Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Virtual Hearing
May 2022 – 1 June 2022, 6 June 2022 – 9 June 2022
& 13 June 2022 – 15 June 2022

Name of registrant:	**Iestyn Bryant**
NMC PIN:	09I1856E
Part(s) of the register:	Nursing – Sub Part 1 RN – Adult Nursing, Level 1 1 July 2010
Relevant Location:	Cardiff
Type of case:	Misconduct/Lack of competence
Panel members:	Florence Mitchell (Chair, registrant member) Helen Eatherton (Registrant member) Seamus Magee (Lay member)
Legal Assessor:	Nigel Pascoe QC
Panel Secretary:	Megan Winter
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter
Mr Bryant:	Not present and unrepresented in absence
Facts proved:	Charges 1a, 1b, 1c, 2a, 2b, 3a, 3b, 3c, 5a, 5b, 5c, 6, 7, 8a, 8b, 9, 10a, 10b, 12, 13, 14a, 14b, 15, 16, 17a(i), 17a(ii), 17a(iii), 17b(i), 17b(ii),19a, 19b, 20, 21, 22a, 22b, 22c, 23, 24, 25
Facts not proved:	Charges 4, 11, 18a, 18b, 18c, 18d
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 Bryant was not in attendance and that the Notice of Hearing letter had been sent to Mr Bryant's registered email address on 20 April 2022.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and venue of the hearing and, amongst other things, information about Mr Bryant's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr Bryant has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Bryant

The panel next considered whether it should proceed in the absence of Mr Bryant. It had regard to Rule 21 and heard the submissions of Mr Joshi who invited the panel to continue in the absence of Mr Bryant. He submitted that Mr Bryant had voluntarily absented himself.

Mr Joshi referred the panel to an email from Mr Bryant dated 20 April 2022. In relation to participating in the hearing, Mr Bryant stated in the email *"No as I don't feel the process is fair and puts me at a disadvantage from the outset, there's nothing I can do about it so there's no point."*

In relation to proceeding in his absence, Mr Bryant also stated within the email dated 20 April 2022 *"I haven't been happy with any of the hearings being heard without my presence but that doesn't seem to bother you so why are you asking me now.Do what you want like you have always done and stop pretending to care about me and my feelings."*

The panel has decided to proceed in the absence of Mr Bryant. In reaching this decision, the panel has considered the submissions of Mr Joshi, the correspondence received from Mr Bryant and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Bryant;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- 13 witnesses will participate in the hearing;
- 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 date back to 2017;
- 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.

There is some disadvantage to Mr Bryant in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him electronically, he will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. 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 Bryant's decision to voluntarily absent himself from the hearing.

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

Details of charge

That you, a registered nurse:

1. *On or around 20 August 2017:*

    a. *Attempted to administer and/or administered one or more boluses of propofol to a patient when you were not signed off as competent to administer IV medication.*

    b. *Did not inform Colleague A that you had not been signed off as competent to administer IV medication when she asked you to administer the bolus of propofol.*

    c. *Administered approximately 100ml of propofol in around 15 minutes, when you should have administered a bolus of 2ml.*

2. *On 1 January 2018:*

    a. *Did not inform Colleague C that you had not been signed off as competent to administer IV medication.*

    b. *Administered IV Propofol when you were not signed off as competent to administer IV medication*

3. *On or around 17 January 2018, whilst Colleague B was assisting with another patient, you:*

    a. *Did not alert Colleague B that her patient's IV Labetalol pump alarm was sounding.*

    b. *Turned off Colleague B's patient's IV Labetalol pump.*

    c. *Did not immediately inform Colleague B of your actions when she returned to the bed area.*

4. *On or around 17 January 2018, turned off Colleague B's patient's monitor alarm without discussing this with Colleague B.*

5. *On or before 18 January 2018, failed to maintain a patient's dignity by:*

    a. *Hoisting them out of the bed to the full extent of the hoist*

    b. *When the patient started a bowel movement, tried to catch the movement in the cardboard insert of a bed pan*

    c. *Repeatedly stated that gravity was helping the patient's bowel movement.*

6. *On an unknown date on or before 22 January 2018, wore noise blocking ear plugs whilst working on the ward.*

7. *On 24 May 2018, attempted to administer IV Noradrenaline when you were not signed off as competent to administer IV medication*

8. *On 6 February 2019,*

    a. *Attempted to administer IV Alfentanil when you were not signed off as competent to administer IV medication.*

b. *Did not follow aseptic non-touch technique ["ANTT"] when preparing IV Alfentanil*

9. *On 6 February 2019, attempted to administer IV Noradenaline when you were not signed off as competent to do so.*

10. *On 7 February 2019:*

    a. *By around 9am you had not completed your patient's 8am observations.*

    b. *After around 9am, you backfilled the observations for 8am*

11. *You actions in 10 above were dishonest in that you intended to give the impression you had completed observations at 8am when you had not.*

12. *On 23 June 2019, assisted a colleague with the repositioning of a patient when this should have been done by three people.*

AND in light of the matters set out in one or more of charges 1-12, your fitness to practise is impaired by reason of your misconduct.

13. *On 1 January 2018, disconnected a Clonidine infusion line from a patient's central line whilst the medication was still running*

14. *On 4 June 2018 did not complete your patient's notes in that you:*

    a. *Stopped mid-sentence*

    b. *Did not record all of the required observations.*

15. *On 4 June 2018, did not ensure your patient's endotracheal tube was secured with an anchor fast*

16. *On 4 June 2018, did not ensure your patient's monitor was set to show an active trace line for oxygen saturation*

17. *On 4 June 2018:*

    a. *Did not increase your patient's insulin even though their blood sugar level was higher than 10mmol/L at:*

        i. *11:29*
        ii. *13:06*
        iii. *15:38*

    b. *At 18:22, when your patient's blood sugar level had dropped by 3mmol/L to 8.4mmol/L,*
        i. *You decreased your patient's insulin from 10mL/hour to 3mL/hour when the policy states it should only be decreased by 1-3 units*

        ii. *Recorded the rate as 10mL/hour when it was 3mL/hour.*

18. *Failed IV assessment on 16 February 2019 because you:*

    a. *Needed to be prompted to familiarise yourself with:*

        i. *The patient history*
        ii. *Reason they had been prescribed Noradrenaline*
        iii. *Their sensitivity to Noradrenaline*

    b. *Used a filter needle to inject the medication into a 50ml syringe after having used that needle to draw the medication from a glass ampule*

c. *Misspelled the drug on the drug label*

d. *Demonstrated a loss of concentration when drawing up medication when colleagues entered the bed area.*

19. *On 16 June 2019:*

a. *Did not administer Minoxidil to Patient C*

b. *Did not escalate the fact you were unable to access Minoxidil in Patient C's patient's own medication ["POM"] cupboard*

20. *On 23 June 2019, having administered Potassium Phosphate to a patient, recorded in the controlled register that 1 ampule had been administered, when 3 had be administered.*

21. *On 23 June 2019, were not able to demonstrate an understanding that you would need to order 12.5mg Losartan tablets in order to administer a dose of 112.5mg Losartan.*

22. *On 23 June 2019:*

a. *Did not administer Patient B's Seebri inhaler*

b. *Recorded code 6 in Patient B's MAR chart, but did not record the reason for omitting the medication.*

IN the alternative

c. *Did not query why code 6 had been entered for Seebri on Patient B's MAR chart for your shift.*

23. *On 23 June 2019, inappropriately asked a junior doctor to prescribe nicotine patches to a patient, when they had previously been removed from the patient's prescription chart following a heart attack.*

24. *On 6 August 2019, at a capability process review meeting failed to demonstrate you had met all of the competencies set at a meeting on 25 June 2019.*

25. *On an unknown date, ticked the box on a patient's records to indicate you completed the CAM-ICU form when you had not.*

AND in light of the matters set out in one or more of charges 13-25, your fitness to practise is impaired by reason of your lack of competence.

Background

The NMC received a referral from University Hospital of Wales (the Hospital) regarding Mr Iestyn Bryant who was employed as a nurse within the Critical Care Unit (the Unit). Mr Bryant was employed in the Unit from March 2015 until August 2019 as a Band 5 Staff Nurse. All new staff in the Unit are supernumerary for a period of time and are required to undertake the Nursing Development Programme and achieve competencies in clinical skills including intravenous (IV) drug administration. Mr Bryant did not manage to complete this despite being supernumerary on a number of occasions. By the time Mr Bryant's employment was terminated in August 2019 he had passed some areas of the Nursing Development Programme but further work on achieving all competencies was required.

It is alleged that Mr Bryant failed to progress as would be expected of a new member of staff to the Unit. It would be expected that a new member of staff would meet the full induction programme within six to eight months but Mr Bryant did not manage to complete this during his employment. While employed by the Trust Mr Bryant had long periods of absenteeism.

Mr Bryant was supported by the practice education team throughout his period of employment until he was made subject to the Informal stage of the Trust's Capability Process. He is alleged to have failed to achieve the competencies required in the Informal Capability Process and this resulted in him being made subject to the Formal Capability Process on 6 August 2019. Mr Bryant was given eight weeks to achieve the competencies required in the Formal Capability Process. However, he was dismissed from his post under the Managing Attendance at Work Policy on 29 August 2019.

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

During the course of the hearing, Mr Joshi, on behalf of the Nursing and Midwifery Council (NMC), made an application that parts of this hearing be held in private on the basis that proper exploration of Mr Bryant's case involves reference to the health and personal circumstances of some of his immediate family and himself. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel determined that references to the health and personal circumstances of some of Mr Bryant's immediate family and himself should be heard in private.

Decision and reasons on facts

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

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 A: Band 5 Nurse
- Colleague B: Band 5 Nurse
- Colleague C: Band 6 Senior Nurse
- Colleague D: Band 7 Senior Nurse
- Colleague E: Band 7, Practice Educator
- Colleague F: Zone Leader
- Colleague G: Band 7 Nurse until September 2018, Clinical Development Nurse from late 2017 until early 2018
- Colleague H: Band 6 Nurse
- Colleague I: Band 5 Nurse
- Colleague J: Zone leader
- Colleague K: Band 7 Sister
- Colleague L: Band 5 Nurse
- Colleague M: Band 8a Nurse

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

Charge 1a

1. On or around 20 August 2017:

    a. Attempted to administer and/or administered one or more boluses of propofol to a patient when you were not signed off as competent to administer IV medication.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence from Colleague D.

The panel noted that Colleague D was on duty with Mr Bryant on this shift. The panel noted that his oral evidence corresponded with his recollection of the incident in his witness statement at the time. However, it also noted that he may have been confused about this specific incident as there were other incidents around the same time and due to the time passage that has elapsed since these allegations came to light. Colleague D told the panel that Mr Bryant never achieved independent practice on the Unit.

The panel also took into account the oral and documentary evidence of Colleague A. She stated in her witness statement:

> *"I asked Mr Bryant to administer a small bolus of Propofol to the patient. A bolus of Propofol would amount to adjusting the pump to administer 1-2ml of Propofol at a high speed rate. (approx. over 5 secs). I delegated this task to Mr Bryant because he was at the same side of the infusion pump."*
>
> *"Mr Bryant administered this and the patient became sedated again which meant that we were able to continue turning him"*

The panel relied on the evidence provided by Colleague A who was directly involved in the incident. The witness also had a clear recollection of the event as outlined in her oral evidence which corresponded with her witness statement. Her evidence was further substantiated with a Datix document that was submitted at the time of the incident.

