Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday 7 June 2023 – Friday 9 June 2023
Monday 12 June 2023 – Tuesday 13 June 2023

Virtual Hearing

Name of Registrant:	**David Mpofu**
NMC PIN	01I2703E
Part(s) of the register:	Registered Nurse – Sub Part 1 RNMH: Mental Health Nurse L1 - January 2005
Relevant Location:	Rhondda Cynon Taf
Type of case:	Misconduct
Panel members:	Gregory Hammond (Chair, Lay member) Deborah Hall (Registrant member) Alison Hayle (Lay member)
Legal Assessor:	Gillian Hawken
Hearings Coordinator:	Shela Begum
Nursing and Midwifery Council:	Represented by Simon Gruchy, Case Presenter
Mr Mpofu:	Not present and unrepresented
Facts proved:	Charges 1a, 1b, 1c(i), 1c(ii) and 2a
Facts not proved:	Charges 2b and 3
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (2 years)**
Interim order:	**Interim conditions of practice (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Mpofu was not in attendance and that the Notice of Hearing letter had been sent to Mr Mpofu's registered email address by secure email on 4 May 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Mpofu's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

The panel noted that the Rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision and reasons on proceeding in the absence of Mr Mpofu

The panel next considered whether it should proceed in the absence of Mr Mpofu. It had regard to Rule 21 and heard the submissions of Mr Gruchy who invited the panel to continue in the absence of Mr Mpofu.

Mr Gruchy referred the panel to the documentation which evidences the NMC's attempts to contact Mr Mpofu. He informed the panel that Mr Mpofu has not contacted or responded to any of the communications by the NMC since May 2020. He submitted that, since then, all reasonable efforts have been made by the NMC to contact Mr Mpofu including at his registered postal address. Mr Gruchy further informed the panel that the communication attempts via post were unsuccessful and referred the panel to the Royal Mail 'Track and Trace' capture, which states *'Sorry, we were unable to deliver this item at 22-07-2022 as the recipient is no longer at that address. We're returning the item to the sender.'*

Mr Gruchy submitted that there had been no engagement at all by Mr Mpofu with the NMC in relation to these proceedings since May 2020 and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted the email from Mr Mpofu dated 16 May 2020, which stated:

> *"I am currently in zimbabwe. I was meant to fly back to the UK in March but I could not because of COVID 19 lockdown*."

In a subsequent email dated 22 May 2020, Mr Mpofu stated:

> *"I tried to call you today but I could not get through. I was calling to get the password in order to access tthe[sic] document you sent me. I will therefore respond assuming that my former employer gave you true accounts of what happened.*
>
> *I am not employed at the moment because my former employer told me I was not allowed to work as a nurse anymore.*

I do acknowledge that the incidents did happen. There were instigations in all the incidents and I gave honest accounts of what happened in all the medication errors. I did apologise to my clients and the organisation that employed me.

I also wrote reflective accounts and made reference to the NMC code of professional conduct about preserving safety for my clients. I believe I will not make the same errors again.

May I also let the organisation know that my former work place was a very stressful environment. It was always busy and we were sometimes short staffed. Considering the above and my age (57)?, I wish to take up employment in Psychiatric units that are less busy in future."

May I also take this opportunity to thank NMC for its kind words at this stressful time in my life."

The panel noted that this was the last communication received by the NMC from Mr Mpofu.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Mr Mpofu;

- Mr Mpofu has not engaged with the NMC and has not responded to any of the letters sent to him about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Four witnesses have been warned to attend to give live evidence at this hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Mpofu in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered contact address, he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, Mr Mpofu did cooperate with his employer's internal investigation into the concerns and the panel can take into account his reflective statement and the transcripts of his interview answers. The panel considered that the limited disadvantage is the consequence of Mr Mpofu's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

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

At the outset of the hearing, Mr Gruchy requested that parts of this case be held in private on the basis that during his submissions, he will be referring to matters which are of a sensitive nature and relate to matters personal to Witness 5. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party, or of any third party (including a complainant, witness or patient) or by the public interest.

The panel determined to go into private session in relation to the private matters of Witness 5 as and when such issues are raised in order to protect her privacy given that they are of a sensitive nature and relate to members of her family.

Details of charge

That you, a registered nurse:

1) On 4 May 2019:
    a) Did not confirm Patient A's identity before administering medication to them;
    b) Incorrectly administered to Patient A one or more of the medications set out in Schedule 1;
    c) After you had become aware of your conduct at Charge 1.b.:
        i) Did not take and/or ensure Patient A was taken to hospital immediately;
        ii) Allowed Patient A to go to bed.

2) On 7 November 2019:
   a) Incorrectly gave a Multivitamin tablet to Patient C;
   b) Asked Colleague E not to report the incident at Charge 2.a.

3) Your actions at Charge 2.b. were dishonest and/or a breach of your professional duty of candour in that you deliberately sought to conceal that you had made a medication error.

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

Schedule 1

Clozapine 275mg
Lithium 800mg
Promethazine 50mg
Omeprazole
Bisacodyl 5mg

Decision and reasons on application to admit written statements of Witnesses 5 and 6 as hearsay evidence

The panel heard an application made by Mr Gruchy under Rule 31 to allow the written statements of Witnesses 5 and 6 into evidence. Witnesses 5 and 6 were not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that these witnesses were present, they were unable to attend the hearing during the scheduled dates. Mr Gruchy provided written submissions in respect of his application which included addressing the panel in relation to the guidance from the leading case around hearsay, *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

In respect of Witness 5 he submitted:

16. *"[Witness 5]'s involvement in Incident 1 was that of an investigator. Her witness statement and report contain records of the accounts provided by [Witness 1] and Mr Mpofu in relation to Incident 1. The report itself contains copies of the incident report logged and emails sent as part of the investigation.*

17. *Although the NMC seeks to place some reliance on the contents of [Witness 5]'s statement and RC/01, for the most part, this extends to the accounts provided by Mr Mpofu. It is submitted that, in his absence, it is fair to admit hearsay evidence comprising of Mr Mpofu's local accounts as they may provide some context to Incident 1 and assist the panel to properly test the live evidence.*

Sole or Decisive

18. *[Witness 5]'s evidence extends to information obtained in the course of her investigation into Incident 1. She describes her investigation, which began on 7 May 2019, as 'independent'.*

