# Nursing and Midwifery Council
# Fitness to Practise Committee

## Substantive Hearing
## Tuesday 1 February – Thursday 10 February 2022

Virtual Hearing

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| **Name of registrant:** | Darren Scott Diplexcito |
| **NMC PIN:** | 02A0091S |
| **Part(s) of the register:** | Registered Nurse – Adult Nursing (April 2007) |
| **Area of registered address:** | Paisley |
| **Type of case:** | Misconduct |
| **Panel members:** | Avril O'Meara (Chair, lay member)<br>Sharon Peat (Registrant member)<br>Penny Titterington (Lay member) |
| **Legal Assessor:** | John Bromley-Davenport |
| **Hearings Coordinator:** | Parys Lanlehin-Dobson |
| **Nursing and Midwifery Council:** | Represented by Amanda Bailey, Case Presenter |
| **Mr Diplexcito:** | Not present and unrepresented |
| **Facts proved:** | Charges 5 and 6 |
| **Facts not proved:** | Charges 1, 2, 3 and 4 |
| **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 Diplexcito was not in attendance and that the Notice of Hearing had been sent to his email address, as recorded on the Nursing and Midwifery Council's (NMC's) Register, on 4 January 2022.

The panel took into account the witness statement provided by the NMC case officer confirming service of the notice. The panel noted that the Notice of Hearing provided details of the allegations, the date, time, virtual hearing link and, amongst other things, information about Mr Diplexcito's right to attend virtually, be represented and call evidence, as well as the panel's power to proceed in his absence.

Ms Bailey, on behalf of the 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 Diplexcito has 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 Diplexcito**

The panel next considered whether it should proceed in the absence of Mr Diplexcito. The panel had regard to Rule 21 of the Rules and heard the submissions of Ms Bailey who invited the panel to proceed in the absence of Mr Diplexcito.

Ms Bailey referred the panel to the 'Proceeding In Absence' bundle, which includes an email, in response to the notice of this hearing, from Mr Diplexcito's former

representative at Anderson Strathern. The email is dated 25 January 2022 and states the following:

*"Good morning*

*Please note that Mr Diplexcito has advised us that he no longer wishes to engage with the NMC hearing and we have now withdrawn from acting.*

*He has asked that the attached response to the allegations be placed before the Panel for consideration and he is aware that the Panel may proceed in his absence."*

The panel also noted Mr Diplexcito's 'Reason for not attending' contained in the email of 25 January 2022 where he stated:

*"After much thought, I have decided not to attend this hearing. This long process has had a profound, detrimental effect on my physical and mental health. Recently, I feel I have finally managed to turn a corner, and have begun to rebuild my life. This in turn has been to the benefit of my well-being, and also my livelihood. I want to try to protect this progress. After considerable reflection, I have concluded that I no longer intend to return to the nursing profession in the future, and I now wish to focus my skills and energies in other areas."*

Ms Bailey submitted that Mr Diplexcito, via his representative had indicated that he was aware of these proceedings, had voluntarily absented himself from these proceedings and had provided responses in relation to the allegations. Ms Bailey reminded the panel that there was a public interest in proceeding with the hearing today.

The panel accepted the advice of the legal assessor.

The panel decided to proceed in the absence of Mr Diplexcito. In reaching this decision, the panel considered the submissions of Ms Bailey, the email from Mr Diplexcito's former representative, Mr Diplexcito's reasons for not attending and the advice of the

legal assessor. It also had particular regard to the relevant case law and to the overall interests of justice and fairness to all parties. It noted that:

- Mr Diplexcito has received the Notice of Hearing, is aware that the hearing is taking place today virtually, and has been provided with details of how to attend;
- Mr Diplexcito, through his representative, engaged with the NMC up until 25 January 2022 and did not request an adjournment;
- Mr Diplexcito through his representative has confirmed in writing that he will not be attending or engaging with these proceedings any longer;
- There is no reason to suppose that adjourning would secure his attendance on a future date; and
- Three witnesses have been called to give live evidence at these proceedings
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018 further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

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

There is some disadvantage to Mr Diplexcito in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email address, he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated, somewhat by the responses he has provided in relation to the allegations. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore

any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Diplexcito's decision to absent himself from the hearing, waive his rights to attend, and/or be represented.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Diplexcito. The panel will draw no adverse inference from Mr Diplexcito's absence in its findings of fact.

