical, a nursing agency and you were also registered with KCare Nursing Agency (KCare) but had only worked one shift for them (on 31 July 2018).

On 11 April 2019, you were working as an Agency Nurse at BMI Healthcare Hampshire Clinic which is a private hospital in Basingstoke. During this shift a number of concerns were noted.

On 15 May 2019, you began working shifts with KCare again but did not declare this to the NMC and did not inform KCare of your interim conditions of practice order.

On 5 July 2019, the interim conditions of practice order was reviewed, and you allegedly provided incorrect information to the panel by way of a signed statement. The panel were informed through your statement that you had only worked with KCare for 3 weeks and for this reason you could not provide a reference. However, it is alleged that you had not informed KCare of the NMC proceedings. At the review hearing on 5 July 2019, you were able to provide evidence of further training and positive testimonials from work colleagues and the panel revoked the interim conditions of practice order.

Application to withdraw admission to Charges 5 and 13 under Rule 24(1)

At the close of the NMC's case, Ms Peters on your behalf made an application under Rule 24(1) to withdraw your admission to charges 5 and 13. Ms Peters told the panel that your position has always been that you have accepted that you did not do enough to inform KCare Nursing Agency. However, she told the panel that you recall a telephone conversation with Mr 8, in which you informed him of the interim conditions of practice order during the period specified in Charge 5. She further told the panel that there cannot be an admission to charge 13 as it is predicated by the factual finding in charge 5).

Mr Munday submitted that is a matter for the panel to consider whether or not it would allow you to change your position on the charges. He did not suggest that this would cause him any difficulty and would not be seeking to reopen the NMC's case or recall any witnesses.

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

The panel decided to grant the application and allow you to withdraw your admissions to charges 5 and 13. It noted that there has been some degree of consistency in your verbal and written evidence in respect of you informing Mr 8 of KCare of your interim conditions of practice order during a telephone conversation. It therefore concluded that there will be no prejudice or unfairness to either party to grant the application.

Submissions

Mr Munday, on behalf of the NMC, submitted that the panel could be satisfied that all of the charges in this case are proved. He submitted that all of the NMC witnesses gave evidence clearly, consistently and credibly and that the panel can properly place a good deal of weight on the evidence that they gave. He told the panel that the patients involved in this case had no reason to be untruthful. He made reference to the fact that you had withdrawn your admissions to Charges 5) and 13). He further referred the panel to the relevant documentation including the contemporaneous evidence which supported the patients' and staff version of events and your reflective statement in which you accept you had been disingenuous and dishonest to the NMC Committee on 5 July 2019.

Ms Peters, on your behalf, submitted that apart from the charges you have admitted to, the remaining charges are denied. She told the panel that you deny handling the patient roughly as the patient was awake and you had asked for consent. She also told the panel that you fully intended to adhere to the doctor's instructions and that you deny failing to follow the instructions promptly. You also denied the charges relating to Patient X and Patient Z. She further told the panel that following the imposition of the interim conditions of practice order, you recall having a telephone conversation with Mr 8 of KCare about the order, but that you did not properly inform KCare of the details of the interim conditions of practice order in writing.

The panel heard and accepted the advice legal assessor. He referred the panel to the following cases: *Suddock v NMC* [2015] EWHC 3612 (Admin); *Dutta v GMC* 2020 EWHC 374 (Admin); *Khan v GMC* 2021 EWHC374 (Admin); *Ivey v Gentings Casinos* (UK) Ltd [2017] UKSC 67 and *Uddin v GMC* [2012] EWHC 2669 (Admin).

Facts

At the outset of the hearing, the panel heard from Ms Peters, who informed the panel that you made full admissions to charges 6, 7, 8, 9, 10 and 12. The panel placed no weight on your initial acceptance of charges 5 and 13 and you denied charges 1 – 4 and 11.

The panel therefore finds charges 6 to 10 and 12 proved in their entirety, by way of your admissions.

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

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

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

- Dr 1: Registered Junior Doctor at Basingstoke Hospital
- Ms 2: Health Care Assistant (HCA) at BMI Hampshire Clinic
- Ms 3: Clinical Matron at Hampshire Hospitals NHS Foundation Trust
- Ms 4: Matron at the Hampshire Hospitals NHS Foundation Trust
- Ms 5: Registered Band 5 Nurse at Basingstoke Hospital

- Ms 6: Ward Sister at BMI Hampshire Clinic
- Mr 7: Director of Operations at KCare
- Mr 8: Managing Director at KCare

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witnesses' and documentary evidence provided by both the NMC and Ms Peters on your behalf.

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

Charge 1)

1) On 18 or 19 November 2017 handled an unknown patient roughly whilst taking blood pressure in that you grabbed her arm.

This charge is found proved.

In reaching this decision, the panel had regard to all the relevant evidence including your evidence, the evidence of Ms 3 and Ms 4, the Datix report of the incident and Ms 4's contemporaneous note.

The panel noted that in your oral evidence you said you would not treat patients roughly and it was impossible that this incident had happened. You told the panel that you had knocked on the patient's room, introduced yourself and asked if they were happy for you to do observations to which the patient responded, *"it's fine".* You told the panel that you had lifted the patient's arm and placed the blood pressure cuff *"gently"* and that throughout the time you were with the patient, they had not complained to you. You

accepted that later on in the shift you were told that the patient had complained about you, and you were told not to attend the patient again during the shift.

The panel accepted the Datix report which shows a contemporaneous account of the event. The panel noted that it is not the patient's direct testimony, but that it was a contemporaneous account of what was reported by the patient to staff following the incident. The Datix report states the following:

> *'After being consoled by myself and HCA, the patient calmed herself down enough to be able to speak. She explained that she had been woken up abruptly when the nurse came to do her observations. She reported that she was sleeping on her side when the nurse pulled her arm out from under her and pulled it backwards. She reported that it was very painful and she felt 'abused'.*

The panel noted that there was no direct evidence from the patient, the nurse or HCA who had attended the patient. The panel noted that you were new to this ward and that neither the staff nor patient had a personal grievance or issue with you. You accepted that you attended the patient to do observations, there is a contemporaneous report of the patient's complaint to the staff and the matter was raised with you during your shift. Therefore, the panel considered that it is more likely than not that you handled the patient roughly whilst taking blood pressure, and it is satisfied on the balance of probabilities that you did handle the patient roughly.