19. *The NMC seeks to rely on:*
    1. *Charge 1.a.:*
        1. *Record of meeting with Mr Mpofu* ***[page 18 to 20 hearsay bundle for [Witness 5]]****;*
        2. *Record of investigatory meeting with [Witness 1]* ***[page 21 hearsay bundle for [Witness 5]]****;*
        3. *Mr Mpofu reflective account* ***[page 25 and 26 hearsay bundle for [Witness 5]]****.*
    2. *Charge 1.b.:*
        1. *Mr Mpofu's incident report* ***[page 7 hearsay bundle for [Witness 5]]***
        2. *Record of meeting with Mr Mpofu* ***[page 18 to 20 hearsay bundle for [Witness 5]]****;*
        3. *Record of investigatory meeting with [Witness 1]* ***[page 21 hearsay bundle for [Witness 5]]****;*
        4. *Mr Mpofu reflective account* ***[page 25 and 26 hearsay bundle for [Witness 5]]****.*

20. *Although her witness statement and investigation report provide evidence in support of Charges 1.a. and 1.b., they are neither sole nor decisive.*

21. *The NMC intends to call a witness more directly involved with the events immediately following the incident itself, [Witness 1]. [Witness 1] was the 'bronze on call' at home on 4 May 2019. Within her witness statement, [Witness 1] sets out that any issues that the senior on site needed to escalate would therefore be reported to her.*

22. *[Witness 1] confirms that on the evening of the incident, Mr Mpofu called her and informed her that he had made a serious drug error, in that he had given medication to the wrong patient. [Witness 1] attended Ward 2 and had further interactions with Mr Mpofu. [Witness 1] details two of the medications given at paragraph 10 of her witness statement (Charge 1.b.).*

23. *At paragraph 9 of her witness statement, [Witness 1] expresses that Mr Mpofu had 'evidently' not asked Patient A their name and date of birth and checked this against the drug chart (Charge 1.a.).*

24. *It is submitted that on the basis of [Witness 1]'s evidence alone, the facts in respect of Charges 1.a. and 1.b. are capable of being proved on the balance of probabilities.*

25. *The NMC therefore invites the panel to find that [Witness 5]'s evidence is neither sole nor decisive and that [Witness 5]'s witness statement and RC/01 can fairly be admitted as hearsay evidence.*

26. *Should the panel consider that [Witness 5]'s evidence is sole or decisive, it is submitted that her evidence is demonstrably reliable or, in the alternative, there are some means of testing its reliability.*

Demonstrably reliable

27. *[Witness 5]'s involvement with the incident at charge 1 was her management of the investigation into the alleged medication error. [Witness 5] sets out that she met Mr Mpofu 'in a professional capacity only' when she was asked to carry out the investigation. [Witness 5] can be considered an independent party. It is submitted that her lack of connection to Mr Mpofu and the incident itself serves as evidence of her impartiality.*

28. *[Witness 5]'s witness statement, exhibiting RC/01, is accompanied by a signed statement of truth, confirming that the statement is true to the best of her knowledge and belief. RC/01 is presented as a record of information obtained as part of [Witness 5]'s investigation and there is no reason to suggest that [Witness 5] would inaccurately record such information.*

29. *RC/01 contains a handwritten record of a meeting with Mr Mpofu on 16 May 2019* ***[pages 17 and 20 of the hearsay bundle for [Witness 5]]****. This document is signed by all parties present within the meeting.*

30. *RC/01 also contains a reflective account from Mr Mpofu. The email to which this was attached is reported at* ***page 11.*** *The email shows that this was originally sent by Mr Mpofu on 6 May 2019.*

Testing reliability

31. *As set out at paragraph 21 of these submissions, the NMC intends to call [Witness 1]. It is submitted that [Witness 1]'s live evidence is a means by which [Witness 5]'s hearsay evidence can be tested.*

32. *Mr Mpofu's email to the NMC on 22 May 2020* ***[page 98 Final Exhibit Bundle]*** *can also be used as a means of testing the reliability of [Witness 5]'s evidence. Mr Mpofu sets out that he had been unable to access the documents sent to him by the NMC and it should therefore be noted that he may not have been aware of the dates and details regarding the areas of concern being looked into. Notwithstanding this, it is relevant that Mr Mpofu sets out:*

    'I do acknowledge that the incidents did happen. There were instigations in all the incidents and I gave honest accounts of what happened in all the medication errors…

    I also wrote reflective accounts and made reference to the NMC code of professional conduct about preserving safety for my clients…' [sic]

The nature and extent of the challenge to the contents of the statements/ Whether there was any suggestion that the witnesses had reasons to fabricate their allegations

33. *The NMC's last successful communication with Mr Mpofu occurred on 22 May 2020, as referred to at paragraph 32 of these submissions. Since then, further attempts at communication have been made including but not limited to:*

    3. *On 17 January 2023, copies of the draft bundles including [Witness 5]'s evidence were sent to Mr Mpofu's registered email address;*
    4. *On 26 May 2023, Mr Mpofu was informed at his registered email address that the NMC would be making a hearsay application in relation to [Witness 5]'s statement.*

34. *The NMC has received no information, including that contained within the local investigation papers, to suggest that Mr Mpofu disputes any of the matters contained within [Witness 5]'s witness statement and exhibit RC/01, nor is there any suggestion that [Witness 5] had reason to fabricate the contents of her witness statement and exhibits. It can also be reasonably inferred from Mr Mpofu's signature on the record of the investigatory meeting on 16 May 2019* ***[page 20***

hearsay bundle for [Witness 5]] *that Mr Mpofu endorsed the accuracy of its contents.*

The seriousness of the charge, taking into account the impact adverse findings might have on Mr Mpofu

35. *The Charge to which [Witness 5]'s evidence relates concerns incorrectly administering medications to a patient and failing to confirm the patient's identity before doing so.*

36. *The NMC's Fitness to Practise ('FtP') Library contains guidance at FTP-3b which sets out that concerns that an individual has failed to administer medicines in line with training, law and guidance are serious concerns which could result in harm to patients if not put right.*

37. *The NMC's position is that the alleged conduct at charges 1.a. and 1.b. are capable of amounting to serious misconduct and adverse findings are likely to have an impact on Mr Mpofu's career.*