In terms of whether Mr Bryant was competent to administer IV medication, the panel had regard to Colleague E's written and oral evidence. Colleague E's role involved providing and overseeing education and training to all members of the Unit staff. She stated in her witness statement:

> *"I am aware that Mr Bryant did not complete/pass his IV medication assessment although he went through the NDP programme provided in the preliminary training."*
> *[…]*
> *"I am certain that Mr Bryant was aware that he had not been found to be competent regarding IV medication and therefore was not able to administer IV medications independently."*

The panel therefore determined that, in these circumstances, Mr Bryant attempted to administer and/or administered one or more boluses of Propofol to a patient when he was not signed off as competent to administer IV medication.

The panel therefore found this charge proved.

Charge 1b

1. On or around 20 August 2017:

    b. Did not inform Colleague A that you had not been signed off as competent to administer IV medication when she asked you to administer the bolus of propofol.

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's written and oral evidence. In her witness statement she said:

> *"I only found out that Mr Bryant was not able to administer IVs unsupervised after I reported the incident. [...] At no point during the shift did Mr Bryant tell me that he was not competent to administer IV medication. Usually nurses who were unable to administer IV medication wear yellow badges to indicate this. If I had seen this I would not have asked him to assist but Mr Bryant was not wearing a badge."*

The panel also had regard to Colleague A's oral evidence in which she explained that, had she known that Mr Bryant was unable to administer IV medication, she would have gone to another nurse.

The panel considered the evidence before it and accepted that the evidence of Colleague A was clear and consistent. The panel also had regard to the Datix completed at the time of the incident. There was no evidence to suggest that Mr Bryant had informed her that he was not competent to administer IV medication when she asked him to administer it.

The panel therefore found this charge proved.

Charge 1c

1. On or around 20 August 2017:

    c. Administered approximately 100ml of propofol in around 15 minutes, when you should have administered a bolus of 2ml.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence adduced in this case. Colleague A was working at the opposite side of the bed to the pump and asked Mr Bryant to administer a 2ml bolus to the patient. A short time after, she realised that he had done so incorrectly. She stated in her witness statement:

> *"I realised nearly a whole ampule of Propofol (equating to 100ml of Propofol) had been administered to the patient's blood stream over the course of 15 minutes. It would not be usual to administer Propofol that quickly. In my experience I would expect a 100ml bottle to last just over 3 hours, at 30mls/hour, sometimes just under if given boluses of 2 mls dependent on patients wakefulness."*

When Mr Bryant was confronted about the issue, he denied that he had done anything wrong and said that he had administered the bolus as he had been taught to do. Colleague A also stated that the pump was pre-set to give a 2ml bolus and had been used successfully that morning both by herself and another registered nurse and that they had not altered the pump settings. Colleague A stated that Mr Bryant sought to blame the pump, instead of taking accountability for his actions and admitting any wrongdoing.

The panel noted that the pump was taken away for inspection. However, there was no documentary evidence before the panel to show the results of the inspection. On the basis of the evidence before the panel, it concluded that Mr Bryant administered the IV medication incorrectly.

In all the circumstances, the panel determined that Mr Bryant administered approximately 100ml of Propofol in around 15 minutes, when he should have administered a bolus of 2ml.

The panel therefore found this charge proved.

Charges 2a and 2b

2. On 1 January 2018:

a. Did not inform Colleague C that you had not been signed off as competent to administer IV medication.

b. Administered IV Propofol when you were not signed off as competent to administer IV medication

These charges are found proved.

In reaching this decision, the panel took into account the written and oral evidence provided by Colleague C and Colleague F.

Colleague C asked Mr Bryant to look after his patient whilst he was on his lunch break. The patient had a number of IV infusions running, one of which was Propofol which required changing during his break. Colleague C asked Mr Bryant to administer it. The dose of Propofol had been prepared in advance by Colleague C.

Upon returning from his break, Colleague C checked all of his medication infusions, volumes administered and current amounts to see if anything had been changed. Colleague C noted that the infusion of Propofol had been changed by Mr Bryant. Later that evening, Colleague C overheard two nurses saying that Mr Bryant was on restrictive duties and that he could not administer IV medications. Colleague C stated in his witness statement:

> *"I would have expected Mr Bryant to tell me and the Nurse in Charge, either separately or at the general handover, that he required supervision. Mr Bryant did not volunteer this information at the handover nor did he mention this to me afterwards when we were working next to each other."*

The panel considered the evidence before it. It accepted the evidence of Colleague C and Colleague F which it found to be clear and concise in relation to the incident that occurred.

Given all the factors above the panel was satisfied that Mr Bryant had a responsibility to inform the nurses working with patients in the beds around him; but did not inform Colleague C, that he had not been signed off as competent to administer IV medication. In addition, the panel found Charge 2b proved in that Mr Bryant administered IV Propofol when he was not signed off as competent to administer it.

The panel therefore found Charges 2a and 2b proved.

Charges 3a, 3b and 3c

3. On or around 17 January 2018, whilst Colleague B was assisting with another patient, you:

a) Did not alert Colleague B that her patient's IV Labetalol pump alarm was sounding.

b) Turned off Colleague B's patient's IV Labetalol pump.

c) Did not immediately inform Colleague B of your actions when she returned to the bed area.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account all of the evidence adduced in this case, including the written and oral evidence provided by Colleague B and Colleague G.

Colleague B was asked by a junior nurse for assistance with another patient, she asked Mr Bryant if he was okay to watch her patient whilst she was away. This was standard procedure within the Unit as it operates a 'buddy system'. Nurses who are working next to each other will look after the other nurse's patient if they have their break, or for any other reason that they need to be away from their own patient's bedside. Colleague B stated:

"I told Mr Bryant that the patient's Labetalol medication was connected and up and running. I gave him all the information required to know how to support

the patient including that there was a new IV bag of the Labetalol all ready to go if the infusion that had been set up at the time ran out. I asked him if he was okay to watch my patient whilst I helped the junior nurse. He replied "yeah okay". He did not say that he had any concerns about being able to care for this patient."

"Whilst I was assisting the other nurse with her patient. I could not see what was happening in relation to my own patient. Due to where the other patient was located it was not possible to distinguish the alarm from my patient amongst the alarms of other patients that were sounding on the Unit. When I came back from assisting the other nurse I noticed that my patient's blood pressure was higher than the parameters I had set, and that the Labetalol IV infusion had been switched off completely."

When Colleague B asked another colleague whether or not she switched off the infusion pump, she denied doing so, after which Mr Bryant interrupted to admit that he did it. Her witness statement explained:

"Mr Bryant interrupted and said, "Sorry". He explained he had done this because the alarm had bleeped "KVO" which stands for Keep Vein Open … He said he had switched the alarm off because the Labetalol had run out. I said "yeah I know but there was a full set of Labetalol which had already been prepared and was all ready to be go." I would have done this if I had not been asked to assist the other nurse who approached me."

The panel noted Colleague B's ability to recollect the events in great detail in both her written witness statement and her oral evidence. It considered that this was due to the magnitude and seriousness of the incident. Furthermore, it noted that the patient involved in this incident was in the highest category of vulnerability Level 3 patient who had suffered a bleed to the brain.

Colleague B approached Colleague G to report the incident the following day. The panel had regard to Colleague G's witness statement in relation to Colleague B's reported concerns, this statement is dated 17 January 2018.

The panel considered the evidence before it. It accepted the evidence of Colleague B who was directly involved in the incident. It also had regard to Colleague G's evidence, to whom the incident was reported. It determined that on or around 17 January 2018, whilst Colleague B was assisting with another patient, Mr Bryant did not alert Colleague B that her patient's IV Labetalol pump alarm was sounding. Furthermore, it determined that Mr Bryant turned off Colleague B's patient's IV Labetalol pump.

The panel considered that, whilst Mr Bryant eventually informed Colleague B that he had switched the machine off, he did not do so immediately when she returned to the bed area.

The panel therefore found this charge proved in its entirety.

Charge 4

4. On or around 17 January 2018, turned off Colleague B's patient's monitor alarm without discussing this with Colleague B.

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence adduced in this case, including the written and oral evidence provided by Colleague B, Colleague E and Colleague G.

The panel heard that approximately one hour into Colleague B's shift that Mr Bryant without warning came over to her bed area and started pressing buttons on her patient's monitor. Colleague B asked what he was doing and he said that the sound of the alarm was *"getting on his nerves".* He was told not to as the alarm limits were set for a certain reason. The panel found no evidence in Colleague B's witness statement and in her oral evidence that Mr Bryant had actually turned the monitor alarm off.

The panel considered the witness statements and evidence of Colleague E and Colleague G and note that both of them mentioned turning the monitor off. The panel noted that the evidence provided by Colleague E and Colleague G were not direct eyewitness accounts. The panel preferred the evidence of Colleague B who witnessed the event and was consistent in her witness statement and her oral evidence.

Therefore, while there is evidence that Mr Bryant interfered with the settings of the monitor, the evidence fell short of establishing that the patient's monitor alarm was turned off.

The panel therefore found Charge 4 not proved.

Charge 5a

5. On or before 18 January 2018, failed to maintain a patient's dignity by:

a. Hoisting them out of the bed to the full extent of the hoist

This charge is found proved.

In reaching this decision, the panel took into account Colleague H's written and oral evidence, and her note of concern to her shift leader, dated 18 January 2018.

Colleague H allocated Mr Bryant to a patient who was being weaned off sedatives and ventilation. Colleague H was alerted by a physiotherapist and asked to investigate what was going on with the patient. When she went behind the curtain to investigate the issue she found Mr Bryant in the process of hoisting the patient out of the bed. She described the incident in her witness statement:

"Instead of just lifting him above the bed which would be approximately 20cm above the bed, Mr Bryant had hoisted him as far up as the hoist would allow."

…

"I was shocked at the fact that the patient was so high up. Mr Bryant was able to stand up and lean on the bed underneath the patient."

The panel also had regard to Colleague H's note of concern to her shift leader Colleague F which describes the incident in detail. It was dated 18 January 2018, the same date the incident occurred.

The panel noted that the evidence from Colleague H in her statement dated 18 January 2018, her NMC witness statement and her oral evidence were consistent. All showed that Mr Bryant failed to maintain a patient's dignity by hoisting them out of the bed to the full extent of the hoist.

The panel therefore found Charge 5a proved.

Charge 5b

5. On or before 18 January 2018, failed to maintain a patient's dignity by:

b) When the patient started a bowel movement, tried to catch the movement in the cardboard insert of a bed pan

This charge is found proved.

In reaching this decision, the panel took into account Colleague H's written and oral evidence, and her statement of the incident at the time to her shift leader, dated 18 January 2018.

The panel noted that Colleague H gave clear evidence that Mr Bryant tried to catch the patients bowel movement with a cardboard insert of a bedpan. Her oral evidence supported her witness statement to the NMC which stated:

"Mr Bryant had obtained the cardboard insert of a bed pan and was holding this under the patient. I could see Mr Bryant was attempting to line up the bowl with where the patient was having his bowel movement."

It also had regard to Colleague H's statement of the incident at the time, it stated:

> *"I immediately went behind the curtains to find the patient high in the air (in hoist) with Iestyn trying to line up the bedpan to were the motion would drop!!"*

The panel noted that this statement was contemporaneously written by Colleague H on the same day of the incident. Further, the panel considered that Colleague H's account of the incident did not differ at all with the accounts she gave both in her NMC witness statement and her oral evidence at the hearing.