**Background**

The charges arose whilst Mr Diplexcito was employed as a registered nurse by Greater Glasgow and Clyde Health Board (the Board). The NMC received a referral from the Chief Nurse at the Board. On 27 September 2018. Mr Diplexcito was employed from April 2016 until 1 December 2019 as a band 5 nurse at the Royal Alexandra Hospital (the Hospital). The referral followed Mr Diplexcito's suspension from duty on 22 July 2018 pending further investigation by the Board relating to a number of alleged incidents between May and July 2018.

Mr Diplexcito worked on Ward 24 at the Hospital from early 2018. Ward 24 is step down ward for High Dependency and Post –Surgical patients.

It is alleged that Mr Diplexcito on or around 17 and 18 May 2018 failed to carry out a post void bladder scan on a patient and told the patient's consultant that he had carried out the scan when he had not.

It was further alleged that on a night shift on 30 June in to 1 July 2018, Mr Diplexcito fraudulently recorded a patient's blood sugar observations twice on a National Early Warning Score (NEWS) chart.

**Decision and reasons on application to amend the charges**

At the outset of the hearing the panel heard an application made by Ms Bailey on behalf of the NMC, to amend charges 5 b) and 5 c).

The proposed amendment was to change the time stated in charge 5 b) to ‘00:20’ and to change the time stated in charge 5 c) to ’04:10’. Ms Bailey referred the panel to the NEWS chart and the times recorded on this and submitted that the proposed amendments would more accurately reflect the evidence.

After hearing oral evidence from the witnesses involved in this case, Ms Bailey made a further application to amend charges 1, 2, 5a) and 6.

In respect of charges 1 and 2 the proposed amendment was to substitute the words *“On 17 May 2018”* and “*On 18 May 2018”* to read instead *“ On or around 17 May 2018”* and *“ On or around 18 May 2018”*. It was submitted by Ms Bailey that the proposed amendments would more accurately reflect the oral and documentary evidence available particularly as Colleague 1 in live evidence was uncertain of the exact dates the matters alleged matters had taken place.

Ms Bailey also made an application to amend charges 5a) and 6 in so far as it refers to 5 a). She submitted that the evidence available in relation to charge 5 a) was insufficient to substantiate the charge and it should therefore be deleted. Consequently she submitted that the reference to charge 5a), in charge 6, should also be deleted.

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

As regards charges 5 b) and 5 c) the panel was satisfied that the amendments more accurately reflect the underlying evidence, i.e. the information on the NEWS chart. The panel also took into account Mr Diplexcito’s representations in respect of these charges where he had said *“If this is the recording on the NEWS Chart that I have documented then I have obtained this measurement by conducting a Blood Glucose test.”* The panel therefore determined to allow the application to amend charges, 5 b) and 5 c).

As regards charges 1 and 2 the panel was of the view that the proposed amendments to the dates were not the main concern here and that the panel was satisfied that it would not cause prejudice or unfairness to Mr Diplexcito if these amendments were made. It was still a matter for the NMC to prove that the matters alleged had taken place whether on or around the dates 17 and 18 May 2018.

As regards charges 5 a) and 6 (in so far as it referred to charge 5 a), the panel noted that the oral and documentary evidence provided (including the NEWS chart) did not reflect the charge at 5 a) and the NMC had no evidence to support that charge and no longer wished to pursue it. The panel was satisfied that these amendments were in the interests of both parties and would not cause any unfairness to Mr Diplexcito.

The panel was of the view that the amendments, as applied for, would not result in any unfairness or prejudice to Mr Diplexcito and it therefore allowed the amendments.

**Details of charges (as amended)**

That you, a registered nurse:

1. On or around 17 May 2018 failed to carry out a post void bladder scan on patient A.

2. On or around 18 May 2018 during a ward round said to patient A's consultant, in the presence of colleague 1:

a) that you had carried out a post void bladder scan on patient A, or words to this effect.

b) that the result of the scan was that patient A had 125mls left in his bladder, or words to this effect.

3. Your responses at '2a)' and/or '2b)' were dishonest in that you knew you had not carried out a post void bladder scan on patient A.