Accordingly, charge 1 is found proved.

Charge 2)

2) On 18 or 19 November 2017 failed to gain consent from an unknown patient before taking blood pressure.

This charge is found proved.

In reaching this decision, the panel took into account all the relevant evidence including your oral and written evidence, the evidence of Ms 3 and Ms 4 and the Datix report. The panel noted that neither party disputed that you were required to obtain consent from the patient prior to taking their blood pressure.

The panel noted your account of the event and that you said that as part of your regular practice, you had introduced yourself to the patient and had explained what you would be doing. You told the panel that the patient was awake when you had entered the room and that you had obtained consent.

However, the panel accepted the account of events in the Datix report. It noted that it is not the patient's direct testimony, but that it was a contemporaneous account of what was said by the patient and reported to staff. The panel noted that you were new to this ward and that neither the staff nor patient had a personal grievance or issue with you. It accepted the Datix report which outlines the account of events experienced by the patient in question. It states the following: *'She reports that she was sleeping on her side when the nurse pulled her arm out from under her and pulled it backwards'*. The panel accepted that by implication, consent was not obtained by you.

Accordingly, Charge 2 is found proved.

Charge 3a) and b)

3) Between 2 February 2018 and 4 February 2018 failed to promptly follow a doctor's instructions to;

   a) Administer Oxygen to Patient C;
   b) Start an electrocardiogram for Patient C;

These charges are found NOT proved.

In reaching this decision, the panel took into account all the relevant evidence including your evidence, Dr 1's evidence, Ms 5's evidence and Datix report dated 4 February 2018. The panel noted that neither party disputes that there was an obligation to follow the doctor's instructions promptly. The panel noted that the everyday meaning of promptly means *'with little or no delay*.'

The panel noted in your evidence that it was your intention to adhere to the doctor's instruction, but that you also tried to balance this with your duty to administer medication to a patient you said was "*confused and took their medication really slowly"*. It noted that you were not expressly told by the doctor to stop what you were doing nor of the urgency of the care required by Patient C. The panel also noted that you had not refused to follow the doctor's instructions. The panel also noted that it was accepted by Dr 1 and Ms 5 that it was not unreasonable for you to finish administering medication to the patient you were attending to and lock the trolley before attending to Patient C.

The account of the incident provided by you and Dr 1 suggest that there was a period of between 5 to 10 minutes between you initially receiving Dr 1's instructions and commencing the tasks requested of you. The panel is satisfied that in that time you were administering medication to the patient you were dealing with and locking the drug trolley. According to Dr 1, when she returned after a period of 5 to 10 minutes, you had started putting the tape for the electrocardiogram (ECG) on Patient C. The panel therefore decided that the NMC has not proved that you failed to act 'promptly'.

Accordingly, Charges 3a) and 3b) are not proved.

Charge 3c)

3) Between 2 February 2018 and 4 February 2018 failed to promptly follow a doctor's instructions to;
   c) Start a syringe driver for Patient C.

This charge is found proved.

In reaching this decision, the panel took into account all the relevant evidence including your evidence, Dr 1's evidence, Ms 5's evidence and the Datix entry dated 4 February 2018.

The panel took into account the evidence of Dr 1 who told the panel that the syringe driver was prescribed for Patient C at approximately 10:30 to start at 11:00 and that she told you this at 10:30. It noted Dr 1's witness statement which states the following:

> *'The Registrant was aware of the urgency of the syringe driver being set up promptly; I told her very clearly at 10:30 that it had been prescribed to start at 11:00.'*

You told the panel that you accept that Dr 1 had requested you to start a syringe driver for Patient C and that you went looking for a syringe driver "*within one hour"* of getting the instruction. You told the panel that you had checked in the treatment room, on the shelf where the syringe driver was usually kept, but could not find one. You also told the panel that at around 11:30, you told the nurse in charge (Ms 5) that you could not locate a syringe driver on the ward or any other wards that you had asked. You told the panel that you had asked the nurse in charge and a new nurse to help you find a syringe driver, but with no success. You had also told Dr 1 between 12:00 and 13:00 that you could not find a syringe driver and the doctor also made attempts to find one.

The panel noted the Datix dated 4 February 2018 authored by Dr 1 which states the following:

> '*Syringe driver prescribed at 10:30… Reviewed patient at 16:00, no syringe driver in place.'*

The panel also took into account Ms 5's witness statement where she states that:

> *'The doctor requested that the Registrant set up the syringe driver at around 10:00. I was unaware of the request at this time and was only made aware by the doctor asking me about it at around 16:00. I raised this issue with the Registrant and it became apparent that she had not set up the syringe driver. The Registrant was oblivious when I asked her and said that she couldn't find a syringe driver.'*

The panel noted that although the syringe driver was prescribed to start at 11:00, you went to search for it within an hour of receiving the instruction at 10:30. The panel was satisfied that Dr 1's and Ms 5's evidence was consistent and it placed a good deal of weight on their evidence. The panel accepted that Dr 1 and Ms 5 only became aware that the syringe driver had not been set up at around 16:00. The panel considered that had you told them earlier in the day that you could not find a syringe driver, they would have remembered this and conducted a thorough search at that point. The panel noted that Patient C was very acutely unwell, at the end of his life and died later that day. The panel therefore concluded that despite the attempts you say you had made to locate a syringe driver, you did not promptly escalate this to either Ms 5 or Dr 1 or take any steps to ensure that the syringe driver was promptly started. The panel therefore determined that you failed to promptly start a syringe driver for Patient C when instructed to do so by Dr 1.

Accordingly Charge 3c) is found proved.

Charge 4a)

4) On 11 April 2019;

   a) Failed to respond immediately on hearing concerns that Patient X was experiencing breathing difficulties;

This charge is found NOT proved.

In reaching this decision, the panel took into account all the relevant evidence including your evidence, Ms 2's evidence and Ms 6's evidence and contemporaneous notes. The panel acknowledged that charge 4a) does not specify the nature of any response, merely that there was not an immediate response.