The panel was therefore satisfied that Mr Bryant failed to maintain a patient's dignity by trying to catch a patient's bowel movement in the cardboard insert of a bedpan.

The panel therefore found Charge 5b proved.

Charge 5c

> 5. On or before 18 January 2018, failed to maintain a patient's dignity by:
>
> c. Repeatedly stated that gravity was helping the patient's bowel movement.

This charge is found proved.

In reaching this decision, the panel took into account Colleague H's written and oral evidence, and her statement to the zone leader, dated 18 January 2018.

The panel noted that Colleague H gave clear evidence that Mr Bryant stated that gravity was helping the patient's bowel movement. Her oral evidence supported her witness statement to the NMC which stated:

> *"He did not appear to be listening to me and kept repeating the word "gravity" whilst dancing around under the patient who was opening his bowels in the*

hoist. I asked him what does he mean about gravity and he said that gravity would help the patient to open their bowels."

It also had regard to Colleague H's statement of the incident at the time, it stated:

"I demanded Iestyn lowered the patient immediately but he refused stating "gravity is a good thing and will do the work" and "this is what we do on the wards". I reminded him that we are not in fact on a ward and to lower the patient immediately and if used the hoist to sit up correctly on the bedpan then that was all the position the patient would need to aid a bowel motion. He continued to have resistance talking about gravity so I had to enforce my position and only then did he lower the patient."

The panel noted that all of Colleague H's accounts of the incidents were consistent and clear. It was therefore satisfied that Mr Bryant repeatedly stated that gravity was helping the patients bowel movement.

The panel therefore found Charge 5c proved.

Charge 6

6. On an unknown date on or before 22 January 2018, wore noise blocking ear plugs whilst working on the ward.

This charge is found proved.

In reaching this decision, the panel took into account Colleague E's clear recollection of the incident. Her oral evidence supported her witness statement to the NMC which stated:

"I also referred to the incident where it was reported to me that Mr Bryant was in a patient's bed area with ear plugs that looked like ones that can be worn on airplanes to prevent noise disturbance. At the time, I went over to him and challenged him on why he was wearing these whilst on the CCD as he would

need to be able to hear if any of the patient's monitors had their alarms sounding. He replied that there was too much noise and he could not cope with hearing it all. He did not appear to understand the danger of what he was doing."

The panel noted that Colleague E's accounts of the incident in her NMC witness statement and her oral evidence were consistent and clear. It was therefore satisfied that on or before 22 January 2018 Mr Bryant wore noise blocking ear plugs whilst on the ward.

The panel therefore found Charge 6 proved.

Charge 7

7. On 24 May 2018, attempted to administer IV Noradrenaline when you were not signed off as competent to administer IV medication

This charge is found proved.

In reaching this decision, the panel took into account Colleague D's clear recollection of the incident. His oral evidence supported his witness statement to the NMC which stated:

"I was walking through B3 South and I saw Mr Bryant was near the IV pumps which were attached to the patient in Bed 13. I knew he was not competent to be administering IV medications from previous incidents. I went over to Bed 13 and asked him what he was doing. He replied saying that he was changing the Noradrenaline syringe. I said to him that he knew he was not competent to be doing this independently and I asked him to say who was supervising him. He told me that I was supervising him, which I was not as I was just walking past."

The panel noted Colleague D's knowledge and expertise on the administration of Noradrenaline. It is exceptionally important that Noradrenaline is administered by a

competent professional due to its short half-life. This means that it stops working on a patient within a couple of seconds of being administered.

Mr Bryant had not been signed off as competent to administer IV medication. Therefore, as stated in the Hospital's Medication Management Policy (the Policy), the practice educator should be informed so that further training can be arranged where an incident relates to the administration of medication. Colleague D referred to the incident in a contemporaneous email to Colleague E and Colleague F, the email was dated 25 May 2018. It stated:

> *"Yesterday when I was walking through B3 South I noticed Iestyn Bryant near the IV pumps in bed area 13. I know he isn't IV competent so I asked him what he was doing. He told me he was changing the noradrenaline syringe. I asked him who was supervising him and he said "you are!" – obviously I wasn't as I was just walking past. I did check the syringe – it was countersigned by another nurse and I swapped the syringe – my hand [sic] was forced as the existing noradrenaline syringe alarmed KVO."*

The panel noted that Colleague D was clear about this incident and that his recollection was strong.

The panel also had regard to Colleague E's, the practice educator, oral evidence. Colleague E confirmed that Mr Bryant never progressed from a novice or advanced beginner and therefore was not permitted to administer IV medication.

The panel noted that Colleague D's accounts of the incident in his NMC witness statement and his oral evidence were consistent and clear. It was therefore satisfied that on 24 May 2018 Mr Bryant attempted to administer IV Noradrenaline when he was not signed off as competent to administer IV medication.

The panel therefore found Charge 7 proved.

Charge 8a

8. On 6 February 2019,

    a. Attempted to administer IV Alfentanil when you were not signed off as competent to administer IV medication.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence adduced in this case, including the written and oral evidence provided by Colleague E and Colleague J.

On 6 February 2019, Colleague E was walking past the bed of a patient that Mr Bryant had been assigned to care for. Colleague E saw that he was handling a syringe and that there were no other nurses around him at that time as they were behind the curtains of the adjacent patient's bed. Colleague E was concerned as Mr Bryant had not passed the relevant competencies to be able to administer IV medications independently and there was no one else around him at the time supervising what he was doing.

Colleague E intervened to prevent the safety of the patient being compromised due to his actions. When challenged, Mr Bryant said that the patient's Alfentanil had run out and he had prepared a further syringe to replace the syringe that was now empty. Colleague E's witness statement stated:

> *"I said to Mr Bryant that I was aware that he knew that he was not supposed to be preparing IV medications unsupervised. He replied that he felt that the nurses he was working with were not supporting him and were too busy to help when he noticed that the infusion was running out."*

The panel also had regard to the written and oral evidence provided by Colleague J who was present at the time. Colleague J assigned Mr Bryant to care for a patient who was situated between two patients who were being cared for by experienced nurses. She said in her witness statement:

"I did not specifically tell Mr Bryant to ask either nurse to observe him giving IV medication because he knew he could not do IVs so I assumed he would know to ask. However, I did speak to the two nurses and tell them that they needed to keep an eye on Mr Bryant because he had not passed his IV competencies."

"Ms Wood told me that because I had not been with Mr Bryant, he had drawn up the patient's next dose of Alfentanil and Noradrenaline independently."

"I looked at Mr Bryant and asked him why he had drawn up the medication when he knew he could not give IVs independently, and why he had not asked me for help. Mr Bryant replied by saying he had just got on and done it. I told him that he was not allowed to do that and he said it was fine because he could get it checked after he had drawn it up. He said he thought that if he drew up the medication it would save time."

The panel also had regard to Colleague J's contemporaneous note which was consistent with her NMC witness statement and oral evidence. The note was in the form of an email created on the same day of the incident, 6 February 2018, sent to Mr Bryant's line manager. In the email, she stated:

"I was there to help Iestyn but on my arrival I discovered that he had drawn up Alfentanil without it being checked and without being supervised.
Iestyn said that he felt unsupported with the drawing up of his IV medication. I asked him had he asked anyone to help and he said that everyone was behind the curtains and he was going to ask a qualified nurse to check his already drawn up alfentanil and check the empty bottles when someone was free but in the meantime he would just draw it up."

The panel considered Colleague E and Colleague J's accounts of the incident to be consistent and clear. It was further satisfied with their accounts having been provided with a contemporaneous note created at the time of the incident. It therefore concluded that on 6 February 2019 Mr Bryant attempted to administer IV Alfentanil when he was not signed off as competent to administer IV medication.

The panel therefore found Charge 8a proved.

Charge 8b

8. On 6 February 2019,

b. Did not follow aseptic non-touch technique [“ANTT”] when preparing IV Alfentanil

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence adduced in this case, including the written and oral evidence provided by Colleague E and Colleague J.

Mr Bryant had not ensured he followed the procedure for ensuring that the risk of infection was minimised, the correct procedure to do so required him to use ANTT. This was the process which was meant to be followed strictly.

Colleague E was aware that the ANTT approach had not been followed because the next syringe of Alfentanil was already prepared and was on a tray on top of the patient’s cupboard by their bed. Colleague E described this incident in her witness statement:

> *“There was dirt and dust on the tray directly next to the syringe. There were also droplets of dried blood on the tray. I believed that the blood was the patient’s own because each patient has a tray that the medication is prepared on and carried over to the patient. However, it is supposed to be cleaned thoroughly between uses and it was clear to me Mr Bryant had not cleaned the tray.”*

It was very important to use ANTT on the Critical Care Directorate (the CCD) as all of the patients were critically ill and therefore susceptible to infections which may

impact their wellbeing and ultimately their recovery. The ANTT process was supposed to be used within the Hospital when administering all medications, not just IV medications. Colleague E challenged Mr Bryant about why he had not followed the ANTT process. He said that he was too busy.

The panel also had regard to the contemporaneous note created by Colleague J, dated 6 February 2019. In the email she stated:

> *"As this issue was discovered by Bernie and he was not using the ANTT procedure I felt I had to speak to him about both these issues. Iestyn said he had felt supported by myself but all staff were busy so he just thought it would save time if he drew the drug up and had it checked later when it was due to be changed."*

The panel considered Colleague E and Colleague J's accounts of the incident to be consistent and clear. It was further satisfied with their accounts having been provided with a contemporaneous note created at the time of the incident. It therefore concluded that on 6 February 2019 Mr Bryant did not follow the ANTT technique when preparing IV Alfentanil.

The panel therefore found Charge 8b proved.

Charge 9

9. On 6 February 2019, attempted to administer IV Noradenaline when you were not signed off as competent to do so.

This charge is found proved.

The panel noted that this charge relates to IV Noradrenaline and Charge 8a relates to IV Alfentanil, both of which were prepared by Mr Bryant at the same time.

The panel found Charge 9 proved for the same reasons as set out for Charge 8a.

Charge 10

10. On 7 February 2019:

a) By around 9am you had not completed your patient's 8am observations.

b) After around 9am, you backfilled the observations for 8am

These charges are found proved.

In reaching this decision the panel considered the evidence before it, including Colleague K's NMC witness statement, oral evidence, and contemporaneous documentary evidence from the time of the event.

Colleague K was working on the same shift as Mr Bryant on 7 February 2019. The patient he was allocated to was critically ill, but stable. The patient required observations to be taken every hour. As the patients were so unwell, a lot details needed to be monitored about their condition including whether they were producing urine or not, whether pumps administering medication to the patients was working correctly, as well as normal observations such as blood pressure.

The panel had regard to Colleague K's witness statement:

> *"I was checking the patients and saw on the patient in question's MAR chart that the 8am observation checks had not been carried out. By this time it was closer to the 9am checks and therefore I completed these for Mr Bryant and left the 8am checks blank as no one had completed these. When I returned from break, I checked the records again and saw that he had back filled the records."*
>
> *"I spoke to Mr Bryant about the incident and said that I had filled in the 9am observations. I told him that it would have been better for him to admit that he had not done the 8 a.m. observations, instead of attempting to backfill the records after the time of the observations. Every nurse may miss a set of*

observations but they should do them as soon as possible after the event and fill in the time that they have done them so that anyone reading the records can see if there is a trend or not. If you back date them and do not record the correct time, it is not a true reflection of the patient's condition at the time of the event. All of the nursing staff on the Unit are busy but still manage to complete the observations as close to the time as possible."