4. On the night shift 30 June 2018 into 1 July 2018 failed to carry out any blood sugar checks on patient B.

5. Recorded on patient B's NEWS chart:
a)…

b) a blood sugar reading of 9.8 on 1 July 2018 around 00:20 hours.

c) a blood sugar reading of 9.7 on 1 July 2018 around 04.10 hours.

6. Your recordings at '5b)' and/or 5c were dishonest in that you knew you had not carried out any blood sugar checks on patient B around the times stated.

**Decision and reasons on facts**

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

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

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: Colleague 1 is a registered Band 5 Staff Nurse. Colleague 1 worked with Mr Diplexcito on Ward 24. Colleague 1's oral and

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| | documentary evidence speaks directly to charges 1 to 3. |
| • Colleague 2: | Colleague 2 is also a registered Band 5 Staff Nurse. Colleague 2 also worked with Mr Diplexcito on Ward 24. Colleague 2's oral and documentary evidence speaks directly to charges 4 to 6. |
| • Colleague 3: | Colleague 3 is also a registered Band 5 Staff Nurse. Colleague 3 also worked on ward 24. Colleague 3 provided evidence in relation to charges 4 and 5. |

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the oral witness and documentary evidence provided by the NMC and Mr Diplexcito's responses to the allegations document dated 25 January 2022.

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

**Charge 1**

1. On or around 17 May 2018 failed to carry out a post void bladder scan on patient A.

**This charge is found NOT proved.**

In reaching this decision, the panel had regard to Mr Diplexcito's Response to NMC Charges and the oral and documentary evidence provided by Colleague 1. It also had regard to Patient A's Clinical nursing notes.

Colleague 1's witness statement, dated 11 January 2021, stated: "*Later that day I asked Darren if he done the bladder scan as Patient A was one of his allocated patients. Darren stated to me that he had not done it because he did not think that it was essential"*. In oral evidence, Colleague 1 confirmed the contents of the witness statement and told the panel that towards the end of the shift on 17 May Mr Diplexcito said he had not done the scan.

Colleague 1 also told the panel that the following day during a ward round she heard the junior doctor say to the consultant that he had enquired before finishing shift whether the scan had been done and it had not. And also the patient had told Colleague 1, after the ward round that no bladder scan had been carried out on him by Mr Diplexcito on the previous day.

The panel also noted that the statement Colleague 1 provided around August 2018, for the internal investigation, included details of what Mr Diplexcito had said to Colleague 1, the conversation the following day during the ward round and the conversation after the ward round with Patient A.

In his 'Response to NMC Charges', dated 25 January 2022, Mr Diplexcito stated:

***"1.*** *On 17 May 2018 failed to carry out a post void bladder scan on patient A. Do you admit: • the facts alleged in the charge above?* ***No***

***Response:*** *I have documented in the nursing notes that I have conducted a bladder scan on the patient and this practice is within keeping with the NMC Code and supports my original evidence, however the evidence given from* [Colleague 1's] *is that this is her Bladder Scan and she asked me to document this on her behalf, this is something I would not do as you would only document the care that you were providing and in addition there is no further documentary evidence to support* [Colleague 1's] *claims."*

The panel also had regard to Patient A's clinical nursing notes dated 17 May 2018, an entry at 16:00 documents the following: *"Secondary bladder scan conducted – 235 ml in bladder"*. Whilst giving oral evidence Colleague 1 confirmed that this entry was made

and signed by Mr Diplexcito. The panel also noted that next to the entry were the initials 'DSD' along with a printed name and it was satisfied that this name was 'Diplexcito'.

Having considered all the evidence available to it the panel determined that on this occasion the NMC had not discharged its burden of proof. It was of the view that Colleague 1 had provided evidence that Colleague 1 believed to be accurate and true. The panel considered that whist Colleague 1 was honest and did her best to assist the panel, some of the evidence which Colleague 1 provided in relation to this charge was hearsay evidence from the junior doctor and Patient A. The panel did not see any evidence that the NMC had made attempts to obtain evidence directly from those witnesses. The panel determined that it could only give very limited weight to the hearsay evidence provided by Colleague 1. Although Colleague 1's statements were consistent, the panel noted that they were not contemporaneous and had been produced some time after the events alleged. The panel determined it could place only limited weight on Colleague 1's evidence as there was no corroborating evidence to support Colleague 1's recollection of what was said to her.

