Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Thursday 27 April – Thursday 4 May 2023
Monday 14 – Wednesday 16 August 2023

Virtual Hearing

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Simon David Woodward**
NMC PIN	19I1154E
Part(s) of the register:	Registered Nurse – Children's Nursing (March 2020)
Relevant Location:	London Borough of Camden
Type of case:	Lack of competence and Misconduct
Panel members:	Michael Murphy (Chair, registrant member) Jude Bayly (Registrant member) Ian Dawes (Lay member)
Legal Assessor:	Ian Ashford-Thom (27 April – 4 May 2023) John Bassett (14 -16 August 2023)
Hearings Coordinator:	Alice Byron (27 April – 4 May and 14-15 August 2023) Max Buadi (16 August 2023)
Facts proved:	Charges 1a), 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 and 22
Facts not proved:	Charges 1b) and 3
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mr Woodward's registered email address by secure email on 13 March 2023.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time and first possible date of the meeting.

In the light of all of the information available, the panel was satisfied that Mr Woodward has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address. Service was deemed to have taken place on 13 March 2023.

Details of charges

That you, a registered nurse
Between 5 August 2020 and 5 January 2021 failed to demonstrate the standards of knowledge, skill and judgement required to practise as a Band 5 nurse in that you:

1) On 14 or 15 September 2020
   a) gave Patient C their feed 45 minutes late;
   b) asked Colleague 1 to feed Patient C too early.

2) On 14 or 15 September 2020 connected ECG stickers and/or leads in the incorrect place on Patient D's body.

3) On 22 September 2020 applied Ametop cream to Patient E's skin and failed to remove it after 20 minutes.

4) On 25 September 2020 failed to get clean sheets for Patient F's bed in a timely manner.

5) On 25 September 2020 gave incorrect information to Patient F's parents.

6) On 1 October 2020 in respect of Patient HK:-
   a) administered Captopril at 17.57pm without getting the medication second checked by another nurse;
   b) failed to check the patient's blood pressure prior to administering Captopril;
   c) failed to check the patient's blood pressure every 15 minutes for the hour following administration of Captopril.

7) On 5 October 2020 during a simulation exercise:-
   a) a) failed to identify that the patient's heart rate and/or saturations and/or respiratory rate were not within normal range;
   b) failed to consider appropriate interventions such as oral medication and/or administering oxygen and/or escalating the patient's condition.

8) On 15 October 2020 :-
   a) were unable to calculate the correct dosage of medication to administer;
   b) failed to escalate a patient's dropped oxygen saturation levels to a doctor;
   c) provided incorrect information during handover with respect to the manner in which medication and/or fluids were being administered;
   d) failed to demonstrate a basic understanding of medication;
   e) demonstrated poor time management;
   f) needed prompting to check blood test results or to contact the laboratory for results.

9) On 14 or 15 October 2020 prior to medication being administered to Patient Q:-
   a) required prompting with respect to the “8Rs” of medication administration;
   b) failed to demonstrate an understanding that the medication to be administered required a second checker.

10) On 21 October 2020 in relation to an unknown patient:-
   a) required prompting with respect to the “8Rs” of medication administration;
   b) did not check when medication had been opened or the expiry date in respect of one or more medications;
   c) failed to demonstrate an understanding that the medication to be administered required a second checker.

11) On 21 October 2020 in relation to Patient R:-
   a) used a wristband which was on a clipboard outside the patient’s room to identify the patient;
   b) attached medication to the nasogastric tube before checking that the nasogastric tube was in the correct position.

12) On 26 October 2020 prior to administering Nystatin to Patient P:-
   a) failed to check that the medication related to the correct patient;
   b) failed to check the correct dose in the British National Formulary;
   c) failed to ask Patient P’s mother what allergies they had despite Patient P wearing a red wristband.

13) On 2 November 2020 in relation to Patient T:-
   a) scanned a wristband placed on a clipboard into a Rover device instead of the wristband on Patient T’s wrist;
   b) failed to correctly check the British National Formulary for Children for the appropriate dose of paracetamol to be administered to Patient T;
   c) failed to securely attach a syringe to a naso-gastric tube;
   d) attempted to administer Nystatin via a naso-gastric tube instead of orally.

14) On or around 6 November 2020 failed to escalate to your supervising nurse when Patient J told you that you had not administered their antibiotic medication.

15) On 16 November 2020 documented and verbally confirmed to Colleague 2 that bedside safety checks for Patient U had been completed when:-
    a) an ambu bag and non rebreathe face mask were absent from the patient's bedspace;
    b) a low flow suction port was connected instead of a high flow suction port.

16) On 24 November 2020 when instructed by a doctor to stop Patient L's Heparin infusion failed to escalate the instruction to another nurse.

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

17) On 15 September 2020 copied the "Plan for Shift" section from Patient B's Nursing Shift Plan created at 20.27pm on 14 September 2020 by Colleague 3 and pasted it into Patient B's Nursing Shift Plan at 11.32am on 15 September 2020.

18) Your conduct at paragraph 17 above was dishonest in that you intended to create the false impression that the entry on 15 September 2020 was a new care plan based on the patient's needs that day.

19) On 16 November 2020
    a) Failed to comply with restrictions placed upon you by your Manager(s) at that time by administered Nystatin medication to Patient K without direct supervision;
    b) Incorrectly made an entry in Patient K's MAR chart to indicate that Colleague 4 had second checked Nystatin medication before administration.

20) Your conduct at paragraph 19b) above was dishonest in that you intended to create the false impression that Colleague 4 had second checked the medication when she had not done so.

21) On 5 January 2021 incorrectly made an entry in Patient M's Intake/Output Flowsheet to indicate that Colleague 5 had second checked expressed breast milk prior to administration at 17.00pm.

22) Your conduct at paragraph 21 above was dishonest in that you intended to create the false impression that Colleague 5 had second checked the expressed breast milk when she had not done so.

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

Background

The charges arose whilst Mr Woodward was employed as a Band 5 Nurse on the Bear Ward ("the Ward") in a supernumerary role at Great Ormand Street Hospital ("the Hospital").

Mr Woodward was employed as a newly registered nurse on the Ward from 15 June 2020 until 25 January 2021. During this time it is alleged that Mr Woodward failed to achieve the objectives required to pass his probation. Mr Woodward was provided with significant support, which included:

a. An extended supernumerary period;
b. An additional 45 hours of teaching with the graduate and education teams at the Hospital;
c. A reduced workload;
d. Regular probation review and feedback meetings;
e. [PRIVATE];
f. [PRIVATE]; and
g. An extended probation period.

Despite this support, it is alleged that Mr Woodward continued to make multiple errors as outlined in the charges. As a result of these concerns, regular meetings, assessments and measures were put in place to support Mr Woodward without success. Mr Woodward's employment was terminated following a Probationary Review Hearing on 25 January 2021.

Decision and reasons on facts

The panel bore in mind that there is no information before it relating to Mr Woodward's response to the charges as drafted by the NMC. In the absence of any clear unequivocal admissions, the panel approached this case as if all the charges were disputed. In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the written representations made by 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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Colleague 1: Senior Staff Nurse at the Hospital at the time the charges arose.
- Colleague 2: Staff Nurse at the Hospital at the time the charges arose.
- Colleague 4: Senior Staff Nurse at the Hospital at the time the charges arose.
- Colleague 5: Staff Nurse at the Hospital at the time the charges arose.
- Witness 6: Charge Nurse at the Hospital at the time the charges arose.
- Witness 8: Practice Educator at the Hospital at the time the charges arose.
- Witness 9: Junior Sister at the Hospital at the time the charges arose.
- Witness 11: Senior Staff Nurse and Practice Facilitator on the Ward at the time the charges arose.

- Witness 12: Senior Staff Nurse at the Hospital at the time the charges arose.
- Witness 13: Practice Facilitator on the Graduate Team at the Hospital at the time the charges arose.
- Witness 14: Respiratory Practice Facilitator at the Hospital at the time the charges arose.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1a)

1) On 14 or 15 September 2020
   a) gave Patient C their feed 45 minutes late;

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took into account Witness 6's witness statement, dated 24 March 2022, in respect of this charge which states:

"The other issue Colleague 1 identified was about Simon keeping track of feeds. [….]. On the Ward, we need to be conscious of fluid intake as it can have a negative impact on the child's health, in particularly [sic] the heart of a patient in heart failure, and some of our patients are on a strict fluid regime because of this."

The panel noted that, in her witness statement, Colleague 1 detailed this allegation and stated:

"I had several concerns about Simon's practice over the two days we worked together. The first was about the administration of feeds to patients. Whilst I was away from the Ward on my break, we received a new patient from the Intensive Care Unit ("ICU"). As I wasn't there, Simon received the handover, and he was told that the patient was due to be fed soon at a specific time. When I returned to the Ward, it was 45 minutes after the scheduled feed time. I asked Simon if the feed had been given and he said it had not. We then administered the feed, but the patient had gone without it for 45 minutes."

The panel bore in mind that, following this shift, on 17 September 2020 Colleague 1 had sent an email to Witness 8 and Mr 7, with Witness 6 copied in, in which she stated:

"We had an admission from CICU, Simon gave this patient's feed 45 mins late (I was unaware of timings as I was with another patient during the handover) […]."

The panel noted that this email was sent contemporaneously in relation to the incident, and supports Colleague 1's account as outlined in her witness statement.

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC, however, it noted his responses to this concern at a meeting with Witnesses 6 and 8 on 22 September 2020. In this meeting, Mr Woodward said that he could not remember the frequency of Patient C's feeds.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the

balance of probabilities, on 14 or 15 September 2020 Mr Woodward gave Patient C their feed 45 minutes late.

The panel therefore found this charge proved.

Charge 1b)

1) On 14 or 15 September 2020
   […]
   b) asked Colleague 1 to feed Patient C too early.;

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took into account Witness 6's witness statement, dated 24 March 2022, in respect of this charge which states:

> *"The other issue Colleague 1 identified was about Simon not keeping track of feeds. Colleague 1 said Simon attempted to feed a baby after 1 hour and Patient C was on a 3 hourly feed plan. […]. This meant if Patient C was fed at 12pm, their next feed would be 3pm not 1pm. On the Ward, we need to be conscious of fluid intake as it can have a negative impact on the child's health, in particularly [sic] the heart of a patient in heart failure, and some of our patients are on a strict fluid regieme [sic] because of this.*
>
> *[…]*

The risk of harm was fluid overload from overfeeding which could increase the chance of heart failure post-surgery"

The panel noted that, in her witness statement, Colleague 1 detailed this allegation and stated:

"I had several concerns about Simon's practice over the two days we worked together. The first was about the administration of feeds to patients. Whilst I was away from the Ward on my break, we received a new patient from the Intensive Care Unit ("ICU"). As I wasn't there, Simon received the handover, and he was told that the patient was due to be fed soon at a specific time. When I returned to the Ward, it was 45 minutes after the scheduled feed time. I asked Simon if the feed had been given and he said it had not. We then administered the feed, but the patient had gone without it for 45 minutes.

I said we would have to delay the next feed, but Simon said he would give this feed at the originally scheduled time to "get back on track". I told him that we couldn't do this because this would mean that that feed would be an hour early. If he were not being supervised, I think that Simon may have gone ahead and administered the next feed early. If patients are fed early this can cause vomiting, which can put extra stress on the heart. This could potentially have serious consequences for cardiac patients."

The panel bore in mind that, following this shift, on 17 September 2020, Colleague 1 had sent an email to Witness 8 and Mr 7, with Witness 6 copied in, in which she stated:

"We had an admission from CICU, Simon gave this patient's feed 45 mins late (I was unaware of timings as I was with another patient during the handover), Simon then asked me if I could then give another feed only an hour later. If I had not questioned the timings, I feel Simon would have then administered the feed an hour early."

The panel noted that this email was sent contemporaneously in relation to the incident.

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC. However, noted his responses to this concern at

a meeting with Witnesses 6 and 8 on 22 September 2020. In this meeting, Mr Woodward said that he could not remember the frequency of Patient C's feeds. Further, in an email from Witness 9 to Witness 6, Mr 7 and Witness 8, dated 18 September 2020, she reported that Mr Woodward had told her that Colleague 1 was lying about the feed being given too early.

The panel took account of the evidence which supports this charge. It noted that Colleague 1's contemporaneous account, from 17 September 2020, indicates that Mr Woodward asked her to feed Patient C too early, whereas in her witness statement, which she confirmed to be correct to the best of her knowledge on 18 January 2023, Colleague 1 outlined that Mr Woodward said that he himself would feed Patient C too early. Indeed the content of the email dated 17 September 2020 is arguably contradictory. The panel found this to be a material contradiction in relation to the charge. The panel therefore found that, on the balance of probabilities, there was insufficient evidence before it to support a finding that Mr Woodward asked Colleague 1 to feed Patient C too early.

The panel therefore found this charge NOT proved.

