Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
16 - 21 September 2021
Wednesday 5 January 2022

Virtual Hearing

Name of registrant:	Michael Mpofu
NMC PIN:	14F1264E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing (September 2014)
Area of registered address:	Newcastle
Type of case:	Misconduct
Panel members:	Suzy Ashworth **(**Chair, Lay member) Jennifer Childs (Registrant member) Jayanti Durai (Lay member)
Legal Assessor:	David Swinstead
Panel Secretary:	Anya Sharma
Nursing and Midwifery Council:	Represented by Vanya Headley, Case Presenter
Mr Mpofu:	Present and unrepresented
Facts proved:	All
Facts not proved:	None
Fitness to practise:	**Impaired**
Sanction:	**Strike-off**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to amend the charges

The panel heard an application made by Ms Headley, on behalf of the Nursing and Midwifery Council (NMC), to make various amendments to the charges, many of which were either to correct dates, employer names, typographical or grammatical errors, and to simplify or clarify the wording of a charge.

Ms Headley stated that the current charge 3 provided the interim order date as 4 March 2018, when in fact it should be 14 March 2018. Ms Headley further stated that the current charge 4 set out some dates, but did not set out the entirety of the alleged dates and rather than add further sub particulars, she submitted that providing a date range instead streamlined matters. Ms Headley further submitted that she proposed to include 'interim' for 'conditions of practice order' to provide clarity and consistency.

Ms Headley also stated that she proposed to withdraw charge 10 in its entirety. She submitted to the panel that there was no evidence before it to support these allegations and it was an oversight that these were included in the notice of hearing.

Ms Headley submitted that a copy of the proposed amendments to the charges had been sent to you in advance, and that you were given notice in advance that the NMC would be applying to make amendments to the charge.

Ms Headley submitted that the proposed amendments did not change the substance or add to the severity of the charges. She submitted that they merely reflected/corrected the position that was supported by the evidence. She submitted that the amendments would not prejudice you, and the removal of charge 10 was likely to be of benefit to you rather than injustice.

It was submitted by Ms Headley that the proposed amendments would not cause any injustice and that they were amendments that the panel could be satisfied were proper in the circumstances.

"That you, a registered nurse:

3) Failed to inform your employer, Ottley House Care Home that you were subject to an interim conditions of practice order imposed in ~~4~~ 14 March 2018.

4) Worked at the Ottley House Care Home in breach of the interim conditions of practice order ~~in charge 3 on the following dates:~~

~~a. 23 April 2018~~

~~b. 24 April 2018~~

~~c. 27 April 2018~~

~~d. 29 May 2018~~

~~e. 4 June 2018~~

~~f. 5 June 2018~~

~~g. 10 June 2018~~ on one or more occasions between 23 April 2018 – 10 June 2018

8) On 23 July 2018 worked as a registered nurse for Regis Healthcare in breach of an interim suspension order imposed on 9 July 2018. ~~on the following dates:~~

~~a) 23 July 2018~~

~~10) On 23 July 2018 in relation to Patient B;~~

~~a) Sought to administer an Intramuscular injection (IMJ) when it was not appropriate to do so~~

~~b) Did not take account of colleagues views when considering treatment for Patient B~~

~~c) Made an inappropriate comment when challenged about the IMJ namely: "I don't care, I am going to do it anyway"~~

You had no objection to the application to amend the charges.

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

The panel was of the view that such amendments, as applied for, were in the 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, as applied for, to ensure clarity and accuracy.

Details of charge

That you, a registered nurse:

1) On 7 February 2018, whilst working for Hunters Moor Neurological Rehabilitation Centre renewed Patient A's transdermal patch too early.

2) In relation to the error in charge 1:
   a) failed to adhere to the duty of candour in that you were unwilling to complete an incident form
   b) did not complete an incident form

3) Failed to inform your employer, Ottley House Care Home that you were subject to an interim conditions of practice order imposed in 14 March 2018.