In contrast, Mr Diplexcito's response that he carried out a bladder scan on Patient A, on 17 May 2018, is supported by Patient A's clinical nursing notes. The panel therefore determined that there is insufficient evidence available in order for it to find the charge proved on the balance of probabilities.

The panel therefore found this charge not proved.

**Charge 2)**

*"2. On 18 May 2018 during a ward round said to patient A's consultant, in the presence of colleague 1:*

a) *that you had carried out a post void bladder scan on patient A, or words this effect.*

b) *that the result of the scan was that patient A had 125mls left in his bladder, or words to this effect."*

**This charge is found NOT proved.**

In reaching this decision, the panel had regard to Mr Diplexcito's Response to NMC Charges and the oral and documentary evidence provided by Colleague 1. It also had regard to the Investigatory Meeting Notes document dated 30 August 2018.

In her witness statement Colleague 1 stated: *"The following morning 18 May 2018 … When Darren joined the ward, the consultant asked Darren why he hadn't carried out the bladder scan on Patient A. Darren responded by saying that he had done the scan and that there was 125mls in his bladder."*

In his Response to NMC Charges document, dated 25 January 2022, Mr Diplexcito stated:

***"2.*** *On 18 May 2018 during a ward round said to patient A's consultant, in the presence of colleague 1:*

*a) that you had carried out a post void bladder scan on patient A, or words this effect. Do you admit: • the facts alleged in the charge above?* ***No***

***Response:*** *As previously highlighted on several occasions during this process and by submitting evidence, I was not on-duty on the 18th May 2018 and was actually out with colleagues having a Day Out, evidence has been submitting showing Social Media Posts highlighting I was out with my colleagues and not in working, with pictures taken of us all. In addition I also highlighted that I was not on the duty roster for working this day either.*

*b) that the result of the scan was that patient A had 125mls left in his bladder, or words to this effect. Do you admit: • the facts alleged in the charge above?* ***No***

***Response:*** *As previously stated I could not have done this as I was not on-duty on the 18th May 2018 and as previously referred to, I have highlighted this on several occasions and have submitted substantial evidence that supports I was not there on that date."*

Having considered all the evidence available to it the panel determined that the NMC had not discharged its burden of proof. It considered that the evidence put forward by the NMC, to substantiate this charge, is uncorroborated.

In its consideration of Mr Diplexcito's response to this charge, the panel took into account that he disputes this charge and claims that he was not working at all on 18 May 2018. Whilst Mr Diplexcito has not put forward any corroborating evidence to support this claim, the panel reminded itself that the burden rests on the NMC to prove the facts alleged. It was of the view that it would have been assisted if the NMC had put forward evidence corroborating Colleague 1's evidence, such as confirmation of the dates Mr Diplexcito worked on Ward 24, witness evidence from the Consultant or Junior Doctor and medical notes or clinical nursing notes covering more of the relevant period.

On this basis the panel determined that due to the limited supporting evidence available it could not be satisfied on the balance of probabilities what took place on or around the 18 of May, including whether Mr Diplexcito had told the consultant that he conducted the scan or if he was even on the ward on the day in question.

Therefore this charge is found not proved.

**Charge 3)**

3. Your responses at '2a)' and/or '2b)' were dishonest in that you knew you had not carried out a post void bladder scan on patient A.

**This charge is found NOT proved.**

Having found Charges 1, 2a and 2b not proved the panel determined that this charge is also not proved.

**Charge 4)**

4. On the night shift 30 June 2018 into 1 July 2018 failed to carry out any blood sugar checks on patient B.

**This charge is found NOT proved.**

In reaching this decision the panel had regard to the Patient B's NEWS chart and a glucometer report for readings taken by Mr Diplexcito. It also had regard to the oral and documentary evidence provided by Colleague 2 and Colleague 3. It also had regard to Mr Diplexcito's Response to NMC Charges document.