The panel also had regard to Colleague K's email to Colleague F outlining her concerns in relation to 7 February 2019. The email, dated 10 February 2019 outlined a number of concerns in relation to Mr Bryant who she said had appeared distracted, leaving his bed area frequently and the unit for personal phone calls without letting anyone know. Colleague K stated in her email:

"I noticed that Iestyn had not completed the 8 or 9clock observation for fluid balance. I filled these in for 9 o'clock and then noticed that after my breakfast he had back filled in the 8 o'clock observation."

The panel considered the evidence before it including Colleague K's witness statement, oral evidence and the contemporaneous documentary evidence from the time of the event including an email from Colleague K to Colleague F and the patients notes which had been backfilled. The panel found Colleague K's evidence to be clear and consistent in that the observation had been backfilled. It was of the view that it was unlikely that anyone else had backfilled the observation as the patient was allocated to Mr Bryant. The panel therefore drew the reasonable inference that by around 9am Mr Bryant had not completed his patient's 8am observations. Further, it determined that after around 9am Mr Bryant backfilled the observations for 8am.

The panel therefore found Charges 10a and 10b proved.

Charge 11

11. You actions in 10 above were dishonest in that you intended to give the impression you had completed observations at 8am when you had not.

This charge is found NOT proved.

In reaching this decision, the panel considered the documentary and oral evidence before it in relation to this charge. Namely, it had regard to Mr Bryant's response to Colleague K at the time of the incident when he said more than once that he could not speak to her as he did not have the time.

Mr Bryant was aware that another nurse had completed the 9am observations and would therefore have known that he hadn't completed the 8am observations. In the circumstances, the panel concluded that it was unlikely that Mr Bryant was attempting to deceive his colleagues because he already knew that at least one member of staff was aware of his previous omission.

The panel was of the view that there was insufficient evidence before it to suggest that Mr Bryant's actions in the charge above were dishonest in that he intended to give the impression he had completed observations at 8am when he had not.

The panel therefore found this charge not proved.

Charge 12

12. On 23 June 2019, assisted a colleague with the repositioning of a patient when this should have been done by three people.

This charge is found proved.

In reaching this decision the panel considered the evidence before it, including Colleague H's NMC witness statement and oral evidence.

Colleague H informed the panel that whenever a patient requires turning on the intensive care unit (ICU), three members of staff must be present. This is part of the training given on the ICU. It always has to be three members of staff, but they do not all have to be qualified nursing staff. All patients in intensive care require turning every three hours. This is considered a basic aspect of intensive care nursing. Mr

Bryant would have had multiple opportunities to observe and learn the correct way of turning a patient.

Colleague H came across Mr Bryant moving a patient alone whilst another nurse was fitting the sheets on the patient's bed. The patient had a chest drain in place, therefore it was particularly important that the patient was moved with the upmost care and caution as the patient's lung could collapse again. Colleague H said in her witness statement in relation to Mr Bryant's actions:

> *"This was contrary to the usual practice on ICU when turning patients as there were only two staff present to assist."*
>
> *"I put my apron on and gloves and assisted Mr Bryant and the other nurse in manoeuvring the patient. Whilst both nurses were carrying out the procedure incorrectly, I believed at the time it was more Mr Bryant's responsibility because he was more senior than the nurse allocated to care for the patient who was being moved, and therefore was in a position of responsibility in the situation."*
>
> *"I said to Mr Bryant that the way he was manoeuvring the patient was not safe or appropriate. My Bryant's immediate reaction was that it was ok to move the patient as he did because the patient was "only little" so that he did not need assistance."*

The panel found Colleague H's written and oral evidence to be both clear and consistent, it also noted that Colleague H was a direct witness of the incident. It was satisfied that on 23 June 2019 Mr Bryant assisted a colleague with the repositioning of a patient when this should have been done by three people.

The panel therefore found this charge proved.

Charge 13

13. On 1 January 2018, disconnected a Clonidine infusion line from a patient's central line whilst the medication was still running

This charge is found proved.

In reaching this decision the panel considered the evidence before it, including Colleague C's NMC witness statement and oral evidence.

On 1 January 2018, the patient Mr Bryant was allocated to was due to be transferred from the Unit. The patient had a central line in place, which Mr Bryant removed because the patient no longer needed it. The medication that the central line had been administering was Clonidine.

Towards the end of the shift, Colleague C saw that there was a puddle of liquid on the floor which he identified had been coming from the IV bag hanging on the IV stand in Mr Bryant's patient's bed space. In relation to the incident, Colleague C said in his witness statement:

> *"Mr Bryant had disconnected the infusion from the central line and left it hanging from the IV stand. The infusion was left running and had therefore spilt onto the ground. I made Mr Bryant aware of the infusion running on the ground, he promptly stopped the infusion and cleaned the spilled infusion up"*
>
> *"Mr Bryant's actions were not in line with the correct procedure. The correct procedure I would have expected Mr Bryant to follow in order to disconnect the infusion is to turn off the pump (which was called a volumetric pump), take down and disassemble the IV medication, disconnect the central line from this, and then dispose of the IV infusion equipment appropriately."*

The panel was of the view that the evidence Colleague C provided in relation to this incident, both written and orally, was largely consistent. It also noted that he was consistent in that Mr Bryant failed to follow the regular procedure and was unable to identify the risks which could have arisen. The panel was satisfied that on 1 January

2018 Mr Bryant disconnected the Clonidine infusion line from the patient's central line whilst the medication was still running.

The panel therefore found this charge proved.

Charge 14

14. On 4 June 2018 did not complete your patient's notes in that you:

    a) Stopped mid-sentence

    b) Did not record all of the required observations.

These charges are found proved.

In reaching this decision the panel considered the evidence before it, including Colleague I's NMC witness statement and oral evidence.

Colleague I received a handover from Mr Bryant and reviewed the notes of the patient to see how their condition had been over the course of the previous shift when they were under his care. This is considered a standard part of handover in order to understand what has happened on a previous shift and what medication the patient is receiving.

Colleague I raised further concerns in relation to Mr Bryant's handover and the patient's records being incomplete within her witness statement:

> *"The first concern was that the patient's notes were not clear and were incomplete in that they stopped in the middle of a sentence […] It was clear Mr Bryant had not taken the time across his shift to fill in the notes as he administered care, so there was no accurate record of what care had been provided on his shift."*

Colleague I raised further concerns in relation to how Mr Bryant had written the patient's observations, in that he had not recorded all the observations required.

Whilst some of the information on the chart had been completed by Mr Bryant during his shift, there were gaps. He had completed some of the more routine observations but had omitted many of the safety assessments. Colleague I called Colleague K to the patient's bed to discuss her concerns. The panel noted that Colleague K was an experienced ICU nurse with 15 years of experience. It is Colleague K who wrote the email the following day having witnessed those concerns.

The panel had regard to the contemporaneous notes before it in relation to this charge including an email sent the following day on 5 June 2018. The email was sent by Colleague K to Colleague E, detailing the concerns reported by Colleague I.

The panel was of the view that the evidence Colleague I provided in relation to these concerns, both written and orally, was consistent. It noted that Colleague I's recollection of the events initially was not comprehensive due to the passage of time since the concerns arose. However, once she read the email from Colleague K her memory was refreshed. In light of the information provided, the panel was satisfied that on 4 June 2018 Mr Bryant did not complete his patient's notes in that he stopped mid-sentence and did not record all of the required observations.

The panel therefore found Charge 14a and Charge 14b proved.

Charge 15

> 15. On 4 June 2018, did not ensure your patient's endotracheal tube was secured with an anchor fast

This charge is found proved.

In reaching this decision the panel considered the evidence before it, including Colleague I's NMC witness statement and oral evidence.

Colleague I raised concerns regarding the patient's endotracheal tube in that it had not been appropriately secured in line with the training they had both received at the Nursing Development Programme they attended.

Colleague I relied on the email dated 5 June 2018 by Colleague K to remind her of the events that occurred given both the passage of time and the fact she was no longer employed by the Trust.

The panel had particular regard to Colleague K's email which was written one day after the event occurred, it considered this a contemporaneous record of the incident. The email stated:

> *"The patient's anchor fast tube holders had not been secured to the patient properly, thus resulting in the tube not being secure."*

In light of the information provided, the panel was satisfied that on 4 June 2018 Mr Bryant did not ensure his patient's endotracheal tube was secured with an anchor fast.

The panel therefore found Charge 15 proved.

Charge 16

1. On 4 June 2018, did not ensure your patient's monitor was set to show an active trace line for oxygen saturation

This charge is found proved.

In reaching this decision the panel considered the evidence before it, including Colleague I's NMC witness statement and oral evidence.

Colleague I informed the panel that there are several things monitored on a patient in critical care. The most common things that are monitored are the patient's heart rate, blood pressure, oxygen, and the amount of carbon dioxide they are breathing out.

Colleague I raised concerns about how Mr Bryant had set up the monitor meaning that the oxygen saturation measurement was not displaying an active trace line and was only showing the value of the oxygen saturation. The numbers can either be viewed via a trace line or as a value which is simply a number on the screen of the monitor.

It is best practice to use the trace line as it gives a clear view of blood oxygen levels over a period of time whereas the value only shows the blood oxygen level at any given time. This was standard practice on the Unit. Colleague I stated in her witness statement that:

> *"It is concerning that Mr Bryant did not use the trace line because using the trace line means that you can see further in advance if the patient's condition is deteriorating."*

The panel also had particular regard to Colleague K's email which was written one day after the event occurred, it considered this a contemporaneous record of the incident. The email stated:

> *"On the patient's monitor, the SpO2 line/trace was not active and the number was placed in a box at the bottom of the screen. Therefore, he would not be able to determine whether the trace was "good" or "bad" when using the number generated and not be able to act upon this accordingly.*

In light of the information before it, the panel was satisfied that 4 June 2018 Mr Bryant did not ensure his patient's monitor was set to show an active trace line for oxygen saturation.

The panel therefore found Charge 16 proved.

Charge 17

17. On 4 June 2018:

a) Did not increase your patient's insulin even though their blood sugar level was higher than 10mmol/L at:

i) 11:29

ii) 13:06

iii) 15:38

b) At 18:22, when your patient's blood sugar level had dropped by 3mmol/L to 8.4mmol/L,

i) You decreased your patient's insulin from 10mL/hour to 3mL/hour when the policy states it should only be decreased by 1-3 units

ii) Recorded the rate as 10mL/hour when it was 3mL/hour.

This charge is found proved in its entirety.

In reaching this decision the panel considered the evidence before it, including Colleague I's NMC witness statement and oral evidence.

Colleague I raised concerns about an issue with the patient's blood sugar levels and the insulin Mr Bryant had administered to them. It is common that a patient in intensive care will require insulin to lower their blood sugar levels even if they are not diabetic. In intensive care if the patient's blood sugar levels surpass 10 mmol/L, then they must be given insulin to lower this.

The panel had regard to the Insulin Administration Policy (the Insulin Policy) which could be found in the bedspace of every patient.

The panel noted that Colleague I's oral evidence supported her witness statement to the NMC which stated:

"The patient's blood sugar went higher than 10 mmol/L, Mr Bryant had not increased the insulin levels to tackle this. Mr Bryant had recorded three

readings over a number of hours which indicated that the patient's blood levels were above 10 mmol/L but he has not reacted to this."

"I do not recall that there was anything in the notes to indicate that Mr Bryant had sought advice from anyone to vary the treatment given to the patient away from what the policy stated […] I assumed he had acted on his own initiative which I do not believe was appropriate."

