Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 23 January 2023 – Monday 30 January 2023

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

Name of Registrant:	Gloria Germain Wight
NMC PIN	97D0083E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (April 2000) Registered Midwife Midwife – (October 2007)
Relevant Location:	Kent
Type of case:	Misconduct
Panel members:	Louise Guss (Chair, Lay member) Lorna Taylor (Registrant member) June Robertson (Lay member)
Legal Assessor:	Robin Hay
Hearings Coordinator:	Max Buadi
Nursing and Midwifery Council:	Represented by Leonard Wigg of counsel
Mrs Wight:	Present and represented by Mr Richard Mukurubira (both present via telephone from 24 January 2023)
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Impaired

Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

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

[PRIVATE]

Decision and reasons on application to admit video link evidence and for you to appear virtually

Mr Mukurubira submitted that there is no evidence that Ms 1 cannot attend in person. He stated that he wanted Ms 1 to attend the hearing in person. He said that he wanted her present at the hearing so that you and the panel can see her reactions, during cross examination, to the "lies she has been telling".

Mr Mukurubira further submitted that if Ms 1 is allowed to attend the hearing virtually, then you should be able to do the same. He said that he has seen no reason why Ms 1 cannot be present in person and that you will not attend the hearing in person if Ms 1 is allowed to give evidence virtually.

Mr Wigg said that Ms 1 has produced evidence to support this application while you have not. [PRIVATE]

[PRIVATE]

Mr Mukurubira reiterated that if Ms 1 is allowed to give evidence virtually, then you will not attend the hearing in person.

Mr Wigg said that there is no objection to you attending virtually.

In response to a question from the panel, Mr Mukurubira confirmed that he is making an application for you to attend the hearing virtually. He submitted if Ms 1 is allowed to attend virtually, then you will do the same for the entirety of the hearing. He submitted that his application was made on grounds of fairness.

Panel decision on Rule 31 applications

[PRIVATE]

Mr Mukurubira opposed the application on the basis that you want Ms 1 to be present in person to give evidence and to be cross examined. However, the panel also considered that if Ms 1 were to give evidence via video link you would not be deprived of the opportunity to cross examine.

In reaching its decisions the panel considered all the information before it together with the submissions made by Mr Wigg and you. It accepted the advice of the legal assessor.

The panel determined that it would be fair and relevant to allow Ms 1 to give evidence via video link. The panel also determined that it would be fair to allow you to attend the remainder of the hearing via video link.

In regard to your submissions, [PRIVATE], the panel has decided that it is important to allow you to participate fully in any way possible.

The panel bore in mind that the NMC has expressed no objection to your application.

Details of charge

That you, a Registered Nurse, whilst employed/seeking employment at the Withens Nursing Home;

1) On one or more occasion on 3 & 4 April 2019, failed to complete Patient MAR Charts to indicate that medication had been administered/refused at the prescribed time, as listed in schedule 1.

2) On 5 April 2019;

   a) On one or more occasion, retrospectively signed MAR Charts to indicate that medication had been administered/refused at the time of prescription, as listed in schedule 1.
   b) On one or more occasion, did not indicate that the MAR Chart entries for Patients were retrospective, as listed in schedule 1.

3) Did not comply with Paragraph 8 (a) of the Interim Conditions of Practice Order ("ICOPO") imposed on 24 October 2018 by an Investigating Committee of the NMC, in that you;

   a) Between 7 March 2019 and 5 April 2019 did not disclose to your employer that you were subject to an Interim Conditions of Practice Order.

4) On 8 April 2019 you inaccurately informed your employer that you unware of the ICOPO until 6 April 2019.

5) Your actions in charge 3 a) & 4) above were dishonest in that you attempted to conceal from your employer that regulatory restrictions had been placed upon your practice.