Charge 2)

2) On 14 or 15 September 2020 connected ECG stickers and/or leads in the incorrect place on Patient D's body.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took into account Witness 6's witness statement, dated 24 March 2022, in respect of this charge which states:

"Simon was carrying out an ECG on Patient D and Colleague 1 offered help to carry out the ECG. […]. Simon said to Colleague 1 I don't need your help. Patient D's ECG was not carried out correctly based on the reading and Colleague 1 saw Simon had connected the pins in the wrong place. Unfortunately, the ECG is not available as Colleague 1 identified the leads were in the incorrect place via the monitor and corrected this at the time, so a corrected ECG could be taken. Simon was given feedback on 22 September 2020 on how to work better with the nurses on shift with him"

The panel noted that, in her witness statement, Colleague 1 detailed this allegation and stated:

"I also had concerns about Simon's ability to do an Electrocardiogram ("ECG") procedure. Simon told me that he had done an ECG a number of times and was confident doing it. I suggested that we did it together, but Simon insisted that he did it on his own. I then went on a 15-minute break and when I returned Simon was doing the ECG. I noticed that all of the ECG leads were in the wrong place on the patient's body, so I showed Simon how to place them correctly. When we left the room, I asked Simon why he had said he was competent in doing ECG's. He just shrugged and said he thought he had been able to do the procedure."

The panel bore in mind that, following this shift, on 17 September 2020, Colleague 1 had sent an email to Witness 8 and Mr 7, with Witness 6 copied in, in which she stated:

"We had an ECG to carry out on a patient which I said I would help and supervise him through, Simon told me that he was capable of doing this on his own and there was no need for me to help. Whilst he was doing the ECG I entered the room and found most of the stickers were in the wrong place. I reassured Simon that if he did not know it is important that he tells me so we can go through it"

The panel noted that this email was sent contemporaneously in relation to the incident, and supports Colleague 1's account as outlined in her witness statement.

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC, and that his responses to this concern were not provided at the meeting with Witnesses 6 and 8 on 22 September 2020. Further, in an email from Witness 9 to Witness 6, Mr 7 and Witness 8, dated 18 September 2020, she reported that Mr Woodward *"claimed there was nothing wrong with his ECG".*

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 14 or 15 September 2020 connected ECG stickers and/or leads in the incorrect place on Patient D's body.

The panel therefore found this charge proved.

Charge 3)

3) On 22 September 2020 applied Ametop cream to Patient E's skin and failed to remove it after 20 minutes.

This charge is found not proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Witness 6's witness statement, dated 24 March 2022, in respect of this charge which states:

> *"We first discussed the Ametop incident with Simon. […]. Ametop is a numbing cream that is applied to a patient in advance for blood test samples to be taken. Ametop should not be on a patient for more than 40 minutes and Simon was told this by […] [the] Heart Failure Clinical Nurse Specialist.*

Simon had applied Ametop to Patient E and it had been on for 40 minutes. […]. Simon was handing over to the incoming Nurse [Witness 11] about Patient E. [Witness 8] was in her office and overheard the handover. [Witness 8] recalls that [Witness 11] asked Simon how long the Ametop had been on Patient E. Simon said he didn't know."

The evidence before the panel indicates that Ametop should not be on a patient for more than 40 minutes rather than 20 minutes as referred to in the charge. As such Mr Woodward would not have been under a duty to remove the Ametop from Patient E after 20 minutes. On this basis alone the charge is not proved. However, the panel wish to state that had the charge referred to 40 minutes, it would have found the charge proved on the basis of Witness 6's evidence and the note of the meeting on 22 September 2020 which indicates that Ametop had remained on Patient E for up to 90 minutes.

The panel therefore found this charge not proved.

Charge 4)

1) On 25 September 2020 failed to get clean sheets for Patient F's bed in a timely manner.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took into account Witness 6's witness statement, dated 24 March 2022, in respect of this charge which states:

"On 25 Semptember 2020 [sic], a verbal complaint was received from Patient F's parents and I met with Simon to discuss this. […] Patient F's dad called me into the room and raised concerns about Simon. The dad was quite angry that Simon lacked compassion and care, he felt Simon did not care about the basic needs of Patient F

Patient F had been incontinent and the bed was wet, the dad had asked Simon to get new bedsheets whilst his dad cleaned up Patient F. Patient F's dad removed the soiled sheets from the bed, cleaned Patient F and the bed. The dad found a place for Patient F to sit and waited for Simon to return

I cannot recall if the parents pressed the buzzer again or Simon returned to the room but Simon did not have clean sheets with him. The parents asked for the clean sheets again and Simon said he will get them. Simon eventually got the clean sheets. Patient F's dad was very annoyed at the fact Simon knowing that the sheets were soiled, he didn't prioritise it."

The panel bore in mind that, following this shift, on 25 September 2020, Witness 6 and Witness 8 met with Mr Woodward to discuss this concern. The panel had regard to the notes of this meeting, which states:

"The parent's complaint was that Simon had not been attentive to the basic needs of their child. The child had soiled the sheets and the parents used the call buzzer to ask for help. Simon left the room for sheets and did not return. The father of the child was required to clean up his child, strip the bed of the dirty linen, leave the dirty sheets in a pile on the floor, clean the bed and find something for the child to sit on whilst he waited for clean linen. After some time Simon returned for another reason and did not have clean sheets. When asked for a second time, he was able to provide the child with clean linen.

Simon did not know why he had not been able to meet the needs of the child or family in this incidence [sic]. It was reiterated to Simon that these are basic tasks which are part of the nursing care of a child and family."

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC, and that the only information as to his response to this concern is contained within the notes of the meeting from 25 September 2020.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 25 September 2020 Mr Woodward failed to get clean sheets for Patient F's bed in a timely manner.

The panel therefore found this charge proved.

Charge 5)

5) On 25 September 2020 gave incorrect information to Patient F's parents.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took into account Witness 6's witness statement, dated 24 March 2022, in respect of this charge which states:

> *"The parents also asked a question about anticoagulation to Simon which Simon answered incorrectly. I had told Simon and all other members of staff to not pretend to know something, if you do not know say you will find out, instead of guessing and getting something wrong. The reason for this is the parents often are well versed in the care of their child and the medication, they would ask something to reaffirm or test the care provider. Patient F's*

Step Dad told me Simon didn't know about the correct testing of warfarin and herparin (INR and APTT), And this worried him as Simon was looking after his child who had a mechanical valve and was reliant on anticoagulation.

[…] The parents were concern [sic] that Simon was providing the wrong information therefore was not providing the correct care to Patient F"

The panel bore in mind that, following this shift, on 25 September 2020, Witness 6 and Witness 8 met with Mr Woodward to discuss this concern. The panel had regard to the notes of this meeting, which states:

"The second concern from the parent was regarding information that Simon had given to them, this information had proven to be wrong information regarding the child's medication (the patient was transitioning between a heparin infusion and oral warfarin-their usual medication at home) The parent's concerned [sic] were that if Simon was providing them with the wrong information was he giving the correct care in other areas such as administering the correct amount of a medication to the parents [sic].

When discussed with Simon the parent's concerns it was reiterated that if he does not know an answer he should be honest with the families and tell them that he can discuss with his colleagues to find the answer. It was also discussed with Simon that a lot of the families at GOSH are experts in their child's care and treatment and so they may ask difficult questions, so he will need to check with the teams that know more specific information about the patient's management. Simon said he understood."

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC, and that the only information as to his response to this concern is contained within the notes of the meeting from 25 September 2020.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the

balance of probabilities, on 25 September 2020 Mr Woodward gave incorrect information to Patient F's parents.

The panel therefore found this charge proved.

Charge 6)

6) On 1 October 2020 in respect of Patient HK:-
   a) administered Captopril at 17.57pm without getting the medication second checked by another nurse;
   b) failed to check the patient's blood pressure prior to administering Captopril;
   c) failed to check the patient's blood pressure every 15 minutes for the hour following administration of Captopril.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took into account Witness 6's witness statement, dated 24 March 2022, in respect of these charges which states:

> *"On 1 October 2020 Simon administered a test dose of Captopril to Patient HK without getting the medication double checked by another Nurse. I discovered this error when I received feedback from Ms 10, Senior Staff Nurse regarding the 1 October shift. Whilst Ms 10 was in another room with a patient, Simon went to administer captopril test dose to a patient. Simon did not get the medication double checked despite this being a Bear Ward high risk medication and did not complete the vital observations required when*

giving the medication. The SSN working with him that day noticed the error. Captopril is an ace inhibitor, used to manage blood pressure ("BP") and heart failure. Too much Captopril could drop your BP dramatically. With Captopril you give a test dose to see how the patient's body reacts to it, as everyone has a different reaction. The test dose is usually a small dose and you slowly increase it.

Before administering, we first check the patient's BP before giving it, if the BP is low we do not administer Captopril. With a small dose, we carry out observations every 15 minutes for an hour afterwards to check for any adverse effects. On this occasion Simon didn't get the medication checked despite knowing he should. We gain our oral competency so we can administer some medication on our own but controlled drugs or high risk medication require a second Nurse to check. Captorpril is a high risk medication. Simon also failed to carry out observations on Patient HK before he administered the dose and after. Simon's last observations record were for 17:00 before administration and then the night staff carried out observations at 21:00.

There was no harm caused by Simon's actions but there was risk of harm. […]"

The panel bore in mind that, following this shift, on 5 October 2020, Witness 6 and Witness 8 met with Mr Woodward to discuss this concern. The panel had regard to the notes of this meeting, which states:

*"**Incident:** Simon administered a test dose of Captopril to a patient at 17.57 on 01/10/2020, without getting the high risk medication double checked as per policy and without performing additional blood pressure observations pre or post administering the medication. Simon performed observations at 17.00 and then the next observations were documented at 21.00 by the night staff.*

***Discussion:** When asked about double checking the medication, Simon reported he was aware that the medication was a high risk medication and*

required double checking. Simon also said he knew about the chart on the Bear Ward drugs room wall stating the medications on Bear Ward that require double checking.

Simon thought there may have been a problem with the rover he used to administer the medication and that was the problem; Simon reported there had been problems across the day. When asked if Simon had reported a problem with the equipment he was using he said 'no 'and Simon did not know who he checked the medication with. When asked if Simon had thought of using the fixed computers in the drug room or a roaming WOW when administering medication if a Rover wasn't working well, Simon hadn't considered that option.

Regarding the lack of additional observations, Simon reported not being aware of these. When Simon was asked again about double checking the first dose of a medication and asking questions to the checker, Simon said 'I should of asked someone'.

Simon remains in supernumerary practice with a supervisor on each shift he is working. Simon did not discuss the test dose of the medication being prescribed with his supervisor for the shift and as he had been signed off to give non IV medication, he administered the medication solo.

It was discussed with Simon how dangerous high risk medication can be and this is the reason why these medications are double checked. It was also discussed with Simon that test doses of Captopril are given as we don't know how patient's B/P will respond to the medication and so giving them a very small dose to start with and doing 15min observations for the first 1hour to determine their response is the safest practice."

The panel had regard to Patient HK's observation charts from 1 October 2020, which it noted corroborates the account given by Witness 6 in his witness statement.

The panel also had regard to the Hospital's Code of Practice for Administration of Medicines, which sets out Mr Woodward's duties, as outlined by Witness 6. The panel noted that this policy contains a flow chart for the administration of medicines, and the following extract in relation to observations:

> *"The administering practitioner is responsible for monitoring the effects of medicines administered and recording results in the patient's clinical record."*

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC, and that the only information as to his response to this concern is contained within the notes of the meeting from 5 October 2020, and Mr Woodward's comments surrounding this incident in his Probation Review Hearing on 25 January 2021, in which he said:

> *"Prior to that, I actually did double check the medication in the drug room with another nurse. But when I got to the room with another nurse. But when I got to the room, the Rover turned itself off on me, and like that, I did the normal protocols for scanning the patient and giving the drugs. It wasn't until I'd, basically, pressed accept, that I'd forgotten to put in the comment section that it was checked.*
>
> *I forgot about it, basically. That's my only defence to that one. I did double-check it, and I always had been double-checking my medication to that point, it didn't matter what it was, whether it was double-checked. I just wanted to make sure I had the correct dose because I was still a relatively new nurse, I didn't want to make the mistakes.*
>
> *I thought the blood pressure situation, the medication was given within an hour of the previous blood pressure. I thought that was okay. I didn't realise you had to do it sooner than an hour. And I do admit that I didn't check it after giving the medication".*

The panel noted that Mr Woodward partially admitted this charge, and where it is denied, he seeks to attribute blame to other people or systems. However, panel found the

evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 1 October 2020 in respect of Patient HK, Mr Woodward administered Captopril at 17.57pm without getting the medication second checked by another nurse, failed to check the patient's blood pressure prior to administering Captopril and failed to check the patient's blood pressure every 15 minutes for the hour following administration of Captopril.

The panel therefore found this charge proved.

Charge 7)

7) On 5 October 2020 during a simulation exercise:-
   a) failed to identify that the patient's heart rate and/or saturations and/or respiratory rate were not within normal range;
   b) failed to consider appropriate interventions such as oral medication and/or administering oxygen and/or escalating the patient's condition.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took into account Witness 6's witness statement, dated 24 March 2022, in respect of these charges which states:

> *"On the Ward we run simulations of potential scenarios every week. These are replications of real scenarios we have to face on the Ward. At this point, Simon had been at GOSH for 4 months. On 5 October 2020, the scenario was a child experience an anaphylactic shock. Simon struggled to carry out*

the assessment and struggled with the scenario. Simon could not identify the heart rate was not in a normal range and did not flag this. Simon did not consider interventions, oral medication or oxygen levels.

There was no harm caused as it was a simulation but showed Simon's lack of ability and knowledge."

The panel noted that, in his witness statement, Witness 11 detailed this allegation and stated:

"During the exercise, the dummy began to de-saturate (i.e. the oxygen levels fell below the normal level). Simon struggled to work his way through the "A to E" assessment, which is the standard assessment that should be performed in an emergency. He could identify that the saturation numbers were low, but he took no action in response to this. From what I observed, Simon didn't seem to comprehend what was happening. An appropriate response in these circumstances would have included applying oxygen and escalating the situation.