Whether there is good reason for the Witness' non-attendance; Whether the Respondent had taken reasonable steps to secure their attendance

38. *It is submitted that there is a good reason for [Witness 5]'s non-attendance at the hearing.*

39. *It is evident that at the time of signing her witness statement, 28 July 2022, [Witness 5] confirmed that she was willing to attend a hearing and give evidence before a Committee of the NMC if required to do so* ***[page 4 hearsay bundle for [Witness 5]].***

40. *On 21 April 2023, in response to an email from the Case Coordinator setting out the dates of the hearing, [Witness 5] similarly confirmed her attendance* ***[page 27 hearsay bundle for [Witness 5]]****.*

41. *[Witness 5] was sent a notice of hearing by email on 12 May 2023 and by post on 15 May 2023.*

42. *On 16 May 2023, the Case Coordinator telephoned [Witness 5] and informed her that the notice of hearing had been sent to her. [Witness 5] stated that she would check and get back to the Case Coordinator.*

43. *Having received no further communication from [Witness 5], the Case Coordinator sent an email to [Witness 5] on 22 May 2023* ***[page 40 hearsay bundle for [Witness 5]]****. Within the email, the Case Coordinator reminded [Witness 5] of her*

own duty as a Registered Professional to cooperate with the proceedings and set out that the NMC could seek a witness summons in order to secure her attendance.

44. *[PRIVATE].*

45. *On 23 May 2022, the Case Coordinator responded to [Witness 5]'s email expressing the possibility that, if she chose not to give evidence on this occasion, she may have to do so at a later date* ***[page 42 hearsay bundle for [Witness 5]]****. The Case Coordinator provided details of the support the NMC can offer to witnesses, including information about the witness liaison team and the Emotional Support Line.*

46. *The NMC has received no further communication from [Witness 5].*

47. *Owing to the nature of [Witness 5]'s current circumstances and her statement as to the impact that giving evidence at this time may have on her, the NMC considered that it would not be appropriate to seek a witness summons from the High Court.*

48. *Although an adjournment may secure [Witness 5]'s attendance at a later date, it is submitted that the fairness of admitting her hearsay evidence, taking into account that it is neither sole nor decisive, is such that Mr Mpofu's and the public interest in concluding these proceedings expeditiously outweighs that of the NMC's interest in [Witness 5] attending to give live evidence before a panel.*

The fact that the Appellant did not have prior notice that the witness statements were to be read.

49. *The NMC had initially hoped that it would be able to secure [Witness 5]'s attendance at the hearing. Having received the email from [Witness 5] on 22 May 2023, the NMC took steps to put Mr Mpofu on notice that a hearsay application may need to made. An email was sent to Mr Mpofu's registered email address on 26 May 2023, notifying him of the intention to do so and attaching the hearsay bundle for [Witness 5].*

CONCLUSION

50. *The Panel is respectfully invited to admit the hearsay evidence in respect of the witness statement of [Witness 5] and RC/01 on the basis that in all the circumstances, it is fair to both parties and it is in the interests of justice.*

51. *[Witness 5]'s evidence is neither sole nor decisive and her recent loss and challenging personal circumstances amount to a good reason for her non-attendance. It is submitted that the rights of Mr Mpofu can be guaranteed by the panel's duty to properly assess the evidence adduced and that it is in the public*

interest for the hearsay to be adduced in order to facilitate the proper administration of justice.

52. *Any prejudice caused to Mr Mpofu as a result of the admission of the evidence can be properly addressed by the hearing process."*

In respect of Witness 6, he submitted:

"*16. The NMC seeks to place some reliance on [Witness 6]'s evidence in support of charge 2.a.:*

i. *Mr Mpofu's admissions in the Disciplinary Hearing on 13 December 2019 (DH/01)* ***[page 5 to 11 hearsay bundle for [Witness 6]]****;*
ii. *Mr Mpofu's admissions in the letter dated 20 December 2019 (DH/02)* ***[page 14 to 17 hearsay bundle for [Witness 6]]****.*

17. *It is submitted that the substance of [Witness 6] evidence extends only so far as providing Mr Mpofu's account of Incident 2. The exhibited accounts provide some context to the incident as well as setting out Mr Mpofu's denial to charge 2.b. which, if proved, will require further consideration as regards dishonesty. In light of the seriousness of the charges, it is submitted that it is in the interest of fairness to all parties that [Witness 6]'s witness statement, DH/01, and DH/02 be admitted into evidence.*

Sole or Decisive

18. *[Witness 6]'s evidence extends to information obtained in the course of the investigation into Incident 2. [Witness 6] explains that he was the disciplinary officer in Mr Mpofu's disciplinary meeting* ***[DH/01]****. [Witness 6] also exhibits a letter from Mr Mpofu dated 20 December 2019* ***[DH/02]****. Although [Witness 6]'s evidence provides evidence in support of Charge 2, it is neither sole nor decisive.*

19. *The NMC intends to call the witnesses more directly involved with the events immediately following the incident itself, [Witness 5]. [Witness 3] was the 'Senior Staff Nurse' on Caernarfon ward on the date of the incident.*

20. *[Witness 3] sets out that on the day of the incident, she was approached by Patient C who told [Witness 3] that they had been given the wrong medication by Mr Mpofu (charge 2.a.).*

21. *The NMC therefore invites the panel to find that [Witness 6]'s evidence is neither sole nor decisive.*

Demonstrably reliable

22. *[Witness 6] sets out within his witness statement that his relationship with Mr Mpofu was 'strictly on a work basis'. His role in relation to the allegation was as a 'disciplinary officer' for the disciplinary meeting and prior to conducting the meeting, [Witness 6] confirms that he reviewed the initial investigation. [Witness 6] can therefore be considered independent of the incident and investigation. It is submitted that his lack of connection to Mr Mpofu and the incident itself serves as evidence of his impartiality.*

23. *[Witness 6]'s witness statement, exhibiting DH/01 and DH/02, is accompanied by a signed statement of truth, confirming that the statement is true to the best of his knowledge and belief. DH/01 and DH/02 are presented as records of information obtained from Mr Mpofu and there is no information to suggest that [Witness 6] would inaccurately record or provide such information.*