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

Schedule 1:

1) Co-codamol to Resident A at 09:00 on 4 April 2019

2) Amlodipine to Resident B at 09:00 on 4 April 2019

3) Citalopram to Resident C at 09:00 on 4 April 2019

4) Risperidone to Resident C at 09:00 on 4 April 2019

5) Sinemet Plus to Resident D at 09:00 on 4 April 2019

6) Sinemet Plus to Resident D at 17:00 on 4 April 2019

7) Rotigotine to Resident D at 17:00 on 4 April 2019

8) Sinemet Plus to Resident E at 17:00 on 3 April 2019

9) Mirabegron to Resident F at 09:00 on 4 April 2019

10) Madapor to Resident G at 09:00 on 3 April 2019

11) Madapor to Resident G at 13:00 on 3 April 2019

12) Olive oil ear drops to Resident H at 09:00 on 4 April 2019

13) Ferrous sulfate to Resident H at 13:00 on 4 April 2019

14) Paracetamol to Resident H at 13:00 on 4 April 2019

Background

On 24 October 2018 an interim conditions of practice order ('ICOPO') was imposed on your registration in relation to allegations that are not relevant to these proceedings. You were present and represented by counsel at that hearing. Condition 8 stated:

8) You must immediately tell the following parties that you are subject to a conditions of practice order under the NMC's fitness to practise procedures, and disclose the conditions listed at (1) to (7) above, to them:

   a) Any organisation or person employing, contracting with, or using you to undertake nursing or midwifery work;

On 7 March 2019, you applied for a nursing position at Withens Nursing Home ('the Home') and you were interviewed on the same day by NMC witness Ms 1, Home Manager who interviewed you at the relevant time.

It is alleged that neither in the application documentation nor at the interview nor at any time until 8 April 2019 did you disclose to the Home that your registration was restricted with an ICOPO.

Ms 1 alleged that when asked about the NMC in interview you stated that there was nothing to report. You say that you provided Ms 1 with a print-out from the NMC's website disclosing the fact that you were subject to an ICOPO.

You began your employment at the Home on 2 April 2019 when you commenced a medicines competency assessment which was overseen by Ms 2. You passed this assessment on 3 April 2019 and you were deemed competent in medicines administration in the Home.

On 5 April Ms 2 raised concerns with Ms 1 regarding the MAR charts not being filled correctly on 3 and 4 April 2019 by you.

It is alleged that Ms 1 telephoned you on Friday 5 April 2019 and informed you that a number of residents had not received their medication. Ms 1 asked you to attend a meeting on the Monday 8 April 2019 to discuss the matter.

Ms 1 alleged that on 5 April 2019, you attended the Home and asked to see the MAR charts. Further, while left alone with the MAR charts, that you completed some of these retrospectively and you did not document this to be the case.

Ms 1 also alleged that, during the meeting on 8 April 2019, you told her that you were unaware of the ICOPO until 6 April 2019.
You stated that Ms 1 did not telephone you but sent you a text to attend the Home on 8 April 2019. You denied that you attend the Home at all on 5 April 2019, and stated that you had properly completed the MAR charts on 3 and 4 April 2019.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence together with the submissions made by Mr Wigg and by Mr Mukurubira on your behalf.

It accepted the advice of the legal assessor.

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.

Ms 1, at the relevant time the Manager of the Home, was called as a witness on behalf of the NMC.

You also gave evidence.

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

Charge 1

1) On one or more occasion on 3 & 4 April 2019, failed to complete Patient MAR Charts to indicate that medication had been administered/refused at the prescribed time, as listed in schedule 1.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1, including the MAR charts of the residents and your evidence.

In her witness statement Ms 1 stated:

> *"…On 5 April 2019 [Ms 2] discovered that there were lots of gaps on MARs to indicate that medication had not been administered. This led her to conduct a full audit which identified that a number of residents had not received various medications on 3 and 4 April 2019. [Ms 2] presented to me a handwritten list which detailed the residents effected, the medications that were missed and the dates and times the medication should have been administered...It was identified that the registrant had made the errors as she had worked from 08:00 until 20:00 on both days. On these shifts she would have been responsible for administering medications to the effected [sic] residents. [Ms 2] also checked the medication blister packs…"*

Ms 1 reiterated this in her evidence and confirmed that on 3 and 4 April 2019, you worked from 08:00 to 20:00.