My biggest concern was that Simon did not call for help or escalate the condition of the patient during the exercise. Also, when other people did get involved, he struggled to communicate and hand over information to them about what was happening. In particular, he struggled with the standard "SBAR" handover procedure, which was particularly important in emergency situations. Similar to his handover on the Ward, I noticed that Simon would fall silent for periods of time."

The panel noted that these statements are supported by feedback from Witness 11 which states:

"Simon attended a simulation conducted by the simulation team on Bear and I observed in my role as practice facilitator and to support the simulation team. Simon started the simulation by making assessment of his patient. Simon struggled to work through his A-E assessment and did not identify that the "patient's" saturations, heart rate or respiratory rate were not within normal ranges. This was despite identifying the values displayed on the

monitor. Simon required prompting to escalate during the simulation and found it difficult to provide a SBAR handover. He repeated himself and seemed to lose concentration as well. Simon also struggled to consider any interventions as applying oxygen for the "patient"."

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 5 October 2020 during a simulation exercise Mr Woodward failed to identify that the patient's heart rate and/or saturations and/or respiratory rate were not within normal range and failed to consider appropriate interventions such as oral medication and/or administering oxygen and/or escalating the patient's condition.

The panel therefore found this charge proved.

Charge 8)

8) On 15 October 2020:-
   a) were unable to calculate the correct dosage of medication to administer;
   b) failed to escalate a patient's dropped oxygen saturation levels to a doctor;
   c) provided incorrect information during handover with respect to the manner in which medication and/or fluids were being administered;
   d) failed to demonstrate a basic understanding of medication;
   e) demonstrated poor time management;
   f) needed prompting to check blood test results or to contact the laboratory for results.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the

panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took into account Witness 6's witness statement, dated 24 March 2022, in respect of these charges which states:

> *"On 22 October 2020, I received an email from Witness 12, Senior Staff Nurse regarding her shift with Simon on 15 October 2020. Witness 12's concerns were:*
>
> *a. Simon struggled with drug calculation despite using a calculator. Simon could not work out the correct dose to administer;*
> *b. Simon didn't understand reasoning behind the medication*
> *c. Basic medication knowledge was lacking*
> *d. Poor time management*
> *e. Did not escalate dropped oxygen levels to doctors*
> *f. Gave wrong information in handover.*
>
> *As a Nurse we should have a basic understanding of medication and be able to calculate correct dosages. We must also plan our day so our time management is not poor, so if a feed is due at 12 you gather your equipment before 12. Simon would not do his prep until it was the time to do the task. [PRIVATE].*
>
> *Simon struggled to get on top of his time management. In some instances, if the child was visibly hungry Simon would wait for the time of the feed before feeding the child. If a child is crying its ok to feed them slightly early i.e. 15 minutes earlier but not if it is 1-2 hours early. Simon lacked awareness.*
>
> *I questioned Simon and he made excuses. Simon said the Night Nurse left no equipment in the room but Witness 12 had informed me Simon needed a lot of prompting. Simon had to be prompted to check the blood results, if not received to call the lab but Simon was not doing this or realising he needed*

to do this. I had to remind Simon, Witness 12 was there to support him not provide the care or tell him what to do. Simon was supposed to be taking the lead on the care of his patient.

Patient G's mum was finding it difficult to deal with the situation and went into the room. […]. Simon stood in the room and did not ask what was wrong or provide support. Simon lacked compassion. Witness 12 found this to be odd. Simon didn't explain why he did this.

Simon had given the wrong information in his handover. Simon handed over the incorrect way in which medication or fluids were being given/set up. Witness 12 corrected this. Simon also did not escalate a drop in Patient I's oxygen levels. […]. Witness 12 had to tell Simon he needed to go speak to the doctor."

The panel noted that, in his witness statement, Witness 12 detailed this allegation and stated:

On 15 October 2020, I was working directly with Simon on the Ward. This would either have been because I had been assigned to work with him directly, or because I was working in my capacity as Team Support, in which I would oversee the work of newly-qualified nurses and healthcare assistants. In either role I would be overseeing Simon's work.

Simon had been given a couple of patients to care for during the shift. One patient had a BT shunt, so it was important to monitor their oxygen saturation and fluid balance levels very carefully. For patients like this, these levels should be between 75% and 85%. If levels dropped below this it would be a red flag, and the matter would have to be escalated. When I asked Simon what should happen if the levels dropped below this, he couldn't really tell me what to do and didn't propose any response. This was not a particularly challenging question, and is one that I would usually ask student nurses.

During the shift, I told Simon that we needed to keep an eye out for blood tests being returned, and that we may need to chase these up. However, he needed a

lot of prompting about this, as well as various other issues, and he did not seem to be able to follow direct instructions.

In respect of medications, I noted that Simon could not calculate the correct dosages, even when using a calculator. This included common medications such as aspirin, which is really important for our patients. Simon also appeared to lack knowledge of what various medications were used for. Again, this included medications that we commonly used, such as paracetamol and nystatin (used for oral thrush prevention).

I also had concerns about Simon's time management. Our patients rely on their fluid balances being precisely maintained, and this means they need to be fed regularly at specific times. I noticed that Simon had not prepared the necessary equipment in advance of a scheduled feed time, which led to the feed being delayed. When I asked Simon about this, he said it was because the nurse on the night shift had not placed the necessary equipment in the room. I advised Simon that it wasn't the night shift nurse's job to do this.

I also noticed that Simon could not hand over information about what had happened during the shift to colleagues. He could not provide information fully or correctly. This was worrying because, should a junior member of staff act on this information without questioning it, there could be serious consequences. Also, if Simon were caring for a deteriorating patient, I was concerned that he would not be able to hand this over effectively to doctors or other nursing staff, which again could have serious consequences.

Overall, I was concerned that Simon could not cope, even when given direct instructions, and I found it quite tiring to keep going over things for him. He did not have sufficient knowledge to fulfil his nursing role."

The panel bore in mind that, following this shift, on 22 October 2020, Witness 12 sent an email to Witness 6, Mr 7 and Witness 8, in which she stated:

"I worked with Simon on the 15/10/20 day shift. He was friendly to parents and patients. He was able to do the observations and fluid balance without

any prompting. He struggled a little bit with drug calculations and had to use a calculator to work out oral frusemide and when using a calculator he managed to get the incorrect dose for asprin x 2 (was 0.5ml out). Simon couldn't understand why someone who was on IVABS also had nystatin, although he knew what nystatin was for. His drug knowledge even for every day medications we use on the ward was very basic or poor. I found that Simon had difficulty in time management. He started to get feeds ready at 12.00 that were due at 12.00 and didn't use the baby cries as a cue to start getting the feed prep ready before it needed to be given. His excuse was that the night nurse should have left extra syringes etc in the room for use in the day. He needed a lot of prompting in doing things for patients that have been asked on ward round. (I had to look up bloods etc – I had asked him to phone the labs and ask then for bottles etc which he never did. I went in and spoke to his patient's mum who started to cry, Simon stood there not really asking if anything was wrong and didn't really offer any comfort. Simon did start writing a plan for the day of when feeds and obs and meds were due but he didn't seem to be able to adapt from that. When I asked him questions he never gave a confident answer and often it was an incorrect guess. He also handled wrong information over (about CVL lines and saturation targets) and seemed confused after direct instructions. He didn't seem to know when to ask a doctor for help, I had to tell him to go and speak to the doctors about a patients saturations, he never used his initiative to go and ask what the doctors wanted to do about a baby that was desaturating. He never really asked questions. I tried explaining things to him but I felt like he wasn't listening but just agreeing with what I had said."

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 15 October 2020 Mr Woodward was unable to calculate the correct dosage of medication to administer, failed to escalate a patient's dropped oxygen saturation levels to a doctor, provided incorrect information during handover with respect

to the manner in which medication and/or fluids were being administered, failed to demonstrate a basic understanding of medication, demonstrated poor time management and needed prompting to check blood test results or to contact the laboratory for results.

The panel therefore found this charge proved.

Charge 9)

9) On 14 or 15 October 2020 prior to medication being administered to Patient Q:-
   a) required prompting with respect to the “8Rs” of medication administration;
   b) failed to demonstrate an understanding that the medication to be administered required a second checker.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward’s referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Witness 13’s witness statement, dated 2 March 2022, in respect of these charges which states:

> *“We began practising oral medication administration. Simon required a lot of prompting, he was scrolling up and down the BNF unaware which section was applicable to Patient Q going from oral to intravenous medication and the different reasons the drug was required. […]. Simon needed reminded to go through the 8R’s of medication administration. I had to prompt Simon in the drug room. Simon also did not highlight this medication required a second checker and for the need for this to be document on the system. The*

system would not prompt a second check, so the nurse preparing the medication would need to do this manually. This can be done by typing the second nurses' details into the comment box. On The Ward they have a poster of what medication would need a second checker as they are high risk documented and all practitioners would be made aware of these but Simon seemed as if he was not aware."

The panel bore in mind that, following this shift, Witness 13 sent a feedback email to Mr Woodward, which stated:

*"**Oral medication***

- *Try avoid using the rover for preparation, as it gets very confusing with two devices the rover and the BNF on your phone. Whereas when you use PC you can click the link straight to the BNF rather that scrolling and also you can clearly see all of the mar and patient details unlike the rover.*
- *Every time you administer medication go through your 8R's and explain them. Using the method I showed you yesterday where the 7 out of the 8 R's follow a line on the MAR on the PC- Name, Medication, Dose, Route, Time, Documentation and reason*
- *When using the BNF remember the two R's that will help you look for the heading. The reason i.e pain and the route i.e oral or IV so that you don't have to keep scrolling through all the headings and dosages.*
- *When getting a double check make sure, if it does not prompt for a double checkers signature, that it is documented in the comments at the time. Such as, what I did yesterday which was I went back on and wrote a note in the comment box saying I had signed it, then you have clear documentation of who checked with you*

When you were preparing the medication your calculations, drawing up and verbally checking dates and names on the bottle was brilliant.

Handover

- *Just as you had told me the structure you are following for you handover on EPIC continue with this: problem list, PEWS/ABCDE assessment, devices, fluid balance etc*
- *In your note pad please write a short bullet point page to prompt you to do these steps in case you forget at the time of handover. Then you can have your note pad open on this page, this will help you to not forget a step at the time of handover or you can refer to this."*

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 14 or 15 October 2020 prior to medication being administered to Patient Q, Mr Woodward required prompting with respect to the "8Rs" of medication administration and failed to demonstrate an understanding that the medication to be administered required a second checker.

The panel therefore found this charge proved.

Charge 10)

10) On 21 October 2020 in relation to an unknown patient:-
    a) required prompting with respect to the "8Rs" of medication administration;
    b) did not check when medication had been opened or the expiry date in respect of one or more medications;
    c) failed to demonstrate an understanding that the medication to be administered required a second checker

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the

panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Witness 13's witness statement, dated 2 March 2022, in respect of these charges which states:

> *"On 21 October 2020, I worked alongside Simon again to practice oral medication administration along with line dressings. We began practising oral medication and I felt Simon had the same issues as 15 October 2020. Simon needed to be prompted in the drug room to check the 8 rights of medications administrations for both medications: right, patient, right drug, right dose, right time, right route, right documentation, right reason and right response. Simon did not check the 8 rights of medication administration for the second medication, therefore not checking the medication is safe to administer.*
>
> *Simon had skipped safety checks prior to preparation, Simon would pick up the medication and tell me the medication name, but did not check when it was opened or the expiry date. Simon again forgot about the second check element due to this drug being high risk."*

The panel bore in mind that, following this shift, Witness 13 sent a feedback email to Mr Woodward, which stated:

> *"**Oral medication***
> *You practiced administering 2 oral medications with me, one which was high risk.*
>
> - *You automatically picked up the rover to use in the drug room preparation. I had to remind you about what I had said last time, about being easier to view name, DOB, allergies and all the R's on one page. Please avoid using the rover when preparing medications as it*

is a lot harder to visual see all the information and you can easily access the BNF.

- *You was not very verbal during your practices. You went through the 8R's in the way I had shown you before which was great to see and need minimal prompting. Unfortunately you needed prompting to go over the R's for the second drug as well as the first drug and also to read what medication was, when it expires and when it was opened.*
- *You needed promoted [sic] to highlight that it was a high risk drug, and the importance of documenting the second checker to me […]"*

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 21 October 2020 Mr Woodward required prompting with respect to the "8Rs" of medication administration, did not check when medication had been opened or the expiry date in respect of one or more medications and failed to demonstrate an understanding that the medication to be administered required a second checker.

The panel therefore found this charge proved.