Testing reliability

24. *As set out at paragraph 19 of these submissions, the NMC intends to call [Witness 3]. It is submitted that [Witness 3]'s live evidence is a means by which [Witness 6]'s hearsay evidence can be tested.*

25. *Mr Mpofu's email to the NMC on 22 May 2020* ***[page 98 Final Exhibit Bundle]*** *can also be used as a means of testing the reliability of [Witness 6]'s evidence. Mr Mpofu sets out that he had been unable to access the documents sent to him by the NMC and it should therefore be noted that he may not have been aware of the dates and details regarding the areas of concern being looked into. Notwithstanding this, it is relevant that Mr Mpofu sets out:*

'I do acknowledge that the incidents did happen. There were instigations in all the incidents and I gave honest accounts of what happened in all the medication errors…

I also wrote reflective accounts and made reference to the NMC code of professional conduct about preserving safety for my clients…' [sic]

The nature and extent of the challenge to the contents of the statements/Whether there was any suggestion that the witnesses had reasons to fabricate their allegations

26. *The NMC's last successful communication with Mr Mpofu occurred on 22 May 2020, as referred to at paragraph 25 of these submissions. Since then, further attempts at communication have been made including but not limited to:*

    a. *On 17 January 2023, copies of the draft bundles including the previously unexhibited DH/01 and DH/02 evidence were sent to Mr Mpofu's registered email address;*
    b. *On 15 May 2023, [Witness 6] signed witness statement was sent to Mr Mpofu's registered email address;*
    c. *On 18 and 26 May 2023, Mr Mpofu was informed at his registered email address that the NMC would be making a hearsay application in relation to [Witness 6]statement.*

27. *The NMC has received no information, including that contained within the local investigation papers, to suggest that Mr Mpofu disputes any of the matters contained within [Witness 6]'s witness statement nor exhibits. Further, there is no suggestion that [Witness 6] had reason to fabricate the contents of his witness statement and exhibits.*

The seriousness of the charge, taking into account the impact adverse findings might have on Mr Mpofu

28. *The Charge to which [Witness 6]'s evidence relates concerns incorrectly administering medication to a patient.*

29. *The NMC's Fitness to Practise ('FtP') Library contains guidance at FTP-3b which sets out that concerns that an individual has failed to administer medicines in line with training, law and guidance are serious concerns which could result in harm to patients if not put right.*

30. *The NMC's position is that the alleged conduct at charge 2 is capable of amounting to serious misconduct and adverse findings are likely to have an impact on Mr Mpofu's career.*

Whether there is good reason for the Witness' non-attendance; Whether the Respondent had taken reasonable steps to secure their attendance

31. *It is submitted that there is a good reason for [Witness 6]'s non-attendance at the hearing.*

32. *It is evident that at the time of signing his witness statement, 12 May 2023, [Witness 6] confirmed that he was willing to attend a hearing and give evidence before a Committee of the NMC if required to do so* ***[page 3 hearsay bundle for [Witness 6]].***

33. *On 15 May 2023, in response to an email from the Case Coordinator providing the Notice of Hearing and requesting [Witness 6]'s attendance at the hearing on 9 June 2023, [Witness 6] set out that he would be out of the country from 7 to 16 June* ***[page 18 hearsay bundle for [Witness 6]]****.*

34. *Although an adjournment would likely secure [Witness 6]'s attendance at a later date, it is submitted that the fairness of admitting his hearsay evidence, taking into account that it is neither sole nor decisive, is such that Mr Mpofu's and the public interest in concluding these proceedings expeditiously outweighs that of the NMC's interest in [Witness 6] attending to give live evidence before a panel.*

The fact that the Appellant did not have prior notice that the witness statements were to be read.

35. *The NMC had initially hoped that it would be able to secure [Witness 6]'s attendance at the hearing. Having received the email from [Witness 6] on 12 May 2023, the NMC*

took steps to put Mr Mpofu on notice that a hearsay application may need to made. An email was sent to Mr Mpofu's registered email address on 18 May 2023, notifying him of the intention to do so.

CONCLUSION

36. *The Panel is respectfully invited to admit the hearsay evidence in respect of the witness statement of [Witness 6], DH/01, and DH/02 on the basis that in all the circumstances, it is fair to both parties and it is in the interests of justice.*

37. *[Witness 6] is out of the country during the entirety of the listed hearing and will not be able to give evidence until after 16 June 2023. [Witness 6]'s evidence presents Mr Mpofu's account of Incident 2 through the minutes of a disciplinary meeting and subsequent letter written by Mr Mpofu himself. Although the NMC seeks to rely on Mr Mpofu's account in support of charge 2.a., it is submitted that it is in Mr Mpofu's own interests for the panel to accepts his recorded account of Incident 2, particularly where he has stopped engaging with these proceedings.*

38. *It is submitted that the rights of Mr Mpofu can be guaranteed by the panel's duty to properly assess the evidence adduced and that it is in the public interest for the hearsay to be adduced in order to facilitate the proper administration of justice. Any prejudice caused to Mr Mpofu as a result of the admission of the evidence can be properly addressed by the hearing process."*

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 applications in regard to Witnesses 5 and 6 serious consideration.

In respect of Witness 5, the panel noted that the 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 information, knowledge and belief' and signed by her.

The panel found the evidence of Witness 5 to be relevant to the charges. It noted that it is not the sole or decisive evidence in respect of any of the charges. Further, it noted that there are other witnesses who will be attending this hearing to give live evidence and corroborate her evidence. The panel considered the nature and extent to which Mr Mpofu may challenge the evidence of Witness 5 and it noted that any challenge that Mr Mpofu did wish to put to her, he did at a local level. The panel was satisfied that there is good reason for Witness 5's non-attendance at this hearing and further it was satisfied that the NMC has made sufficient efforts to secure her attendance.

The panel next considered the application in respect of Witness 6. It noted that Witness 6'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 information, knowledge and belief' and signed by him.