In your evidence you stated that you had completed all the medication rounds in question and "did not make a mistake".

The panel took account of the contemporaneous handwritten list of missed medications for residents on 3 to 4 April 2019. This list states for Resident D "ROTIGOTINE PATCH 4mg/24hrs 17:00" and for Resident H "EAR DROPS 9am" and FERROUS SULFATE

200mg 13:00". There appear to be two styles of handwriting on this list. Ms 1 confirmed that the first was that of Ms 2 and she did not recognise the second.

The panel is aware that this evidence is hearsay as neither Ms 2 nor the other author had attended to give evidence at this hearing or provided formal witness statements.

The panel is aware that it is not an expert at handwriting and that no expert evidence has been called. It did however, bear in mind that you stated that you had seen this list.

In particular, the panel observed that the MAR chart for Resident D stated under the title "Medication Profile", "ROTIGOTINE patch 4mg/24 hours…". Further, that under the date of 4 April 2019, and next to the time "5pm" there is no signature to indicate that the Rotigotine had been administered, nor was there any code inserted to indicate a reason for non-administration.

Further, the MAR chart for Resident H under the title "Medication Profile" stated, "OLIVE OIL Ear Drops…". Further that under the date of 4 April 2019, and next to the time "9am" there is no signature to indicate that the Olive Oil Ear Drops had been administered, nor was there any code inserted to indicate a reason for non-administration.

The MAR chart for Resident H stated under the title "Medication Profile", "FERROUS SULFATE tablets 200mg…". Further that under the date of 4 April 2019, and next to the time "1pm" there is no signature to indicate that the Ferrous Sulfate had been administered, nor was there any code inserted to indicate a reason for non-administration.

In your evidence you said that you had read the "RCH Care Homes Management of Medicines Policy" which states:

> *"…Only those items which have been given are to be signed for…"*

"…Should the Resident be unable/unwilling to take his/her medication at the time (e.g. asleep; eating etc.), then staff may return to that individual later in the medication round. Staff should be aware that medication may be administered up to one hour later than the time specified on the MAR. However, should non-administration go beyond that time period, then that non-administration should be recorded on the MAR using the appropriate coding…"

It is apparent from the MAR charts that on three occasions, on 3 and 4 April 2019, there are no signatures and no alternative code inserted. This would indicate that medication had not been administered/refused at the prescribed time. These were:

7) Rotigotine to Resident D at 17:00 on 4 April 2019
12) Olive oil ear drops to Resident H at 09:00 on 4 April 2019
13) Ferrous sulfate to Resident H at 13:00 on 4 April 2019

Therefore, the panel found this charge proved.

Charge 2a

2) On 5 April 2019;
   a) On one or more occasion, retrospectively signed MAR Charts to indicate that medication had been administered/refused at the time of prescription, as listed in schedule 1.

This sub-charge is found proved.

Ms 1 in her witness statement stated:

"…I called the registrant on Friday 5 April 2019 to inform her that we had found that a number of residents had not received their medication on 3 and 4 April 2019 and invited her into the Home on Monday 8 April 2019 to discuss the errors. Later the

same day the registrant arrived at the Home and asked to see the MARs. Friday was the day that we used to do all the reports so it was pretty chaotic. I gave her the MARs and left her alone with them for approximately 15 minutes. I did not show her the blister packs. When I returned I found her filling in the MARs. I asked her what she was doing and she told me that she was just putting the MARs right. I told her that she could not fill the MARs in after the event explaining that for one, she might not remember correctly what was and wasn't administered…"

In your evidence, you denied that this occurred at all. You stated that you completed all the medication rounds and made no mistakes. You also stated that since 3 and 4 April 2019 you were never shown the MAR Charts despite asking for them.

Ms 1 in her witness statement and in her evidence stated that the medication errors were initially identified by Ms 2, Ms 3, and another unknown individual on 5 April 2019. Ms 2 presented a contemporaneous handwritten list of missed medications for residents on 3 to 4 April 2019.

You confirmed that you had seen this list, although you do not accept its accuracy. Ms 1's evidence was that, upon the medication errors being brought to her attention, she checked the MAR charts and confirmed that there were gaps where your signature should have been.