The panel noted the witness statement of Ms 6 where she states the following:

> *'At approximately 17:00, HCA Ms 2 came into the nurses' office to report a concern that had been raised with her by Patient X's sister that Patient X could not breathe…I was also present in the office at this time. The Registrant responded to Ms 2 by saying to her "go and do obs". I said to the Registrant that she needed to attend to Patient C and address the concern of her struggling to breathe; the Registrant responded that she was busy completing patient discharge paperwork. I reiterated to the Registrant that she had to attend to Patient C as the concern reported was that Patient X "cannot breathe". The Registrant attended to Patient X approximately one or two minutes following the report of the concern by Ms 2.'*

The panel also noted that in Ms 2's and Ms 6's oral evidence, you were informed that Patient X was experiencing shortness of breath and the panel is satisfied that you immediately responded to Ms 2's update on changes to Patient X's health by instructing her to do observations and attended Patient X one or two minutes after being prompted by Ms 6.

Accordingly, Charge 4a) is found not proved.

Charge 4b)

b) Failed to identify the cause of Patient X's breathing difficulties;

This charge is found proved.

In reaching this decision, the panel took into account all the relevant evidence including your evidence, Ms 2's evidence, Ms 6's evidence and the handwritten note dated 11 April 2019.

You told the panel you had asked Ms 2 to do observations and you then attended to Patient X. You said that Patient X's oxygen saturations were around 98%. You said that the patient was *"lying a bit uncomfortably"*, that you looked for someone to help you reposition the patient but were unable to find help, there you used two pillows to support the patient. You don't recall speaking to Ms 6 about the patient.

The panel noted Ms 6's witness statement which states the following:

> *'The Registrant returned to the nurses' office five minutes after leaving to attend to Patient X and reported that her SATS were stable at 98% and that she "she didn't know what was wrong with her…When I attended to Patient X, I immediately identified the cause of her shortness of breath. She was slumped over and scrunched up in the bed…'*

The panel accepted the evidence of Ms 6 who had prepared a contemporaneous note of the events. Ms 6's note indicates that the patient had complained of shortness of breath to Ms 2, who had then asked you to see your patient. Ms 6 said that on your return to the nurses' office you told her that you did know what was wrong with the patient and that she should go and see her. Ms 2 and Ms 6 had then attended Patient X and both have consistently and clearly indicated in their evidence that the patient was *"slumped in the bed"* and that they repositioned Patient X which immediately relieved their shortness of breath.

The panel accept the evidence of Ms 6, the handwritten note dated 11 April 2019 and the evidence of Ms 2. It is satisfied that the account of events by Ms 2 and Ms 6 are contemporaneous, clear and consistent and that you did not identify the cause of Patient X's shortness of breath when as a nurse you should have.

Accordingly, the panel find Charge 4b) proved.

Charge 4c)

c) Did not remove a lantern drain correctly from Patient Z in that you;
   i) Caused pain to patient Z;
   ii) Did not de-vac the drain;
   iii) Did not to use aseptic technique.

Charge 4c) i) ii)

In reaching this decision, the panel took into account all the relevant evidence including your evidence and Ms 6's evidence and her note dated 11 April 2019.

The panel noted that your recollection of events varies from what the patient had told Ms 6 and Ms 6's evidence. You told the panel that Patient Z had thanked you and had not raised any concerns throughout the procedure.

In your oral evidence, you told the panel that you had previously de-vacced a drain on three occasions, the last one being sometime in 2016 or 2017. However, the panel noted that de-vaccing was not something you had done on a regular basis or often. You also told the panel that you had not spoken to Ms 6 about removing the lantern drain or de-vaccing it.

The panel considered Ms 6's witness statement which states the following:

'The Registrant returned to the nurses' office while I was on the telephone and told me she could not remove the drain. I asked whether she had devac-ed the drain to which she responded "what's that? I told her to wait and that I would show her how to remove the drain. However, the Registrant did not wait and instead returned to Patient Z…"'

The panel carefully considered the handwritten note and witness statement of Ms 6. The panel find Ms 6's evidence more persuasive given her recollection is supported by a contemporaneous note of events. The panel is satisfied that she had a conversation with you, that you were not clear on how to de-vac the drain, that she told you to wait and that she would help you. The panel also noted that in your oral evidence, you did not give a very clear account of the steps you had taken to remove a lantern drain correctly.

Although, the panel did not have direct evidence from Patient Z, it noted Ms 6's contemporaneous note dated 11 April 2019 which states that:

'The patient felt that the nurse didn't really know what she was doing. Unhappy with advice and care…Ibe came to office wearing gloves saying she couldn't get drain out. She had not devacced the drain first and was pulling on the tube…Patient said he felt the care he received was what he would expect from a third world country'"

The panel considered in light of Ms 6's evidence and the patient's account to Ms 6 that it is more likely than not that you did not de-vac the drain and in doing so caused Patient Z pain when removing the lantern drain.

Accordingly, Charge 4c) i) ii) are found proved.

Charge 4c) iii)

You told the panel that when you had attended Patient Z to remove the drain, you were unable to locate the trolley and used one tray comprising of a sterile pack dressing; and another tray to open a sterile pack. You told the panel that you recall utilizing the aseptic technique when removing the lantern drain and that you had used sterile equipment and maintained a sterile environment to remove the drain. You also said that you had used protective equipment including gloves, aprons and prepared the patient accordingly.

The panel took into account the evidence of Ms 6's handwritten note dated 12 April 2018 which reads as follow:

> *'Post removal lantern left handing onside of bed, blood dripping on floor. Used only a hand tray (no trolley aseptic) with gauze and tape and mepore to remove. Tray was balanced on top of phone in patient's room'*

The panel also noted the witness statement of Ms 6 which reads as follow:

> *'I saw the Registrant in the hallway on my way to Patient Z and she told me that she had removed the drain. She was carrying the removal equipment in a blue tray and I noticed that the removal had not performed aseptically as she had only used gauze, tape, mepore and non-sterile gloves…I was also concerned that the procedure was not performed in an aseptic fashion; the Registrant left the removed drain dripping on the floor by the patient's bed instead of disposing of it. She also used non-sterile gloves and a plastic tray during the removal instead of sterile gloves and a dressing trolley'*

You told the panel that you had used two trays to perform the aseptic technique as you could not locate a trolley. It noted that on the basis of Ms 6's evidence, the aseptic technique can be carried out with two trays if a trolley cannot be located. However, the best practice in these circumstances is to use a dressing trolley.