Charge 11a)

11) On 21 October 2020 in relation to Patient R:-
    a) used a wristband which was on a clipboard outside the patient's room to identify the patient;

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the

circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Witness 13's witness statement, dated 2 March 2022, in respect of these charges which states:

> *"The main issue I had with Simon on the day was identification with Patient R. […]. Outside Patient R's room there was a clipboard with 2 name bands for both his patients. Simon took one of the name bands for Patient R before we entered Patient R's room. I did not want to interrupt Simon for two reasons, in case he was going to do the correct identification process to apply the name band to the patient prior to signing for the medication, so that I was not telling him what to do before he has a chance to do it the correct way independently and to avoid pressuring Simon which could have led to a mistake. I was there and would intervene if I witnessed Simon do anything wrong or unsafe.*
>
> *Simon had two ways of carrying out the identification process, if the patient had photo ID, Simon needed to:*
>
> a. *Check and Scan photo ID using the Workstation on Wheels ("WOW");*
> b. *Check for allergies;*
> c. *Document administration on the WOW;*
> d. *Then administer the medication.*
>
> *If Simon did not have photo ID, Simon needed to verify he had the correct patient by:*
>
> a. *Scanning the patient's wristband if on Patient's wrist; or*
> b. *Ask a family member to confirm from the patient name band:*
> i. *Patient name;*
> ii. *Patient date of birth;*
> iii. *Patient allergies.*
> c. *Then apply the wrist band to the child and use this to scan on the rover or WOW once confirmed.*

Once Simon had verified he had the correct patient, Simon should have:

a. *Document and signed administration on the WOW/ROVER (portable computer) - You sign the second check in the drug room this stays on the computer at the bedside so a second check signature does not need to be done again by me at the bedside;*
b. *Administered the medication.*

Simon on the day had a ROVER with him which he could not use for photo ID. Patient R had photo ID, so Simon needed a WOW to check the patient's identity and scan the patients photo ID. Rovers can only been used on name bands that the patients has [sic] on them. Simon decided to proceed with using the name band he took from the clipboard outside of the room that had not been confirmed and placed on the patient's wrist. I prompted Simon at this point he needed to verbally confirm the details with Patient R's parent. I do not recall if it was Patient R's father or mother in the room at that point. Patient R's room was a fairly large room and the parent was not right next to Patient R, they did not hear Simon read the patients details out so they were unaware he was addressing them.

Simon began saying Patient R's details out loud without any acknowledgement from the Parent. I wasn't happy as the parent did not respond. I asked Simon to do this again and the Parent responded this time stating these were the correct details for patient R. Simon shouldn't have taken the name band from the clipboard, there was no confirmation it belonged to Patient R, this is bad practice and unsafe In this situation, Patient R had photo ID, Simon should have got a WOW and signed medication using the photo ID. The rover is only for when the patient is wearing the name band as this is the scanner.

There was no harm caused as I was there monitoring Simon. My approach is not to tell the person what to do, I watch them, prompt when required and stop them if they are unsafe. I ensured patient safety by prompting Simon where I felt he was doing something wrong. The risk of harm was Simon

could have administered the wrong medication to the wrong patient, wrong dose of medication could have been administered or it could have been a medication the patient was allergic to as he had not confirmed this was the right patient. This could have led to harm for the patient but because he was supervised the risk of harm was mitigated."

The panel bore in mind that, following this shift, Witness 13 sent a feedback email to Mr Woodward, which stated:

*"**Oral medication***

You practiced administering 2 oral medications with me, one which was high risk.

[…]

- *When we went into the room the patient had photo ID but you bought [sic] a wrist band into the room, you then scanned it on the rover. I said this patient has photo ID you should be using that on the WOW. I said to verbally confirm with the patients details [sic]. You had said it but didn't address the relative so they were aware you was speaking to them. I said are they happy? So you had to repeat it again to the relative and you responded yes.*
- *You also should not keep patient ID bands outside the rooms on the clip board as they should be on the patient or if they don't have one you need to use the photo ID and scan it on the WOW at the time of administration."*

The panel had regard to the Hospital's Patient Identification Policy, which states: *"all patients must be positively identified before any treatment or intervention is undertaken. […]. The Trust uses printed patient identification wristbands to support this process.".* It noted the inclusion of a flow chart which visually set out the process to follow for patient identification. The Trust's Medication Administration policy also states: *"patients must be positively identified before administering any medicines"*. This should be done by scanning the patient's identification band, which must be attached to the patient's wrist or ankle, and NOT attached to beds/cots or equipment."

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC. However, it had regard to Mr Woodward's comments surrounding this concern in his Probation Review Hearing on 25 January 2021, in which he said: *"obviously I shouldn't have been… I shouldn't have scanned a name that wasn't on the patient".*

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 21 October 2020 Mr Woodward used a wristband which was on a clipboard outside the patient's room to identify the patient.

The panel therefore found this charge proved.

Charge 11b)

11) On 21 October 2020 in relation to Patient R:-

[…]

b) attached medication to the nasogastric tube before checking that the nasogastric tube was in the correct position.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Witness 13's witness statement, dated 2 March 2022, in respect of this charge which states:

"Simon also did not check the nasogastric ("NG") tube was in the correct position for Patient R. This is something we would do before administration in case the tube has moved to the lungs, you would draw back on the syringe to obtain a small amount of liquid. You would then check the liquid using PH paper depending on the reading you will know if it is in the correct position. If the PH was above 5.5 you would not give the medication via the NG tube, you would troubleshoot until you can confirm it is [definitely] in the correct position. If you could not confirm correct position you would not administer the medication.

Simon had a 20ml syringe (empty), the medication and a syringe with a water flush on the medication tray. Simon picked up the medication (I do not recall what the medication was) and screwed it on to the NG tube. I stopped Simon at this point and asked "what do we do first?" he then remembered he needed to check the NG tube positioning prior to the medication. If I had not stopped Simon he would have administered the medication without undertaking the correct safety checks to confirm positioning. There was no harm caused as I interrupted Simon and the NG tube was checked prior to the medication being administered."

The panel bore in mind that, following this shift, Witness 13 sent a feedback email to Mr Woodward, which stated:

*"**Oral medication***
You practiced administering 2 oral medications with me, one which was high risk.

[…]

- *You also need to remember to always test the NG tube before administering anything down it. As when you went to give the medication I had to remind you what do we do first? And then you realised you needed to test the NG tubes PH."*

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 21 October 2020 Mr Woodward attached medication to the nasogastric tube before checking that the nasogastric tube was in the correct position.

The panel therefore found this charge proved.

Charge 12)

12) On 26 October 2020 prior to administering Nystatin to Patient P:-
   a) failed to check that the medication related to the correct patient;
   b) failed to check the correct dose in the British National Formulary;
   c) failed to ask Patient P's mother what allergies they had despite Patient P wearing a red wristband.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Witness 14's witness statement, dated 14 February 2022, in respect of these charges which states:

> *"On 26 October 2020, I carried out a non IV assessment of Simon. I provided my feedback to Simon verbally and followed up with an email to ensure*

Witness 8 and Mr 7 were updated. […]. Simon was not competent with his non IV medication and asked for help with this.

The assessment took place on the Ward, as this was Simon's usual work setting so he would be familiar with the ward setting. We were looking to administer Nystatin to Patient P. […]. Nystatin is a medication used to treat oral thrush and it is usually given 4x a day, there is a possibility of overdosing Nystatin. Simon recited his 8 rights (Right patient, drug, dose, route, time, reason, reaction, documentation) correctly but needed prompting to apply these checks to this administration. Simon did not check if the medication related to the right patient, he did not check if the dose was correct in the BNF."

The panel bore in mind that, following this shift, Witness 14 sent a feedback email to Mr 7, Witness 8 and Mr Woodward, which stated:

"Emailing to feedback after a non-IV medication practice with Simon today. We gave Nystatin orally.

In the drug room, Simon was able to recite his 8 rights, but needed reminding to relate this to the drug we were administering, e.g. Simon remembered that the dose needs to be checked, but needed a reminder to look on the BNF and check the dose we were about to give. Once all these checks were completed, Simon was able to draw up this medication accurately using an oral syringe. Our first oral syringe wrapper fell on the floor – Simon remember if your 'key parts' have been compromised we need to dispose of these to ensure infection control is adhered to.

On going to the patient's room, Simon needed reminding to check the wristband that the patient was wearing. Simon had a wristband printed off, but this was not on the patient and had not been checked with mum, so was not appropriate to be used to check patient ID. On scanning and checking the patient wrist band, which was red, Simon did not ask about patient's allergies and I had to do this. Simon – please remember the importance of all

the checks, including those at the bedside and for allergies. These are vital to protect patient safety, and have been designed to try and prevent errors on every administration."

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 26 October 2020, Mr Woodward failed to check that the medication related to the correct patient, failed to check the correct dose in the British National Formulary and failed to ask Patient P's mother what allergies they had despite Patient P wearing a red wristband.

The panel therefore found this charge proved.

Charge 13)

13) On 2 November 2020 in relation to Patient T:-

a) scanned a wristband placed on a clipboard into a Rover device instead of the wristband on Patient T's wrist;
b) failed to correctly check the British National Formulary for Children for the appropriate dose of paracetamol to be administered to Patient T;
c) failed to securely attach a syringe to a naso-gastric tube;
d) attempted to administer Nystatin via a naso-gastric tube instead of orally.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Witness 6's witness statement, dated 24 March 2022, in respect of these charges which states:

> *"Simon had recently failed a competency assessment with Witness 8 on 2 November 2020. Before administration we scan the name band of a patient which confirms on EPIC the right medication, dosage and timing for the patient. We would still need to check the 5 Rs (Right patient, Right Medication, Right dosage, right time and right route), Simon struggled with the identification process. Simon checked the name band of a patient that was on a clipboard rather than reading/comparing to the MAR and scanning the name band on the arm of the patient. Simon needed to check the name band on the patient, compare with the computer and follow the 5 Rs instead of relying on a name band not attached to a patient."*

Further, the panel took account of Witness 8's witness statement, dated 2 March 2022, in respect of this charge which states:

> *"Simon failed his non-IV medication assessment on 2 November 2020 for a number of reasons. Simon did not check BNFc (British National Formulary for Children) for the correct dosing of paracetamol. The BNFc clarifies the dosage we should give of a medication to our patient groups by age or weight for example; neonates, 1-2 months and so forth. Simon was looking to give Patient T a neonatal dose, despite Patient T being 5 weeks old. […]*
>
> *A further issue was with Simon's checks within the patient's room. Within the patient's room nurses identify the patient using their photo ID or name band which is attached to their wrist or ankle. Patient T had a name band on and there was an additional name band sat on a table in the room. Simon did not scan the name band on Patient T, instead he scanned the other name band taken from the table in the room. This name band could have been someone else's, following good practice and the medication administration policy, Simon should have scanned the one on Patient T. Simon's checks were to follow the 'R's of drug administration' meaning that he had the right drug,*

dose, patient, time, route and what he did meant we did not identify the patient correctly. I had to remind Simon that he was not following good practice and the GOSH medication administration policy in his practice.

I told Simon we need to scan the name band using the Rover device (a handheld computer device). Simon began reading the details off the patient's name band in his hand and not the Rover which is the prescription. The correct process is to check the wristband, scan the wristband to see if the details match those on the Rover and then check the wristband again before administration. If Simon was signed off as competent, Simon would need to identify the patient, scan using the ROVER then administer medication.

Simon then began administering the paracetamol to Patient T (once we had safely completed our patient ID checks.) via the Nasogastric ("NG") tube (which he had also checked the placement of using PH strips). After the administration of a medication via an NG tube we need to follow up with a flush for water to make sure the medication does not remain in the tube. Simon attempted this, but the water was leaking on to the bed. Simon asked me to check in case there was an issue with the NG tube. There was no problem with the NG tube, I re twisted on the syringe to the NG tube and administer the water flush without any leakage.

This again was not a new skill for Simon, this was a something he would have been practicing whilst a student as well as since qualifying as a nurse. Simon did not report any problems with co-ordination. In this case the paracetamol was administered to the patient but there was a risk that the paracetamol (or another medication) could have been on the bed resulting in a patient being in pain in the case of not receiving paracetamol.

The second medication to be administered during this non-IV medication administration was Nystatin this was prescribed orally. Simon attempted to administer Nystatin via the NG tube. Nystatin is administered orally and is used to treat oral thrush. Nystatin is usually applied using a sponge in the patient's mouth for babies and infants as it ensures a coating is applied

around the oral cavity. As Simon went to administer the Nystatin, I stopped him telling him it was the wrong route (using the NG tube). Simon corrected himself."

The panel had further regard to the Hospital's Medication Administration and Patient Identification policies, as previously detailed. It also took into account the contemporaneous feedback which you were given by Witness 8 following this assessment, which states:

"When using the BNFc you were not looking at the correct age for your patient. A baby of 5 weeks of age would fit into the 1month-2month category not the neonate category. Although the drugs room was empty today, it can be difficult when there are a number of options in the BNFc and it may be of benefit to use the strategy discussed previously of checking the BNFc outside of the busy drugs room, to help focus on the information and reduce the risk of drug errors.

[…]

On entering the patient's room you automatically went to a wrist band on the side and did not use the wrist band which was attached to the patient. Once looking at the patient you did check the wrist band correctly but needed to be reminded to check against your drug prescription on the MAR and not the extra name band in your hand.

[…]

When administering the medication you gave the paracetamol correctly but then needed to be told that you were about to give the nystatin via the wrong route. You then corrected yourself and administered the Nystatin correctly orally.

Whilst administering the flush for the Paracetamol you had a problem with the nasogastric tube (NGT) leaking which we were unable to find a cause

when trouble shooting. In the future make sure your purple syringe is correctly inserted into the luer lock on the NGT to ensure your patient receives the whole dose of medication as this could be the cause of leakage."

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on 2 November 2020 Mr Woodward scanned a wristband placed on a clipboard into a Rover device instead of the wristband on Patient T's wrist; failed to correctly check the British National Formulary for Children for the appropriate dose of paracetamol to be administered to Patient T; failed to securely attach a syringe to a naso-gastric tube; and attempted to administer Nystatin via a naso-gastric tube instead of orally.

The panel therefore found this charge proved.