The panel found the evidence of Witness 6 to be relevant to the charges. It noted that his statement is not the sole or decisive evidence in respect of any of the charges. Further, it noted that there are other witnesses who will be attending this hearing to give live evidence and corroborate the evidence of Witness 6. The panel noted that Witness 6 is currently abroad and therefore cannot attend this hearing. It was satisfied that the NMC had made sufficient efforts to try and secure the attendance of Witness 6

In respect of both of the witnesses, the panel concluded that there is no suggestion before it that either witness had reason to fabricate their evidence. It noted that neither witness raised the allegations against Mr Mpofu.

The panel considered whether Mr Mpofu would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witnesses 5 and 6 to that of allowing the written statements into evidence. The panel considered that Mr Mpofu

had been provided with a copy of the written statements of Witnesses 5 and 6 and, as the panel had already determined that Mr Mpofu had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine the witnesses in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. Moreover, admission of the evidence would allow the panel the benefit of taking into account Mr Mpofu's own responses to the areas of concern in the notes of the internal investigatory and disciplinary meetings.

In these circumstances, the panel determined that it would be fair and relevant to accept into evidence the written statements of Witnesses 5 and 6 but would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

Background

The charges arose whilst Mr Mpofu was employed as a registered nurse by Heatherwood Court Hospital (the Hospital).

It is alleged that on 4 May 2019, whilst working on Cardigan Unit, Mr Mpofu did not follow the basic checking procedure for identifying patients and subsequently incorrectly administered Patient A the medication intended for Patient B. It is further alleged that he did not immediately take the patient to hospital and allowed the patient to go to bed.

It is further alleged that on 7 November 2019, whilst working on Caernarfon Unit, Mr Mpofu incorrectly administered a multivitamin tablet to Patient C. Further, it is alleged that upon realisation of his error, Mr Mpofu asked Colleague E not to report this incident.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mr Mpofu.

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: Senior Staff Nurse, Ludlow Street Healthcare, Heatherwood Court Hospital
- Witness 2: Unit Manager, Heatherwood Court Hospital
- Witness 3: Ward Manager, Heatherwood Court Hospital
- Witness 4: Clinical Lead, Ludlow Street Healthcare, Pinetree Hospital

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 the NMC.

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

Charges 1a and 1b

1) On 4 May 2019:

a) Did not confirm Patient A's identity before administering medication to them;

b) Incorrectly administered to Patient A one or more of the medications set out in Schedule 1;

These charges are found proved.

In reaching this decision, the panel took into account that Mr Mpofu has never sought to deny having not confirmed Patient A's identity before administering medication and having incorrectly administered one or more medications to Patient A.

The panel had regard to the reflective account by Mr Mpofu on this incident in which he states:

> *"At about 21:30 hrs agency nurse [Nurse 1] who was the nurse in charge and also the medication nurse asked me to dispense and administer medication for patients who had asked for medication, because she was busy at the time completing 1:1 observations. [Patient A] I dispensed and gave it to her. I also dispensed [Patient B] after dispensing [Patient B] medication I went to the hatch and called [Patient B] for her medication. [She] presented herself at the hatch and I thought it was the patient I had called for medication. I handed the medication to her, She took the medication, checked it and she asked me what the other blue tablets were and I told her it was Promethazine. She accepted the medication.*
>
> *At about 22:00 hrs when [Nurse 1] who was allocated to administer medication asked me if [the patient] had taken her medication I went to the clinic room to check on drug charts that I had signed to confirm this. On checking drug charts I found that I had given Patient A, Patient B's medication by error. I reported the error to the nurse in charge and informed the client. The medication was*
>
> *Clozapine 275mg*

Lithium 800mg
Promethazine 50mg
Omeprazole
Bisacodyl 5mg"

The panel also heard evidence from Witness 1 which was consistent with Mr Mpofu's account of the incidents.

The panel therefore concluded, on the basis of the evidence before it, that it is more likely than not that Mr Mpofu did not confirm Patient A's identity before administering medication to them and further that he incorrectly administered to Patient A one or more of the medications set out in Schedule 1.

Charge 1c(i) and 1c(ii)

c) After you had become aware of your conduct at Charge 1.b.:

   i) Did not take and/or ensure Patient A was taken to hospital immediately;

   ii) Allowed Patient A to go to bed.

These charges are found proved.

In reaching its decision, the panel took into account that during Witness 1's evidence, she told the panel:

"[Mr Mpofu] informed me that it was his intention to take this lady to the hospital. But this lady was actually in a wheelchair, so there was no way that this gentleman was going to get her into a car and out of a car…

He's actually given this patient medication and unfortunately when I got there, he actually put this lady to bed and hadn't done any physical observations or anything like that, despite the fact that, you know, given a quite serious medication"

The panel had regard to the documentary evidence which included minutes of a local investigatory meeting with Witness 1 dated 21 May 2019 in which it states:

> *"Witness 1 arrived on site at HWC at 11pm. [Mr Mpofu] had let the patient go to bed. He explained the drug error happened at 9:30pm…*
> *[Mr Mpofu] informed [Witness 1] that the plan was to take the patient in a company vehicle to the hospital. [Witness 1] explained she could not understand why she had not gone sooner and why she was allowed to go to bed"*

The panel found that the documentary evidence was consistent with the evidence it has heard from the witnesses. Further, it found that the account of the incident provided by Witness 1 to be consistent. It considered her evidence and account of events to be fair to Mr Mpofu and found her evidence to be reliable and credible.

In relation to having not taken Patient A to hospital immediately, the panel noted that the medications were incorrectly administered at around 21:30. It noted that Mr Mpofu explained in his reflective account that he realised his error just after 22:00. It took into account that he states in his reflective account:

> *"Duty Doctor advised client to be sent to hospital. Ambulance was called and when they spoke to me. They asked what dose the patient had taken and also her weight. After I gave them the figures they told me the patient had not taken a dose that was dangerous enough to cause toxicity[…] I also told them that the patient had not taken Clozapine before and that alone could cause complications I insisted that they attend to the patient"*

The panel concluded that, on the basis of the information before it, Patient A was not taken to hospital immediately after Mr Mpofu realised he had incorrectly administered medications prescribed for another patient. It noted that the medications were administered at around 21:30 and Mr Mpofu realised his own error at some time just after

22:00. When Witness 1 arrived at the ward at around 22:50, she found Patient A in bed. Further, the panel has not heard conflicting evidence in relation to Patient A being allowed to go to bed and noted that there was no dispute in relation to this.