Ms 1 said that she telephoned you on 5 April 2019 and asked you to come to the Home, on 8 April 2019, to discuss the medication errors identified. In evidence she initially stated that she believed you came to see her as soon as possible but could not recall whether it was the 5 or 6 April 2019, however later in evidence Ms 1 confirmed that it was indeed 5 April 2019 when you to attend the Home.

In your evidence, you denied that this conversation took place and stated that you received a text message on 5 April 2019 which stated *"I want to see you at Kesson House on 08.04.2019"* from a telephone number beginning with "01474"

Ms 1 in evidence said that she could not have sent you a text message from this number as it is a landline number for the Home, this being the area code for Gravesend and not a mobile number. Further, despite your saying that you had received a text message, there is no screenshot available of the actual text message to demonstrate this.

Ms 1 stated that despite being asked to attend on 8 April 2019, you attended the home on 5 April 2019 and asked to see the MAR charts. Ms 1 said that she provided you with the MAR charts and left you alone with them for approximately 15 minutes. She said that the Home was busy on that day.

Ms 1 stated that when she returned, she saw you signing the MAR charts. Then when she had asked you what you were doing you said you were "*putting the MARs right*".

Ms 1's evidence was that she gave the MAR charts to you so you could see where the mistakes had been made. She said that she was trying to be fair to you, as she does with all her staff, and did not expect you to complete the MAR charts but just to consider them.

Your evidence was that you did not attend the Home on 5 April 2019 and did not do so until 8 April 2019 but you called Ms 1 to obtain the time of the appointment. Further, that you were not shown the original MAR charts on that day or subsequently.

The panel preferred the evidence of Ms 1 and considered her version of events to be plausible. Her evidence was consistent with her witness statement in relation to the initial identification of the medication errors, the audit undertaken and her calling you to attend the Home to discuss this.

In contrast you have denied making any medication errors and stated that you were not called by Ms 1 and only attended the Home on 8 April 2019.

The panel therefore concluded that, on the balance of probabilities, on one or more occasions, you retrospectively signed MAR Charts to indicate that medication had been administered/refused at the time of prescription, as listed in schedule 1, identified in charge 1.

Therefore, the panel found this sub-charge proved.

Charge 2b

2) On 5 April 2019;
    b) On one or more occasion, did not indicate that the MAR Chart entries for Patients were retrospective, as listed in schedule 1.

This sub-charge is found proved.

The panel found charge 2a proved, in that you had retrospectively signed MAR Charts to indicate that medication had been administered/refused at the time of prescription, as listed in schedule 1.

In this context, the panel took account of the "RCH Care Homes Management of Medicines Policy" which you confirmed you had read in your oral evidence. It stated:

> *"…If the person whose signature is missing has left the building, they must be contacted immediately to request they come back to the site as soon as reasonably possible and sign for the medication they administered and record that this is in retrospect and the reason why…"*

And

> *"…If for any reason the person cannot be contacted, or cannot return to the Care home within 24 hours, the missing signature must be recorded on an incident form.*

Before documenting the error, the medication must be counted to determine if it was administered…"

Further in relation to charge 1, the panel found that there were signatures completely absent on MAR Charts, on 3 and 4 April 2019. This occurred once for Resident D and twice for Resident H. Further, there is no record of a retrospective signature next to the medication with a reason as to why this has been done.

The panel has therefore determined that, on the balance of probabilities, on one or more occasion, you did not indicate that the MAR Chart entries for patients were retrospective, as listed in schedule 1, as identified in charge 1.

Therefore, the panel found this sub-charge proved.

Charge 3a

3) Did not comply with Paragraph 8 (a) of the Interim Conditions of Practice Order ("ICOPO") imposed on 24 October 2018 by an Investigating Committee of the NMC, in that you;

    a) Between 7 March 2019 and 5 April 2019 did not disclose to your employer that you were subject to an Interim Conditions of Practice Order.

This charge is found proved.