4) Worked at the Ottley House Care Home in breach of the interim conditions of practice order on one or more occasions between 23 April 2018 – 10 June 2018

5) Failed to adhere to the Duty of Candour by working unsupervised when you were aware that your interim conditions of practice order required supervision.

6) Were dishonest in relation to your conduct in charge 4 and / or 5 in that you withheld the existence of the interim conditions of practice order so as to induce others to believe that you were able to practice as a registered nurse without restriction.

7) Failed to inform your employer Regis Healthcare Services and/or Lily healthcare services that you were subject to an interim suspension order imposed on 9 July 2018.

8) On 23 July 2018 worked as a registered nurse for Regis Healthcare in breach of an interim suspension order imposed on 9 July 2018.

9) Were dishonest in relation to your conduct in charge 8 in that you:

a) Withheld the existence of the interim suspension order so as to induce others to believe that you were able to practice as a registered nurse
b) Told Colleague 1 that you were not aware of the suspension order when you were

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

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you made full admissions to charges 4, 7, 8 and 9a).

During the course of your evidence on 17 September 2021, you admitted charge 3.

The panel therefore found charges 3, 4, 7, 8 and 9a) 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 Ms Headley on behalf of the NMC and by you.

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

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

- Colleague 1: Manager at Lily Healthcare Services at the time of the incident
- Colleague 2: Staff Nurse at Hunters Moor Neurological Centre at the time of the incident
- Colleague 3: Deputy General Manager of Ottley House Care Home at the time of the incident

The panel also heard evidence from you under affirmation.

Background

It is alleged that on 7 February 2018, whilst working as an agency nurse at Hunters Moor Neurological Centre (the 'Centre'), you administered a transdermal patch 24 hours too early to a patient. It is further alleged that whilst you reported the drug administration error to the staff nurse taking over on the unit, you did not go on to complete an incident report despite being asked to.

As a result of that initial referral, an interim conditions of practice order was placed on your practice on 14 March 2018. You were present and represented at the NMC hearing. It is alleged that between 23 April 2018 and 10 June 2018, you worked shifts unsupervised at Ottley House Care Home ("the Home"), in contravention of your interim conditions of practice order.

As a result of these concerns, the matter was brought back before the NMC Investigating Committee on 9 July 2018, at which time your interim conditions of practice order was replaced by an interim suspension order. It is alleged that following this change, you did not tell your employer that your registration was subject to an interim suspension order. It is alleged that on 23 July 2018, having been booked through Lily Healthcare ("the Agency"), you worked at Regis Healthcare ("Regis"), as a registered nurse, whilst suspended.

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

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

Charge 1

That you, a registered nurse:

1) On 7 February 2018, whilst working for Hunters Moor Neurological Rehabilitation Centre renewed Patient A's transdermal patch too early.

This charge is found proved.

In reaching this decision, the panel took into account Colleague 2's evidence and your evidence. The panel would have been assisted by the MAR chart and Controlled Drug (CD) Book in making its decision, however these were not produced by the NMC as part of its case.

The panel found Colleague 2's evidence to have been credible, reliable, clear and consistent. It noted that Colleague 2 had written the incident report on the same day as the events had occurred, and its contents had been reiterated in their written statement and oral evidence. Colleague 2 was clear that you had renewed the transdermal patch as you had thought it was due, and that you had *'reported to [Colleague 2] that [you] had made a medication error'* and that you had told Colleague 2 *'don't worry, I'll be on shift tomorrow, I will just not do it (apply the patch) tomorrow'.* The panel also noted that when questioned by you, Colleague 2 had stated that they '*one hundred percent remember you reported an error, you accidently gave it'.* The panel further noted that the Clinical Lead at the Home had countersigned the incident form and made the referral to the NMC.