In her witness statement Colleague 2 stated: "*On the night of 30 June 2018 I was again working night shift on Ward 24 …When I returned from my breaks during the night Darren informed me that he had completed the blood sugar checks for Patient B at 00:30 and again at 4:30 am. …. At 6:30 am I was carrying out routine observations of all of my patients prior to the end of my shift Patient B was awake at this time and I explained to him that I was going to check his vital signs but was not going to check his blood sugar level as this had only been done two hours ago. Patient B informed me that he had not been disturbed through the night and that e blood sugars had not been taken since 9pm the night before.*"

Patient B's NEWS chart documents an entry made on 30 June 2018 by Mr Diplexcito at 08:20, with a blood sugar reading of 9.6. The glucometer report also shows an entry on 30 June 2018, taken by Mr Diplexcito at 08:29 with a blood sugar reading of 9.6.

The panel heard evidence from Colleague 2 and Colleague 3 that some of Mr Diplexcito's entries on Patient B's NEWS Chart on 1 July 2018 did not correlate with those on the glucometer report from the central archive system, specifically blood sugar testing at 00:20 and 04:10. However the panel had regard to the specific wording of the charge "On the night shift **30 June 2018** into **1 July 2018** failed to carry out ***any*** blood

sugar checks on patient B". As the panel determined that Mr Diplexcito conducted a blood sugar test on Patient B at 8:29, on 30 June 2018 during the night shift, it therefore found this charge not proved.

**Charge 5)**

5. Recorded on patient B's NEWS chart:

b) a blood sugar reading of 9.8 on 1 July 2018 around 00:20 hours.
c) a blood sugar reading of 9.7 on 1 July 2018 around 04.10 hours.

This charge is **PROVED.**

In reaching this decision the panel had regard to the Patient B's NEWS chart, Mr Diplexcito's Response to the charges document. It also had regard to the oral and documentary evidence of Colleague 2 and Colleague 3.

Patient B's NEWS chart shows blood sugar readings of 9.8 around 00:20 hours and a reading of 9.7 around 4:10 on 1 July 2018.

In his response to the NMC charges document Mr Diplexcito stated:
***"5.*** *Recorded on patient B's NEWS chart:*

*a) a blood sugar reading of 9.6 on 1 July 2018 around 00:20 hours. Do you admit: • the facts alleged in the charge above?* ***Yes***

***Response:*** *If this is the recording on the NEWS Chart that I have documented then I have obtained this measurement by conducting a Blood Glucose test.*

*b) a blood sugar reading of 9.8 on 1 July 2018 around 04:10 hours. Do you admit: • the facts alleged in the charge above?* ***Yes***

***Response:*** *If this is the recording on the NEWS Chart that I have documented then I have obtained this measurement by conducting a Blood Glucose test.*

*c) a blood sugar reading of 9.7 on 1 July 2018 around 08.00 hours. Do you admit: • the facts alleged in the charge above?* ***Yes***

***Response:*** *If this is the recording on the NEWS Chart that I have documented then I have obtained this measurement by conducting a Blood Glucose test."*

Having considered all the available evidence the panel determined that Mr Diplexcito accepts that he made the entries on Patient B's NEWS chart and this is supported by the NEWS chart and Mr Diplexcito's signature. The panel therefore found this charge proved.

**Charge 6)**

6. Your recordings at '5a)' and/or '5b)' and/or 5c were dishonest in that you knew you had not carried out any blood sugar checks on patient B around the times stated.

This charge is found **PROVED**

In reaching this decision the panel had regard to Mr Diplexcito's response (including as set out above in Charge 5), Patient B's NEWS chart and the oral and documentary evidence provided by Colleague 2 and Colleague 3.
In his response to the NMC charges document Mr Diplexcito stated: "*I have continually remained steadfast in my response with regards to these charges and am more than aware of the blood glucose monitoring system and how the audit trail and recording of results to a central database takes place, so why would I falsely chart these recordings."*

Colleague 2 and Colleague 3 informed the panel that the blood sugar readings they had seen on Patient B's NEWS chart completed by Mr Diplexcito at 00:20 and 04:10 on 1 July 2018 were not recorded on the glucometer locally or centrally for Patient B. Both

colleagues stated that if blood sugar readings had been done for Patient B using the networked glucometer then they would show on the central archive system.

