Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 27 November 2023 – Friday 1 December 2023

Virtual Hearing

Name of Registrant:	Fredy Amador Rios Vigil
NMC PIN	96Y0301E
Part(s) of the register:	RNLD, Registered Nurse – Learning Disabilities (2 October 1999)
Relevant Location:	Hertfordshire
Type of case:	Misconduct
Panel members:	Dale Simon Chair, lay member) Lisa Punter (Registrant member) Catherine Cooper (Registrant member)
Legal Assessor:	Caroline Hartley
Hearings Coordinator:	Yewande Oluwalana
Nursing and Midwifery Council:	Represented by Rowena Wisniewska, Case Presenter
Mr Rios Vigil:	Present and unrepresented
Facts proved by admission:	Charges 1a, 1b, 2a, 2b, 2c, 3, 4, 5b, 5c, 6, 7
Facts not proved	Charges 5a, 5d
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

1) On 04 January 2020: **[PROVED BY ADMISSION]**

    a) prepared medication for administration to Patient A:

        i) without having checked his prescription chart to ascertain what medication he was prescribed.

        ii) in the absence of a second checker.

    b) allowed Zuclopenthixol Decaonate 400mgs to be administered to Patient A instead of Aripiprazole Maintena 400mgs.

2) On 19 May 2020: **[PROVED BY ADMISSION]**

    a) did not conduct a seclusion review of Patient B at 19.20.

    b) inaccurately completed Patient B's seclusion form to indicate that you had conducted a seclusion review at 19.20.

    c) inaccurately completed Patient B's seclusion form to indicated that Colleague A had conducted a seclusion review with you at 19.20.

3) Your conduct at charge 2b and/or 2c was dishonest in that you knew you had not completed a seclusion review of Patient B at 19.20 or, in the alternative, you knew that Colleague A had not conducted a seclusion review with you at 19.20. **[PROVED BY ADMISSION]**

4) On 02 November 2021, did not safely dispose of spoiled medication. **[PROVED BY ADMISSION]**

5) On 18 December 2021:

   a) administered an overdose of Haloperidol to Patient D. **[FACTS NOT PROVED]**

   b) amended or caused to be amended Patient D's medication chart such that it appeared you had not administered Haloperidol. **[PROVED BY ADMISSION]**

   c) denied having administered Haloperidol to Patient D when questioned by Colleague B and/or C. **[PROVED BY ADMISSION]**

   d) attempted to persuade Patient D to deny you had administered Haloperidol to him. **[FACTS NOT PROVED]**

6) Your conduct at charges 5b and/or 5c and/or 5d was dishonest in that you knew you had administered Haloperidol to Patient D. **[PROVED BY ADMISSION]**

7) Between 01 December 2021 and 06 January 2022 worked as a nurse when you were not registered with the NMC. **[PROVED BY ADMISSION]**

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Wisniewska on behalf of the Nursing and Midwifery Council (NMC) under Rule 31 to allow the hearsay evidence contained within Witness 2's written statement into evidence. Ms Wisniewska informed the panel that the

hearsay application was in relation to the following paragraphs: 7, 8, the first half of 9, the second half of 10, 12, 13, 21, 22, 23, 24, 25 and 29. Ms Wisniewska said that the evidence relates to evidence collated at the time by Witness 2 during the local investigation. She submitted that this evidence is relevant but not the sole evidence that goes directly to the charges.

Ms Wisniewska invited the panel to accept the hearsay application.

You did not oppose the application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to the relevant paragraphs contained in Witness 2's written statement that contained hearsay serious consideration. The panel noted that Witness 2's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my knowledge and belief' and signed by her.

The panel considered whether you would be disadvantaged by allowing the hearsay evidence contained in Witness 2's statement to be admitted. However, it noted that the majority of the hearsay evidence related to issues which were not in dispute and had regard to the fact that you did not object to the application.

In these circumstances, the panel concluded that the evidence was relevant and that it would be fair to accept into evidence the hearsay evidence contained within Witness 2's written statement but that it would give what it deemed to be appropriate weight to the hearsay evidence once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit written statements into evidence

Ms Wisniewska made a further application under Rule 31 to allow the written statements of Colleague A, Colleague C, Colleague D and Ms 1 into evidence. The following witnesses were not present at this hearing as their evidence was predominantly in relation to charges that you have admitted and neither the NMC nor you required them to give live evidence.