The panel also had regard to other documentary evidence including the Training Record which included Insulin Competency training that Mr Bryant had completed. It also had regard to Colleague K's email which was written one day after the event occurred. The email stated:

"The patient was receiving an [sic] insulin infusion and was being quite resistant to its effect. Despite the blood glucose level being greater than 10 mmol/L he did not alter the rate of the insulin for any of the gasses:

Time	*BG Level*	*Rate recorded*
11:29	*12.4mmol/L*	*10ml/hr*
13:06	*12.6mmol/L*	*10ml/hr*
15:38	*11.4mmol/L*	*10ml/hr*
18:22	*8.4mmol/L*	*10ml/hr (but he actually dropped it to 3ml/hr but not documented it anywhere)*

When the next ABG was taken by [Colleague I] at 20:56 the blood glucose was 11.8 and she then increased the insulin as per the protocol.

There was no documentation as to why he dropped the rate from 10 to 3 as he had not completed it as mentioned earlier."

In light of the information before it, the panel was satisfied that on 4 June 2018 Mr Bryant did not increase his patient's insulin even though their blood sugar level was higher at 10mmol/L at 11:29, 13:06 and 15:38. It is satisfied that at 18:22, when his

patient's blood sugar level had dropped by 3mmol/L to 8.4mmol/L, he decreased the patient's insulin from 10mL/hour to 3mL/hour when the policy states that it should only be decreased by 1-3 units. Furthermore, it is satisfied that the Mr Bryant recorded the rate as 10mL/hour when the pump was set at 3mL/hour.

The panel therefore found Charge 17 proved in its entirety.

Charge 18

18. Failed IV assessment on 16 February 2019 because you:

    a. Needed to be prompted to familiarise yourself with:

        i. The patient history
        ii. Reason they had been prescribed Noradrenaline
        iii. Their sensitivity to Noradrenaline

    b. Used a filter needle to inject the medication into a 50ml syringe after having used that needle to draw the medication from a glass ampule

    c. Misspelled the drug on the drug label

    d. Demonstrated a loss of concentration when drawing up medication when colleagues entered the bed area.

This charge is found NOT proved in its entirety.

In reaching this decision the panel considered the documentary evidence before it, namely an IV Assessment feedback form dated 29 January. It showed that the IV assessment was done on 29 January 2019 and not 16 February 2019. Therefore, the date stated in the feedback form did not coincide with the date stated in the charge. The panel also noted that no further evidence had been provided in relation

to this charge. In order to prove the charge, the panel considered that the dates being correctly stated within the charge as being critical.

The panel therefore found Charge 18 not proved in its entirety.

Charge 19

19. On 16 June 2019:

    a. Did not administer Minoxidil to Patient C

    b. Did not escalate the fact you were unable to access Minoxidil in Patient C's patient's own medication ["POM"] cupboard

This charge is found proved in its entirety.

In reaching this decision the panel considered the evidence before it, including the NMC witness statements and oral evidence provided by Colleague L, Colleague K and Colleague M.

The panel also had regard to the contemporaneous notes from the time of the incident, namely a Datix created on 17 June 2019 and an email dated 17 June 2019 from Colleague K to Colleague M outlining the incident. The email stated:

> *"It has been brought to my attention that on the day shift 16/06/19 Iestyn Bryant did not give Minoxidil at 10:00 due to not having access to the POMS cupboard. He did not tell either myself or [Zone Leader] who was Zone leading. I have filled in a Datix and sent it to you as Darren is currently off sick and I know that he is being managed by you."*

Patient C was receiving long term dialysis which would indicate that he had renal failure. The patient was also suffering with Cryo-immunoglobulinemia, a rare blood condition. Mr Bryant was the nurse responsible for caring for the patient on the night

shift. Colleague L was allocated to care for Mr Bryant's patient following a handover from Mr Bryant on the morning of the incident.

During the handover, Mr Bryant told Colleague L that the patient was prescribed Minoxidil, given to treat hypertension, and is delivered in tablet form. It is kept in the patient's locker next to their bed for safe keeping. Mr Bryant informed Colleague L that the patient's locker where their medications were kept could not be opened. He therefore was unable to administer the patient's medication. He also said he was unable to find Minoxidil on the Unit or locate it anywhere else.

The panel noted that Colleague L's oral evidence supported his witness statement to the NMC which stated:

> *"The locker door was opened soon after I reported this, as they replaced the batteries for me. I was able to administer the medication to the patient when the next dose was due. It was a very easy process."*

The panel also had regard to the witness statement and oral evidence of Colleague K. In her witness statement, she stated:

> *"I approached Mr Bryant at the bedside of the patient in question and asked to speak to him about the issue. I asked him why he had not given the medication. He replied "yeah, yeah I know" and went on to say that the reason was that he had not been able to get into the patient's POM cupboard."*

The panel noted that Colleague K, Colleague L and Colleague M's accounts of the incident in their NMC witness statements and oral evidence were consistent and clear. It was therefore satisfied that on 16 June 2019 Mr Bryant did not administer Minoxidil to Patient C, nor did he escalate the fact that he was unable to access Minoxidil to Patient C's POM cupboard.

The panel therefore found Charge 19 proved in its entirety.

Charge 20

20. On 23 June 2019, having administered Potassium Phosphate to a patient, recorded in the controlled register that 1 ampule had been administered, when 3 had be administered.

This charge is found proved.

In reaching this decision the panel considered the evidence before it, including the NMC witness statements and oral evidence provided by Colleague D, contemporaneous documents, namely a copy of the relevant sections of the Controlled Drugs Book, and a Datix in relation to the incident. It was also provided with a Medication Management Policy.

Colleague D was informed by a Senior Nurse (SN) on shift who was undertaking a review of the Controlled Drugs Register. Potassium Phosphate is a controlled drug, and therefore extra precautions must be taken as it can have potentially serious consequences to patients if administered incorrectly.

Colleague D said in his evidence that the Controlled Drug Register recorded one ampule as being removed for a patient, but the patient's medication chart showed three ampules had been given. Colleague D found that the last patient to be given the medication had been given three ampules of Potassium Phosphate at 16:45, this was administered by Mr Bryant. This was identified by the SN reviewing the Controlled Drug Register and reconciling with all patients who were receiving Haemofiltration that day. From that review, it could be identified which patients were receiving Potassium Phosphate. This would account for the two ampules that were missing from the cupboard.

It was correct for Mr Bryant to give three ampules, therefore the incident was dealt with as a record keeping error. The entry in the Controlled Drug Register was made by Mr Bryant but every time medication is removed to be administered there is supposed to be a second checker. Colleague D said in his evidence:

"We were only able to read Mr Bryant's signature because the other signature was illegible. We were not able to identify who the second signature belonged to."

The panel had regard to a Datix in relation to the incident which Colleague D asked the SN to complete, dated 24 June 2019. The Datix reported:

"When completing a stock check for the controlled drugs, it was discovered that 2 ampoules of potassium phosphate are missing. The last documented removal of potassium phosphate is documented that only one ampule was removed, but the total was changed from 25 ampoule's to 23ampules. When checking the stock there were only 22 ampoules in the cupboard."

The panel found that Colleague D's evidence was cogent, reliable and consistent and he maintained his position under cross examination. It also noted that Colleague D is an experienced Band 7 nurse. The panel therefore accepted the evidence of Colleague D and determined that Mr Bryant, having administered Potassium Phosphate to a patient, recorded in the controlled register that one ampule had been administered, when in fact three had been administered.

The panel therefore found Charge 20 proved.

Charge 21

1. On 23 June 2019, were not able to demonstrate an understanding that you would need to order 12.5mg Losartan tablets in order to administer a dose of 112.5mg Losartan.

This charge is found proved.

In reaching this decision the panel considered the evidence before it, including the NMC witness statements and oral evidence provided by Colleague H and Colleague D.

Colleague H was the Zone Leader for the area Mr Bryant was working in on 23 June 2019. She received a handover from the Zone Leader for the previous shift. Colleague H said in her witness statement that the nurse giving the handover explained that Losartan needed to be ordered from the pharmacy for a particular patient who was on dialysis. This was because there was only 100mg in the cupboard and the patient required 112.5mg.

Mr Bryant was allocated to the patient who required the Losartan to be ordered. Colleague H said in her witness statement:

> *"I said to him that he had to order the 12.5 mg dosage of the Losartan drug and that he should do this early on in his shift to ensure that it was delivered by the pharmacy in time to give to the patient when required. Mr Bryant replied "yes, yes, no problem".*
>
> *"Later on during the shift, I asked Mr Bryant about the Losartan as I did not think he had ordered it yet. He replied that there was no need as he had found the Losartan in the patient's drug cupboard next to the patient's bed. I asked if he was sure of this because I was aware that we did not have this the day before and he was adamant that it was fine. I asked Mr Bryant to show me that we had the drugs."*
>
> *"I could only see the 100mg tablets. I asked him if there was another box of tablets because the patient also required 12.5mg as well. Mr Bryant said he did not know what I meant. I explained that he could not accurately cut 100mg tablet into 12.5mg. He appeared not to understand what I was saying."*
>
> *"I just said to Mr Bryant that this was not right and that he would need to order the 12.5mg tablets."*

The panel took into account that Mr Bryant would have received the same training as all the other nurses on the Unit, this was the National Diploma Intensive Care Nursing Level 1 foundation level. It was compulsory for Mr Bryant to have passed

this course despite not passing his IV competency because the course applied to the administration of all medications.

Colleague H alerted Colleague D about the incident. Colleague D then raised his concerns with the Ward's practice educator, Colleague E. He expressed his concerns in an email dated 23 June 2019:

> *"Today, [Colleague H] went through his patients drug chart with him to order medications. Losartan 112.5mg was prescribed, but he did not see the need to order it as he had 100mg. [Colleague H] tried to ascertain how he planned on giving the 12.5mg difference and he could not understand the issue."*

The panel considered all of the evidence before it, including the witness statements and oral evidence provided by two senior nurses. It found these witnesses evidence to be consistent, clear and cogent. It also had regard to the contemporaneous note of the incident recorded in an email by Colleague D at the time. The panel was therefore satisfied that Mr Bryant was unable to demonstrate an understanding of why he would need to order 12.5mg Losartan tablets in order to administer a dose of 112.5mg Losartan.

The panel therefore found Charge 21 proved.

Charge 22

22. On 23 June 2019:

a) Did not administer Patient B's Seebri inhaler

b) Recorded code 6 in Patient B's MAR chart, but did not record the reason for omitting the medication.

This charge is found proved.

In reaching this decision the panel considered the evidence before it, including the NMC witness statements and oral evidence provided by Colleague L, Colleague D and Colleague M.

There were a number of codes in the prescription chart, each indicated a reason why the medication could not be administered, for example if a patient refuses a medication. Code 6 indicated that there were other reasons why it had not been given that were not covered by another code. It was also expected that the nurse would record in the records section the reason as to why it was marked as other.

Colleague L discovered that Mr Bryant recorded Code 6 on the patient's records with no justification. Colleague D challenged Mr Bryant, he said in his witness statement:

> *"I approached Mr Bryant and asked him about the note in the records. He claimed that he had not written this on the patient's records, but it was his style of writing and his patient and therefore it was attributed to him."*

The panel had regard to the handover sheets, patient records and a Datix created by Colleague L in relation to the incident. The panel considered the Datix to be a contemporaneous note of the incident as it was created the following day. The Datix reported:

> *"When my patients care was being handed over, I asked about a Seebri Inhaler that had been prescribed but had not been given, code 6 had been used but with no explanation. There was a note on the bottom of the prescription that the patient would be unable to use the drug when Intubated and ventilated as it was a powder inhaler. The medicine was not in the patients drug cabinet and the member of staff handing over was unable to give a reason as to why it had not been given, claiming that he did not write the 6 in the chart for that dose."*

The panel had regard to an email from Colleague D to Colleague M, the practice educator, which outlined his concerns. The email was dated 23 June 2019, the same day of the incident.