Colleague 2 stated that Patient B told her that he had not been woken up during the night for blood sugar readings to be conducted. Colleague 3, in oral evidence told the panel that it would have been unlikely that the readings could be taken whilst Patient B was asleep as this involve lancing a patient's finger and it is common practice to ask the patient for consent and warn them that they will feel a *"slight prick"*.

The panel considered the glucometer report for blood sugar readings taken by Mr Diplexcito and in particular the readings taken on 30 June and 1 July 2018.

The panel heard evidence about the way the Hospital's glucometer system worked. The panel questioned both Colleague 2 and Colleague 3 in detail about the possibility of error in the system, Patient B's results being recorded elsewhere or his blood sugar having been measured in a different way. Colleague 2 had a good working knowledge of the system and Colleague 3 was the 'user expert'. The panel considered that had Mr Diplexcito taken the blood sugar readings for Patient B at 00:20 and 04:10 on 1 July 2018 that these would have been recorded on the glucometer central archive system. Therefore the panel was satisfied on the balance of probabilities that Mr Diplexcito had not taken the blood sugar readings for Patient B as set out in this charge.

Having found charge 5 proved in its entirety the panel considered all the available evidence, including Mr Diplexcito's response and it concluded that Mr Diplexcito had acted dishonestly. As Mr Diplexcito had not conducted blood sugar readings for Patient B at 00:20 and 04:10, the panel was satisfied that when completing the NEWS chart for Patient B, Mr Diplexcito must have known that the entries he made for these times were false. Therefore the panel concluded that Mr Diplexcito knew what he was doing was wrong and by the standards of ordinary members of the public his actions were dishonest. 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 misconduct and, if so, whether Mr Diplexcito'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 misconduct. Secondly, and only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Diplexcito's fitness to practise is currently impaired as a result of that misconduct.

**Submissions on misconduct**

Ms Bailey invited the panel to take the view that the facts found proved amount to misconduct. She submitted that the acts and omissions of Mr Diplexcito involved serious failings, including dishonesty, linked to his nursing practice. She submitted that these failings fell short of the conduct expected of a nurse in the circumstances. She directed 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.

Ms Bailey referred to the specific points of The Code where Mr Diplexcito's actions amounted to misconduct.

Ms Bailey said that Mr Diplexcito's conduct had put Patient B at risk of serious harm. Ms Bailey submitted that there is a vulnerability around any patient in hospital but especially patients who are unwell and who are being cared for in the middle of the night. Ms Bailey also submitted that Mr Diplexcito had breached the trust of Colleague 2 who was also caring for Patient B. Colleague 2 had trusted Mr Diplexcito to undertake observations, including the blood sugar checks on Patient B, during the night shift and he had failed to do so on two occasions.

**Submissions on impairment**

Ms Bailey 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Bailey submitted that if the panel are satisfied that the matters found proved do amount to misconduct, the next matter the panel must consider is whether Mr Diplexcito's fitness to practise is currently impaired by reason of that misconduct.

Ms Bailey referred the panel to the judgment of Mrs Justice Cox in the case of *Grant* and the test when considering impairment. She submitted that the panel is likely to find the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of *Grant* instructive. Those questions as are relevant in this case are:

a) Has in the past, and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;
b) Has in the past and/or is she liable in the future to bring the profession into disrepute;
c) Has in the past, and/or is she liable in the future to breach one of the fundamental tenets of the professions;

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

Ms Bailey submitted that limbs a, b, c and d of the test are engaged in this case. She referred the panel to a previous finding of impairment on Mr Diplexcito's practice which led to his temporary removal from the register in 2014 for 9 months. Ms Bailey submitted that current impairment can be found both on the basis that there is a continuing risk to patients and that the public confidence in the nursing profession and the NMC as regulator would be undermined if such a finding were not made. Ms Bailey submitted that the panel in 2014 had also found dishonesty charges proved. She submitted that this is indicative of a deep-seated attitudinal issue.

Ms Bailey submitted that dishonesty is difficult to remediate and it was a matter for the panel to determine whether Mr Diplexcito's misconduct in this case is remediable. She referred the panel to Mr Diplexcito's reflective statement and submitted that it is of limited value in that he has failed to reflect deeply on the nature of the allegations against the background of a previous finding of impairment due to dishonesty. She submitted that his insight into his misconduct is limited, that he has not shown any remorse, there is no evidence of remediation and given his history of dishonest conduct (in 2014) which was also linked to his nursing practice, there is a high risk of repetition.