You did not object to the application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application.

The panel gave the application in regard to Colleague A, Colleague C, Colleague D and Ms 1 written statements serious consideration. The panel noted that Colleague A, Colleague C, Colleague D and Ms 1's statements had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my knowledge and belief' and signed by each individual.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimonies of Colleague A, Colleague C, Colleague D and Ms 1 to that of their written statements.

In these circumstances, the panel came to the view that as the evidence provided by these witnesses related predominantly to charges that you had admitted, the evidence was relevant and it would be fair to accept into evidence the written statements of Colleague A, Colleague C, Colleague D and Ms 1. The panel would give what it deemed to be appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The NMC received a referral on 27 January 2022 from Hertfordshire Partnership University NHS Foundation Trust ('the Trust'). You have been employed by the Trust since 2005, initially as a Staff Nurse and subsequently, following the alleged incident on 18 December 2021, as a clerical member of staff.

The Trust have reported a number of incidents involving you where it is alleged your actions amount to misconduct and some also include allegations of dishonesty:

1. On 4 January 2020, it is alleged that you prepared and allowed an incorrect medication to be administered to Patient A without checking their prescription chart and without a second checker present.

2. On 19 May 2020 you were working as the nurse in charge. It is alleged that you failed to complete a two hourly nursing review of a patient in seclusion, however you documented on the patient record that this had been completed. It is also alleged you documented that a second registered nurse had been present for the review when this was not the case.

3. On 2 November 2021 it is alleged you completed the medication round and signed a patient's medication chart to show the medication had been given. However, the Trust state the patient's medication was found in the medicine cupboard by another registered nurse.

You were given a letter of concern regarding your alleged failure to adhere to policy in relation to medication storage and disposal following this incident.

4. On 18 December 2021 it is alleged you administered double the prescribed dose of Haloperidol to Patient D and it is further alleged that this caused Patient D to become unwell.

The medication chart was reviewed, and it was noted that your initials indicating that the prescribed medication had been administered had been crossed out. The inference being that it was you who altered the chart in order to give the false impression that the

medication had not been given. It is also alleged you attempted to persuade Patient D to deny that you had administered Haloperidol to them.

A Charge Nurse spoke to you and explained Patient D was physically unwell. During this conversation it is alleged you admitted you had lied and amended the medication chart, and you are alleged to have confirmed that you had administered the medication. It is also alleged that you failed to escalate the error once you became aware of it and took steps to conceal it instead.

A Fact-Finding Investigation was completed by the Trust in relation to this incident. As a result of which you were suspended from clinical duties and placed in an office-based role.

5. It is also alleged that you failed to renew your NMC registration on 30 November 2021 but continued to work as a registered nurse until you were suspended from duty on 6 January 2022 following the incident on 18 December 2021.

You had also failed to renew your NMC registration in 2020. In this instance you did pay the fee, however failed to complete your revalidation.

Decision and reasons on facts

At the outset of the hearing, the panel heard you made full admissions to charges 1a, 1b, 2a, 2b, 2c, 3, 4, 5b, 5c, 6, 7.

The panel therefore finds charges 1a, 1b, 2a, 2b, 2c, 3, 4, 5b, 5c, 6, 7 proved in their entirety, by way of your admissions.

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will

be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1 (Colleague B): Nursing Associate at Warren Court at the time of Charge 1, Charge Nurse at Warren Court at the Trust at the time of the incident at Charge 5.

- Witness 2: Team leader at Warren Court at the Trust at the time of the incidents.

The panel also heard live evidence from you under affirmation.

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

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

Charge 5a)

5) On 18 December 2021:

a) administered an overdose of Haloperidol to Patient D.

This charge is found NOT proved.

In reaching this decision, the panel took into account the following:

- The oral and documentary evidence of Witness 1
- The oral and documentary evidence of Witness 2
- Your oral evidence
- Datix Forms
- Local investigation report (including contemporaneous statements from you, Witness 1 and Colleague C).

The panel noted that you said that you gave the correct dosage of medication to Patient D but you later feared that the T2 authorisation was not in place and you then panicked because of [PRIVATE] and fear that Colleague B "would try to bury" you. The panel also noted that you had stated in the local investigation that you gave the correct dosage of 3.5ml to Patient D on the 18 December 2021.