It therefore concluded as a matter of fact that, after he had become aware of his conduct at Charge 1.b, Mr Mpofu did not take and/or ensure Patient A was taken to hospital immediately and allowed Patient A to go to bed.

Charge 2a

2) On 7 November 2019:
    a) Incorrectly gave a Multivitamin tablet to Patient C;

This charge is found proved.

In reaching this decision, the panel took into account the incident report dated 26 November 2019, which stated:

> *"During the medication round at tea time [Patient C] was called for her medication, before taking her medication she counted the medication and this was correct and she stated the colours were all correct, and then proceeded to take her medication, however when the medication nurse [Mr Mpofu] was telling her what was in her medication pot, [Patient C] spat out the medication and shouted these are not mine. [Mr Mpofu] apologised to [Patient C] this incident was reported to the [Nurse in Charge]… [Patient C] did not take the medication, she spat this out when she was told what was in there."*

The panel noted that Mr Mpofu has never sought to deny that he incorrectly gave a multivitamin tablet to Patient C. It had regard to the local investigation report which states:

"[Mr Mpofu] then stated that [Patient C's] medication needs to be crushed so he began to do that, then after crushing he turned back to [Patient C] and to the trolley where he had put the multi vitamin picked up a pot and then handed her the Quetiapine crushed and the pot. [Mr Mpofu] then stated that he told [Patient C] about that the tablet was a multi vitamin as she was about to put it in her mouth. [Mr Mpofu] stated that the multi vitamin never went into [Patient C]'s mouth at any point."

The panel concluded that, on the basis of the evidence before it, Mr Mpofu did incorrectly give a Multivitamin tablet to Patient C. It noted Mr Mpofu's account and Patient C's account as relayed to Witness 3 were broadly consistent. It therefore found this charge proved.

Charge 2b

2) On 7 November 2019:
   b) Asked Colleague E not to report the incident at Charge 2.a.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence as well as the evidence of Witnesses 3 and 4.

It had regard to the documentation of the local investigatory meeting which took place on 26 November 2019 between Witness 3 and Witness 4. It states:

"[Witness 3]: … she was senior on that day so I reported it to her then I went and filled in an incident form and then staff told me he had gone off the ward he was very upset then I saw him and he said I could lose my job because of this"

The panel noted that what is stated by Witness 3 suggests that Mr Mpofu said “I *could lose my job because of this*” after she had already reported the incident to the senior nurse, and it noted that there is no suggestion during this interview by Witness 3 that she was asked not to report the incident by Mr Mpofu.

During her evidence, Witness 3 explained that on the date of the incident she was ‘supernumerary’ meaning that she was away from the ward and dedicated to carrying out her administrative duties. She explained she came onto the ward for some information she required and that was when the patient had reported the incident to her. She stated during her evidence:

> *“I spoke to [Mr Mpofu] about an allegation that had been made against him about medication that I needed to report. He told me he would lose his job, “don't report it, I'd lose my job”.”*

Witness 3 told the panel that she does not know why this was not reflected in the recording of the meeting dated 26 November 2019. She suggested that it was not reflected because of the way that it had been recorded, as she had recalled accurately the sequence of what had occurred. However, the panel noted that during her evidence Witness 4 explained that the meeting was recorded via audio and that notes were being taken by a member of staff from HR. She agreed that this was a near-verbatim recording of the meeting.

Further, Witness 4 explained during her evidence that Witness 3 was acting as nurse in charge on the day of the incident and not supernumerary. She explained that Mr Mpofu had been moved across from another unit and that automatically places the nurse who regularly works on the unit as the nurse in charge and explained that in this case it was Witness 3. She stated that Witness 3, on reflection when interviewed at a later date, had not wanted to take responsibility for being in charge on that day, and she cannot account for Witness 3’s rationale.

Witness 4 said that in a different conversation prior to the investigation she remembered Witness 3 telling her that Mr Mpofu had asked her not to report the incident, but no record of this was provided to the panel. Upon further enquiry by the panel, Witness 4 said that Witness 3 had not been '100% sure' of what Mr Mpofu had said and consequently Witness 4 had decided it would be unfair to explore this in her local investigation. As such the allegations had not been put to Mr Mpofu for him to have the opportunity to respond. Hence no allegation of dishonesty or a failure in Mr Mpofu's duty of candour was ever investigated locally.

The panel found the evidence provided by Witness 3 to be inconsistent. It noted that she has provided conflicting accounts of when Mr Mpofu suggested being worried about losing his job. It noted that, closer to the time of the incident, in the record of the meeting, she reported him saying it after she had already reported the incident to the senior nurse; in contrast, her witness statement to the NMC stated that it had happened before she reported the incident to the senior nurse. It was Witness 4's evidence that the conversation between Mr Mpofu and Witness 3 took place after Witness 3 had reported the incident, rather than before.

The panel found that the evidence in support of this charge was inconsistent and unreliable. It considered that the evidence provided by Witness 3 during the hearing contradicts the information in the near verbatim record of the contemporaneous investigations carried out by the Hospital. The panel was further persuaded by Witness 4's evidence that, when she had asked Witness 3 for clarity, Witness 3 was not confident of what she had heard at the time.

The panel was therefore not satisfied, on the basis of the information before it, that it was more likely than not that Mr Mpofu asked Colleague E (Witness 3) not to report the incident at Charge 2a. It therefore found this charge not proved.

Charge 3

3) Your actions at Charge 2.b. were dishonest and/or a breach of your professional duty of candour in that you deliberately sought to conceal that you had made a medication error.

This charge is found NOT proved.

The panel concluded that, given it has found charge 2b not proved, charge 3 falls away. It therefore found this charge not proved.

Fitness to practise

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

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

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

Submissions on misconduct and impairment

Mr Gruchy addressed the panel on the issue of impairment and 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.

Mr Gruchy submitted that based on the charges found proved and the context within which the regulatory concerns occurred, the panel should consider if Mr Mpofu's practice could still present risks to the health, safety, or wellbeing of the public. Further, it should consider whether there has been any demonstration of any learning or insight.

Mr Gruchy submitted that the regulatory concerns relate to administering medication incorrectly on 2 occasions. He acknowledged that there was no actual harm to the two patients involved but he invited the panel to consider whether there is evidence to suggest that the regulatory concerns exposed the patients to a risk of harm.