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

**Decision and reasons on misconduct**

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

The panel was of the view that Mr Diplexcito'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. It was of the view that Mr Diplexcito's actions breached the following tenets of The Code:

> *'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*
>
> *8.5 work with colleagues to preserve the safety of those receiving care*
>
> *10.3 complete records without falsification*
>
> *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*
>
> *20.1 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 take advantage of their vulnerability or cause them upset or distress*

The panel appreciated that breaches of The Code do not automatically result in a finding of misconduct. It took account of all the evidence before it and the circumstances of the case as a whole and determined that Mr Diplexcito's actions were serious failings involving dishonesty directly linked to his nursing practice and did amount to serious misconduct.

The panel determined that Mr Diplexcito's actions fell significantly short of the standards expected of a registered nurse. It was of the view that Mr Diplexcito's misconduct was serious, abhorrent and would be considered deplorable by members of the profession and the public.

The panel considered that due to Mr Diplexcito's failure to conduct the blood sugar checks and falsification of the blood sugar readings, Patient B had been left unchecked overnight, putting Patient B at real risk of serious harm. Patient B was particularly vulnerable being on a ward that was one step down from high dependency he needed close and frequent monitoring. He was additionally vulnerable overnight when sleeping. The panel was of the view that Mr Diplexcito showed a callous disregard for a vulnerable patient's wellbeing.

Further the panel considered that Mr Diplexcito had also deliberately misled and compromised his colleagues that were also on the night shift by falsifying Patient B's NEWS chart and misleading them into thinking that the blood sugar observations had been conducted overnight when they had not been, creating a false impression of the Patient's condition.

**Decision and reasons on impairment**

The panel next went on to decide if as a result of the misconduct, Mr Diplexcito'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. 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;'*

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

The panel found that all of the limbs in Grant were engaged in this case.

The panel found that Mr Diplexcito placed Patient B at a direct and serious risk of harm due to his particular vulnerabilities and was of the view that the nature of the behaviour was such that Mr Diplexcito is liable to act in a similar way in the future. The panel determined that Mr Diplexcito did not adhere to the standards expected of a nurse, had breached The Code, had brought the profession into disrepute and had breached fundamental tenets of the profession, including failing to act with honesty and integrity at all times.

The panel had regard to a previous finding of impairment of Mr Diplexcito's practice in 2014. It noted that the charges found proved and misconduct in that case were also of a dishonest nature and there was dishonesty over a lengthy period. It considered that despite reflective work done for the previous proceedings, after a return period of approximately four years on the Register, Mr Diplexcito had repeated his dishonest behaviour in relation to a vulnerable patient. It formed the view that there is evidence of a deep-seated attitudinal issue.

The panel considered whether Mr Diplexcito's misconduct in this case is capable of remediation. It determined that although dishonesty is difficult to remediate, Mr Diplexcito's misconduct would be capable of remediation were it an isolated event. However, the panel took into account Mr Diplexcito's dishonesty in 2014 which persisted over a lengthy period, and his persistent denial of dishonest conduct in relation to Patient B. It considered that Mr Diplexcito has not expressed any remorse or shown any insight into his misconduct. It considered Mr Diplexcito's reflective document to be general and academic. Whilst he was able to cite the standards expected of a nurse, he failed to demonstrate what changes he would make to his practice as a result of learning from his misconduct. Mr Diplexcito's written reflections did not address the potentially serious impact his misconduct could have had on Patient B, Patient's B family, his colleagues and the reputation of the profession. The panel therefore considered that given his history of dishonesty and the absence of any insight there is a high risk Mr Diplexcito may repeat the misconduct found proved in this case.

The panel determined that a finding of impairment on the grounds of public interest was also necessary. It considered that a fully informed member of the public would expect the panel to make a finding of impairment to uphold the reputation of the profession and the NMC as a regulator and to declare and uphold proper standards.

In all the circumstances the panel determined that a finding of current impairment is necessary on the grounds of public protection and in the public interest.

**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 Diplexcito's name off the Register. The effect of this order is that the NMC Register will show that Mr Diplexcito's name has been removed from 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**

Ms Bailey submitted that given the seriousness of the regulatory concerns, the repeated history of dishonesty together with Mr Diplexcito's insufficient insight, lack of remorse and remediation the appropriate sanction is to strike-off Mr Diplexcito's name from the register.