The panel had sight of Patient D's MAR chart and noted that the Haloperidol prescription appeared to have been amended from 7mls to 7mg or vice versa but had no information as to when this had been amended or by whom.

The panel also considered the oral evidence of Witness 1 who said that he witnessed you with a 5ml syringe in the clinic room drawing up the medication of Haloperidol. Although Witness 1 told the internal investigation that he had seen you draw up 7mls of Haloperidol, he could not confirm this during his oral evidence. During panel questions Witness 1 confirmed that he did not see you administer the Haloperidol to Patient D.

No expert evidence was provided to the panel in respect of the side effects that would be caused if an overdose of Haloperidol had been administered. However, Witness 1 and Witness 2 both confirmed that the side effects suffered by Patient D could have been either as a result of an overdose or the patient's reaction to receiving their first dose of the prescribed 3.5mls of Haloperidol. The panel noted within the internal investigation regarding the dosage given was inconsistent and unclear.

The panel also noted that Witness 1 stated that you were seen with a 5ml syringe and as such, on the evidence presented, it would not have been possible for you to administer 7ml of Haloperidol with a 5ml syringe.

The panel is not satisfied that the NMC has discharged its burden of proof and it therefore finds this charge not proved.

Charge 5d)

5) On 18 December 2021:

    d) attempted to persuade Patient D to deny you had administered Haloperidol to him.

This charge is found NOT proved.

In reaching this decision, the panel noted that you denied trying to persuade Patient D to deny you had administered Haloperidol to them. You told the panel you had been checking on Patient D. The panel also had regard to Witness 1's oral and documentary evidence. In his written statement he said '…*The bedroom door was open and I heard the Nurse say "say no". I knew it was the Nurse who said this because they have a distinct accent.'* During oral evidence when you asked why he had alleged that you tried to persuade Patient D to deny that you had administered Haloperidol to them, Witness 1 stated *"I didn't say that you are putting words into my mouth".* The panel was of the view that there was no evidence before it that supported the charge and therefore determined that the NMC had not discharged its duty and this charge could not be found proved on the balance of probabilities.

Fitness to practise

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

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

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

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

Submissions on misconduct

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

Ms Wisniewska identified the specific, relevant standards of the Code 1, 1.2, 4.1, 4.2, 4.3, 8, 8.2, 8.5, 10, 10.3, 14, 16, 19, 19.1, 20, 20.2, and 22 that the NMC submit applied to the charges found proved by your admission. She submitted that your actions amounted to misconduct. Ms Wisniewska referred the panel to the case of *Nandi v General Medical*

Council [2004] EWHC 2317 (Admin) in which Justice Collins set out that the word serious must be given its proper weight. In another context, there's been reference to conduct which would be regarded as deplorable by fellow practitioners. Ms Wisniewska submitted that there are a number of concerns that are deemed to be serious, and that dishonesty is conduct that is serious.

Ms Wisniewska submitted that you have admitted to the dishonesty charges which are serious because they involved the falsifying of medical records and then initially denying and hiding the administration of Haloperidol to Patient D, which delayed Patient D getting medical attention.

Ms Wisniewska further submitted that you failed to deliver the fundamentals of care effectively to patients in your care and did not communicate effectively with colleagues when discussing the care of patients and did not escalate concerns once drugs were administered.

Ms Wisniewska submitted that taking into account the standards and requirements imposed by the NMC code, your actions amount to serious professional conduct.

You invited the panel to consider your written reflections and oral evidence when considering misconduct.

Submissions on impairment

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

Ms Wisniewska referred the panel to paragraph 76 of Mrs Justice Cox in the case of CHRE v NMC and Grant, where she referred to Dame Janet Smith's “test”. She submitted that limbs a) b) c) and d) are engaged in your case when looking at your past conduct and what you may do in the future.

Ms Wisniewska submitted that you placed patients at risk of harm, and you are therefore liable to act in such a way in the future. She said that you have made a considerable number of admissions including the dishonesty charges in your case. Ms Wisniewska further submitted that your past misconduct is an indication of unwarranted risk of harm to patients going forward.

Ms Wisniewska submitted that you have in the past brought and/or are liable in the future to bring the nursing profession into disrepute. She submitted that that such a finding is inescapable when taking all the relevant circumstances of the case and evidence into account.

Ms Wisniewska submitted that you have breached the fundamental tenets of the profession in the following ways: in that you have failed to be honest; failed to practise effectively and take measures to ensure patients involved were safe; and then you failed to communicate with your colleagues.