He submitted that the evidence indicates that, due to the types of medication given in error in the first incident and the allergies of the patient in the second incident, there was a very clear risk to patients.

Additionally, he submitted that the panel might conclude that the evidence of Witnesses 1 and 3 is such that the risk could have been exacerbated by the delay in the taking of appropriate action in response. He submitted that these concerns do fall under the category of concerns that can be addressed. However, when considering insight and the reflective accounts that have been provided by Mr Mpofu, and indeed considering the contextual factors, the panel may be of the view that these are not sufficient to absolve Mr Mpofu from his personal professional responsibilities to establish and confirm the identities of patients and check prescriptions fully before administering medication.

Mr Gruchy submitted that there is no reflective account from Mr Mpofu in relation to the second of the two incidents, and as Mr Mpofu has ceased to engage with the NMC for some considerable time now, it is difficult to assess whether Mr Mpofu has remediated the

concerns or developed further insight. He submitted that it is unknown to the NMC what Mr Mpofu has been doing or whether there has been a period of safe practice and whether any of the concerns that have been proved have been addressed.

Mr Gruchy submitted that there are no testimonials or references before the panel that deal with his current position or the resolution of previous risks, insofar as they impact upon the panel's assessment of current risk.

Mr Gruchy submitted that in the absence of any additional information from Mr Mpofu, the risk of repetition is high and insufficient insight has been demonstrated to fully address the regulatory concern. As such the evidence suggests that he remains a risk to the health, safety or wellbeing of the public. He submitted that a finding of impairment can properly be made on the grounds of departure from the code and indeed on the first three of the four limbs of Dame Janet Smith's guidance.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on 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.'*

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

The panel determined that Mr Mpofu's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Mpofu's actions amounted to a breach of the Code, specifically the following:

1 Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

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

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

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

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel went on to consider whether Mr Mpofu's actions as set out in the charges amount to misconduct.

The panel first considered whether Mr Mpofu's actions as set out in charges 1a and 1b amount to misconduct. The panel is of the view that a registered nurse would be expected to check and confirm a patient's identity before administering any medications. The panel further considered that confirming a patient's identity is one of the most fundamental things you do as a nurse before administering medication. It concluded that, in this case, Mr Mpofu's errors had potential for catastrophic consequences and are sufficiently serious to amount to misconduct.

The panel next considered misconduct in respect of charges 1c(i) and 1c(ii). The panel considered whether Mr Mpofu, without an unreasonable delay, took an appropriate course of action. The panel noted that Mr Mpofu had realised his error shortly after 22:00 and, having realised, he had called his senior to explain what had occurred and called the hospital and explained what had happened including information about the patient and the medications provided. The panel noted Mr Mpofu's statement that the hospital did not regard this as an emergency but would send an ambulance when one was available. Additionally, the panel noted that Mr Mpofu had called the on-call Doctor. The panel considered that Mr Mpofu sought assistance from more than one direction, without any delay, and had been given assurances that there was no need for emergency services at that time. It therefore concluded that Mr Mpofu's actions as set out in charges 1c(i) and 1c(ii), although they had more likely than not occurred, did not demonstrate a failure on Mr Mpofu's part as the panel does not consider there to have been a duty on him to get the patient to hospital as an emergency or to prevent the patient from going to bed. The panel therefore concluded that his actions in charges 1c(i) and 1c(ii) do not amount to misconduct.

The panel finally considered charge 2a. The panel considered the circumstances in which this error had occurred, and it determined that Mr Mpofu made a relatively minor error

which he quickly recognised and corrected. Although this was a second medication error from him, the panel found that in itself it was not sufficiently serious to amount to misconduct.

The panel found that Mr Mpofu's actions in charges 1a and 1b did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must 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) *[…].’*

The panel found that limbs a, b and c are engaged in this case. The panel finds that Patient A was put at a real risk of harm as a result of Mr Mpofu’s misconduct. Mr Mpofu’s misconduct had breached a fundamental tenet of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel has had regard to Mr Mpofu’s reflective account in relation to the incident as set out in charges 1a and 1b. The panel did find that Mr Mpofu demonstrated an understanding of what he did wrong and what he should have done differently. However, the panel did not have evidence of insight from Mr Mpofu beyond the reflective account. It did not have any evidence that Mr Mpofu has demonstrated an understanding of how his actions impacted negatively on the reputation of the nursing profession.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or

not Mr Mpofu has taken steps to strengthen his practice. The panel has not had any information before it to confirm what Mr Mpofu has been doing since May 2020 in terms of nursing practice and does not have any information to demonstrate Mr Mpofu's his ability to practise safely in the areas in which he has been found to have fallen short.

The panel considered that these concerns arose in the context of Mr Mpofu being taken out of his usual working environment and placed in different, higher pressure, ward where he was not familiar with the patients. The panel further noted the evidence Witness 2 who spoke highly of Mr Mpofu's clinical skills when working on his own ward area.

However, the panel considered that, in respect of a risk of repetition, Mr Mpofu has not engaged with the NMC since May 2020 and has not demonstrated how he would ensure that a repeat of his errors would be avoided. Additionally, the panel considered that, although it found that the medication error as set out in charge 2a did not cross the bar of seriousness and amount to misconduct, it noted that it was a repeated error relating to medications administration. It therefore was not satisfied that the risk of repetition in this case is low. The panel therefore decided 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 determined that a finding of impairment on public interest grounds is required as it concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It therefore also finds Mr Mpofu's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of two years. The effect of this order is that Mr Mpofu's name on the NMC register will show that he is subject to a conditions of practice order and anyone who enquires about his registration will be informed of this order.

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

Submissions on sanction

Mr Gruchy informed the panel that in the Notice of Hearing, dated 4 May 2023, the NMC had advised Mr Mpofu that it would seek the imposition of a striking off order if it found Mr Mpofu's fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submitted that a suspension order with a review is more appropriate in light of the panel's findings.

Mr Gruchy identified the aggravating features in this case as: conduct which put a patient at a real risk of harm, repeated medication errors and Mr Mpofu's limited insight. He submitted that the incidents occurred in circumstances where Mr Mpofu was placed in an unfamiliar or challenging environment, which could be considered as a mitigating feature in this case. In addition, he submitted that the positive witness evidence in relation to Mr Mpofu's clinical practice and his expressions of remorse are also mitigating features in this case.