Charge 14)

14) On or around 6 November 2020 failed to escalate to your supervising nurse when Patient J told you that you had not administered their antibiotic medication.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Witness 6's witness statement, dated 24 March 2022, in respect of these charges which states:

"We discussed Patient J, a 14 year old girl, who told Simon one of her drugs was missing. The NMC asked me for the name of Patient J, unfortunately I do not know as it was anonymised. Patient J was very aware of the drugs she has, she said to him, when he was in the room, one drug is missing and it is the one that is usually prepared by the Nurse. Unfortunately as the patient was anonymised I cannot locate the documentation in relation to this incident. It was a new antibiotic that was kept in the fridge. All other medication are in the patient's room. For medication in the fridge, the nurse would get. On this occasion the patient reminded Simon. Simon did not understand what Patient J was asking for and told her she had had all her medications.

Patient J told the incoming Nurse she had missed her dosage but the incoming Nurse was told by Simon he had administered all medication. In some instances, it is the parents and patient who give the medication especially the older independent children, if they said it had not been given then it hadn't. Simon should have escalated this to the nurse supervising him but didn't. Simon should have checked with his supervising Nurse, parent and patient and administered the medication from the fridge. No harm was caused to Patient J but the delay in medication had a potential of harm. As it was an antibiotics, not being given them can cause a surge in infection."

The panel had further regard to the Hospital's Medication Administration policy, which states:

"All communication with patients, their families and carers following harm to a patient to due the care of GOSH services must be documented in the patient's health record and follow the Duty of Candour".

The panel also noted that this concern is detailed within a letter to Mr Woodward on 9 November 2020 following his final probation review meeting, which states:

We spoke about a separate incident which was highlighted this week regarding a patient whose parents and herself were predominantly

administering her medications. The patient highlighted to you that there was 'one missing, one that is usually prepared by the nurse', the patient was referring to a newly introduced antibiotic which was kept in the drug fridge in a locked room. The patient said you informed her that all the medications had been given. The patient told the nurse on the oncoming shift that she had no [sic] received the previous dose as it was not given to her by you. I spoke about the importance of getting each medication checked against the MAR (Medication Administration Chart) on EPIC to ensure all medications are administered and accounted for. You said that you completed this with the parents and patient, but in their review of the situation this was not done. You reiterated that it wasn't handed over to you that there was a drug in the fridge. I said I appreciate that this wasn't handed over to you, but if a patient or family is highlighting this to you, this should act as a red flag for you to question the situation […]. On asking for comment you said that you could not remember the specifics of the situation just that it was not handed over to you by the nurse on the previous shift"

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC, and the only indication which it has as to his response to this charge is that contained in his final probation meeting, as outlined above.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities, on or around 6 November 2020 Mr Woodward failed to escalate to his supervising nurse when Patient J told Mr Woodward that he had not administered their antibiotic medication.

The panel therefore found this charge proved.

Charge 15)

15) On 16 November 2020 documented and verbally confirmed to Colleague 2 that bedside safety checks for Patient U had been completed when:-

a) an ambu bag and non rebreathe face mask were absent from the patient's bedspace;
b) a low flow suction port was connected instead of a high flow suction port.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Colleague 2's witness statement, dated 9 March 2022, in respect of these charges which states:

> *"On 16th November 2020, at the start of the shift Simon told me he was not signed off as competent to administer medication, this was also confirmed by the educational team. Simon expressed his desire to take lead on caring for two patients. Therefore, we made a plan for Simon to care for two patients and all oral medication to be administered by myself or another nurse. My concerns with Simon during this shift were:*
>
> *a. Simon documenting and verbally confirming that bedside safety checks had been completed. Then on inspection, the safety equipment in the room was inadequate or not present.*
>
> *Specifically, point 'a' above, refers to Patient U. Both an ambu bag and non rebreathe face mask were not in the patient's bed space. Patient U's room also had a low flow suction port still connected rather than a high flow suction port. The safety checks had been documented and verbally confirmed by Simon as being correct. All three of these aspects are essential safety equipment needed in case of patient deterioration, failure to have these in place can cause a delay in emergency treatment being delivered. Normal*

ward practice is to check this equipment is present and working following handover then to document to confirm that this has taken place on the 'safety checks' tab of our online documentation system 'EPIC'. As the patients were anonymised I am unable to remember the patient and locate any documentation.

I rectified the safety equipment, minimising any harm to the patient then I discussed these issues with Simon, highlighting each piece of equipment and its importance to emphasise the safety implications. Simon seemed to process this information but did not seem to acknowledge the seriousness of these actions."

The panel also noted that Colleague 2 reiterated this concern in her feedback document, on 16 November 2020, which states:

"Two incidences took place during the shift as detailed below. The first incident related to bedside safety checks. Simon had documented the bedside safety checks had been completed however, on checking these there were the following errors:

- *There was no ambubag for one patient*
- *There was no non rebreathe mask in the room for the same patient*
- *There was a low flow suction port still in the wall was not in use but had tubing connected leading to a potential patient safety incident, for the same patient."*

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to these charges as drafted by the NMC.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities On 16 November 2020 Mr Woodward documented and verbally confirmed to Colleague 2 that bedside safety checks for Patient U had been completed

when an ambu bag and non rebreathe face mask were absent from the patient's bedspace and a low flow suction port was connected instead of a high flow suction port.

The panel therefore found this charge proved.

Charge 16)

16) On 24 November 2020 when instructed by a doctor to stop Patient L's Heparin infusion failed to escalate the instruction to another nurse.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

The panel took account of Witness 6's witness statement, dated 24 March 2022, in respect of these charges which states:

"On 24 November 2020, Simon did not follow instructions from Dr 17. I completed the fact find for this incident. […] Simon had been asked by Dr 17 to stop the Heparin infusion for Patient L due to the levels being high. Heparin infusion is used to prevent blood clotting, strokes and manage risk of mechanical valves blocking. Heparin infusions are constantly monitored and if the APPT level is too high, it must be stopped immediately. When an APPT greater than 180 there is a risk of the patient bleeding. Simon was not aware of this or the anti-coagulation policy. […]

At 13:10, Dr 17 had told Simon the APPT level was too high and the infusion needed to be stopped immediately for 30 minutes. After 20 minutes, this had not been done and Dr 17 escalated it to the Nurse in Charge, Ms 16.

Dr 17 felt when she told Simon, Simon did not respond well enough and she was concerned he would not follow through with the instruction which is why she returned to the Ward 20 minutes later. Dr 17 would not normally do that but Simon's reaction was of a concern to her that she felt she had to return to the Ward to check.

Simon was not responsible for Patient L but Dr 17 did not know that and Simon did not say anything at the time. […] Ms 16 asked Simon why the infusion wasn't stopped, Simon denied being asked by Dr 17 to do it. Simon should have escalated to the Nurse, whose patient it actually was or told his supervisor for the day, Ms 15, Staff Nurse. Ms 16 asked Witness 11 to stop the infusion and restart when required.

When a Nurse goes on a break, they would ask another nurse to keep an eye on their patients for 15 minutes. Patient L was one of Ms 15's patients. Simon was keeping eye on the patients. Whilst Simon could not administer or be near medication but he could escalate to someone. If Dr 17 didn't return the infusion would have ran for longer. Dr 17 was worried about Patient L which is why she came back and double checked.

Patient L did not suffer any known harm but there was a potential of harm. The high APPT could have led to internal bleeding, stroke and death. Witness 8 told Simon the importance of following up request in a timely manner. Witness 8 asked to have a meeting with Simon at the time but Simon declined. Witness 8 wanted to discuss the anti-coagulation policy with Simon."

Further, the panel took account Witness 8's witness statement, dated 2 March 2022, in respect of this charge which states:

"On 24 November 2020, I met with Simon following an incident on the Ward involving a Heparin infusion. Simon had been asked by Dr 17 to stop a heparin infusion for Patient L. Simon remained working in a supernumerary

capacity and so was not responsible for Patient L, Simon was also not signed off on his IV medication administration and so should not have turned off the medication, but as the nurse was not available and Dr 17 had asked him, Simon had the responsibility to escalate something outside of his scope of practice to the responsible nurse or the nurse in charge on the shift. The doctor was not comfortable with Simon's response, and so when the request had not been carried out within 30mins Dr 17 escalated to the nurse in charge of the shift themselves. The Doctor also alerted me to this incident as one of the ward Practice Educators to highlight the importance and dangers of a heparin infusion.

I spoke to Simon on the day about this incident […]. I met with Simon on my own on this occasion and reminded him the importance of escalating when something is outside the scope of competence. Whilst people remain unable to administer their medication unsupervised on the ward there is always a qualified nurse who has this responsibility for the shift. As Simon was not signed off for his IV competency so he should escalated to the Nurse in charge or the Nurse responsible for his medication who he would also have been working the shift with as he remained working in a supernumerary capacity.

During this time I reminded Simon about the risks to the patient from not escalating the request from Dr 17 of turning the heparin infusion off and how this should have been done immediately. I also reminded Simon of the anticoagulation policy we have on the ward and how we should be following this, which is what Dr 17 was doing. I explained if Patient L had bled the impact could have been catastrophic possibly leading to patient death Simon said he was not aware of the policy. I had covered this with Simon during the induction, I would not expect Simon to know the policy by heart but at least be aware of the policy. Simon had cared for patients on heparin before Patient L and so would have been aware of the policy.

I agreed with Simon to go over the anticoagulation policy after he had his lunch to help him to learn from this incident. I went to Simon at 5pm to go

over the anticoagulation policy but Simon did not want to go through it. Simon asked me to leave to the side and he will go through it at home. My plan was to go back through my training slides and point out the relevant parts including the table for APPT as had previously been done during Simon's local induction to the Ward in June 2020. […]. As Simon was not receptive to this opportunity for teaching, I planned to cover the anticoagulation policy with Simon on his next shift.

On 27 November 2020, I met with Simon again alongside Witness 6. […]. After this meeting I covered the anticoagulation policy with Simon. I'm not sure if Simon took what I said on board, I felt at times from his nonverbal communication that Simon did not seem to be receptive to feedback/ teaching and saw it as a punishment or something personal rather than opportunity to learn and develop his practice."

The panel also had regard to the summary of incident, dated 24 November 2020, which set out:

"Simon Woodward asked by Dr 17 to stop heparin infusion for 30mins acting on high APTT on blood results and then to restart the infusion at a reduced rate following the policy. Simon was covering the break for this patient with his supervising nurse Ms 15, Ms 15 was attending to a patient at the time the request was made, The request was also documented onto the patient's chart on EPIC.

At 13.30 Dr 17 escalated to the Nurse in Charge (Ms 16) that Simon had not followed through with the request.

[…]

When Simon was asked by Ms 16 why he had not escalated the request made he reported Dr 17 did not ask him [sic]."

The panel also had sight of the anti-coagulation guidelines.

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to this charge as drafted by the NMC.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities on 24 November 2020 when instructed by a doctor to stop Patient L's Heparin infusion Mr Woodward failed to escalate the instruction to another nurse.

Charge 17)

17) On 15 September 2020 copied the "Plan for Shift" section from Patient B's Nursing Shift Plan created at 20.27pm on 14 September 2020 by Colleague 3 and pasted it into Patient B's Nursing Shift Plan at 11.32am on 15 September 2020.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Witness 6's witness statement, dated 24 March 2022, in respect of these charges which states:

"On 15 September 2020, Simon was discovered copying and pasting entries. I was alerted to this incident when I received an email from Ms Colleague 1, Staff Nurse, on 17 September 2020 […] and I spoke to Simon about it on 22 September 2020. Colleague 1 noticed that Simon had copied and pasted an entry in the care plan from the previous day. For Patient B. Simon had

copied Colleague 3's (HCA) entry from 14 September 2020. If you look at both entries side by side they read identical […] the entries have the same spelling and grammar mistakes. The 14 September 2020 entry mentions a "Walrus appointment tom [sic] at 13:00", Simon's entry also has the same text. It was now 'tomorrow' and so Simon should have wrote appointment today but as it was copied it was again written appointment tomorrow, now signalling a day later.

Simon was expected to document using the same headings but write a new care plan for the day. Simon would first need to check the patient and then document the care then document the care needed not copy and paste the previous entry.

Simon did the same with Patient B […]. Colleague 1 knew he was copying and pasting from look [sic] at different entries, […]. The issue with this was the information was wrong, incorrect and fraudulent.

[…]

We discussed the copying and pasting incident and mentioned that fraudulent documenting is also bad nursing practice. Simon then admitted to copying and pasting previous entries on the care plans. We then had a long discussion on why documentation needs to be accurate and how it will be used as evidence of the care required/provided on the day, so he needed to be mindful of what he was documenting and what he wasn't."

Further, the panel took account of Witness 9's witness statement, dated 2 March 2022, in respect of this charge which states:

"The next meeting I had with Simon was on 18 September 2020. This was based off an email from Colleague 1 (Staff Nurse) regarding shifts with Simon. I was sent this email from Witness 6. […]. I met with Simon by myself based off Colleague 1's email and there were no notes made. Simon […]

copied a care plan entry. The way we realised this was the information was identical to the previous entry including the spelling mistakes.

Simon denied everything, accused me and Colleague 1 of lying, I did not have the care plan entries with me at the time. I took this away as personal learning to have care plans or document with me. Simon said he was annoyed that he wasn't given the feedback at the time by Colleague 1. Simon was very defensive and I felt uncomfortable at the meeting from the way Simon was talking to me."