You gave your account in which you noted that the patch was a 72 hour patch. You said that the MAR chart showed that the patch had been renewed on 2 February 2018 but not 5 February 2018 when it was next due. You believed the patient to be in pain and, having noted an omission on 5 February 2018, gave the patch on 7 February 2018, rather than on 8 February 2018 when it was next due. You said you wanted to discuss this with the clinical lead the following day and complete an incident report then rather than on 7 February 2018 as suggested by Colleague 2. You said that as you were dismissed you were unable to complete an incident report the next day.

The panel noted that you had denied that you spoke to Colleague 2 separately about the incident at 19:45, but this was recorded in the contemporaneous incident form, and reiterated by Colleague 2 in their evidence. The panel did not accept your evidence that you gave details about what had happened in front of the night team at the handover at 20:00.

The panel noted that whilst you had told the panel that Resident 1 had no capacity and was nonverbal, the incident report stated that Resident 1 was *'alert, communicating, declined clinical observations, was not in distress'.*

The panel preferred the evidence of Colleague 2 over your evidence.

The panel therefore found this charge proved.

Charge 2a)

2) In relation to the error in charge 1:

    a) failed to adhere to the duty of candour in that you were unwilling to complete an incident form

This charge is found proved.

In reaching this decision, the panel took into account the evidence provided by you and Colleague 2.

The panel considered that Colleague 2 was a credible and reliable witness and preferred their evidence. The panel noted that Colleague 2 had stated in the incident form that:

'I asked him to do/complete an incident report to have a record of the incident and to cover himself that he had followed the right process in reporting an incident however nurse mike declined to do so as I am only making it big… he is rushing to go and leave the unit'.

You said that you intended to discuss the patch the next day with the Clinical Lead and to get more evidence about the circumstances.

The panel noted that Colleague 2 was very clear in their evidence that there had been no conversation as you suggested about needing further information before completing the incident form. The panel noted that Colleague 2 in their oral evidence stated several times *'we did not have this conversation'.*

It also noted that the duty of candour requires openness with colleagues and patients regarding incidents, and compliance with relevant reporting policies. Preferring the evidence of Colleague 2, as supported by the contemporaneous documentation, the panel was satisfied that you were unwilling to complete an incident form and that this contravened the duty of candour, notwithstanding that you disclosed to Colleague 2 that an incident had occurred.

Charge 2a) is therefore found proved.

Charge 2b)

1) In relation to the error in charge 1:

    b) did not complete an incident form

This charge is found proved.

In reaching this decision, the panel took into account its findings in charge 2a). It considered your evidence where you accepted that you did not complete an incident form:

‘I did not complete the report as all the shifts were cancelled’. The panel noted that the only incident form was completed by Colleague 2 and the Clinical Lead.

This charge is therefore found proved.

Charge 5

5) Failed to adhere to the Duty of Candour by working unsupervised when you were aware that your interim conditions of practice order required supervision.

This charge is found proved.

The panel found Colleague 3 to be a credible, reliable witness who came across as very sensible, organised and clear in their evidence. The panel noted that there was a conflict of evidence between you and Colleague 3 in relation to whether you had worked day or night shifts and preferred the evidence of Colleague 3. The panel noted that you had stated in your evidence that you were working day shifts, and Colleague 3 was very clear in their evidence that you worked night shifts. The panel accepted Colleague 3’s evidence that it was not possible to provide the supervision you required on night shifts.

The panel noted your evidence that you had told SB Medics, the agency, about the interim conditions placed upon your practice and that you felt that you had discharged your duty of disclosure by doing this, although you accepted that you had worked at the Home unsupervised.

In reaching this decision, the panel considered the evidence of Colleague 3 and your evidence. The panel noted that you had stated in your evidence that you had informed your agency, SB Medics, of your interim conditions of practice order and had been assured by the agency that the Home would make arrangements in this respect. It noted that you had worked at the Home for several months and concluded that it must have become clear to you that you were not being provided with supervision, particularly direct

supervision when administering medication. The panel took account of your statement that you were partly to blame for not informing the Home and that you had breached your supervision condition.

The panel noted that it is a nurse's responsibility to adhere to conditions placed on their practice, and that the duty of candour applied in that you should have been honest and transparent with your colleagues in respect of the restrictions on your registration, particularly in respect of medication administration.