Colleague M who oversees the nurses training on the Ward said in her witness statement in relation to Mr Bryant's knowledge of administering medication:

> *"If a drug is prescribed by a doctor or consultant the nurse has a duty to administer this or provide a clear explanation of why they have not done so. He would have known this due to the length of time he had already been on the unit and it is an aspect of the basic training programme for nurses to learn to administer medication as dictated by the prescription. The administration of medications is a topic which is discussed during the Nurse Development Programme which is delivered by the directorate Practice Educators. Mr Bryant would have undertaken this programme."*

The panel considered all of the evidence before it, including the witness statements and oral evidence provided by two nurses and the practice educator. It found these witnesses evidence to be consistent, clear and coherent. It also had regard to the contemporaneous records of the incident recorded at the time. The panel was therefore satisfied that Mr Bryant did not administer Patient B's Seebri inhaler, nor did he record the reason for recording code 6 in Patient B's MAR chart.

The panel therefore found charge 22 proved in its entirety.

Charge 23

23. On 23 June 2019, inappropriately asked a junior doctor to prescribe nicotine patches to a patient, when they had previously been removed from the patient's prescription chart following a heart attack.

This charge is found proved.

In reaching this decision the panel considered the evidence before it, including the NMC witness statements and oral evidence provided by Colleague H and Colleague D.

An agency nurse reported concerns about Mr Bryant to Colleague H. Colleague H said in her statement that the agency nurse said that Mr Bryant had insisted that the patient needed a nicotine patch and that he had convinced the doctor to prescribe this. However, the agency nurse said that the patient had been in hospital for a number of weeks and that to apply the nicotine patch now would mean that Mr Bryant would have been re-introducing nicotine to the patient. Colleague H said in her witness statement:

> *"I discussed my concerns with Mr Bryant. I asked him why he felt the patient needed to have this. Mr Bryant kept saying that the patient was twitchy. When I asked him what he meant by twitchy, he started doing a little jig on the spot to demonstrate."*
>
> *"He kept saying that he had been a smoker and he knew what it was like and asked me if I knew what it was like. I said no I did not because I was not a smoker, nor had I seen any symptoms of shaking in the patient."*
>
> *"I told Mr Bryant that it was the worst thing that could be given to the patient because it is a vasodilator which means the blood pressure is lowered which could risk further cardiac problems for the patient."*

Colleague H reported the incident to Colleague D. Colleague D emailed his concerns to Mr Bryant's team leader, it is dated 23 June 2019. The email stated:

> *"[Mr Bryant] encouraged one of the medical staff to prescribe a 21mg nicotine patch to a patient who had been here for over three weeks as he was in his words "twitchy" and did a little dance to demonstrate this. The agency nurse in the adjacent bed highlighted his concerns to [Colleague H] who after discussion with [the doctor] had the nicotine patch removed."*

The panel found Colleague H and Colleague D's oral evidence to be clear and consistent with their witness statements in indicating their concerns. The panel therefore accepted their evidence and the contemporaneous documents provided in relation to the incident. It concluded that, Mr Bryant inappropriately asked a junior

doctor to prescribe nicotine patches to a patient, when they had previously been removed from the patient's prescription chart following a heart attack.

The panel therefore found charge 23 proved in its entirety.

Charge 24

24. On 6 August 2019, at a capability process review meeting failed to demonstrate you had met all of the competencies set at a meeting on 25 June 2019.

This charge is found proved.

In reaching this decision the panel considered the evidence before it, including the NMC witness statement and oral evidence provided by Colleague M.

As a result of the incidents concerning Mr Bryant's practice, he was required to restart the capability programme. Colleague M discussed the competencies with Mr Bryant which were set out in a table. The competencies were created by the All Wales Critical Care Education Network for nurses. Colleague M said in her witness statement:

> *"All we were asking him to do was to perform his role as Band 5 nurse within the Critical Care team. I was clear that he was not being singled out and that he was only being asked to obtain what any nurse working here needs to be competent in."*
>
> *"Mr Bryant replied that he understood and that he was happy to accept this process."*

Colleague M received feedback from the Band 6 nurses Mr Bryant was working with:

> *"Their general feedback was that they felt he was a capable nurse who was able to work to the set competencies when he was being watched and*

prompted by them. However, they did not feel that he was able to work to these competencies independently."

A meeting was held on 6 August 2019 to discuss the competencies set out at a meeting on 25 June 2019. As Mr Bryant had not completed all the competencies, it was agreed to extend his supernumerary time to enable him to achieve them. However, Mr Bryant's employment on the Unit was terminated under the Managing Attendance at Work Policy before he completed the set competencies during his extended period of working supernumerary.

Colleague M said in her witness statement:

"Mr Bryant responded that he did not believe he had been given long enough to achieve all the competencies. Neither [MP] nor I accepted this as he had been given significantly longer than we had originally intended to give him. This was because during the meeting held on 25 June 2019 it was agreed Mr Bryant would be given a four week period to complete his set out competencies. Mr Bryant actually had six weeks in which to complete his competencies due to annual leave. Mr Bryant was given a further eight weeks, from 6 August 2019, to continue working on the set competencies."

The panel had regard to a number of documents in relation to this issue, including the minutes of two capability process meetings held on 25 June 2019 and 6 August 2019. These discussed action points for Mr Bryant to complete including a time frame for completion of his agreed objectives.

The panel found Colleague M's oral evidence to be clear and consistent with her witness statements. The panel therefore accepted the evidence and documents provided in relation to this charge. It concluded that, on 6 August 2019, Mr Bryant failed to demonstrate that he had met all of the competencies set for him at a meeting on 25 June 2019.

The panel therefore found this charge proved.

Charge 25

25. On an unknown date, ticked the box on a patient's records to indicate you completed the CAM-ICU form when you had not.

This charge is found proved.

In reaching this decision the panel considered the evidence before it, including the NMC witness statement and oral evidence provided by Colleague G.

Colleague G saw that the relevant box on a patient's observation chart had been ticked which indicated that the CAM-ICU form had been completed. Colleague G said in her witness statement:

> *"I said to him "oh great, you've done it". Mr Bryant replied "not yet" but that he would carry out the process in a minute. I told him that he should not be recording as completed something he had not yet done. The concern was that by ticking the relevant box on the observation form this indicated that he had completed the CAM-ICU when in reality he had not yet done this."*

The panel had regard to Colleague G's statement in relation to the incident which she said she recorded at the time.

The panel noted that all of Colleague G's accounts of the incidents were consistent and clear in both her written statements and oral evidence. It found her evidence to be both clear and cogent. It was therefore satisfied that Mr Bryant had ticked the box on a patient's records to indicate he had completed the CAM-ICU form when he had not.

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/or lack of competence and, if so, whether Mr Bryant'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. Firstly, the panel must determine whether the facts found proved amount to misconduct and/or lack of competence. Secondly, only if the facts found proved amount to misconduct and/or lack of competence, the panel must decide whether, in all the circumstances, Mr Bryant's fitness to practise is currently impaired as a result of that misconduct and/or lack of competence.

Submissions on lack of competence, misconduct and impairment

Mr Joshi submitted that Mr Bryant lacks competence in relation to medication administration, working within the limits of his competency and following policies and procedures. He further submitted that Mr Bryant's repeated failings are serious and fall short of what would be expected of a registered nurse in these circumstances. The areas of concern relate to basic nursing skill requirements. He stated that the failings involve a serious departure from expected standards and put patients at risk of harm and submitted that these failings are likely to cause risk to patients in the future if they are not addressed.

Mr Joshi submitted that the concerns involving Mr Bryant's practice continually arose over a four year period. Further the lack of competence was displayed in circumstances where Mr Bryant had been in receipt of support and been put on a personal improvement plan to facilitate his development.

Mr Joshi invited the panel to find that the facts found proved amount to lack of competence in relation to charges 13, 14a, 14b, 15, 16, 17a(i), 17a(ii), 17a(iii), 17b(i), 17b(ii),19a, 19b, 20, 21, 22a, 22b, 22c, 23, 24 and 25. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ("the Code") and identified the paragraphs which he submitted Mr Bryant breached. Mr Joshi submitted that Mr Bryant's actions were serious and inappropriate both inidividually and collectively fall seriously short of the conduct expected of a registered nurse and amount to misconduct in relation to charges 1a, 1b, 1c, 2a, 2b, 3a, 3b, 3c, 5a, 5b, 5c, 6, 7, 8a, 8b, 9, 10a, 10b and 12.

Mr Joshi submitted that, when looking back at the catalogue of errors Mr Bryant has made, the most worrying errors are those in which he received direct instructions. He submitted that on multiple occasions Mr Bryant was in receipt of clear instructions which he chose to ignore. He referred to the incident in Charge 6, where Mr Bryant wore noise blocking earplugs in ICU which could have put patients at risk. Mr Joshi submitted that this was a blatant example of Mr Bryant putting patients at risk by refusing to hear what was going on in a critical care unit whilst there were vulnerable people at risk.

In respect of Charge 5 where an individual was suspended from a hoist, Mr Joshi submitted that Mr Bryant breached sections of the Code, particularly part 20 which relates to upholding the reputation of one's profession at all times. Several requested were made for Mr Bryant to bring the patient down from the hoist before he acted and then proceeded to laugh. He submitted that Mr Bryant's actions in relation to this charge were not a case of stupidity and questioned what would have prompted Mr Bryant to do such a thing to a fellow human being.

Mr Joshi referred to the other aspects found proved such as the nicotine patch incident, issues concerning medication administration and the incident concerning a giving set that had been detached and rather than disposing of it appropriately Mr Bryant left it running and overflowing onto the floor. He submitted that issues continued to arise throughout Mr Bryant's employment at the Trust, despite the fact constant supervision took place and regular meetings with him were held to discuss his practice.

Mr Joshi submitted that Mr Bryant was shocked when confronted with matters put to him. He submitted that these matters were serious misdemeanours but Mr Bryant was of the view that his actions were appropriate. Other nurses found themselves in the *"firing line"* because of Mr Bryant's refusal to follow basic procedures. He contended that Mr Bryant was a serious risk not only to patients but also to colleagues.

Mr Joshi submitted that Mr Bryant is an individual who deliberately chose to take unreasonable risks. He submitted that his failures were not system failures as his colleagues were aware of the procedures in place and were able to follow them. Mr Joshi submitted that, rather than Mr Bryant gaining any insight or acting on the constant feedback during his four years of employment in the Unit, he continued to avoid accountability and referred to the concerns raised against him as a *"witch hunt"*.

Mr Joshi moved on to the issue of impairment. He stated that in the absence of any remediation, or evidence of current safe practice, there remains a risk to the health, safety and wellbeing of the public should Mr Bryant return to unrestricted practice. He further stated that it is accepted that there have been continued failings despite ongoing support provided by his employer.

Mr Joshi submitted that in light of the above, due to Mr Bryant's lack of competence, misconduct and insufficient evidence of remediation, Mr Bryant is liable in the future to put patients at unwarranted risk of harm where he to practise without restriction. For these reasons, he submitted that Mr Bryant's fitness to practise is currently impaired.