Ms Wisniewska submitted that you have admitted to the charges of dishonesty and there is a risk that you are liable to act dishonestly in the future. Given that dishonesty is not easily remediable, Ms Wisniewska submitted this showed a serious attitudinal failing which conflicts with the standards expected of a registered nurse.

Ms Wisniewska submitted that you have shown some insight and reflection in your written reflection and oral evidence. But she stated that these are serious failings, and the dishonesty aspect is particularly serious.

Ms Wisniewska invited the panel to find you impaired by virtue of your past misconduct being an indicator for the risk that you present to patients both at the present time and in the future.

You invited the panel to consider your written reflection and oral evidence when considering impairment.

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

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the submissions made by Ms Wisniewska, you, the advice of the legal assessor and the Code.

The panel was of the view that the following paragraphs of the Code had been breached in this case:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***8.6** share information to identify and reduce risk*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *To achieve this, you must:*
>
> ***10.3** complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

18.4 *take all steps to keep medicines stored securely*

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:

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

22 Fulfil all registration requirements'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered the charges found proved individually and considered whether they amounted to misconduct.

In respect of Charge 1a) i) the panel determined that you put Patient A at risk of harm by disregarding the procedure for checking the medication chart to see what was prescribed. This was a clear and serious departure from the standards expected of a registered nurse. The panel therefore concluded that your actions amounted to misconduct.

In respect of Charge 1a) ii) the panel determined that your actions did not amount to misconduct. The Trust's Medicines Policy did not appear to require a second checker to be present when preparing the medication. Therefore, the panel were unable to conclude that your failure to have a second checker present had breached policy.

In respect of Charge 1b) the panel determined that your actions by allowing the wrong medication to be administered to Patient A put them at risk of harm and was a serious departure from the standards expected of a registered nurse. The panel therefore determined that your actions amounted to misconduct.

In respect of Charges 2a and 2b the panel had regard to your unchallenged evidence about the circumstances in which you decided to conduct the seclusion review on your own. You made strenuous efforts to get two colleagues to assist you with the review and the panel had regard in particular to the witness statement of Colleague A who stated,

> *'Reflecting on this incident, I feel that the Nurse had no choice, as I had told them I was not available to assist as I understood* [Colleague E] *could assist, but according to the Nurse they refused to help…. I feel quite guilty that I was not there to assist the Nurse.'*

The panel therefore concluded that your actions did not amount to misconduct.

In respect of Charge 2c, your decision to deliberately falsify the records by adding the name of a second colleague who was not present at the seclusion review was a serious departure from the standards expected of a registered nurse did amount to misconduct.

In respect of Charge 3 which related to dishonesty, the panel determined that dishonesty will almost always amount to misconduct. In this regard, the panel found that your actions were a serious departure from the standards expected of a registered nurse and did amount to misconduct.

In respect of Charge 4 the panel was of the view that you did not follow the correct procedure, however, given the circumstances at the time in that the medication was left in the locked medication cupboard whilst you were responding to an emergency, therefore the panel determined that this did not amount to misconduct.

In respect of Charges 5b and 5c, the panel determined that by your amending Patient D's medication chart to indicate that you had not administered the medication amounted to falsifying their records and you put them at potential risk of harm. You then denied that this occurred to your fellow colleagues. The panel was of the view that your actions singularly and cumulatively amounted to a serious departure from the standards expected of a registered nurse and therefore amounts to misconduct.

In respect of Charge 6 which related to dishonesty, the panel determined that dishonesty will almost always amount to misconduct. In this regard, the panel found that your actions were a serious departure from the standards expected of a registered nurse and did amount to misconduct.

In respect of Charge 7, whilst the panel recognises that it is essential that nurses keep their registration up to date. The panel had regard to the particular circumstances in your case and the documentation provided by your bank in respect of your direct debit being cancelled by them. In view of this explanation the panel determined that this failing did not amount to misconduct.

The panel found that your actions in respect of Charges 1a)i), 1b), 2c, 3, 5b, 5c, 6 did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

‘The question that will help decide whether a professional’s fitness to practise is impaired is:
“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”
If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not 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/ fitness to practise is impaired in the sense that S/He:

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

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

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

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

In light of the panel's findings in respect of misconduct the panel finds that all the limbs are engaged as set out in detail above.