This charge is therefore found proved.

Charge 6

6) Were dishonest in relation to your conduct in charge 4 and / or 5 in that you withheld the existence of the interim conditions of practice order so as to induce others to believe that you were able to practice as a registered nurse without restriction.

This charge is found proved.

In reaching this decision, the panel considered the evidence of Colleague 3 and your evidence, as well as the legal advice received in respect of dishonesty.

The panel considered your evidence that you had told SB Medics about your interim conditions of practice order, and that they had assured you that you were able to work at the Home. However, the panel noted that it is clear from the interim conditions themselves, which were put in place at a hearing at which you were present and represented, and from the NMC Code, and that the duty of candour, that it was your responsibility to ensure that your place of work was aware of your interim conditions of practice order. It considered that once it became apparent that you were breaching your

interim conditions of practice order whilst you were working at the Home, you should have quickly realised and informed them.

The panel noted that in the particular circumstances in which you were working at the Home, you withheld the information about the restrictions on your practice, which would have induced your colleagues to believe that you were able to practice unsupervised. The panel found that in these circumstances where you worked at the Home between April and June 2018 in breach of your interim conditions of practice order this would be considered dishonest and therefore fulfils the criteria in *Ivey v Genting Casinos (UK) Ltd Trading as Crockfords* [2017] UKSC 67 on the issue of dishonesty.

This charge is therefore found proved.

Charge 9b)

9) Were dishonest in relation to your conduct in charge 8 in that you:

b) Told Colleague 1 that you were not aware of the suspension order when you were

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 1 and your evidence. It also noted your admission that you knowingly worked in breach of your interim suspension order.

The panel considered Colleague 1 to be a credible, reliable and clear witness and noted that they had worked with you for a number of years. Colleague 1 was clear that they had formed the impression that you were not aware of the interim suspension order during the telephone call. However, the panel noted that you had stated in your evidence that you had told Colleague 1 that you had not received the letter from the NMC informing you of

the interim suspension order, but that you knew of the suspension order and that you were not trying to hide the suspension from Colleague 1. The panel preferred Colleague 1's evidence and considered that they were clear that you had seemed surprised when they asked you about your suspension.

This charge is therefore found 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 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.

In coming to its decision, the panel 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.'*

Submissions on misconduct

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

Ms Headley identified the specific, relevant standards where your actions amounted to misconduct, and submitted that the following points of the 2015 Code might be relevant in this case:

> *14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place*
>
> *14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*
>
> *20 Uphold the reputation of your profession at all times*
>
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people*
>
> *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.*

Ms Headley further referred the panel to the professional duty of candour:

> *'All healthcare professionals have a duty of candour, a professional responsibility to be honest with patients or people in your care when things go wrong'. As a doctor, nurse or midwife, you must be open and honest with your patients, colleagues and employers'.*

Ms Headley submitted that the breaches of this part of the Code go a considerable way to assisting the panel in its decision as to whether or not this amounts to misconduct. She submitted that the misconduct in this case not only relates to your clinical practice and ability to safely and accurately administer medication, but also to your behaviour and your attitude towards your registration and regulator. She submitted that accurate administration, management and recording of medication is at the heart of safe nursing practice and acting with honesty and integrity and acting within the limitations of one's registration are both basic and fundamental requirements of the profession. Ms Headley submitted that the failings the panel found proved are serious, are clear examples of misconduct, and fall short of what is deemed proper conduct of a registered nurse. She submitted that these errors are at such a fundamental level that they would be considered deplorable by other registered professionals and therefore invited the panel to find that misconduct has been found in your case.

You set out during your submissions that you want the panel to consider that you have completed a few other training courses, which include medication management. In your submissions you explained to the panel that you are unsure of the dates of the training courses but that you did them right before the Covid-19 lockdown in late 2019/early 2020. You explained that due to Covid some of the training certificates have expired as you have not had the chance to renew them, but that you have done quite a few training courses relating to medication management that you wish to share with the panel.