The panel bore in mind that Ms 6 did not directly witness you removing the lantern drain. The panel determined that there was insufficient evidence that you had not used sterile gloves to remove the lantern drain and that you had not used aseptic technique when removing the drain.

Accordingly, Charge 4c) iii) is found not proved.

Charge 5)

5) Between 15 May 2019 and 4 July 2019 failed to inform KCare Nursing Agency that you were subject to an interim Conditions of Practice Order.

This charge is found proved.

In reaching this decision, the panel took into account all the relevant evidence including your evidence, Mr 7's and Mr 8's oral and written evidence. The panel placed no weight on your initial acceptance of Charge 5).

You told the panel that following your return from Africa on 9 or 10 May 2019, you recall a telephone conversation with Mr 8, where you had informed him of the interim conditions of practice order. You accept that it was your responsibility to inform KCare of the interim conditions of practice order and provide a copy of the conditions. The panel noted your oral and written evidence where you were consistent in that you admitted that you: *"had not properly informed KCare Agency or the Trusts that I was placed, so were unaware of the order."* In your evidence you explained that while you had informed KCare of the existence of the interim conditions of practice order you had not 'properly' informed them as you had not written to them or copied the NMC's letter to them.

The panel also took into account the written statement of Mr 8 which reads as follows:

'The Registrant did not disclose any investigations or suspension on her registration during the interview. The Agency did not at any point receive an alert from NHS England or any other organisation indicating that there were any restrictions or conditions on the Registrant's registration…I understand from Gavin Garman, Director of Operations at the Agency, that he was made aware of an issue with the Registrant when the Agency attempted to place her at Oxfordshire NHS trust on 6 September 2019…It was the Registrant's responsibility to make the Agency aware of any changes in respect of her registration. However, she did not disclose to anyone at the Agency that conditions had been placed on her practice despite it being her obligation to o so one she was registered as a candidate at the Agency.'

The panel considered that a telephone call may have taken place between you and Mr 8 following your return from Africa and prior to you taking work from KCare. However, it was not satisfied that you had told Mr 8 or KCare that you were subject to an interim conditions of practice order. It considered that had you done so, Mr 8 would have asked you to provide KCare with details of the interim conditions of practice order and these would have been taken into account in finding you work. Both Mr 8 and Mr 7 confirmed that KCare had not received any information from you about the interim conditions of practice order. The panel therefore accepted the evidence of Mr 8 and Mr 7 in that between 15 May and 4 July 2019 you failed to inform KCare that you were subject to interim conditions of practice order.

Accordingly, Charge 5 is found proved.

Charge 11)

11) Were dishonest in that your actions in charges 5, 6, 7, 8, 9 and/or 10 were intended to conceal the fact that you were subject to an Interim Conditions of Practice Order.

This charge is found partially proved.

In considering this charge and charge 13) the panel adopted the test for dishonesty as set out in the case of *Ivey* that states:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

The panel also followed the approach set out in the case of Uddin and considered whether there might be an alternative explanation for the Registrant's actions such as a mistake or oversight.

In reaching this decision, the panel took into account all the relevant evidence including your oral and written evidence.

You told the panel that you accept that between 15 May 2019 and 4 July 2019 you did not inform the employers set out in the charge, of the fact that you were subject to an interim conditions of practice order. You said you did not intend to conceal this and believed that KCare would have told the employers about the interim conditions of practice order. You now accepted that it was your responsibility to inform your employers of the interim conditions of practice order. However, the panel have already found that you had not told KCare about the order, but that you knew you should have done so.

The panel also noted your personal circumstances at the time [PRIVATE]. However, the panel was not satisfied that your personal circumstances provide an alternative and excusable explanation other than that you were intending to conceal the interim conditions of practice order. It also noted that you had accepted that you had not discussed with any of your employers the restrictions you knew had been imposed on your practice. It was therefore satisfied that you deliberately decided not to tell your employers and KCare of the interim conditions of practice order. The panel was further satisfied that your conduct would been seen to be dishonest by the standards of ordinary decent people.

The panel does not find Charge 11) proved in relation to charge 6. The NMC would have known about the interim conditions of practice order.

The panel found that your actions in charges 5, 7, 8, 9 and 10 were intended to conceal the fact that you were subject to interim conditions of practice order. Accordingly Charge 11) is found partially proved.

Charge 13)

13)Were dishonest as you knew your statement in charge 12 to be untrue because you had not informed KCare Nursing Agency of NMC proceedings.

This charge is found proved.

In reaching this decision, the panel took into account all the relevant evidence including your oral evidence and reflective statement dated 21 October 2021 in which you state the following:

> *'I fully accept that I was not forthcoming in my statement to the investigation committee as the comment in my statement dated 5th July 2019 was*

disingenuous as I had not properly informed KCare Agency or the Trusts that I was placed, so were unaware of the order.

While I had only worked a short time with each placement, I fully accept that I did not inform them of the conditions of practice order and this was dishonest as it was not due to the short time worked on the placement but because I had not ensured that I had informed my employers and those that I provide nursing services for as per the standards expected of me in the NMC Code of conduct.

Upon reflection, I realise that I should have been fully open and honest with the investigation committee about my failures and by not doing so means that as my regulator, you cannot trust in the care that I provide to patients, nor that I will place the interests of patients over my own.'

The panel was satisfied that there is a clear admission by you that you were disingenuous and had not been fully open and honest with the NMC Committee on 5 July 2019. Given its finding in relation to Charge 5) the panel found that the reason you set out in your statement on 5 July 2021, for not providing a report from your employer, was not true as KCare had not been informed by you of the interim conditions of practice order. Further, giving the account you did, was dishonest as you intended to try and mislead the NMC Committee about the true reason for the failure to provide a report. The panel was further satisfied that your conduct would been seen to be dishonest by the standards of ordinary decent people.

Accordingly, Charge 13) is found proved.

Decision and reasons on interim order

Under Rule 32(5), the panel considered whether it was necessary to impose an interim order.

In reaching its decision, the panel considered the documentation and evidence before it, together with submissions by Mr Munday and submissions by Ms Peters. The panel accepted the advice of the legal assessor and took account of the guidance issued by the NMC to panels considering interim orders and the appropriate test as set out at Article 31 of the 'Nursing and Midwifery Order 2001' (the Order). 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 is in your own interest.