The panel was of the view that you have not demonstrated sufficient insight into your past failings to satisfy the panel that you could currently practise safely, kindly and professionally without restrictions. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel is aware that this is a forward-looking exercise and accordingly, it went on to consider whether your misconduct was remediable and whether it had been remediated. The panel then considered the factors set out in the case of *Cohen v GMC* [2007] EWHC 581 (Admin).

The panel considered that acts of dishonesty are difficult to remediate. However, the panel is of the view that because of the contextual matters discussed above your dishonesty is remediable.

Regarding insight, the panel considered that you have developing insight into your actions. It noted that during the local investigation you admitted to some of the concerns and had also made early admissions on the case management form to the NMC. The panel noted that you were remorseful, open and honest and you understood that you put patients at risk of harm. However, the panel was of the view that your insight still needs to develop further, particularly in regard to the duty you owe to your colleagues in recognising that reporting poor practice is a positive and necessary requirement of safe practice. You only had limited insight into the impact your actions may have had on your colleagues. The panel also noted in your written statement that your reflections as to the impact of your actions upon patients and the potential consequences of your actions were limited.

The panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account that you have kept up to date with your mandatory training, and you provided some character references. The panel noted that some of these references were undated, and it was unclear whether the referees were fully aware of the nature of the regulatory proceedings and attached the appropriate weight to them. The panel took into account your written reflections.

The panel is of the view that there is a risk of repetition, based on the fact that following the January 2020 incident, you were subject to a detailed Action Plan with the Trust which included reflection, retraining and reassessment. The following year you demonstrated similar conduct in December 2021, again failing to comply with policies and procedures. This raises concerns for the panel about your ability to practise safely, kindly and professionally at the current time. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel also determined that as you have admitted to dishonesty in more than one charge public confidence in the profession would be undermined if a finding of impairment were not made in this case. It therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months with a review. The effect of this order is that the NMC register will show that your registration has been suspended.

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, submissions made by Ms Wisniewska and you.

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Wisniewska outlined that there is no rule or test for imposing a sanction and that the panel must exercise its professional judgement. The sanction must be proportionate and necessary, not punitive, and must be the least restrictive way of meeting the aim of protecting the public and maintaining public confidence in the profession.

Ms Wisniewska informed the panel that in the Notice of Hearing, dated 14 November 2023, the NMC had advised you that it would seek the imposition of a striking off order if the panel found your fitness to practise currently impaired. She submitted that this remained the most appropriate sanction in light of the panel's findings of you being impaired on public protection and public interest grounds.

Ms Wisniewska submitted that the following aggravating factors applied in your case:

- The charges were largely admitted by you
- Direct risk to patients
- Limited insight
- The implications of dishonesty are serious

Ms Wisniewska submitted that there were no mitigating factors that applied in your case.

Ms Wisniewska referred the panel to the SG. She submitted that no order or a caution order would not be appropriate in your case as your conduct was not at the lower end of the spectrum and your misconduct was serious. Given the findings of dishonesty, more must be done by way of sanction to protect the public from harm and to maintain public confidence in the profession.

Ms Wisniewska submitted that a conditions of practice order would not appropriately address the concerns about public protection and also the public interest, in particular maintaining public confidence in the profession and upholding the standards of conduct and behaviour. There are no workable or measurable conditions that could address the misconduct, given your failings amounted to dishonesty and the other findings of misconduct as well.

In respect of a suspension order, Ms Wisniewska submitted that this would not be the appropriate and proportionate sanction in this case. She submitted that the SG states this is not appropriate where there is evidence of a harmful deep-seated personality or attitudinal problem, and where there is significant risk of repetition. She submitted this was

not the case for you. Ms Wisniewska further submitted, that you had fallen short of the requirement to act with honesty and integrity at all times. She submitted that there is no evidence that you have remediated the dishonesty and therefore a risk of repetition remains.

Ms Wisniewska submitted that a striking off order would be the most appropriate and proportionate sanction in all the circumstances. She submitted that the SG states that there are key considerations that must be taken into account when deciding on whether to impose a striking-off order. Ms Wisniewska submitted that the regulatory concerns raise fundamental questions about your professionalism. Secondly, public confidence in nurses, midwives and nursing associates cannot be maintained if you are not removed from the register. Thirdly, a striking-off order is the only sanction which will be sufficient to protect patients, members of the public and maintain professional standards. She further submitted that the dishonesty committed by you was serious enough to justify removing you from the register.