Mr Gruchy submitted that taking no action or imposing a caution order are considered not to be appropriate by the NMC. He submitted that these would not address the public protection risks.

Mr Gruchy submitted that, on the face of it, a conditions of practice order would be appropriate if Mr Mpofu had engaged as the risk would be capable of being addressed with conditions. He submitted that Mr Mpofu has previously demonstrated potential to respond positively to retraining through his previous engagement with these matters at a local level.

However, Mr Gruchy submitted that at this stage, there is no evidence at all that there remains a willingness from Mr Mpofu to respond to positively to retraining. He further submitted that, for a considerable period of time, the NMC has been unable to trace Mr Mpofu's whereabouts. As such, he submitted that a conditions of practice order would be unworkable given the circumstances.

Mr Gruchy referred the panel to the SG and drew its attention to the section headed 'When and how to get other people's input when setting conditions'.

Mr Gruchy invited the panel to consider imposing a suspension order. He submitted that either Mr Mpofu or the NMC can seek an earlier review of the order should further information become available. He submitted that the length of the order is a matter for the panel. He submitted that, if Mr Mpofu decides to re-engage with the NMC, he may request an early review and if he was able to demonstrate a willingness to respond positively to retraining, and a reviewing panel may well consider at that stage imposing a conditions of practice order.

In closing, Mr Gruchy acknowledged that this is a case that relates to a single instance of misconduct, with no evidence of harmful deep-seated personality or attitudinal problems and that Mr Mpofu has demonstrated some insight. He accepted that Mr Mpofu's actions

are not fundamentally incompatible with continued registration and therefore a striking-off order would not be the appropriate sanction in this case.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Conduct which put Patient A at risk of suffering harm; and
- A second error relating to medication administration, albeit one that was not sufficiently serious to be found misconduct in itself.

The panel also took into account the following mitigating features:

- Incidents arose when Mr Mpofu was placed in an unfamiliar, high-pressure working environment;
- Evidence of Witness 2 that Mr Mpofu has a previous history of good nursing practice;
- Evidence of Mr Mpofu's remorse;
- Evidence of Mr Mpofu's insight into his errors within his reflective account of the incidents set out at charges 1a and 1b; and
- Mr Mpofu's previous willingness to engage in retraining and his successful completion of a competency assessment after the incident occurred, as well as his full cooperation with the local investigations at the Hospital.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the need to protect the public. 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 public protection issues identified, an order that does not restrict Mr Mpofu's practice would not be appropriate in the circumstances. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *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 conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practicable conditions which would address the failings highlighted in this case. In reaching its decision, the panel had regard to the SG which sets out the following:

> *"The panel needs to be confident that the conditions of an imposed order are workable, however, neither the nurse, midwife or nursing associate, employer, nor*

anyone else who may be affected by a conditions of practice order, needs to expressly agree to the terms of the conditions for it to be imposed."

The panel noted that Mr Mpofu had previously engaged with the local investigations at the Hospital and also with the NMC until May 2020. The panel determined that it does not have reasons for Mr Mpofu's disengagement since May 2020, other than that, having been told by his employer that he could no longer work as a nurse, he travelled to Zimbabwe and was then unable to return to the UK because of the Covid-19 pandemic.

Further, it had regard to the fact that these incidents happened a long time ago and that, other than these incidents, the panel has heard that Mr Mpofu was working well as a nurse. The panel considered that it was in the public interest that, with appropriate safeguards, Mr Mpofu should be able to return to practise as a nurse. The panel considered, in light of the guidance above, that Mr Mpofu's current lack of engagement is not a bar to the imposition of a conditions of practice order.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel determined that to impose a suspension order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mr Mpofu's case. The panel found that Mr Mpofu's previous engagement with the process, together with the insight he has demonstrated in his reflective account and previous willingness to comply with retraining, demonstrate that a conditions of practice order could be workable. Further, the panel found that a conditions of practice order would provide the public with the necessary protection and meet the wider public interest.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must be directly supervised at any time that you are administering medications until you have undergone refresher training in medications administration and successfully completed a competency assessment.

2. Thereafter, you must ensure that you are supervised by a registered nurse at any time you are administering medication. Your supervision must consist of:
    - Working on the same shift as, but not always directly observed by a registered nurse.

3. You must keep the NMC informed about anywhere you are working by:
    - Telling your case officer within seven days of accepting or leaving any employment.
    - Giving your case officer your employer’s contact details.

4. You must keep the NMC informed about anywhere you are studying by:
    - Telling your case officer within seven days of accepting any course of study.

- Giving your case officer the name and contact details of the organisation offering that course of study.

5. You must immediately give a copy of these conditions to:
   - Any organisation or person you work for.
   - Any agency you apply to or are registered with for work.
   - Any employers you apply to for work (at the time of application).
   - Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
   - Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

6. You must tell your NMC case officer, within seven days of your becoming aware of:
   - Any clinical incident you are involved in.
   - Any investigation started against you.
   - Any disciplinary proceedings taken against you.

7. You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   - Any current or future employer.
   - Any educational establishment.
   - Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for two years, which the panel decided would be a sufficient period for Mr Mpofu to re-engage with the NMC and nursing practice in the UK, and complete a competency assessment in medication administration and demonstrate a period of safe practice. It will be open to Mr Mpofu to request an early review of this order on completion of the assessment.

Before the order expires, a panel will hold a review hearing to see how well Mr Mpofu has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Mr Mpofu's attendance at the next hearing;
- Evidence of successful completion of the competency assessment in medications administration;
- Evidence of any training attended and/or completed;
- A testimonial from a line manager or employer surrounding Mr Mpofu's experience in the administration of medication; and
- A further reflective piece addressing the wider impact of his misconduct on the reputation of the profession.

This will be confirmed to Mr Mpofu in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Gruchy. He made an application for an 18-month interim conditions of practice order on the grounds of public protection and the wider public interest to cover the 28-day appeal period.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to 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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover the period in which any appeal may be lodged by Mr Mpofu and the period in which it may be heard.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mr Mpofu is sent the decision of this hearing in writing.

That concludes this determination.