Ms Bailey provided the panel with a list of aggravating factors which included but were not limited to:

- Abuse of position of trust
- Lack of remorse, insight and remediation
- Previous similar regulatory concerns

Ms Bailey submitted that Mr Diplexcito's misconduct was dangerous, dishonest and unacceptable. She submitted that there are no mitigating factors in this case. To conclude she submitted that having repeated his dishonesty in a clinical setting, Mr Diplexcito is a real risk to patient safety and to his colleagues, and his actions render him incompatible with remaining on the Register.

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

**Decision and reasons on sanction**

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

The panel took into account the following aggravating features which it considered were present in this case:

- Abuse of a position of trust
- A vulnerable patient was put at a real risk of serious harm
- Previous findings of dishonesty in 2014
- Falsification of patient records
- Repeated and continued denial of his dishonest
- Lack of insight
- Lack of remorse

The panel determined there were no mitigating features in this case.

Further the panel had regard to the NMC sanctions guidance 'Considering sanctions for serious cases'. The panel determined that Mr Diplexcito's misconduct was serious in that it involved a vulnerable patient and a deliberate breach of Mr Diplexcito's professional duty of candour by, failing to undertake blood sugar checks, falsifying blood sugar readings and misleading colleagues about the care he had delivered to a patient.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues identified. 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, an order that does not restrict Mr Diplexcito'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 Diplexcito's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Diplexcito's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. 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 relate to dishonesty. Furthermore, the panel concluded that the placing of conditions of practice on Mr Diplexcito's registration would not adequately address the seriousness of this case, would not protect the public and would not be in the public interest given the risks identified.

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

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

The panel considered that in this case, it was not a single instance of misconduct and that there was significant evidence of deep-seated attitudinal concerns given Mr Diplexcito's history of dishonesty. Further, it considered that Mr Diplexcito has not displayed any insight into the regulatory concerns and that there remains a real risk of the misconduct being repeated.

The panel found that whilst the charges related to one night shift and one patient, Mr Diplexcito failed to take multiple blood sugar readings, falsified patient records to imply that he had taken them, and persisted in his denial of what he had done. Further, Mr Diplexcito has maintained a position of denial up until he recently ceased engagement with the NMC. The panel considered the previous findings of dishonesty in 2014 were persistent and considered in that he repeatedly gave false accounts to those investigating over a long period. Despite extensive reflective work around the impact of dishonesty in the previous proceedings and the assurances provided by Mr Diplexcito to the review panel in 2015, Mr Diplexcito has now repeated his dishonest behaviour. Given Mr Diplexcito's failure to remediate, the panel determined his behaviour is highly likely to be repeated and, as a consequence, he poses a real risk to patients or service users.

Mr Diplexcito's misconduct, as highlighted by the facts found proved, was very serious and a significant departure from the standards expected of a registered nurse.

In this particular case, the panel determined that a suspension order would not therefore be a sufficient, appropriate or proportionate sanction.

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 determined that Mr Diplexcito's misconduct raises concerns about his professionalism, and considered that other nurses would find it difficult to place their confidence in a colleague who had acted in such a dishonest manner, and deliberately placed a patient at risk of harm. Further, members of the public would also find it difficult to place their trust in a nurse who had falsified records and put a patient at real risk of harm.

The panel also considered the NMC guidance *'*Cases involving dishonesty', in particular:

> *"The most serious kind of dishonesty is when a nurse, midwife or nursing associate deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone's care…*
>
> *… Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients"*

The panel determined that Mr Diplexcito's misconduct and dishonesty were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with remaining on the Register. The panel was of the view that the findings in this particular case demonstrate that Mr Diplexcito'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 and would not uphold or maintain professional standards.

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 Diplexcito's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this sanction would be sufficient in this case.

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

**Interim order**

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

**Submissions on interim order**

The panel took account of the submissions made by Ms Bailey. She submitted that an interim suspension order is necessary for a period of 18 months.

**Decision and reasons on interim order**

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

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

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

This decision will be confirmed to Mr Diplexcito in writing.

That concludes this determination.