The panel heard and accepted the advice of the legal assessor. He advised the panel of the considerations that it must take into account when determining misconduct and lack of competence. He also advised the panel on the matter of impairment, should it find that the charges found proved amounted to misconduct and/or a lack of competence. The legal assessor included reference to a number of relevant judgments, these included: *Calhaem, R (on the application of) v General*

Medical Council [2007] EWHC 2606 (Admin) (*Calhaem*), *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) (*Grant*) and *Cohen v General Medical Council* [2007] EWHC 581 (Admin) (*Cohen*).

Decision and reasons on misconduct and lack of competence

The panel went on to consider whether the facts found proved amounted to misconduct and/or lack of competence. To achieve this the panel looked at each charge individually and collectively. When determining this, the panel had regard to the terms of the Code.

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

> ***1 Treat people as individuals and uphold their dignity***
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
> ***6 Always practise in line with the best available evidence***
> *6.1 make sure that any information or advice given is evidence based including information relating to using any health and care products or services*
> *6.2 maintain the knowledge and skills you need for safe and effective practice*
> ***8 Work co-operatively***
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> *8.2 maintain effective communication with colleagues*
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
> *8.4 work with colleagues to evaluate the quality of your work and that of the team*

8.5 work with colleagues to preserve the safety of those receiving care

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

9.1 provide honest, accurate and constructive feedback to colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10 Keep clear and accurate records relevant to your practice

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

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13 Recognise and work within the limits of your competence

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

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

13.5 complete the necessary training before carrying out a new role

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

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

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
19.3 keep to and promote recommended practice in relation to controlling and preventing infection
20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel then moved on to consider each charge found proved individually.

The panel first considered Charge 1. It noted that this charge relates to Mr Bryant administering IV medication whilst not signed off as competent to do so and failing to inform his colleague that he had not been signed off as competent. The panel noted the large amount of IV medication which was administered over a short period of time. It was of the view that this could have had a very serious effect on the patient, it heard evidence from Colleague D in relation to this. Colleague D said:

"It can be dangerous for the patient if the bolus Propofol is not correctly administered. This is because it can cause hypotension which means that the blood pressure of the patient could fall dangerously low."

"No lasting harm was caused to the patient in question, but there was a significant period of hypotension."

In relation to Charge 2 the panel had the same reasoning as set out for Charge 1. Additionally, it noted that that this incident occurred following the similar incident on 20 August 2017. Therefore, the panel considered this to be a pattern of similar

misconduct. The panel concluded that Mr Bryant's actions in both instances fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

The panel next considered Charge 3; that Mr Bryant did not alert Colleague B, whilst she was assisting another patient, that her patient's IV Labetalol pump alarm was sounding, turned off Colleague B's patient's IV Labetalol pump and did not immediately inform Colleague B of his actions. It noted that Mr Bryant was given precise instruction which he failed to follow. His actions had put a patient at serious risk of harm as they were deprived of their medication. It also bore in mind Mr Bryant's response to his colleagues and was of the view that this demonstrated an attitudinal issue. Therefore, the panel was of the view that Mr Bryant's failings in Charge 3 are so serious that Mr Bryant's actions did fall seriously short of the conduct and standards expected of a nurse and therefore amount to misconduct.

The panel then considered Charge 5, it related to Mr Bryant failing to maintain a patient's dignity by hoisting them out of the bed to the full extent of the hoist, trying to catch the patient's bowel movement in the cardboard insert of a bedpan and repeatedly stating that gravity was helping the patient. The panel noted that this charge concerned a highly vulnerable weaning patient who was unable to speak but would have been fully aware of what was happening. It considered Mr Bryant's response was that he had not done anything wrong and failed to understand there was any wrongdoing, he said this was a practice he had adopted on wards he previously worked in. The panel was of the view that Mr Bryant's actions in this charge demonstrated that he had no respect for the dignity and safety of this patient. The panel determined that this is very serious and is unacceptable behaviour of a nurse. It therefore found that Charge 5 amounts to misconduct.

In relation to Charge 6, the panel was of the view that this charge relating to Mr Bryant wearing noise blocking ear plugs whilst working was serious. It noted that it was particularly serious as Mr Bryant was working on the ICU which cares for highly vulnerable patients who rely on alarms for when they need attention. The panel was of the view that listening for alarms in any circumstance is basic nursing care. It was

therefore of the view that Mr Bryant's actions were serious and that Charge 6 amounts to misconduct.

The panel next considered Charges 7 and 9. These charges relate to Mr Bryant administering the drug Noradrenaline when he had not been signed off as competent to do so on two occasions. The panel noted that it is a very serious matter to administer any medication when you are not competent to do so. It also noted Colleague D's knowledge and expertise on the administration of Noradrenaline. He said that it is exceptionally important that Noradrenaline is administered by a competent professional due to its short half-life. This means that it stops working on a patient within a couple of seconds of being administered. The panel considered the significant risks in taking longer to administer this medication, which could cause the patient's heart rate to fall dramatically, causing death. It was of the view that administering medication only when signed off as competent to do so is a fundamental part of nursing practice. The panel determined that Mr Bryant's actions were serious and that Charges 7 and 9 amount to misconduct.

The panel considered Charge 8. This charge concerned Mr Bryant's attempt to administer IV Alfentanil when not signed off as competent to administer IV medication and his failure to follow ANTT technique when preparing IV Alfentanil. Mr Bryant was aware that he was not deemed competent to administer IV drugs yet, despite this, he still attempted to do so and was therefore acting outside his scope of competence. The panel was particularly concerned about Mr Bryant's inability to follow the ANTT technique when preparing IV medication and therefore not adhering to basic infection control in an area of vulnerable patients. It considered this to be a fundamental nursing skill. It was of the view that his actions in Charge 8 were serious and had the potential to place patients at a risk of harm. The panel determined that Mr Bryant's actions were serious and that Charge 8 amounts to misconduct.

In relation to Charge 10, the panel was of the view that this charge was less serious and that your failure to complete the patient's 8am observations. The panel noted from other witnesses that it was not uncommon for nurses to miss observations occasionally. It therefore determined that Charge 10 does not, as one isolated incident, amount to misconduct.

The panel considered Charge 12. This charge was in relation to Mr Bryant assisting a colleague with the repositioning of a patient when this should have been done by three people. The panel heard evidence that the patient was connected to a number of tubes. It also heard evidence that Mr Bryant moved the patient alone while the colleague who assisted him made the bed. It was of the view that Mr Bryant moving the patient alone is serious and created significant risk of harm to the patient. The panel concluded that Mr Bryant's actions in this instance fell seriously short of the conduct and safety standards expected of a nurse and amounted to misconduct.

The panel concluded that Mr Bryant's actions in the above charges demonstrate that there has been a falling short so serious that it can properly be described as misconduct going to Mr Bryant's fitness to practise. The panel was of the view that Mr Bryant's failings are so serious and that Mr Bryant's actions did fall seriously short of the conduct and standards expected of a nurse and therefore amount to misconduct. In addition, the panel was of the view that the charges both individually and collectively amount to misconduct.

The panel then moved on to consider if charges 13, 14a, 14b, 15, 16, 17a(i), 17a(ii), 17a(iii), 17b(i), 17b(ii),19a, 19b, 20, 21, 22a, 22b, 22c, 23, 24 and 25 amount to lack of competence.

In assessing lack of competence, the panel noted that the public is entitled to expect that the work of a registered nurse working in any specialty was at the standard applicable to that post and in that specialty. The panel took into account the NMC's guidance in relation to lack of competence which states "*a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice".* In addition, the panel bore in mind the case of *Calhaem* in which lack of competence is described as "*a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the [doctor's] work."*

The panel considered all of the charges relating to lack of competence individually and collectively. The panel considered that the competency concerns included care of diabetic patients, medication administration, incorrectly using equipment and record keeping issues all demonstrate underlying competency concerns. It also noted that action plans were put in place however Mr Bryant still failed to meet the competencies expected. In addition, Mr Bryant made numerous errors which were wide-ranging, serious and relate to core and critical nursing functions. The panel also noted that Mr Bryant's repeated failings occurred over a protracted period of time, namely a four year period.

The panel bore in mind that Mr Bryant received extensive support to ensure that he passed the required competencies. It had regard to the evidence in relation to the Mr Bryant's inability to satisfactorily meet the objectives required. It referred to Colleague E's witness statement, she said:

> *"There were always concerns regarding his conduct in that there were continual inconsistencies in his approach to management and administering of patient's medications both in relation to his inability to follow instructions regarding his need for supervision and how he carried out the procedures surrounding the administration of medication such as the failure to follow the ANTT approach."*

The panel noted that Mr Bryant had numerous attempts to complete the competencies required due to a number of long periods of sickness which meant each time he returned to work he had to restart the training programme. It also noted that Mr Bryant was practicing supernumerary for a substantial period of time whilst working in the Unit. The panel had regard to Colleague D's witness statement, he said:

> *"Mr Bryant was often on sick leave and this was regularly for prolonged periods. When he was working, he was constantly under supervision due to the number of issues in relation to his practice in an attempt to improve his practice. This would often be interspersed with periods of sick leave, the clock*

was reset and we had to go through training with him again because of the length of time he was on sick leave."

The panel was of the view that when considering Mr Bryant's professional short-comings individually and collectively. On the whole, they comprised a fair sample of Mr Bryant's work. Further, they were in some cases repeated and, as they related to basic areas of nursing practice, were indicative of an unacceptably low level of competence for a registered nurse. The panel determined that Mr Bryant's actions in the charges are indicative of a lack of competence and that his practice was below the standard expected of a registered nurse.

In all the circumstances, the panel concluded that, taking into account the charges both individually and collectively, Mr Bryant's behaviour in charges 13, 14a, 14b, 15, 16, 17a(i), 17a(ii), 17a(iii), 17b(i), 17b(ii),19a, 19b, 20, 21, 22a, 22b, 22c, 23, 24 and 25 amounted to a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct and lack of competence, Mr Bryant'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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

The panel considered the 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) *….'*

The panel found that limbs a, b and c were engaged in this case. It noted that Mr Bryant's misconduct and failure to demonstrate a satisfactory level of competency related to a number of wide ranging basic nursing skills. It was of the view that Mr Bryant's actions in all of the facts found proved placed patients at unwarranted risk of harm. The panel next considered if Mr Bryant has in the past brought and/or is liable in the future to bring the nursing profession into disrepute. It took into account Mr Bryant's poor practice, his repeated failures and not following instructions and was of the view that his behaviour and actions have brought the profession into disrepute. The panel next considered if Mr Bryant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the nursing profession. It noted

that Mr Bryant's failures were wide ranging and related to the basic and core skills of nursing. The panel concluded that Mr Bryant's actions breached fundamental tenets of the nursing profession.

The panel next considered Mr Bryant's level of insight and remorse. It took into account that Mr Bryant regularly failed to take accountability for his questioned actions and deflected blame and responsibility onto others, was defensive and would not accept feedback. Further, the panel had no evidence from Mr Bryant recognising the impact of him failing to meet his agreed objectives.