You stated that you will accept the verdict of what the panel decides and if it finds misconduct in your case, you will directly accept whatever sanction or whatever conditions the panel decides on and will go ahead and follow it. You stated that if there was any way of getting a second chance, then you will solemnly go back and work as a registered nurse. You told the panel that you regretted what had happened and that it has been a very 'nasty' experience, and that you do not want a repetition of what has taken place. You told the panel '*I will be humble and honest… It was my mistake and I will never do it again*'.

Submissions on impairment

Ms Headley 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. She made reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin)*, Bolton v The Law Society* [1994] 1 WLR 512*, Kimmance v General Medical Council* [2016] EWHC 1808 (Admin).

Ms Headley invited the panel to consider the approach/test recommended by Dame Janet Smith in her Fifth Shipman report. She submitted that the panel had found failures relating to the maladministration of medication and a failure to document that accordingly. She submitted that you had then failed to comply with restrictions placed on your practice, which were specifically placed on your registration because of concerns about patient safety and risk of harm. Ms Headley submitted that this demonstrates that you have in the past acted so as to place patients at unwarranted risk of harm.

Ms Headley set out that in regard to the reputation of the nursing profession, the public should feel assured that their needs will be met and, if they cannot be confident in a registered nurse's ability to be open when things have gone wrong, or to comply with the directions of the regulator particularly through the investigating committee, this does undermine the reputation of the profession. She submitted that the public are reliant upon the NMC, as a regulator, to uphold certain levels of standards and would be appalled at such disregard for restrictions on your practice. Ms Headley submitted that your actions have brought the nursing profession into disrepute and that you have breached fundamental tenets of the nursing profession.

Ms Headley submitted that in relation to the fourth limb of the test in *CHRE v (1) NMC (2) Grant* [2011] EWHC 927 (Admin), you have acted dishonestly, on more than one occasion and in more than one way. She submitted that therefore all four limbs are engaged and

current impairment can be found on the basis that there is a continuing risk of harm to the public or patients and that the public confidence in the nursing profession and the NMC as a regulator would be undermined if a finding of impairment was not made.

Ms Headley invited the panel to consider the questions posed in *Cohen v General Medical Council* [2008] EWHC 581 (Admin) with regard to current and future risk, namely whether misconduct is easily remediable, whether it has been remedied, whether it's likely to be repeated and whether this is a one-off incident. She submitted that the matters the panel found proved took place over a period of several months. She submitted that when looking at whether the conduct can be remedied, clinical errors are fairly remediable with training, education or supervision, but behavioural and attitudinal errors, such as non-compliance with orders or dishonesty, are much harder to remediate. Ms Headley submitted that in respect of whether or not the conduct has been remedied, the panel had very little evidence before it of any targeted training. Whilst the panel do have some certificates in respect of training undertaken by you, these are all expired and no longer in date, and not necessarily targeted to the failings that the panel had found.

Ms Headley submitted that when considering the risk of repetition, the panel may take into account that you were initially asked to complete an incident report but you did not do so. You had also found yourself subject to an interim conditions of practice order, which you did not comply with, you were then suspended and also breached that interim order. She submitted that the risk of repetition therefore remains high.

Ms Headley referred the panel to the case of *Kimmance*, which describes insight as *'A doctor or other professional who has done wrong, looking at his or her conduct with a self-critical eye, acknowledging fault, saying sorry and convincing a panel that there is real reason to believe that he or she has learned a lesson from the experience'.* She submitted that this is a matter for the panel taking into account all of the information provided and using its professional judgement. Ms Headley submitted that you have not provided any evidence of insight into the severity of your actions or their impact on not

only the wider public but also the reputation of the nursing profession or the NMC as a regulator.