The panel had regard to Patient B's notes for 14 and 15 September 2020, and noted that the wording of the entries was identical, including the spelling mistakes, save for the dates. It also noted that this allegation was contained in an email from Colleague 1, dated 17 September 2020.

The panel also took into account the contemporaneous notes of a meeting with Witnesses 6 and 8, to discuss this concern, which took place on 22 September 2020, which stated:

"Simon started by reporting that this was not true and he said that he has never copied and pasted other people's plans into his assessment. When shown screen shots of the care plans and plan for the day and shown that they were word for word the same, with the same mistakes and wrong information and that Simon had documented that the patient was due to attend an appointment on the Walrus ward the next day when the appointment would have been on that day, Simon was silent. It was discussed that copying other people's assessment is bad nursing practice, can lead to disciplinary hearings and later NMC fitness to practice hearing, and Simon said he understood."

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to this charge as drafted by the NMC.

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the

balance of probabilities on 15 September 2020 Mr Woodward copied the “Plan for Shift” section from Patient B’s Nursing Shift Plan created at 20.27pm on 14 September 2020 by Colleague 3 and pasted it into Patient B’s Nursing Shift Plan at 11.32am on 15 September 2020.

The panel therefore found this charge proved.

Charge 18)

18) Your conduct at paragraph 17 above was dishonest in that you intended to create the false impression that the entry on 15 September 2020 was a new care plan based on the patient’s needs that day.

This charge is found proved.

In reaching this decision, the panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of Ivey v Genting Casinos UK Ltd t/a Crockfords [2017] UKSC 67:

> *‘When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual’s knowledge or belief as to the facts…. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.’*

In ascertaining Mr Woodward’s subjective knowledge and belief as to the facts, the panel noted that when first asked about this matter he had vehemently denied copying and pasting the “plan for shift” section from Patient B’s nursing shift plan and had accused Colleague 1 and Witness 9 of lying about it. It was only when shown the relevant entries at the meeting on 22 September 2020 that he admitted doing so. The panel has also noted that in a meeting on 25 January 2021, Mr Woodward said:

"Like I said, I don't remember actually doing… I don't copy and paste that information. I would never do that. So when it was presented to me, I didn't know what to do, I didn't know what to say because they had… I just said I had… I must have done that. I didn't admit complete guilt because I didn't know."

The panel concluded that the fact that Mr Woodward only admitted copying and pasting the entry when confronted with the identical entry is indicative that not only did he copy and paste the entry, but also that he knew he should not do so. If he was unaware that he should not have done so, there would have been no logical reason for alleging Colleague 1 and Witness 9 had lied. Nor does the panel consider Mr Woodward's explanation, at the 25 January 2021 meeting, for his admission to be credible. It is satisfied that it is simply an attempt to revert to his original denial.

The panel then applied the standards of ordinary, decent people. It concluded that, by copying and pasting patient records to present those entries as his own, an ordinary, decent person would find Mr Woodward's actions to be dishonest as they are inaccurate, false and did not fully demonstrate Patient B's care needs at the time of the entry.

The panel therefore finds this charge proved.

Charge 19)

19) On 16 November 2020
    a) Failed to comply with restrictions placed upon you by your Manager(s) at that time by administered Nystatin medication to Patient K without direct supervision;
    b) Incorrectly made an entry in Patient K's MAR chart to indicate that Colleague 4 had second checked Nystatin medication before administration.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

Further, the panel took account of Witness 6's witness statement, dated 24 March 2022, in respect of these charges which states:

> *"On 16 November 2020, Simon documented an oral medication had been double checked. Colleague 2, Staff Nurse told Mr 7 about this incident who informed me via email. Colleague 2 was supervising Simon and Colleague 2 went on her break. Colleague 2 asked Colleague 4, Float Nurse to help Simon with his medication preparation. Colleague 4 went over to Simon who had already administered Nystatin to Patient K. […]*
>
> *Nystatin is a medication to treat and prevent mouth thrush. Children can get thrush in their mouths from the medication they get such as antibiotic treatment. Simon had administered this medication by himself and signed the MAR chart as being checked by [C4]. Unfortunately, as the patient was anonymised I cannot locate the MAR chart in relation to this incident.*
>
> *Colleague 4 noticed this and said to Colleague 2 that she did not double check Nystatin with Simon. Colleague 2 checked the MAR chart and saw it had been administered and signed for. Colleague 2 asked Colleague 4 who said she did not sign the MAR chart. Simon had fraudulently documented that Colleague 4 had checked the Nystatin.*
>
> *It was a low risk medication so there was no harm caused. It was unlikely to cause harm, the issue was Simon administering medication unsupervised despite knowing he couldn't. Simon went against policy and had his oral competency taken away previously.*

Further, the panel took account of Colleague 2's witness statement, dated 2 March 2022, in respect of this charge which states:

> *"On 16th November 2020, at the start of the shift Simon told me he was not signed off as competent to administer medication, this was also confirmed by the educational team.*
>
> *[…]*
>
> *Upon returning to the Ward, Colleague 4 told me that she did not administer the Nystatin to Patient K because the medication had already been administered according to the medications administration record ('MAR chart'). Upon us checking the administration documentation together, the MAR chart showed that the drug had been signed for by Simon and checked by the initials of '[C4]'.*
>
> *Simon verbally confirmed that he had administered the drug by himself but that it had been checked. Then when asked why Simon had done this as he is not signed off in administering oral medications and was not per the plan discussed prior to me leaving the Ward, Simon replied that he had administered the Nystatin without supervision 'because the drug was due'. Simon did not seem to recognise during this discussion that this was the incorrect action to take.*
>
> *As the patients were anonymised I am unable to recall the patient and locate the MAR chart. Nystatin is often prescribed for patients as a preventative for fungal infections and a treatment for oral candidiasis. This is a commonly administered drug on the Ward, the dosage according to the BNFc does not alter based on the age/ weight of the child. The administration of the drug needs to be oral, even if the patient for example is fed via a nasogastric tube, this is to ensure the correct absorption and therefore reach the intended use for the child. This factor may not have been known by Simon or have been conducted correctly without the supervision, therefore the child could have*

received the drug dose incorrectly. On assessment no harm was caused to the patient as a direct result of the drug administration.

In addition to Simon administering medication to Patient K, this was also falsely documented to have been checked by the float nurse, Colleague 4. Colleague 4 informed me when we were checking the MAR chart that Simon had documented that '[Colleague 4]' had checked and supervised the administration but that this had not taken place.

I asked Simon if the administration was supervised and who this was by, his response was "with someone". I asked Simon if he checked the Nystatin with Colleague 4 to which he said he did. I asked Simon if he was sure this had taken place, to which he again confirmed that this had taken place. I escalated my concerns to Mr 7, the Ward's Practice Educator.

Mr 7 led a meeting where we discussed this incident. When we mentioned to Simon that we did not think that the drug check by Colleague 4 had taken place, Simon's initial response was that Colleague 4 must not have looked at the bottle properly but insisted that she did check the drug prior to administration. Simon later on in the conversation admitted that Colleague 4 had not checked the drug at all. After the meeting Simon apologised for the incident to myself and Mr 7. Simon seemed eager for this incident to not be a repeated, stating that he felt bad that it had happened."

It also had regard to Colleague 4's witness statement, which set out:

"Simon asked me if I had given the Nystatin to the patient and I confirmed I had not. When I told Colleague 2, she asked me if I could go back and give the Nystatin to the patient, which I agreed to do.

Nystatin is a "single-check" drug, and only needs to be checked by one nurse before admission. However, as Simon was not yet signed off as competent with oral medications, he was not allowed to do the check or admission alone. I thought it would be useful for him to do this under my supervision, so

I went into the drug room to find him. As I went into the drug room, Simon passed me on the was out. I then got into conversation with the Nurse in Charge, who was also in the room, about other tasks that needed to be done.

Once I had finished my conversation with the Nurse in Charge, I logged onto the system and went into the record for Colleague 2's patient. This was when I saw that the Nystatin had been signed for as checked by Simon. I then went to ask Colleague 2 if she had supervised Simon to check and administer the Nystatin, and she confirmed she had not.

Later in the day, I was doing something else for the same patient and went into their record again. It was then that I noticed that Simon had added a comment in relation to the Nystatin to say that I had checked it with him. From what I can recall, it was words to the effect of "Checked by [C4]. I did not supervise Simon to check or administer the Nystatin and I did not make any entries on the patient's record to indicate that I had done so. My understanding was that Simon had administered the Nystatin to the patient and that he had made the entries about this on the patient's record.

Following the shift, I gave an account of the incident to the Practice Educators."

The panel bore in mind that it had before it contemporaneous evidence which supported these statements, including the email referred to by Colleague 4.

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to this charge as drafted by the NMC. However, it noted that in an email to the Graduate Team at the Hospital, dated 17 November 2020, Mr 7 alluded to the fact that Mr Woodward seemingly accepted this allegation and described it as a *"silly mistake".*

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities on 16 November 2020 Mr Woodward failed to comply with

restrictions placed upon him by his Manager(s) at that time by administered Nystatin medication to Patient K without direct supervision and incorrectly made an entry in Patient K's MAR chart to indicate that Colleague 4 had second checked Nystatin medication before administration.

The panel therefore found this charge proved.

Charge 20)

20) Your conduct at paragraph 19b) above was dishonest in that you intended to create the false impression that Colleague 4 had second checked the medication when she had not done so.

This charge is found proved.

In reaching this decision, the panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of Ivey v Genting Casinos, as outlined above.

In ascertaining Mr Woodward's subjective knowledge and belief of the facts, the panel noted that Mr Woodward initially denied this allegation, however soon resiled from this denial. It had regard to the account provided by Colleague 2 of this incident, which states:

> *"During the meeting it was clarified as to whether the shift float had carried out the medication administration with him for which he confirmed a number of times to be correct. The [Practice Educator] then clarified how the medication check was carried out at this point Simon expressed he thought that maybe the shift float hadn't looked at the bottle properly before going on to inform us that the check did not actually take place."*

Given that Mr Woodward was asked about this matter so soon after it occurred, the panel is satisfied that there can be no question of his failing to correctly recall what had happened. The panel concluded that his initial denial is indicative that, not only did he administer Nystatin without it being second checked, but also that he knew he should not

do so. He made the entry to cover up what he had done and only admitted doing so upon realising that he could not realistically maintain his denial.

The panel then applied the standards of ordinary, decent people. It concluded that, deliberately documenting that Colleague 4 had checked the Nystatin, an ordinary, decent person would find Mr Woodward's actions to be dishonest as he had made a false entry on Patient K's records with the intention of leading his clinical colleagues to believe he had sought the appropriate second checks.

The panel therefore finds this charge proved.

Charge 21)

21) On 5 January 2021 incorrectly made an entry in Patient M's Intake/Output Flowsheet to indicate that Colleague 5 had second checked expressed breast milk prior to administration at 17.00pm.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It took into account the Probation Period Summary Report, compiled by Witness 6, which the panel found to be a fair, unbiased and factual account of the chronology of the circumstances which led to Mr Woodward's referral to the NMC. It bore in mind that this summary also contains details of the support which was put in place to help Mr Woodward in his role at the Hospital.

The panel took account of Witness 6's witness statement, dated 24 March 2022, in respect of these charges which states:

"On 7 January 2021, Witness 9 met with Simon about the Expressed Breast Milk ("EBM") incident that took place on 5 January 2021. I was aware of the incident and gained further detail when preparing the probation report. EBM is milk that has been pumped into a bottle from the mother's breast and placed in the fridge. It is done when the baby is poorly and too tired, that they

can't breast feed. Cardiac babies get tired very easily so we don't breast feed instead we use a NG tube and feed via that route. Simon had given a feed of EBM without having another nurse check it to Patient M. […]. Simon had signed the MAR chart to say Colleague 5, Staff Nurse, had second checked it.

Colleague 5 was on her break when Simon had signed the chart to show she had second checked. […]. It shows Colleague 5 was on her break from 16:30-17:30. Colleague 5 noticed when she returned from her break the breastmilk had been signed out using her initials but she didn't do this. Colleague 5 raised this with Witness 9 and I was aware when I prepared the probation report.

This was not the first time Simon had fraudulently documented something. There was no harm caused as it was the correct EBM but if it wasn't there was a risk of harm. Simon could have given another mother's EBM to Patient M and there was a possibility of catching HIV or hepatitis from breastmilk and so we would have had to do additional and unnecessary blood tests on the mother and patients."

Further, the panel took account of Witness 9's witness statement, dated 18 March 2022, in respect of this charge which states:

"The next meeting I had with Simon was on 7 January 2021. The purpose of this meeting was to discuss a documentation concern regarding expressed breast milk ("EBM") that occurred on 5 January 2021. Simon had documented someone had second checked EBM for him to administer to Patient M. Patient M was on EBM feeds every 3 hours via Nasal gastric tube (NG Tube). Before administering any EBM all nurses need to have it second checked as it is a bodily fluid. We need to ensure it is the right EBM for the patient and then document the second check on the system.

On the day, Simon was working alongside Colleague 5 (Staff Nurse), Simon had documented Colleague 5 had carried out the second check. Colleague 5 denied carrying out the second check and the feed occurred whilst Colleague 5 was on her break. At the time, due to Covid we were keeping track of when people were taking their breaks for track and trace purposes. We did this with a break register in the break room. The feed had occurred whilst Colleague 5 was on her break. Colleague 5 was on her break from 16:30-17:30 but the EBM had been second checked at 17:00.