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Mr Bryant appears to have withdrawn his engagement with the NMC and has indicated that he does not want to participate in any NMC proceedings. The panel had sight of correspondence between the NMC and Mr Bryant, which indicates that he does not accept that his nursing practice was fundamentally flawed. The panel had no evidence of meaningful reflection on his nursing practice from Mr Bryant. The panel also had no evidence before it from Mr Bryant in respect of remorse, an understanding of how his actions put patients at a risk of harm, why what he did was wrong, and how his actions impacted negatively on his colleagues and the reputation of the nursing profession. In addition, the panel had no evidence from Mr Bryant regarding how he would handle similar situations differently in the future. In light of the above, the panel was of the view that Mr Bryant has yet to demonstrate any meaningful insight or remorse.

The panel next considered remediation. The panel took into account the guidance as outlined in the case of *Cohen*. It considered whether the misconduct and lack of competence which led to the charges is easily remediable, whether it has been remedied and whether it is highly unlikely to be repeated.

The panel was satisfied that some of the clinical concerns identified in this case may be capable of remediation. However, Mr Bryant went through four years of re-training and being supernumerary but never achieved the competencies required to practice independently. The panel considered that this case also relates to attitudinal issues,

for example deflecting blame and responsibility onto others, being defensive and not accepting feedback. The panel was of the view that these concerns are difficult to remediate, specifically without demonstrating any insight or acceptance of failings. It referred to Colleague E's witness statement, she said:

> *"I had concerns regarding Mr Bryant's attitude in being given feedback. Mr Bryant would never accept responsibility for any of the incidents he was involved in that I was aware of. He never openly admitted any mistakes he had made and always had an excuse ready for why he was not to blame. I never observed any remorse from Mr Bryant for making mistakes or any insight into his conduct. He would only ever deny what had happened. In my opinion, his lack of ability to recognise his own failures was a serious concern."*

The panel heard evidence from a number of witnesses regarding concerns about Mr Bryant's attitude, with some stating they had concerns about patient safety when working alongside him. It had regard to Colleague H's witness statement in which she stated:

> *"It was very stressful to work with Mr Bryant. Whenever he was allocated to my Zone, I would never know which patient to allocate him because I felt that the care that they received would not be to the standard I would like."*

> *"I never felt that I was able to watch him as much as I needed to. I only ever felt that the patient he was allocated to care for was safe when he was under constant supervision. I always felt that my own registration as a nurse was at risk because I had a team of nine members that required supervision but I needed to always be observing him, as if I did not, I did not know what would happen."*

The panel considered if the concerns in this case have been remediated and whether they are likely to be repeated. The panel noted that it had no evidence before it from Mr Bryant of remediation in regards to training or evidence that the deficiencies identified in his practice have been alleviated. In addition, the panel had

no evidence of testimonials on behalf of Mr Bryant. The panel was therefore of the view that in the absence of any evidence from Mr Bryant in respect of remediation, it could only conclude that the deficiencies in this case have not yet been remediated.

The panel next considered whether the conduct in this case is likely to be repeated. It noted that whilst Mr Bryant was employed in the Unit repeated failures occurred despite the high level of support he was given. Taking into account Mr Bryant's lack of insight, the absence of any remediation, or any evidence of re-training, the panel concluded that the concerns identified in this case are likely to be repeated. In addition, taking into account the totality of the facts relating to misconduct, lack of competence, lack of insight and lack of remediation, the panel is of the view that there is a high risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel next considered whether a finding of impairment is necessary on public interest grounds. The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel considered whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case. The panel was of the view that an informed member of the public in receipt of the facts of the case would be appalled if a finding of impairment was not made. The panel therefore determined that a finding of impairment on public interest grounds is required.

Having regard to all of the above, the panel was satisfied that Mr Bryant's fitness to practise is currently impaired as a result of his misconduct and lack of competence on both public protection and public interest grounds.

Sanction

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

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

Submissions on sanction

Mr Joshi invited the panel to impose a striking-off order considering the panel's findings on misconduct, lack of competence and impairment.

Mr Joshi referred the panel to the NMC guidance in relation to striking off orders which states:

> *'A striking-off order is the most serious sanction. It results in removing the nurse, midwife or nursing associate's name from the register, which prevents them from working as a registered nurse, midwife or nursing associate.*
>
> *This sanction is likely to be appropriate when what the nurse, midwife or nursing associate has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:*
>
> - *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
> - *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*
> - *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?'*

Mr Joshi submitted that a striking-off order is necessary to maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest.

Mr Joshi submitted that, where a registrant is not present, the panel must ensure it considers facts on his behalf. He submitted that in order to do this it must strike a balance between protection of the public and the rights of the registrant. He referred the panel to Mr Bryant's response bundle where he sets out his difficult private and personal circumstances, and the fact he had taken extended periods of sick leave to deal with these issues. He referred the panel to an email from Mr Bryant dated 20 September 2019, in it he stated:

> *"I would very much appreciate if you accept this as me raising concerns about my previous department as a whole regarding culture of bullying and intimidation, I feel this needs to be looked into as I would hate see another nurse go through so much trauma as I have with the poor standards of management within that department. With the high sickness rates and high turn over of staff within the department it has led me to witness poor practice which I feel has put patient safety at risk on more than one occasion."*

Mr Joshi submitted that there is nothing by way of evidence to show any aspect of what has taken place within the Unit has in any way shape or form been accepted by Mr Bryant.

In relation to public confidence in the profession and in the NMC as a regulatory body, Mr Joshi submitted that this cannot be maintained if Mr Bryant were to remain on the register. He submitted that, given the panel's findings in relation to Mr Bryant's misconduct and lack of competence and given that some 20 charges have been found proved, resulting in 55 findings of fact, a member of the public would be shocked and concerned if he were allowed to continue to practise as a nurse.

Mr Joshi submitted that, throughout the four years of Mr Bryant's employment within the Unit and throughout his correspondence with the NMC in relation to these proceedings, he has failed to acknowledge any of his failings. Furthermore, no

additional training or objective reflections in relation to his practice not being up to standard have been provided.

Mr Joshi submitted that Mr Bryant has not recognised his failings, seeks to blame his colleagues and those around him and effectively points to systematic failures. He submitted that Mr Bryant has shown no accountability or responsibility for his actions.

Mr Joshi invited the panel to consider that Mr Bryant has failed to demonstrate any accountability even at a late stage. This was bearing in mind the representations he has made in his correspondence to the NMC. In addition, he asked the panel to consider what evidence any member of the public would need to see to be convinced that Mr Bryant is upholding the standards expected of him as a registered nurse.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr Bryant'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:

- Abuse of a position of trust;
- Lack of insight into his failings;
- A pattern of misconduct over a four year period;
- Conduct which put patients at risk of harm; and
- No remorse or acceptance of his failures/shortcomings.

The panel also took into account the following mitigating features:

- [PRIVATE]

The panel first considered whether to take no action. The panel bore in mind that it found that Mr Bryant's actions were very serious and amounted to misconduct and a lack of competence. It noted that it had no evidence of remediation and no evidence of any insight from Mr Bryant. The panel took into account that taking no action would not restrict Mr Bryant's practice and determined that it would be insufficient to mark the seriousness of the charges found proved. The panel was therefore of the view that taking no action would be inappropriate in this case. In addition, to take no action would fail to address the public protection concerns and the wider public interest considerations in this case. The panel was also of the view that taking no action would undermine the public confidence in the NMC as a regulator.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the facts found proved, the misconduct and lack of competence, imposing a caution order which does not restrict Mr Bryant's practice would not be appropriate. Further, to impose a caution order would fail to address the significant public protection concerns and the wider public interest considerations in this case. 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 Bryant's misconduct and lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate. 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 Bryant'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 took into account the SG, in particular, that conditions of practice may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*

The panel first considered if there was evidence of harmful deep-seated personality or attitudinal problems. It reminded itself of its decision in relation to impairment, in that it found Mr Bryant's actions demonstrated underlying attitudinal issues and no insight into his failings as a nurse.

The panel noted that it found significant areas of Mr Bryant's practice that still require retraining, even after four years of effort by his colleagues. In relation to 'no evidence of general incompetence', it noted that the facts found proved in relation to lack of competence were wide ranging and therefore were indicative of general incompetence. Due to Mr Bryant's lack of insight and lack of meaningful engagement, the panel could not have any confidence that Mr Bryant would be willing to respond to any further training or comply with a conditions of practice order.

The panel concluded that even if it could formulate conditions to address the clinical failings, due to the factors identified above, a conditions of practice order would be inadequate to ensure public protection. Nor would it sufficiently address the public interest concerns highlighted in this case. In light of the above, the panel was of the view that a conditions of practice order would not be appropriate.

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 (this list is not exhaustive):

- *A single instance of misconduct but where a lesser sanction is not sufficient;*

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *The Committee is satisfied that the nurse has insight and does not pose a significant risk of repeating behaviour;*

The panel also had regard to the NMC guidance on 'Serious concerns which could result in harm to patients if not put right', in particular:

> *'We wouldn't usually need to take regulatory action for isolated incidents of these failings unless the incident suggests that there may be an attitudinal issue such as displaying discriminatory views and behaviours. This may indicate a deepseated problem even if there is only one reported incident. A pattern of incidents is usually more likely to show risk to patients or service users, requiring us to act.'*

The panel noted that this is not a single instance of misconduct and lack of competence as it found proved a number of charges over a significant period of time. Mr Bryant's misconduct and lack of competence persisted despite having a number of opportunities to correct his behaviour and act in a professional way. The panel found that Mr Bryant has demonstrated no insight into his misconduct and thus his behaviour is likely to be repeated. As a consequence, he poses a risk to patients. The panel was of the view that considerable evidence would be required to show that Mr Bryant no longer posed a risk to the public.

The panel was of the view that Mr Bryant's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that there are multiple serious breaches of the fundamental tenets of the profession evidenced by Mr Bryant's actions and found his conduct fundamentally incompatible with remaining on the register. The panel considered that a suspension order would not be sufficient to mark the seriousness of this case, maintain proper professional standards, or maintain public confidence in the profession.

The panel therefore moved on to consider a striking-off order. The Sanctions Guidance indicates that this sanction is likely to be appropriate in cases where:

> *'… what the nurse, midwife or nursing associate has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:*
>
> - *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
> - *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate 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?'*

In reaching its decision, the panel bore in mind that its decision could have an adverse effect on Mr Bryant, both professionally and personally. However, the panel was satisfied that the need to protect the public and address the public interest elements far outweighs the impact on Mr Bryant.

In balancing all of the factors, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Bryant's misconduct and lack of competence 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 a striking-off order would be the appropriate sanction in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the nursing profession. It determined that a striking-off order would send a clear message to the public and the nursing profession that behaviour of this kind will not be tolerated. Mr Bryant's actions were completely contrary to the standards expected 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 is in Mr Bryant's own interest until the striking-off order takes effect.

Submissions on interim order

Mr Joshi invited the panel to impose an interim suspension order for a period of 18 months. He submitted that an interim order is necessary on the grounds of public protection and is otherwise in the public interest bearing in mind the panel's findings in respect of misconduct and lack of competence.

Decision and reasons on interim order

The panel accepted the advice of the legal assessor.

The panel had regard to the seriousness of the facts found proved and the reasons for its findings on the issues of lack of competence, misconduct, impairment and sanction set out in its substantive determination. The panel reminded itself that it had found a risk of repetition. The panel was therefore satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest.

The panel first considered a conditions of practice 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 determined that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. It was of the view that not doing so would be inconsistent with its earlier findings. The panel considered that the appropriate duration of the interim suspension order was for a period of 18

months, because of the length of time likely to be required for any appeal, if brought, to be determined or otherwise finally disposed of.

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

This decision will be confirmed to Mr Bryant in writing.

That concludes this determination.