Mr Munday submitted that an interim suspension order is necessary in the wider public interest. He submitted that an interim suspension order for a period of 12 months is necessary in case there are unforeseen circumstances that would necessitate the adjournment of the resuming hearing. He submitted that an interim suspension order is necessary in the wider public interest because the allegations relating to dishonesty have been found proved.

Mr Munday submitted that an interim suspension order as opposed to an interim conditions of practice order is necessary to uphold public confidence in the professions and in the NMC as a regulator. He submitted that a well-informed member of the public would be concerned to know that you were allowed to practise unrestricted.

Mr Munday submitted that the facts found proved in relation to dishonesty are difficult to remediate and that there has been no clear remediation by you given that the charges were denied. He submitted that an interim conditions of practice order was unworkable in the circumstances of this case, as there are no conditions that would extinguish the risk posed by you. He told the panel that the dishonesty found proved was in effect concealing an interim conditions of practice order. He also submitted that given your

past behaviour, the panel cannot be confident that you would comply with or disclose any interim conditions of practice imposed on you.

Ms Peters reminded the panel that any order should not be imposed unless the panel is satisfied that it is necessary for the protection of public or is otherwise in the public interest or your own interests. She told the panel that you are working with your current employer who is aware of your circumstances and the allegations.

Ms Peters told the panel that there could be conditions that are imposed to allow you to work in a supervised manner. She told the panel that you have been working without restriction and you were able to do so over a lengthy period of time with no concerns raised about your practice. She told the panel that you have completed training and provided the panel with a reflective piece which shows your insight and your recognition of your conduct.

[PRIVATE]. She told the panel that a suspension order would have a detrimental impact on you financially and professionally if the panel decide to impose an interim suspension order.

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

Based on the facts found proved, the panel noted the very serious and repeated nature of the allegations and is of the view that based on the information before it there is a risk of repetition and a real risk of harm to the public should you be allowed to practise without restriction.

The panel considered an interim conditions of practice order and in all the circumstances determined that such an order would be insufficient to protect the public and to meet the wider public interest considerations of this case. The panel was not satisfied that an interim conditions of practice order could be devised which would be workable, measurable and would protect the public given the seriousness of the

allegations. At this stage, given the dishonesty found proved, the panel was not satisfied that you would comply with an interim conditions of practice order.

The panel determined that an interim suspension order was necessary to protect the public and uphold confidence in the profession and the NMC as your regulator. The panel considered that a well-informed member of the public would be concerned to know that you were allowed to practise before the conclusion of this case.

The panel is satisfied that, in the particular circumstances of this case, an interim suspension order is necessary to protect the public and meet the wider public interest. It has decided to make this interim suspension order for a period of six months. It considers that is an appropriate and proportionate period and should allow the NMC to conclude your case.

The panel has noted that this interim order will prevent you from working as a registered nurse and, as a consequence, you may be caused financial hardship. However, in applying the principle of proportionality, the panel determined that the need to protect the public and the wider public interest outweighed your own interests in this regard.

Fitness to practise

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

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

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

Submissions on misconduct and impairment

In reaching its decision, the panel took into account the further written evidence submitted at this stage on your behalf, namely character references and evidence of training. The panel also had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Munday invited the panel to take the view that the facts found proved amount to misconduct. Mr Munday invited the panel to have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code)' in making its decision.

Mr Munday identified the specific, relevant standards where your actions amounted to misconduct. He submitted that the facts found proved both individually and cumulatively amount to misconduct. He submitted that Charges 1 – 4 are demonstrative of an attitudinal issue as you acted at times dispassionately and with a lack of urgency or impetus when it comes to patient safety, wellbeing and comfort.

Mr Munday submitted that the most serious of the charges are the instances where you had been dishonest. He submitted that dishonesty strikes at the core of the values of the nursing profession. He told the panel that you were dishonest on more than one occasion to more than one entity: your agency, the different hospitals at which you worked and the NMC, on two separate occasions.

Mr Munday further submitted that your dishonesty took more than one form. In relation to KCare and the various hospitals, your dishonesty took the form of concealment. Your initial dishonesty to the NMC again was a form of concealment and concealment of the work being undertaken through KCare. Mr Munday further submitted that your witness statement submitted to the Investigating Committee panel was a positive act as opposed to an omission. You deliberately calculated to mislead that committee. He

submitted that this indicated serious concerns about your reliability and the amount of trust others, including the profession, can place in you. Mr Munday therefore invited the panel to find misconduct in this case.

Mr Munday moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Munday submitted that since dishonesty had been found, the panel may feel that the misconduct alone undermines the trust the public may have in the profession. He submitted that the public would, in the circumstances of this case, expect the regulator to take action against you. He told the panel that you were dishonest to your agency, to four separate hospitals and to the NMC.

Mr Munday further submitted that in relation to your dishonesty, there is little evidence of remediation or reflection provided by you. He told the panel that your oral evidence was contrary to the charges you accepted resulting in applications being allowed to deny two of the previously accepted charges. He submitted that by denying the charges, you directly contradicted the sworn reflective statement you had written.

Mr Munday submitted that dishonesty is very difficult to remediate and that there is a real risk of repetition in the future. He referred the panel to your character references attesting to your honesty and reliability and said that the weight to be attached to these is a matter for the panel.

Ms Peters submitted that despite your apologies and attempts to remedy your conduct, you accept that the charges found proved are serious breaches of the Code and would fall short of what is expected of a registered nurse. She told the panel that you accept

your conduct has impacted on the care provided which has breached the best interests of the patients.

Ms Peters invited the panel to consider the circumstances in which the conduct took place and to consider the evidence you have provided to the panel. This includes: duty of candour training, dated 7 April 2022, statutory duty of candour in Health and Social Care Level 3 Assessment, dated 13 October 2021, and your reflective statement which addresses your understanding of dishonesty. She submitted that it is your position that the competency concerns raised are capable of being remedied. You have provided the panel with training certificates which have targeted the areas of concern. In relation to dishonesty, you accept that it is inherently difficult to remedy, but that the panel should have regard to the period of time which the events had occurred. Ms Peters told the panel that you have not had any dishonesty complaints previously or since and that it was only a period of a couple of months where these matters had occurred.