We have had incidents where the wrong EBM was given to a patient which emphasises the need of a second check. There was no harm caused to Patient M as it was the correct EBM. The risk of harm was we would need to carry out further blood tests on both the patient and their mother to determine if any further intervention was required. I met with Simon about the incident with Witness 8 alongside me. […]. Simon was defensive throughout this meeting. Simon was first saying Colleague 5 did check the EBM with him when she had returned from her break. Simon said the feed was late. I did question why Simon gave the next feed early knowing the last feed was late. Simon then changed his account to say it was not late and possibly checked by someone else not Colleague 5. Simon kept changing his account throughout the meeting. I completed a DATIX for this incident. […]. Simon did go on to do a reflective account on our recommendation."

The panel also had regard to Colleague 5's witness statement, which states:

I went on my lunch break from 16:30 to 17:30. I first went to the canteen and then to the break room, and was not the Ward during this time. In order to help with COVID-19 tracing, all staff had to sign in and sign out of their breaks on a Break Register. […]. I confirm that the highlighted entry near the bottom of the page is mine, and that it correctly records that I signed in for my break at 16:30 and signed out at 17:30.

When I returned to the Ward after my lunch break, Simon told me that the 17:00 feed had been given to the patient. I didn't have time to check the

records at that point, as it is usually very busy on the Ward around 18:00 due to medications being administered. When the shift finished at 19:45 I checked the patient's Input/Output chart, which recorded the feeds. In relation to the 17:00 feed, I saw that my initials had been entered to indicate that I had checked the EBM.

I did not check the EBM and I did not enter my initials on the Input/Output chart in respect of the 17:00 feed, as I was away from the Ward on my lunch break at the time. […]

I was shocked to discover this because, apart from this incident, Simon and I had had a good shift. In particular, Simon had an appropriate manner when interacting with patients and families."

The panel bore in mind that it had contemporaneous evidence before it which supported these statements, including the minutes from the meeting on 7 January 201, which set out:

"Simon started by saying that he thought he may have checked the feed with Ms 18 (an ANA currently on placement at the ward), who was working next to that day. Simon was questioned as to why he added Colleague 5's initials to EPIC instead of Ms 18's. Simon didn't answer.

Simon was then questioned if he understood the importance of double checking the EBM and the reasons why this policy is in place, he said he did. Simon was also asked if he understood the implications of signing someone else's initials, Simon reported he did.

Simon then stated that Colleague 5 did check the EBM with him in the patient's room on her return from break. Witness 9 showed Simon the Track and Trace register (which is currently being used for when people are on their break), this showed that Colleague 5 was on break from 16.30 – 17.30. Simon reported he must have given the feed late. He said he would ask Colleague 5.

Witness 9 again highlighted with Simon that he documented that he gave the baby their feed at 17.00 and that Colleague 5 had stated that she didn't check the EBM with him.

Witness 9 then questioned Simon as to why he had fed the baby early for their following feed if he fed them late for the one in question. Simon responded 'he did not'. Witness 9 pointed out to Simon if Colleague 5 was on Break until 17.30, had got herself sorted enough to enter a patient's room to check on him and check the EBM for him, it must have been 17.45-18.00 before the feed was given. Therefore the feed at 20.00 would be nearly 1hr early. Simon then changed his mind and said maybe Colleague 5 hadn't checked the feed he could remember."

The panel bore in mind that there is no evidence before it as to Mr Woodward's response to this charge as drafted by the NMC. However as well as the minutes of the meeting from 7 January 2021, it noted his reflective piece in respect of this incident, which stated:

"For each feed throughout the day Colleague 5 was on hand to double check the feeds but at this particular time, she had gone on break, so I asked Ms 18 a nursing associate working next to me to check instead. Once she was happy I proceeded to administer the feed. Once completed I document the feed but at this point I incorrectly documented that Colleague 5 had checked instead.

At the time I had no idea I had incorrectly documented and I had double checked my documentation before handing over and still missed it. This incident is extremely frustrating for me as I had missed a simple mistake in my documentation. I am aware of importance of checking with another person and correctly documenting to correct double checker. The RCN code [sic] states the importance of documentation making sure it's accurate to the care you're giving.

Looking back on the incident, I can see that I should have checked my documentation more thoroughly and possibly had Colleague 5 go through my

entire days documentation as to avoid such an error. I can now see how an incident like this could have led to administering the incorrect EBM if having the incorrect double checker documented. After discussion with my practice facilitator regarding this incident I understand that I need to develop a better awareness of the importance documenting correctly and not to rush things as this can lead to errors."

The panel found the evidence which supports this charge is clear, consistent and supported by contemporaneous evidence. Accordingly, the panel found that, on the balance of probabilities On 5 January 2021 Mr Woodward incorrectly made an entry in Patient M's Intake/Output flowsheet to indicate that Colleague 5 had second checked expressed breast milk prior to administration at 17.00.

The panel therefore found this charge proved.

Charge 22)

22) Your conduct at paragraph 21 above was dishonest in that you intended to create the false impression that Colleague 5 had second checked the expressed breast milk when she had not done so.

This charge is found proved.

In reaching this decision, the panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of Ivey v Genting Casinos, as outlined above.

Given that Mr Woodward was also asked about this matter so soon after it occurred, the panel is satisfied that there can be no question of his failing to correctly recall what had happened. The panel concluded that the contradictory accounts he gave are indicative that he was aware that there should be a second check of the expressed breast milk prior to its administration, but he knew that he should have done so. His contradictory accounts were made in an attempt to cover up what he had done.

The panel then applied the standards of ordinary, decent people. It concluded that, an ordinary, decent person would find Mr Woodward's actions to be dishonest as he made an incorrect entry in Patient M's Intake/Output Flowsheet with intention of leading his clinical colleagues to believe he had sought the appropriate second checks.

The panel therefore finds 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 a lack of competence in respect of charges 1 to 16, and to misconduct in respect of charges 17 to 22, and, if so, whether Mr Woodward's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to a lack of competence in in respect of charges 1 to 16, and misconduct in respect of charges 17 to 22. Secondly, only if the facts found proved amount to a lack of competence and/or misconduct, the panel must decide whether, in all the circumstances, Mr Woodward's fitness to practise is currently impaired as a result of that lack of competence and/or misconduct.

Representations on lack of competence

The NMC has defined a lack of competence as:

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

The NMC invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Mr Woodward's actions amounted to a lack of competence. A lack of competency needs to be assessed using a three-stage process:

- Is there evidence that Mr Woodward was made aware of the issues around their competence?
- Is there evidence that they were given the opportunity to improve?
- Is there evidence of further assessment?

The NMC invited the panel to find that the facts found proved show that Mr Woodward's competence at the time was below the standard expected of a band 5 registered nurse.

Representations on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of the Code.

The NMC identified the specific, relevant standards where Mr Woodward's actions amounted to misconduct and outlined that the misconduct in this case relates to repeated dishonesty, which falls short of what would be expected of a registered professional and would be considered as deplorable by nursing practitioners.

Representations on Impairment

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Mr Woodward's fitness to practise impaired. The NMC, in written submissions, set out:

> *"The NMC consider the following questions from the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) can be answered in the affirmative both in respect of past conduct and future risk:*
>
> > *i) has [Mr Woodward] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
> > *ii) has [Mr Woodward] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*
> > *iii) has [Mr Woodward] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future; and/or*
> > *iv) has [Mr Woodward] in the past acted dishonestly and/or is liable to act dishonestly in the future.*
>
> *It is the submission of the NMC that all four limbs can be answered in the affirmative in this case.*
>
> *Mr Woodward placed patients at risk of serious harm as the alleged conduct related to medication management, communication, escalation of concerns,*

patient care and record-keeping. The instances of medication errors were repeated, and Mr Woodward could have risked patient safety if he had committed errors in the medication administration without having this double checked.

Mr Woodward failed to adhere to patients' care plans in a timely manner by feeding patients too late or too early, failing to remove cream after 20 minutes, failing to get clean sheets and failing to check for allergies. Furthermore, Mr Woodward failed to accurately record patients' assessments and follow correct procedures such as placing ECG sticks in the correct place, escalating concerns to senior staff, taking observations, and calculating the correct dosage of medication to administer. Failure in adhering to the responsibilities associated with the safe administration of medication could potentially put patients' health at risk if not addressed in the future.

In addition to above, Mr Woodward gave incorrect information to patients' family members and colleagues placing patients at risk of receiving inappropriate care.

Registered professionals occupy a position of trust in society. Mr Woodward's actions have undermined patient confidence in the nursing profession. The public expect nurses to provide safe and effective care and conduct in ways that promote trust. Mr Woodward's actions/inactions could cause patients and members of the public to be concerned about their safety and feel unnecessarily anxious about treatment. This could result in patients and members of the public feeling deterred from seeking medical assistance when they should. Therefore, it is submitted that Mr Woodward's conduct has brought the profession into disrepute and that he has breached the trust placed in him.

The Code divides its guidance for nurses into four categories which it can be considered are representative of the fundamental principles of nursing care. These are:

- *Prioritise people;*
- *Practise effectively;*
- *Preserve safety and*
- *Promote professionalism and trust.*

In light of the breaches of the code detailed above it can be safely concluded that Mr Woodward's has breached fundamental tenets of practice.

Mr Woodward actions were dishonest in that he copied and pasted another healthcare professional's record as well as dishonestly recording that he had a patient's medication and expressed breast milk double checked by a colleague when he did not. Mr Woodward intended to create a false impression that the entries he made were accurate. Such conduct was a breach of the fundamental expectation that all registrants will act with honesty and integrity.

With regard to future risk it may assist to consider the comments of Silber J in Cohen v General Medical Council [2008] EWHC 581 (Admin) namely

(i) whether the concerns are easily remediable;
(ii) whether they have in fact been remedied; and
(iii) whether they are highly unlikely to be repeated.

The NMC have considered their guidance entitled 'Insight and strengthened practice' (Reference: FTP-13) in regards to whether Mr Woodward's conduct is easily remediable. It states that generally, issues that relate to clinical practice are easier to address. Examples of such concerns include medication administration errors and failings in a discrete and easily identifiable area of clinical practice. The guidance also provides examples of conduct which may not be possible to remedy, and where steps such as training courses or supervision at work are unlikely to address the concerns, including dishonesty directly linked to the registered professional's practice.

Some of the concerns raised about Mr Woodward in this case relate to his clinical practice. It is therefore the NMC's view that these particular concerns

satisfy the requirement of the guidance and are capable of being remediated. However, Mr Woodward's dishonesty is directly linked to his clinical practice, and presented risks to patients. This type of conduct therefore falls into the category of being a type of concern which is more difficult to remedy.

The NMC then considered whether Mr Woodward has demonstrated sufficient insight into the concerns. Whilst Mr Woodward participated in meetings at a local level, he has not engaged with the NMC's fitness to practise proceedings. Furthermore, the NMC has not received any evidence of further training or learning in relation to the concerns raised. Therefore, the NMC consider that Mr Woodward has not demonstrated any insight or remediation.

The concerns in this case relate to fundamental aspects of nursing practice. Nurses occupy a position of privilege and trust, and are expected to maintain the health and safety of patients at all times. The evidence in this case suggests that Mr Woodward's clinical performance and associated dishonesty placed patients at risk of harm. Furthermore, acting with honesty and integrity at all times is a fundamental principle of the nursing profession. As the risks posed by Mr Woodward's acts and omissions have not been remediated a serious risk of repetition remains.

A finding of impairment is therefore necessary on public protection grounds.

The panel should also consider the comments of Cox J in Grant at paragraph 101:

> *"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case".*

In accordance with Justice Cox's comment, a finding of impairment is required to uphold proper professional standards and public confidence in the nursing profession. The NMC also considers that a finding of impairment on public interest grounds is required to declare and uphold proper standards of conduct and behaviour.

For the reasons above, it is submitted that Mr Woodward's fitness to practise is currently impaired on public protection grounds and in the wider public interest."

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Breaches of the Code

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

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

1 - Treat people as individuals and uphold their dignity
To achieve this, you must:
1.1 - treat people with kindness, respect and compassion
1.2 - make sure you deliver the fundamentals of care effectively
1.4- make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

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

8 Work co-operatively

To achieve this, you must:

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

8.6 - share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

To achieve this, you must, as appropriate:

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

13.2 - make a timely referral to another practitioner when any action, care or treatment is required.

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 - raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices.

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 - take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse.

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

To achieve this, you must:

18.3 - make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines.

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

To achieve this, you must:

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

20 - Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 - act with honesty and integrity at all times …

20.3 - be aware at all times of how your behaviour can affect and influence the behaviour of other people

Decision and reasons on lack of competence

The panel bore in mind, when reaching its decision, that Mr Woodward should be judged by the standards of the reasonable average band 5 registered nurse and not by any higher or more demanding standard.

The panel considered whether each proven charge amounted to a lack of competence individually and collectively. In respect of charge 1a, the panel bore in mind the evidence before it about the importance of adhering to a feeding timetable for children on a cardiac ward. The panel concluded that Mr Woodward's failure to do so, where he was made

aware of this issue and given the opportunity to improve his practise, amounted to a lack of competence.

In respect of charge 2, the panel accepted the evidence before it, that a correct ECG reading is important to accurately measure a cardiac patient's heart, and there is a serious risk of harm to these patients if this reading isn't taken correctly. The panel considered that a nurse working within the context of a cardiac ward, especially given the high level of support that Mr Woodward received, would be expected to carry out such tasks correctly, and Mr Woodward's failure to do so amounts to a lack of competence.