The panel noted that condition 8 of the interim conditions of practice order stated:

8) You must immediately tell the following parties that you are subject to a conditions of practice order under the NMC's fitness to practise procedures, and disclose the conditions listed at (1) to (7) above, to them:

a) Any organisation or person employing, contracting with, or using you to undertake nursing or midwifery work;

In her witness statement Ms 1 stated:

> *"…When interviewing nurses I always ask if there is anything I need to know regarding the NMC. I asked the registrant this during the interview and she told me that there was nothing to report. I did not record in [Registrant's Interview Record 07/03/2019] that I had asked this question nor did I record the registrant's response which was my mistake. I now check a nurse's status with the NMC prior to them coming for interview…"*

She reiterated this in her evidence. She confirmed that she interviewed you on 7 March 2019, asked you if there were any concerns pertaining to the NMC and you stated you had said there was nothing to report. Ms 1 did however concede that she did not record your response in your interview record for 7 March 2019.

In your witness statement you stated:

> *"…During the interview, General Manager of Withens Nursing Home [Ms 1] asked about my registration status with the NMC and I revealed to her that I have interim Conditions of Practice Order and I presented her my statement of entry dated 07.03.2019 exhibited in the bundle…"*

You reiterated this in your evidence and maintained that you presented Ms 1 with your statement of entry to the NMC register. This document includes your personal details and under the title "Registration Status" it states "Interim conditions of practice order". You also stated that you told Ms 1 "everything" in relation to this ICOPO.

In cross examination, you said that you had also provided Ms 1 with a full copy of your ICOPO and explained it to her.

In your application for employment, dated 7 March 2019, which you stated you completed prior to the interview on the same date, there is no reference to your ICOPO.

In your interview record dated 7 March 2019, written by Ms 1, there is no reference to an interim conditions of practice order. However, it would appear to the panel that had you disclosed this as you have suggested, then it would have been a significant issue for the Home and would have been referenced in the interview record.

The panel therefore determined that you did not comply with Paragraph 8 (a) of the ICOPO because you did not disclose to your employer that you were subject to an ICOPO.

Therefore the panel found this sub-charge proved.

Charge 4

4) On 8 April 2019 you inaccurately informed your employer that you unware of the ICOPO until 6 April 2019.

This charge is found proved.

In her witness statement Ms 1 stated:

"…I first became aware of the registrant's Interim Conditions of Practise Order ("ICOPO") on 5 April 2019. My previous administrator had not checked the registrant's details on the NMC website so I decided to look myself. It was very difficult to find her as I think she had used a different name or a different spelling of her name, I cannot recall exactly. My colleague helped me to locate her on the website which we did and this is when we found that she had an ICOPO…"

"…The registrant attended the Home for an investigatory meeting on 8 April 2019…During the meeting we discussed the registrant's ICOPO. She told me that the NMC had written to her on the Saturday before the meeting, which would have been 6 April 2019, to advise her that the NMC had received two referrals regarding incidents relating to perineal repairs between 2013 and 2018. She said that the NMC were gathering information to find the facts and that she had to attend the NMC on 15 April 2019. I clarified with the registrant that she did not know anything about the ICOPO until 6 April 2019 and she replied, "No" which I found hard to believe…"

Ms 1 reiterated this in her evidence.

The Home's Investigation Meeting Minutes dated 8 April 2019 stated:

"…[Ms 1] Have you had a chance to look at the NMC web site?
[Mrs Wight] Yes I have there is a red line, they wrote me on Saturday. They said they had reports of two referral's regarding incidents related to perineal repairs between 2013 and 2018. They are gathering information to find the facts out and I have to attend on the 15th April.
[Ms 1] So you [knew] nothing until Saturday?
[Mrs Wight] No…"

The minutes of that meeting between you and Ms 1 were consistent with her witness statement.

(Also in evidence Ms 1 confirmed that the word "knew" was missing from the minutes).

In cross examination, you accepted that you were present and represented by counsel at your interim order ('IO') hearing on 24 October 2018.