Ms Peters submitted that you have admitted dishonesty throughout the proceedings and that you have taken practicable steps to remedy the concerns by informing your recent employers of the restrictions on your practice. Ms Peters said that your conduct does not demonstrate deep seated attitudinal issues. She also submitted that your conduct is very unlikely to be repeated in the future as you have taken independent steps to remedy the concerns raised against you. You were of previous good record, engaged throughout the entire NMC proceedings and made attempts to demonstrate how you have changed your attitude and your practice to ensure that there is little risk of repetition. Ms Peters further referred the panel to the character references who unitedly deem you as an educated, trust and caring professional.

Ms Peters submitted that it is the panel's decision to determine whether it is satisfied that a finding of current impairment is required to protect the public, maintain public confidence in the professions and NMC and to uphold proper professional standards.

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*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the 2015 and 2018 Code. The panel considered that the following sections of the Code were engaged in this case:

> **'1. Treat people as individuals and uphold their dignity**
> To achieve this, you must:
>
> **1.1** treat people with kindness, respect and compassion
>
> **1.2** make sure you deliver the fundamentals of care effectively
>
> **1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
>
> **3 Make sure that people's physical, social and psychological needs are assessed and responded to**
> To achieve this, you must:
>
> **3.2** recognise and respond compassionately to the needs of those who are in the last few days and hours and hours of life

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

13 Recognise and work within the limits of your competence

To achieve this, you must:

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

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

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

To achieve this, you must

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20. Uphold the reputation of your profession at all times

To achieve this, you must

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

20.2 act with honesty and integrity at all times…

20.5 treat people in a way that does not…cause them upset or distress

23. Cooperate with all investigations and audits

To achieve this, you must

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that there were a wide range and a number of failings in relation to your conduct as a nurse. The panel considered that the concerns are not just related to your clinical practice but also involve dishonesty and a lack of integrity. The panel considered that a number of the charges found proved demonstrated that you behaved in an uncaring manner and were indicative of an attitude that was not person centred.

The panel then went on to consider whether your actions, both individually and collectively, amounted to misconduct.

Charge 1)

The panel acknowledged that the Datix report was a contemporaneous account of the event and that there was no direct testimony from the patient. However, the panel was satisfied that you had handled the patient roughly and that you did not treat the patient with kindness, respect or compassion. The panel found there to be a breach of the Code 1.1, 1.2 and 20.5. The panel determined that your actions did fall seriously short of what is expected of a registered nurse. In these circumstances, the panel determined that your behaviour was sufficiently serious as to amount to misconduct.

Charge 2)

The panel noted that your conduct, failing to gain consent from the patient before taking blood pressure, fell short of what was expected of a nurse in the circumstances and amounts to a breach of the Code 4.2. The panel determined that when considered in isolation a single incident of failing to gain a patient's consent would often not amount to misconduct. In these circumstances, the determined that this failure was not sufficiently serious as to amount to misconduct.

Charge 3c)

The panel determined that your actions fell significantly below the conduct expected of a registered nurse and found there to be breaches of the Code 1.1, 1.2, 1.4 and 3.2. It noted that Patient C was very acutely unwell, at the end of his life and died later that day. It noted that your failure to promptly start a syringe driver for Patient C was a significant deficiency and shortcoming in the care and treatment you provided to Patient C. In these circumstances, the panel determined that your conduct was sufficiently serious as to amount to misconduct.

Charge 4b)

The panel noted that you did not identify the cause of Patient X's shortness of breath and that identifying the cause of the patient's breathing difficulty in these circumstances was a very basic matter and a fundamental part of what a nurse would be expected to do. The panel noted that you were an experienced nurse and would therefore be expected to identify this and your failure to do so was a significant falling short of the conduct expected in the circumstances. The panel found there to be breaches of the Code 1.1, 1.2, 1.4 and 13.1. The panel determined that this charge was sufficiently serious as to amount to misconduct.

Charge 4c) i) and 4c) ii)

In relation to charges 4c) i) and 4c) ii) the panel noted that you caused pain to the patient. In documentary evidence the patient described the experience as feeling like their '*intestines were coming out'*. The panel found there to be breaches of the Code 1.1, 1.2. 13.3, 19.1 and 20.5.

The panel noted Ms 6's evidence in which she asked you to wait for her assistance to de-vac the drain. You did not do so and despite having had little experience of this procedure you went ahead and did it, causing pain to the patient. In these circumstances, the panel determined that your behaviour fell significantly below the standard expected of a nurse and was sufficiently serious as to amount to misconduct.

Charge 5) 6) 7) 8) 9) and 10)

The panel took into account that your conduct in relation to these charges constitute serious failings and breached the Code. The Code 20.1 and 23.3 require you to act with honesty and integrity and inform your employer of restrictions on your practice.

Over a period of several weeks in May and June 2019 you failed to inform KCare that you were subject to an interim conditions of practice order and worked for four different hospitals whilst subject to that order. Your failure to inform KCare and the four hospitals prevented your employers from assessing the risks associated with your practice and putting in place appropriate measures to ensure, amongst other things, patient safety. Furthermore, your failure to inform the NMC of your employment with KCare nursing agency prevented the NMC from monitoring your practice effectively. The panel noted that you had worked unrestricted for several weeks in breach of the interim order. In these circumstances, the panel determined that your conduct was a significantly serious departure from the standards expected of a nurse and amounted to to misconduct.

Charge 11) in relation to 5, 7, 8, 9, 10

The panel determined that you intended to mislead people and you knew your actions were dishonest. This was deplorable conduct and there could be no reasonable explanation other than a deliberate attempt to mislead the hospitals and the agency. You deliberately concealed information from your employers so that you could continue to work unrestricted. Your behaviour had the potential to cause unwarranted harm to patients and also negatively impact your colleagues. A registered nurse acting without honesty and integrity is a very serious breach of the Code in particular 20.2. In these circumstances, the panel determined that your behaviour fell significantly below the standards expected of a registered nurse and amounted to misconduct.