You asked the panel to give you another chance to prove that you can practise safely and follow policies and procedures. You expressed genuine remorse and regret for your actions. You said *“I apologise deeply to all my colleagues, and it wasn’t my intention to put patients at risk. It was unjustifiable but I would like another opportunity*”.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Conduct which put patients at risk of suffering harm
- Repetition of similar behaviour in respect of failing to follow policies and procedures
- Dishonesty

The panel also took into account the following mitigating features:

- Genuine remorse
- Full admissions at the earliest opportunity at the local investigation stage and you never sought to deny your wrongdoing.
- Contextual evidence in respect of the working environment at the time of these incidents supported by the witness statements of Colleague A and Witness 1
- Positive testimonials
- You are still working with the same employer on the same team albeit in a non-clinical role.

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions.*

The panel is of the view that given the dishonesty charges in this case there are no practical or workable conditions that could be formulated at this stage. The panel referred to the NMC Guidance of '*Considering sanctions for serious cases (Reference: SAN-2)'* and under the sub-heading cases involving dishonesty. The panel considered the dishonest conduct in your case was less serious as it deemed it to have been spontaneous conduct in which you had no direct personal gain. The panel was of the view that the dishonesty in your case was not premeditated but was reactionary when considering the context of the situations at the time.

The panel concluded that the placing of conditions on your practice could have adequately addressed the clinical failings and would have protected the public. However, the panel considered that a conditions of practice order would not address the public interest concerns regarding the dishonesty and therefore it determined that it would not be the most appropriate or proportionate sanction in this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

The panel considered whether the seriousness of this case required temporary removal from the NMC register and whether a period of suspension would be sufficient to protect patients and satisfy the public interest. When considering seriousness, the panel had regard to the extent of the departure from the standards expected of a registered nurse and the damage done to the public interest caused by that departure.

The panel decided that although there had been a clear breach of fundamental tenets of the nursing profession and a significant departure from a number of the standards in the Code, your misconduct was capable of remediation. The panel could find no evidence of harmful deep-seated personality or attitudinal concerns or evidence of repetition of behaviour since the incident. However, the panel was of the view that you have not had the opportunity to remediate the dishonest conduct and that your insight into your actions is still developing.

The panel was of the view that your temporary removal from the Register would be sufficient to address the public interest concerns in this case.

The panel was of the view that you should be afforded the opportunity to demonstrate to a reviewing panel, that you have developed your insight fully and that you understand the impact your actions may have had on patients, your colleagues and the nursing profession. If you are able to demonstrate that your insight has developed and you have remediated to a future reviewing panel, it could be in the public interest to retain an experienced registered nurse who has had a lengthy career and is capable of delivering safe and effective nursing practice.

The panel was of the view that a suspension order would provide you with sufficient opportunity to reflect and develop your insight, explain to a future panel what you will do differently if a similar situation arises in future.

It did go on to consider whether a striking-off order would be appropriate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

In making this decision, the panel carefully considered the submissions of Ms Wisniewska in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a striking-off order was not the only order that can address the public interest concerns. The panel found that it would have been disproportionate to impose a striking-off order given the circumstances in which some of the misconduct and the dishonesty arose. It was of the view that the public interest concerns in your case can be addressed by a short suspension.

The panel determined that a suspension order for a period of six months with a review was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Your continued engagement with the NMC process
- Your attendance at any future review hearing
- A further reflective piece focusing first on the impact your actions had on patients, colleagues, the nursing profession and the wider public, and [PRIVATE]. As well as a detailed description of what steps you would take if a similar situation occurred in the future.
- Further references or testimonials having safely worked in a clinical environment, whether in paid or unpaid employment

This will be confirmed to you in writing.

Interim order

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

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

Submissions on interim order

The panel took account of the submissions made by Ms Wisniewska. She submitted that the NMC is seeking the imposition of an interim suspension order for a period of 18 months to cover any appeal period until the substantive suspension order takes effect.

Ms Wisniewska submitted that given the seriousness of the charges found proved, an interim suspension order is necessary on the grounds of public protection and is also otherwise in the wider public interest.

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 in order to protect the public and the wider public interest to cover the 28-day appeal period and the duration of any appeal should you decide to appeal against the panel's decision.

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

That concludes this determination.