Ms Headley referred the panel to the case of *Bolton v The Law Society,* which states that the reputation of the profession is more important than the fortunes of any individual member and that, whilst membership of a profession brings many benefits that is part of the price. She also referred the panel to the case of *Grant* where, at paragraph 74, it says that, *'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 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 circumstances'.*

Ms Headley submitted that your actions and omissions were serious and that a finding of current impairment is required today, both in order to protect the public and to uphold proper professional standards. She invited the panel to find that it is both appropriate and necessary to make a finding of current impairment in respect of both the public protection and also the wider public interest.

You submitted that the question of impairment in your case rests solely with the panel. You stated that you understand the information that the panel have before it and the decision it has reached in relation to facts. You said that if the panel were to find that your fitness to practise is impaired you would have no objection to that and respect the decision of the panel and that you would also respect the NMC's decision and its interpretation of the NMC Code in relation to your case.

You explained that you understand the seriousness of the circumstances relating to your case in light of the NMC Code and that your actions were a direct breach of the NMC Code of Conduct. You stated that the incident relating to the patch was not life threatening, and that whilst you did make some errors you never refused to complete a report. You told the panel that you know what you did is wrong, that you committed an error and that you breached the NMC Code. You said that you understood that this could

have a direct impact on the public interest and safety, and could also jeopardise public confidence in the nursing profession and the NMC as a regulator.

You explained to the panel that in addition to the formal training that you had completed, you have been working with a mentor to address the concerns surrounding your practice. You stated that your mentor is a registered nurse and has been helping you with the NMC proceedings for your case. You said that you have been able to discuss the breaches of the Code with your mentor and explore your attitude and behaviour. You told the panel that this has however been difficult as the mentor lives quite far away from you. You told the panel that prior to working as a registered nurse you were a lecturer in nursing studies, and continue to support students in their studies which you are very passionate about.

In relation to dishonesty, you told the panel that in the future you will endeavour to make sure that you are open about any personal issues that you have and will make it a point to be open and honest with the NMC when it is needed. You said that in the future you would also speak to your seniors at work if you found yourself in a similar situation so any issue could be resolved.

You told the panel of your remorse. You said *'at times I can't even hold my head, I think what a shame I have done and I am really, really sorry'.*

The panel heard and accepted the advice of the legal assessor which included reference to a number of relevant decisions. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin*), Remedy UK Ltd v GMC* [2010] EWHC 1245 and *Doughty v GDC* [1988] AC 164.

You subsequently put forward some documents for the panel to consider in relation to misconduct and impairment. You explained that these documents date back to 2019 and are from monthly meetings that you would have with your mentor, to whom you were introduced at church. You explained that you and your mentor used to meet up once or

twice a month, and would engage in reflection exercises and write up your discussions after the end of the meeting. You stated that due to Covid you have not seen your mentor recently but still occasionally speak to him on the phone. You informed the panel that these documents are what you were able to salvage from your emails, and the rest of the documents you do not have easy access to. The documents also included an email confirmation of a training course that you had attended in connection with your work as a healthcare assistant. Ms Headley suggested that the panel might not give significant weight to the reflection document given that it was undated and unsigned, but that it represented some evidence that you had reflected on the events and were mindful of the need to undertake training and reflection to avoid repetition.

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 Code. Specifically, you have breached the following sections of the Code:

> *8.5 work with colleagues to preserve the safety of those receiving care*
> *8.6 share information to identify and reduce risk*
>
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
>
> *10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
>
> *14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place*

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

20 Uphold the reputation of your profession at all times

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

23 Cooperate with all investigations and audits

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.

The panel found charge 1 to have been an error but not so serious as to warrant a finding of serious professional misconduct. The panel noted that the simple renewing of the patch a day too early could be considered to be a medication error, and took into account the evidence it heard from Ms 2 in that you said that you had made an error, but just would not do the patch the next day.

The panel had sight of the Incident Form, dated 7 February 2018, where it states that you reported that you made a medication error as soon as your colleague arrived in the unit for a night shift. The panel considered there is provision for nurses making errors in the NMC Code and that no harm was caused to the patient. The panel therefore do not consider it to be serious misconduct.