Charge 12) and 13)

The panel determined that your actions constituted serious misconduct. Your misconduct constituted a breach of the Code 20.1, 20.2 and 23. As a registered nurse you have a duty to cooperate with NMC investigations. However, you deliberately tried to mislead the NMC. The panel considered that dishonesty will always be considered a serious departure from the standards expected of a registered nurse and it was satisfied that any member of the profession, or public, would consider your actions to be deplorable. In these circumstances, the panel determined that this charge was sufficiently serious as to amount to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional 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 *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 determined that patients were put at risk of unwarranted harm as a result of your misconduct. Your misconduct breached the 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 considered the case of *Grant* and found that all four limbs were engaged in this case. In relation to limb a), the panel considered that your actions put patients at an unwarranted risk of harm. The panel noted that there was actual or potential harm caused to the patients in charges 1), 3) and 4). It noted that your misconduct involved a number of patients in different hospitals over a period of approximately 18 months.

In relation to limb b), the panel considered the multiple breaches of the Code including dishonesty. It considered the lack of kindness and compassion you had shown towards patients and your clinical failings. It found that given your misconduct and the broad scope of failings across the Code that you had brought the nursing profession into disrepute.

In relation to limb c), the panel considered your misconduct has breached fundamental tenets of the profession. The panel also noted that your misconduct was wide-ranging and engaged a number of sections of the Code and continued over a protracted period of time (2017 – 2019).

In relation to limb d), the panel considered that given the charges found proved in relation to dishonesty this limb was also engaged. It determined that you were dishonest to the agency, to four separate hospitals and to the NMC.

The panel considered the case of *Cohen* in relation to remediation. It considered that your clinical concerns are capable of remediation. The panel accepted that dishonesty is difficult to remediate, but considered that the actions in this case were capable of remediation. It considered remediation could have been demonstrated through acceptance of what went wrong, through showing an understanding of how your actions impacted on patients, colleagues, the reputation of the nursing profession and your regulator, through demonstration of apology and remorse and through demonstrating steps taken to ensure the behaviour would not be repeated in the future.

The panel then considered whether you had remediated your misconduct. The panel noted that you now accept the panel's factual findings and that the charges found proved amount to misconduct. The panel have not been provided with an up to date reflective piece which takes into account the findings of fact. The panel noted that you did not give oral evidence at this stage. The panel reminded itself of your reflective piece dated November 2021 and took into account the additional information provided to it for this stage.

In relation to your clinical failings, the panel considered the training you have undertaken to remedy the competence concerns including: Consent, Care and Compassion and Patient choice as part of the Dignity and Privacy (Online Training) together with Consent (Online Training); Manual Handling & Moving of People &

Inanimate Objects; Work in a Person Centred Way and Safeguarding Adults Levels 1 & 2 (Adult Support & Protection) online training to address concerns of consent and handling patients. To address the concerns surrounding the Syringe Driver and Lantern drains you have undertaken the Safe Handling & Administration of Medication. You have also recently revisited your understanding of the ABCDE approach to assessing deteriorating or critically ill patients.

The panel acknowledged from your evidence that you had completed training in relation to some of the clinical concerns identified in this case. The panel noted, however, there was no evidence that you had undertaken training in relation to de-vacing of surgical drains.

The panel had regard to your reflective piece dated November 2021 and noted that you demonstrate some reflection and insight into your clinical failings as a registered nurse. However, it determined that you have based your reflections on a version of events that the panel has not found to be credible. The panel was of the view that although there was some acknowledgement by you of your clinical failings, it was concerned that your reflections did not sufficiently address the impact of your failings on patients, their families, colleagues and the nursing profession.

The panel considered that although you now accept its findings of fact, you have not expressed remorse for your clinical failings. Furthermore, as you have not provided any updated reflected piece, you have not demonstrated how you would handle similar situations differently in the future.

The panel considered that some of the positive references provided do attest to your knowledge, skills and good character. However, the references were short, lacked detail, and it was not clear whether the referees were aware of the nature of the proceedings against you. Therefore, the panel attached little weight to the references.

The panel took into account the training you have done since the incidents. The panel considered that you have not demonstrated how you have applied the training and strengthened your practice. The panel was therefore not satisfied that you have demonstrated sufficient insight, remorse or remediation and considers there is a real risk of repetition of the clinical failings the panel have identified.

In relation to your dishonesty, the panel finds that you have begun to recognise that some of your actions were wrong, although this awareness is limited and there is insufficient evidence before the panel to suggest that you have strengthened your practice or remediated the concerns raised. It considered that your reflective piece addressed dishonesty, but it did not address the full nature and extent of the regulatory concerns found proved by the panel. The panel was of the view that this is a serious case which involves deliberate breaches of the Code. The panel noted your evidence where you apologised for the mistakes you made, that you are ashamed and that you would not do the same thing again.

Whilst the panel acknowledged that you addressed some remorse for your dishonesty, the panel determined that your insight into your dishonesty is still at an early stage. Therefore, the panel was of the view that there is a real risk of repetition of dishonest behaviour.

The panel accepted the submissions of Mr Munday that the facts found proved under charges 1, 3 and 4 also show serious concerns about your attitude and character. The panel is of the view that there is a real risk of repetition based on the clinical failings and dishonest conduct found proved. The panel was of the view that there was nothing before it to reassure them that if you experienced any difficulties in the future the misconduct would not be repeated. In reaching this conclusion the panel also took into account the personal circumstances you were experiencing at the time. However, given that you have provided limited insight into your failings, the panel is not persuaded that those failings were caused by your personal circumstances at the time. In all the

circumstances, the panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required. It considered that a well-informed member of the public would be concerned to learn about your misconduct. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel decided that your fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have 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 Munday invited the panel to impose a striking off order. He submitted that a striking off order is necessary in this case both to uphold and maintain public confidence in the profession and the regulator, and to protect members of the public from the risk of future harm. Mr Munday outlined the aggravating and mitigating features in this case. He told the panel that the mitigating features are your acceptance of some of the charges and no previous regulatory concerns.

Mr Munday submitted that the following are aggravating features:

- The unnamed patient's blood pressure was taken whilst they were asleep.
- Patient C was in his last days of life.
- The pain caused to Patient Z.
- Your dishonesty took more than one form and included both omissions and a positive act.
- Your dishonesty was repeated to multiple people and bodies over a significant period of time.

Mr Munday submitted that taking no action or a caution order would not be appropriate considering the seriousness in this case. In relation to a conditions of practice order, he

submitted that no provisions would adequately address your dishonesty and attitudinal issues. He submitted that it is difficult for measurable, workable and proportionate conditions to be imposed in this case to reduce the risk of your misconduct being repeated. Mr Munday submitted that a significant portion of the dishonesty in this case was you concealing the existence of your interim order. He also submitted that your repeated dishonesty in this case means that a conditions of practice order would not be appropriate.