However, although at the investigation meeting, you said that you knew nothing about this until 6 April 2019, the letter sent to you by the NMC, dated 25 October 2018, included a

copy of the determination detailing the outcome of the IO hearing and a copy of the ICOPO.

In your evidence, initially you said that you could not recall the discussions reflected in the Investigation Meeting Minutes dated 8 April 2019. However, you later stated that this discussion did not take place as stated. This is despite your referring to elements of the meeting in your witness statement.

In the Investigation Meeting Minutes, you stated that the NMC wrote to you on 6 April 2019 stating that you "have to attend on 15th April". However, you have not produced this letter at this hearing.

In all the circumstances the panel has concluded that on 8 April 2019 you inaccurately informed your employer that you unaware of the ICOPO until 6 April 2019.

Therefore, the panel found this charge proved.

Charge 5

5) Your actions in charge 3 a) & 4) above were dishonest in that you attempted to conceal from your employer that regulatory restrictions had been placed upon your practice.

This charge is found proved.

In reaching this decision, the panel bore in mind the advice on dishonesty provided by the legal assessor.

With regard to charge 3a), the panel has found this charge proved. In your evidence you accepted that you were present at the IO hearing on 24 October 2018, represented by

counsel and were aware that an ICOPO was imposed and still in place at the time of these events.

Condition 8a is clear. The panel has determined that you would have known that you should have informed your employers immediately that you were subject to ICOPO.

You stated that you sent to your agency the statement of entry from the NMC's website, indicating that you were subject to an ICOPO. However, you did not state on your job application to the Home that you were subject to an ICOPO. Furthermore, the panel has found that you did not tell Ms 1 during the interview on 7 March 2019.

In these circumstances the panel was satisfied that your intention was to mislead the Home in order to secure employment.

With regard to charge 4, the panel has found this charge proved and determined that you inaccurately informed your employer that you unaware of the ICOPO until 6 April 2019.

The investigation minutes record that you said that you had not received any notification about any referrals until 6 April 2019 and that these related to "perineal repairs". However, the determination from your IO, dated 24 October 2018, contains the details of these referrals. There is nothing before the panel to indicate any further referrals.

The panel was satisfied that you were already aware of these referrals at the time of application rather than only on 6 April 2019 as you have suggested. The panel concluded that your actions under charge 4 were clearly intended to conceal the interim order.

The panel therefore concluded that you acted dishonestly in relation to charges 3a and 4.

The panel found this charge proved.

Fitness to practise

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

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

Submissions on misconduct and impairment

Mr Wigg provided the panel with the determination of your substantive hearing, that concluded on 10 March 2022, where a conditions of practice order was imposed for 9 months, and the review of that substantive order which occurred on 30 November 2022. He informed the panel that the substantive decision is subject to an appeal.

Mr Wigg referred the panel to the substantive review where the conditions of practice order was extended by 12 months.

With regard to impairment, Mr Wigg submitted that a breach of an ICOPO is always serious, but dishonesty in relation to that breach is very serious. He submitted that as a result of this, you are impaired and this alone is more than sufficient to find your fitness to practice impaired by reason of your misconduct.
Mr Wigg said that in the alternative, your failure to record important medication information amounts to misconduct. He said that this is serious and it was fortunate that there was no serious harm caused. He submitted that the panel's findings in relation to the MAR charts is serious and, in isolation, amounts to impairment.

Mr Wigg said that you were found to be currently impaired at your last substantive review hearing on 30 November 2022. He submitted that the panel may notice similarities in the charges found proved in the substantive hearing on 10 March 2022 and the charges found proved in this hearing. He drew the panel's attention to similarity to earlier charges relating to your failure to record maternal observations.

Mr Wigg submitted that the most serious charge the NMC rely on is the dishonesty charge to find your fitness to practice impaired.

In response to a question from the panel, Mr Wigg said that he did not need to highlight breaches of the code as the dishonesty speaks for itself.

You made submissions to the panel.

You said that you have worked for the NHS for over 20 years and have always had a clean record in nursing and midwifery. You said that you have not had any complaints or reports against you. You also said that you have never made any errors in terms of medication, documentation or dishonesty.