The panel bore in mind the context of the circumstances which led to charge 4. It considered that, although a simple lapse of memory in providing clean bedsheets to a patient for a short period may not amount to a lack of competence. However, the panel concluded that the given situation where Mr Woodward failed to provide clean bedsheets to a patient after being asked by their family members twice, which led to a verbal complaint would amount to a lack of competence.

In respect of charge 5, the panel concluded that not knowing an answer to a question about patient care would not amount to a lack of competence. However, it bore in mind that Mr Woodward fabricated an incorrect answer, having had prior discussions with Witness 6 and his other clinical colleagues about the importance of being open and honest with patients and their family members. Accordingly, the panel found that Mr Woodward's actions at charge 5 amounted to a lack of competence.

In respect of charge 6, the panel had regard to Mr Woodward's training and the policies in place at the Hospital, including the standard training on the requirement for second checks of certain medications. The panel found that it could therefore be inferred that Mr Woodward had received correct and appropriate training, yet still went on to act in a way which put a patient at a significant risk of serious harm. Accordingly, the panel found a lack of competence.

The panel concluded that Mr Woodward's failures in respect of charge 7 amounted to a lack of competence in that he failed to demonstrate the fundamental knowledge and skills of a band 5 nurse on a paediatric cardiac ward. The panel noted that such training

sessions were held on a weekly basis within the ward, and therefore would have expected Mr Woodward to be able to act appropriately and professionally in such simulation. The panel concluded that Mr Woodward's failure to do so amounted to a lack of competence.

The panel concluded that the skills outlined at charges 8 and 9 related to fundamental nursing competencies and rudimentary tasks which any band 5 nurse would be expected to carry out independently. The panel concluded that Mr Woodward's failure to do so amounted to a lack of competence.

In respect of charge 10, the panel concluded that the evidence before it demonstrates that Mr Woodward failed to follow the Hospital's medication policy on repeated occasions, despite support being provided. Accordingly, the panel concluded that this amounted to a lack of competence.

The panel concluded that the skills outlined at charges 11 and 12 related to fundamental nursing skills, competencies and rudimentary tasks which any band 5 nurse would be expected to carry out independently, including verifying a patient's identity, checking for allergies and checking that equipment is correct before carrying out tasks. The panel concluded that Mr Woodward's failure to do so amounted to a lack of competence.

In respect of charge 13, the panel found that Mr Woodward's failures related to his inability to carry out fundamental nursing duties, including identification of patients and administering medications in the correct form and dose. The panel bore in mind that there was evidence before it that Mr Woodward had been supported in respect of these issues on previous occasions. Accordingly, the panel found a lack of competence.

The panel found that charge 14 amounted to a failure by Mr Woodward to communicate with his patients and treat them with consideration and respect when reporting concerns about their own care. The panel concluded that it would have expected Mr Woodward to check that no error had been made, discuss again with the patient and escalate their concerns. The panel concluded that his failure to do so amounted to a lack of competence.

In respect of charge 15, the panel concluded that it is of the upmost importance that bedside safety checks are carried out correctly, as there is a significant risk of harm to

patients if emergency equipment is needed and it is not there. The panel was concerned that Mr Woodward was unable to identify that the ambu bag and non rebreathe face mask were absent and a low flow suction port was connected, and this therefore amounted to a lack of competence.

The panel found that Mr Woodward's failure in respect of charge 16 related to basic communication and escalation skills which were relevant to the handover of care, which poses a significant risk of harm to patients. The panel would have expected that if Mr Woodward did not understand an instruction he would ask for help, and that he failed to do this. Accordingly, the panel found that his failings in respect of this charge amounted to a lack of competence and his failure to escalate an instruction from a doctor to the relevant nurse responsible for that patient's care.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mr Woodward's practice was below the standard that one would expect of the average registered nurse acting in Mr Woodward's role.

The panel was satisfied that, in respect of all the charges found proved in relation to lack of competence:

- Mr Woodward had been made aware of all the issues around his lack of competence;
- A comprehensive action plan was devised and implemented to support Mr Woodward; and
- Mr Woodward's progress was regularly reviewed and assessed during the period of the action plan.

In all the circumstances, the panel determined that Mr Woodward's performance demonstrated a lack of competence.

Decision and reasons on misconduct

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered whether each charge individually amounted to misconduct.

The panel concluded that Mr Woodward's actions at charge 17 amounted to misconduct. It found that Mr Woodward acted dishonestly in the knowledge that using another colleague's care plan for a different day would result in him failing to assess the needs of that patient at that time, which gives rise to a risk of serious patient harm. The panel found that this is a serious departure from the behaviour expected of a registered nurse and would be regarded as deplorable by Mr Woodward's nursing colleagues. It therefore found that this amounted to misconduct.

In respect of charge 19, the panel had regard to the evidence before it. It bore in mind that that there is evidence that Mr Woodward was provided written instructions about the importance of seeking a second checker, yet recorded that Patient K's medication had been second checked knowing that he had not. The panel also considered that Mr Woodward sought to blame others for his failings. The panel found that this is a serious departure from the behaviour expected of a registered nurse and would be regarded as deplorable by Mr Woodward's nursing colleagues. It therefore found that this amounted to misconduct.

In respect of charge 21, the panel had regard to the evidence before it. It bore in mind that that there is evidence that Mr Woodward was provided written instructions about the importance of seeking a second checker, yet recorded that Patient M's expressed breast milk had been second checked knowing that he had not. The panel also considered that Mr Woodward sought to blame others for his failings. The panel found that this is a serious departure from the behaviour expected of a registered nurse and would be regarded as deplorable by Mr Woodward's nursing colleagues. It therefore found that this amounted to misconduct.

The panel concluded that charges 18, 20 and 22 which relate to dishonesty are serious departures from the behaviour expected of a registered nurse and would be regarded as deplorable by Mr Woodward's nursing colleagues. It therefore found that Mr Woodward's failures in these respects amounted to misconduct.

Accordingly, the panel found that Mr Woodward's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:*

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

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

[PRIVATE]. However, the panel took account of the fact that Mr Woodward was offered a significant amount of support in the workplace. [PRIVATE], including, but not limited to: additional time with the graduate teaching team, IT support, a reduced workload, supervision whilst working, working in a supernumerary capacity, an extended probationary period, and regular reviews with the charge nurse and other senior practitioners at the Trust. Mr Woodward has not engaged with the NMC and has not sought to contradict this evidence.

Despite this support, the panel found that Mr Woodward consistently demonstrated poor practice and acted in a way which resulted in a significant risk to patients in his care. Where improvements were made, the panel found that these were not sustained. Therefore the panel found that there is a serious risk of repetition and potential for patient harm in this matter.

The panel recognised that the lack of competence in this case is ordinarily capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Woodward has taken steps to strengthen his practice. The panel took into account that Mr Woodward has not engaged with the NMC and that there is no evidence before it of any training, or any positive testimonials before the panel which would satisfy it that he has taken any steps to remedy the concerns raised in the referral. Accordingly, the panel found that a finding of impairment is required on the ground of public protection, in relation to Mr Woodward's lack of competence.

In respect of misconduct, the panel concluded that patients were put at a significant risk of harm as a result of Mr Woodward's dishonest conduct in falsifying patient records. It found that Mr Woodward's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty to be extremely serious, and therefore a finding of impairment is required on the ground of public protection, in relation to Mr Woodward's misconduct.

The panel considered that there is no evidence before it of insight or remediation demonstrated by Mr Woodward to satisfy it that he is no longer impaired in relation to his lack of competence and/or misconduct.

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.

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

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

Sanction

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

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

Representations on sanction

The panel had regard to the NMC's written representations on sanction, which set out:

> *"In accordance with Article 3(4) of the Nursing and Midwifery Order ("the Order") the overarching objective of the NMC is the protection of the public. The Order states:-*
>
> > *"The pursuit by the Council of its over-arching objective involves the pursuit of the following objectives-*
> >
> > *(a) to protect, promote and maintain the health, safety and well-being of the public;*
> >
> > *(b) to promote and maintain public confidence in the professions regulated under this Order; and*
> >
> > *(c) to promote and maintain proper professional standards and conduct for members of those professions."*
>
> *Whilst sanction is a matter for the panel's independent professional judgement, the NMC propose that a striking-off order is the most appropriate sanction in this case.*
>
> *The aggravating factors in this case include:*
>
> - *Conduct which placed patients at risk of harm*
> - *Pattern of behaviour over a prolonged period of time*
> - *Repeated dishonesty in relation to record keeping*
> - *Lack of insight*
>
> *The mitigating factors in this case include:*
>
> - *[PRIVATE].*

With regard to the NMC's Sanctions Guidance ("the Guidance") the following aspects have led the NMC to this conclusion. The panel is invited to consider each sanction in ascending order.

No further action - It is submitted that taking no action would not be appropriate in this case. The NMC's guidance states that taking no action will be rare at the sanction stage and this would not be suitable where the nurse presents a continuing risk to patients. In this case, taking no action would not be appropriate.

Caution order - A caution order is the least restrictive sanction which will only be suitable where the nurse presents no risk to the public. Again, given the previously identified public protection concerns a caution order would not be an appropriate outcome.

Conditions of practice order – The NMC's guidance (Reference: SAN-3c) states that a conditions of practice order may be appropriate when there is no evidence of harmful deep-seated personality or attitudinal problems, and where there are identifiable areas of the registered professional's practice in need of assessment and/or retraining. Mr Woodward was previously provided with extensive support and there was no evidence of performance improvement. Therefore, there is no evidence that conditions could be put in place that would protect the public and address the areas of concern. Mr Woodward has not provided any evidence of further training or insight into the concerns raised. Additionally, Mr Woodward appears to have repeated his dishonest conduct and sought to initially conceal his actions. This is demonstrative of an attitudinal concern. There are no conditions that could be put in place that could address the dishonesty concerns. Moreover, a conditions of practice order would not be sufficient to mark the seriousness of the concerns. Even if workable conditions could be devised to address the concerns, as Mr Woodward has failed to engage with the regulatory process, there is no evidence to suggest that he would be willing or able to comply with such conditions.

Suspension order – The checklist in the guidance on Suspension Orders at SAN-3d includes the following factors which do not apply in the present case:-

- *A single instance of misconduct;*
- *No evidence of harmful deep-seated or personality issues;*
- *The Committee is satisfied that the nurse…has insight and does not pose a significant risk of repeating behaviour.*

Charges involving dishonesty are always regarded as serious (SAN-2). Mr Woodward appears to have repeated his dishonest conduct after the Trust had raised this as a concern with him. This is demonstrative of an attitudinal concern. In addition, when confronted, Mr Woodward initially sought to conceal his dishonesty which amounts to a lack of candour.

Striking-off order - The NMC's guidance (Reference: SAN-3e) states that a striking off order is likely to be appropriate when what the nurse has done is fundamentally incompatible with being a registered professional. A striking-off order would not be available to this panel were Mr Woodward's fitness to practise impaired only in relation to lack of competence in accordance with Article 29(6) of the NMC Order 2001. However, in this case the misconduct allegations mean this sanction is available. The NMC's view is that the dishonesty is very serious and raises fundamental questions about Mr Woodward's professionalism. The NMC considers that, in accordance with the guidance on Striking-off orders, public confidence in the profession cannot be maintained unless Mr Woodward is removed from the register. In addition the NMC considers that this is the only sanction which will be sufficient to protect patients, members of the public and maintain professional standards."

Decision and reasons on sanction

Having found Mr Woodward'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:

- Conduct which put patients at risk of harm;
- Pattern of behaviour over a prolonged period of time;
- Repeated dishonesty in relation to record keeping;
- Lack of insight;
- Conduct which potentially compromised colleagues by wrongly signing them as second checkers.

The panel also took into account the following mitigating features:

- [PRIVATE].

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

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

The panel next considered whether placing conditions of practice on Mr Woodward's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the significant period of support across a range of methodology, including 27 weeks of practising in a supernumerary capacity and the provision of 45 hours of study time, which was supported by the Trust. Despite this, the Trust did not find that such support assisted Mr Woodward in improving his practice to a safe level. The panel therefore concluded that it could not be confident that any conditions of practice which it may impose would effectively assist Mr Woodward beyond the support which he has already received. Further, it bore in mind that Mr Woodward has not engaged with the NMC, therefore the panel could not be satisfied that he would effectively comply with any conditions of practice.

Further, the panel concluded that the misconduct identified in this case included serious attitudinal concerns which related to dishonesty, which is not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Woodward's registration would not adequately address the seriousness of this case and would not protect the public.

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:

- *No evidence of repetition of behaviour since the incident*

The panel considered that Mr Woodward's temporary removal from the NMC register may address the concerns raised by Mr Woodward's lack of competence, it did not consider that it would sufficiently address its findings in respect of misconduct. The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Woodward's misconduct, which included dishonesty, is fundamentally incompatible with Mr Woodward remaining on the register.

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

Finally, in looking at a striking-off order in relation to Mr Woodward's misconduct, the panel took note of the following paragraphs of the SG:

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

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

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

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

This will be confirmed to Mr Woodward in writing.

Interim order

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

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

Representations on interim order

The panel took account of the representations made by the NMC:

> *"The NMC seeks an interim suspension order for 18 months to cover the 28 day appeal period and the time it would take for an appeal to be heard should Mr Woodward lodge an appeal against the substantive decision. The grounds for the application are the same as those relied upon above. Such an order is sought on the basis that it is necessary for the protection of the public and is otherwise in the public interest and is proportionate in view of the overarching objective."*

Decision and reasons on interim order

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

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

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

That concludes this determination.