In respect of charge 2 the panel determined that the failure to make a contemporaneous incident report of a medication error when asked to do so by a fellow nurse was conduct that would be considered serious by fellow practitioners and could have safety implications.

In respect of charges 3, 4, 5 and 6, the panel took into account that these findings constitute misconduct as the NMC Code and the duty of candour require you to inform your employer of restrictions on your practice. The panel considered that during your evidence you stated that you felt that you had discharged your obligations by informing the agency about your restrictions but the terms were in fact very clear. The panel considered that once it became apparent that the colleagues you were working with were not informed of your interim order conditions, you should have acted on your disclosure obligations. The panel further noted that you had worked for a significant amount of time in breach of the interim order.

In respect of charges 7, 8, and 9, the panel was of the view that these findings constitute misconduct. The panel considered that the serious of your misconduct escalated with each stage of the proceedings.

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

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act

with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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 finds that patients were potentially put at risk as a result of your misconduct. Your misconduct had 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 consider charges relating to dishonesty extremely serious. All four limbs of the test are therefore engaged in your case.

The panel noted your regret and considerable remorse. Regarding insight, the panel took account of all the information before it and the submissions from Ms Headley and from you. The panel considered your evidence that you have developing insight into your role as an agency nurse and the need to communicate with your colleagues and ensure that policies are being complied with. The panel was of the view that whilst progress is being made and that you are taking these proceedings very seriously and this is something you are working on, your insight is not yet sufficiently developed.

The panel had sight of your reflective piece which was written sometime in 2019. It considered that whilst it does have some relevance in that it speaks of the importance of recordkeeping, it is undated and unsigned. The panel also had sight of a meeting note from a discussion with your mentor. The panel considered that there was no conclusive reflective piece received from you or your mentor.

The panel considered the training certificates that you had provided but noted that these were not relevant to the charges and were also expired. The panel noted that there was therefore no evidence before it of any up to date training. The panel considered the implications of the pandemic but were of the view that online training is also available to you.

The panel was of the view that the misconduct found in relation to these charges indicates a lack of respect for the regulator, the regulatory process, and for your employers given that you failed to inform them when you worked whilst subject to restrictions on your practice.

In considering dishonesty the panel was of the view that this is a serious case which involves you having deliberately breached the duty of candour. 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. The panel considered that there is some developing insight, but the failings have not been fully remediated.

The panel is of the view that there is a risk of repetition based on the attitudinal and behavioural concerns. The panel noted that attitudinal concerns were also picked up by your mentor and had been pointed out to you, and that these can be harder to remediate. The panel was of the view that there was nothing before it to reassure them that if you experienced any personal difficulties in the future the conduct would not be repeated, as there is no detailed insight to satisfy the panel to think otherwise.

The panel noted that you said that you would seek and ask for help if you found yourself in a similar situation and that you would be more willing to discuss any difficulties that you encountered, to see if any help is available. However, this was not sufficient to assure the panel that you have enough strategies in place that would allow you to make different decisions. It considered that there is a likelihood that the dishonesty could be repeated given that it has taken place on two other occasions where the conditions of practice order and the suspension order had been breached.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection, given the attitudinal concerns identified. The panel was of the view that there was a public protection issue in respect of the failure to complete the incident report in a timely manner when asked to do so by a fellow nurse.

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

The panel determined that a finding of impairment on public interest grounds is required as the public would be concerned to find that the fitness to practice of a nurse who has breached an order imposed by his regulator on two separate occasions was not considered to be impaired.

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 was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike 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

Ms Headley submitted that that the following are aggravating factors:

- Conduct which put patients at risk of suffering harm
- A pattern of misconduct
- A lack of insight into failings
- Conduct carried out for financial gain.

Ms Headley submitted that that the following are mitigating factors:

- Previous good practice and good character; that you have been registered with the NMC since September 2014 and there have been no other concerns about fitness to practice prior to 2018
- Personal mitigation – issues at time of misconduct.