You said that at Queen Mary Hospital you were the main member of staff who could be relied on. You said that you were in demand and were relied upon to help out in any Accident and Emergency crisis.

You said that you have a letter from the HR department gave to you highlighting the work you have done.

You said that as a midwife, "nobody can say that you were dishonest or that you did not understand your role". You said that all these regulatory concerns are news to you. You said that these may have arisen because you "stood up and challenged" poor practice. You said that you cannot stop lies being told about you.

You said that practitioners should challenge poor practices and the reports against you are all old problems. You said that Ms 1 and her daughter lied about you.

You said that you want justice. You said that the fight is to prevent poor practice and ensure that the public is protected. You asked when “registrants are going to stop being demonised”.

You then provided the panel with a verbal list of all the training undertaken to keep your practice updated.

Decision and reasons on misconduct

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

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.’* In addition, the panel had regard to the NMC’s definition of misconduct unworthy of a nurse.

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

The panel found that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

20 Uphold the reputation of your profession at all times
…You should be a model of integrity...This should lead to trust and confidence in the profession…

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…

23 Cooperate with all investigations and audits

To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

However, the panel determined that the charges found proved individually and collectively amounted to a serious departure from appropriate standards expected and amounted to misconduct.

Decision and reasons on impairment

The panel next considered whether your misconduct was so serious that your fitness to practise is currently impaired.

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) 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.'*

For reasons already set out above in relation to misconduct, the panel determined that limbs a, b, c and d were engaged by your misconduct.

The panel concluded that you had in the past acted so as to put patients at unwarranted risk of harm. The panel determined that your failings breached fundamental tenets of nursing practice and that your misconduct is liable to bring the nursing profession into disrepute. In the panel's judgement, the public do not expect a nurse to act as you did as they require nurses to adhere at all times to the appropriate professional standards and to safeguard the health and wellbeing of patients.

The panel was also satisfied that confidence in the nursing profession would be undermined if its regulator did not regard misconduct relating to dishonesty as being extremely serious.

The panel however recognised that it must make an assessment of your fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether you would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether you have provided evidence of insight and remorse.

In your evidence you stated that your former colleagues were lying. You suggested that there was a personal grievance against you. There was no recognition of the potential unwarranted risk of harm the medication and documentation errors had on patients nor of the likely impact your misconduct had on patients, colleagues and the nursing profession. You denied all the charges and refuted the accuracy of the records of your meetings at the Home.

In the light of the above, the panel determined that it had no evidence of insight or remorse in relation to charges 1, 2a and 2b.

The panel was satisfied that your misconduct, namely that arising from charges 1, 2a and 2b were capable of remediation. The panel heard some details of multiple courses you stated you had completed, although it had seen no evidence of them. However, apart from a mandatory course in medications management, you have not presented any evidence to demonstrate steps taken to strengthen your practice and remedy the concerns identified in relation to the matters in this hearing.

Misconduct involving dishonesty is often said to be less easily remediable than other kinds of misconduct. However in the panel's judgment, evidence of insight, remorse and

reflection together with evidence of subsequent and previous integrity are all highly relevant to any consideration of the risk of repetition, as is the nature and duration of the dishonesty itself.

In your evidence, you avoided the issue of your dishonesty. Although as was your right you denied the charge of dishonesty, you did not give an objective assessment of how dishonesty within the nursing practice would be viewed. You have not addressed the impact that your dishonesty had on colleagues and in bringing the nursing profession into disrepute. As a result, the panel determined that you had demonstrated no insight on this matter.

The panel concluded that in the absence of any insight from you and your lack of remediation there remains a risk of repetition of the misconduct found proved. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

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

The panel was satisfied that having regard to the nature of the misconduct in this case, "*the need to uphold proper professional standards and public confidence in the profession would be undermined*" if a finding of current impairment were not made. A fully informed member of the public would be concerned by your misconduct should you be permitted to practice as a registered nurse in the future without restriction.

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

Sanction

The panel has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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

Submissions on sanction

Given the seriousness of the charges found proved and the fact that your fitness to practice is currently impaired, Mr Wigg submitted that the panel should impose a striking off order as the sanction.