Mr Munday further submitted that this case involves your lack of urgency and compassion when it came to patient safety, well-being and comfort. He told the panel that you at times caused pain and discomfort to patients. He also submitted that your dishonesty was repeated and took multiple forms. He submitted that this case falls into the higher category of seriousness and a suspension order would not be appropriate in this case.

Mr Munday submitted that your dishonesty and conflicting evidence in the proceedings make this case very serious. He submitted that your behaviour has raised fundamental questions about your professionalism and trustworthiness as a registered nurse. Mr Munday submitted that your dishonesty would seriously undermine the confidence of the profession and the NMC as a regulator. He therefore submitted that the only appropriate sanction is a striking off order for the protection of the public and the wider public interest.

Ms Peters on your behalf submitted that you were of previous good character, with no previous disciplinary hearings or sanctions nor have there been any previous NMC referrals. She told the panel that you have fully accepted the panel's findings and that you have attempted to demonstrate remorse, understanding and insight into your dishonesty and clinical failings. She told the panel that it is not your intention to conceal any wrongdoing.

Ms Peters submitted that you have apologised and have attempted to address these failings by obtaining employment in the health sector. You now realise that there are clear concerns about your abilities in handling patients and you feel ashamed for causing distress to those patients. In relation to your dishonesty, you feel ashamed and you are now fully aware of your duty to inform your employers of any restrictions on your practice and to be open and honest with your regulator. Ms Peters submitted that these proceedings have affected your confidence professionally and personally. She told the panel that it is to your credit that you have provided evidence to demonstrate understanding of your failings as a registered nurse.

Ms Peters invited the panel to consider all aspects of mitigation in this case including your remorse, training and reflection. She told the panel that your current employer deems you to be professional, trustworthy and reliable.

Ms Peters submitted that it is a matter for the panel to impose the sanction it deems necessary in this case. You accept that the panel will consider your dishonesty and that it may find it difficult to determine workable conditions. However, Ms Peters submitted that there have been no issues in relation to your dishonesty since these incidents. She told the panel that you have been open and honest and have informed your employers about the proceedings. She submitted that the panel can be satisfied that there is no risk of repetition.

Ms Peters told the panel that you have secured employment as a HCA and that you have been committed to keeping your nursing skills up to date. You have disclosed the restrictions on your registration and you are honest. She further submitted that you are still in the early stages of showing insight and accepted therefore that a longer period of suspension might be the appropriate sanction in this case.

Decision and reasons on sanction

The panel received an updated reflective piece at the sanction stage. However, the panel attached little weight to this given that it was provided very late in the proceedings and you did not provide oral evidence so this was not tested by questions put to you.

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel determined that the following aggravating features were present:

- You lacked insight into clinical failings and dishonesty
- Your dishonesty was repeated to multiple bodies including your employers over a period of time
- You were dishonest to your regulator and frustrated the regulatory process
- Your clinical failings and dishonesty demonstrated a pattern of misconduct over a period of time
- Your misconduct caused harm to patients and your dishonesty in concealing the interim conditions on your practice also put patients at unwarranted risk of harm

The panel determined the following mitigating features were present:

- You made admissions to some charges at the outset of the hearing
- You demonstrated some remorse

The panel in reaching its decision considered the SG, particularly in relation to cases involving dishonesty. The panel considered your dishonesty to be serious dishonesty. It involved dishonesty to multiple bodies including the NMC, hospital employers and the

agency and it occurred over a period of several weeks. The panel determined that by concealing your interim conditions of practice order and giving the NMC's investigating committee false information your actions put patients at direct risk of harm. Your misconduct was motivated by financial gain to ensure that you could secure employment as a nurse. Your dishonesty also frustrated the NMC's regulatory process.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the 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 your registration would be a sufficient and appropriate response. The panel is aware that any conditions must be proportionate, workable and measurable. It determined that there are no practicable or workable conditions that could be formulated that would address the issues given the nature of your misconduct, including the attitudinal concerns and your dishonesty. The panel took into account that you deliberately concealed your interim conditions of practice order and you have not provided sufficient evidence to address your lack of insight into your misconduct. The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public or satisfy the public interest and public confidence issues.

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 this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. The panel determined that dishonesty in this case was serious and your clinical failings caused harm to patients. Although there was no evidence of repetition since the incidents, it determined that the conduct found proved was not a single instance of misconduct and did show evidence of deep seated attitudinal problems as it was repeated in relation to your clinical failings and your dishonesty. In relation to dishonesty, the panel noted that there had been several opportunities to correct your behaviour and to act in a professional way. However, you continued to conceal the restrictions on your registration for several weeks. The panel was not satisfied that you have shown sufficient insight into your misconduct and determined that there is a real risk of repetition.

Your conduct was a significant departure from the standards expected of a registered nurse. The panel considered that the serious breach of the fundamental tenets of the nursing profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

In this particular case, the panel determined that a suspension order would not therefore be a sufficient, appropriate or proportionate sanction to protect the public and uphold public confidence in the profession and the NMC as a regulator and maintain standards.

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

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

The panel was of the view that the findings in this case raised fundamental questions about your professionalism. Your dishonesty to your employers and regulator was extremely serious, given the context that you were under a regulatory investigation and your clinical failings caused harm to patients. The panel determined that your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to remain on the register would not protect the public sufficiently and would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of your dishonesty, your actions in putting patients at a serious risk of harm, breaching fundamental tenets of the profession and bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should

conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to protect the public and 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 expected of a registered nurse.

Accordingly, the panel is satisfied that a striking off order is necessary for the protection of the public and the wider public interest.

The panel was mindful of the potential impact that such an order may have on you but taking full account of the important principle of proportionality, the panel was of the view that the interests of the public outweighed your interests.

The panel, therefore, directs the Registrar to strike your name from the register. You may not apply for restoration until five years after the date that this decision takes effect.

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 your own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

The panel considered the submissions made by Mr Munday that an interim suspension order for a period of 18 months should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

Ms Peters on your behalf made no submissions and indicated that she did not oppose the application.

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

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.