Ms Headley submitted that a caution order would not offer sufficient safeguards against the identified risks. She stated that you have not recently practised as a nurse and the panel has no information before it as to your current ability to practice safely in accordance with the Code. She submitted that a conditions of practice order would not be relevant or proportionate to address the attitudinal concerns of dishonesty, acting without candour, and not demonstrating the level of professionalism expected by a registered nurse. Ms Headley submitted that it should be considered whether patients would be placed at a risk of harm or danger if conditions were imposed. She submitted that in regard to your previous non-compliance with conditions the panel may determine that conditions would not adequately safeguard patients, given that you have breached conditions in the past.

Ms Headley referred the panel to the relevant factors in the SG. She submitted that the matters before the panel are not from a single instance of misconduct but were repeated breaches over several months and breaches which escalated in their seriousness. She submitted that there is evidence of harmful deep seated attitudinal problems. She submitted that you repeatedly put financial interests ahead of patient safety and you were aware that the original interim order made reference to a potential risk of harm to the

patients but continued to disregard this and worked in breach of the orders imposed on you.

Ms Headley submitted that in your cross-examination and submissions you appeared to suggest that Lily Healthcare was to blame that you worked whilst suspended as they did not carry out regular checks and allowed you to work whilst suspended. She submitted that this indicates an ongoing lack of insight into the severity of the implications of your actions.

Ms Headley submitted that you have shown yourself to be a registrant who cannot be trusted with the responsibility or the privilege of registration. She submitted that the repeated breaches of the interim orders, and your desire to place your own financial needs above your professional duty and patient safety, are evidence of harmful deep seated attitudinal problems, which are fundamentally incompatible with ongoing registration. Ms Headley invited the panel to strike your name off the register.

The panel also bore in mind your submissions. The panel took account of the invoice and 'schedule of works' you had supplied in relation to the mentoring you had arranged and also to the character reference provided by your spiritual advisor. You informed the panel of the personal circumstances and issues you were facing at the time of the incident which affected you. You submitted that you have identified the errors that you have made, particularly your dishonesty. You explained that you have had several discussions with your mentor about the dishonesty and that you don't think it would be fair for you to be struck off the register. You said that despite the significant family and personal issues you were facing at the time you do not think your actions were appropriate and you have realised the importance of seeking help and speaking to others when needed. You said that you are keen to work and to prove to the NMC that what has occurred will not happen again. You said that you have had the opportunity to speak to people and to reflect on what has happened, and that you feel ashamed. You explained that you would be willing to abide by a less restrictive sanction than striking off.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Conduct which put patients at risk of suffering harm
- A pattern of misconduct
- Limited insight into failings
- Conduct carried out for financial gain.

The panel also took into account the following mitigating features:

- Personal mitigation – issues at time of misconduct (including financial and family issues)
- You have made admissions to some of the charges.

The panel in reaching its decision considered the SG, particularly in relation to cases involving dishonesty.

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 of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and the element of dishonesty. The misconduct identified in this case was not something that can be addressed through retraining. The panel took into account that you have already disregarded conditions of practice when you had an opportunity to comply with them. The panel also noted that you have been prevented from working as a registered nurse for a number of years. Furthermore, 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;*
- *…*
- *…*

The conduct, as highlighted by the facts found proved, 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 be a sufficient, appropriate or proportionate sanction. It took into account that a previous interim suspension order on your practice had been breached. It considered that the conduct found proved was not a single instance and did show evidence of deep seated attitudinal problems as it was repeated. The panel was not satisfied that there was no significant risk of repetition.

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

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

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

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

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period or until any appeal is determined, 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.

Submissions on interim order

The panel took account of the submissions made by Ms Headley. She submitted that given the decision of strike off, the only way to ensure sufficient safeguards are in place is to impose an interim suspension order for a period of 18 months, on the grounds of public protection and in the public interest.

You made no submissions in respect of an interim order.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is 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 you are sent the decision of this hearing in writing.

That concludes this determination.