Mr Wigg said that your actions in relation to the non-disclosure of the ICOPO amounts to serious and calculated dishonesty and are fundamentally incompatible with membership of the nursing profession. He also said that your conduct raised concerns about your professionalism and trustworthiness and are incompatible with continued registration.

Mr Wigg referred the panel to the NMC guidance titled “Serious concerns which are more difficult to put right” (reference FTP-3a). Mr Wigg highlighted the following, *“…not telling employers that their right to practise has been restricted or suspended”*. He said that this is a serious concern which is more difficult to remedy.

Mr Wigg also referred the panel to the NMC guidance titled “Striking-off order” (reference SAN-3e) which stated:

- *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*

- *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Mr Wigg said that the first two bullet points are satisfied given the panel's findings that your misconduct breached the fundamental tenets of the nursing profession. Further that the panel found that there remains of risk of repetition of the conduct found proved.

With regard to the third bullet point, Mr Wigg's submission was that your actions were irredeemable given that there is a strong obligation on registrants to make ICOPO disclosures. He said that you were found to be dishonest in this regard and that a striking off order is the only sanction that will be sufficient to protect patients and maintain professional standards.

Mr Mukurubira said that you do not accept the charges as they are based on "concocted evidence". He maintained that you did not breach the NMC code and said that you submitted your ICOPO to the Home.

Mr Mukurubira said that your position is that you do not accept these charges and stated that Ms 1 and her daughter lied.

You said that you do not accept the charges and did not make any errors. You said that your fitness to practice is not impaired and that therefore no sanction is needed.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel then considered what sanction, if any, it should impose. 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 regard to the SG but is aware that sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Absence of insight into the failings;
- Absence of remorse;
- Breach of ICOPO;
- Conduct which put patients at an unwarranted risk of harm;
- Dishonesty in order to obtain employment which is deemed to be so serious that it is difficult to remedy.

The panel also took into account the following mitigating features:

- That you attempted to keep up to date with current clinical practice through online mandatory and voluntary training.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection concerns identified. The panel decided that it would be neither proportionate nor in the public interest to take no further action. Misconduct of this nature demands sanction.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel decided that your misconduct and associated dishonesty was not at the lower end of the spectrum and that a caution order would therefore be inappropriate. The panel determined 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 was mindful that any conditions imposed must be proportionate, measurable and workable. It was aware that you were subject to an ICOPO on your registration and that you breached this order by not disclosing it to the Home.

In the light of the above, the panel determined that although the medication and documentation issues could be addressed by a conditions of practice order, the dishonesty identified did not lend itself to be addressed through conditions.

Furthermore, the panel concluded that imposing a conditions of practice order on your registration would not adequately address the seriousness of this case and would not satisfy the wider public interest.

The panel then considered whether a suspension order would be an appropriate sanction but determined that it was not appropriate in the light of the seriousness of your misconduct and dishonesty. It concluded that your denial of the charges found proved, your willingness to blame others, refusal to accept any mistakes were made, not complying with the ICOPO and your dishonesty is evidence of an attitudinal problem.

The panel also determined that you have shown little if any insight and as a result, there is a high risk of repetition of your misconduct.

The misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with your remaining on the register.

The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register and raise fundamental questions about your professionalism. The panel concluded that the findings demonstrate that your actions were so serious that to allow you to continue practising would not protect the public, would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all these factors the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in putting the public at risk and bringing the profession into disrepute by adversely affecting the public's view of the expected conduct of a registered, the panel has concluded that nothing short of this would be sufficient.

The panel concluded that this order was necessary to protect the public, 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 you 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 your own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Wigg. Given the panel's findings in relation to sanction he submitted that only an interim suspension order for a period of 18 months will be appropriate. He also submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

In the light of your stated intention to appeal the sanction, Mr Mukurubira did not object to the application. However, he said that he does not believe 18 months is necessary and believes the appeal will only require 6 months.

Decision and reasons on interim order

The panel accepted the advice of the legal assessor.

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

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

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

That concludes this determination.