Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 5 June – 14 June 2023

Virtual Hearing

Name of Registrant:	**Zeljko Skrbina**
NMC PIN	01B0821E
Part(s) of the register:	Nursing – Sub Part 1 Adult Nursing – February 2004
Relevant Location:	Stockport, Stoke-on-Trent, Cheshire East, Lancashire and Preston
Type of case:	Misconduct
Panel members:	Simon Banton (Chair, Lay member) Laura Scott (Registrant member) Asmita Naik (Lay member)
Legal Assessor:	Paul Housego
Hearings Coordinator:	Elena Nicolaou
Nursing and Midwifery Council:	Represented by Alban Brahimi, Case Presenter
Mr Skrbina:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3a, 3c, 3d, 3e, 3f, 4, 5a, 5b, 5c, 5e, 5f, 6, 7, 8, 9, 10, 11, 12b, 13, 14, 15, 17a, 17b and 17c.
Facts not proved:	Charges 3b, 3g, 5d, 12a and 16.
Fitness to practise:	Impaired
Sanction:	**Striking-off Order**

Interim order:	**Interim Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Skrbina was not in attendance and that the Notice of Hearing letter had been sent to his registered email address by secure email on 3 May 2023.

Mr Brahimi, 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, that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Skrbina'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 Skrbina has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Skrbina

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

Mr Brahimi referred the panel to the Proceeding in Absence (PIA) bundle, which included various responses from Mr Skrbina to the NMC. He submitted that Mr Skrbina has made it clear that he does not want to engage with the NMC's proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion. He submitted that Mr Skrbina has asked for information regarding voluntary removal from the NMC's register.

Mr Brahimi submitted that although Mr Skrbina has somewhat engaged with the NMC, he has ruled out any possibilities of attending a virtual or physical hearing. Mr Brahimi also reminded the panel that there are a number of witnesses scheduled to give oral evidence at this hearing and adjourning this matter would cause some inconvenience to them.

The panel accepted the advice of the legal assessor.

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 Skrbina. In reaching this decision, the panel has considered the submissions of Mr Brahimi 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 Skrbina;
- Mr Skrbina has made it clear to the NMC that he does not want to engage in or participate with these proceedings;
- There is no reason to suppose that adjourning would secure Mr Skrbina's attendance at some future date;

- Two witnesses have attended on the first day of the hearing to give live evidence, and others are due to attend in the upcoming days;
- 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 as far back as 2010;
- 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 Skrbina in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to Mr Skrbina at his registered address, he has made no detailed response to the allegations. 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, the limited disadvantage is the consequence of Mr Skrbina's decision 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 Skrbina. The panel will draw no adverse inference from Mr Skrbina's absence in its findings of fact.

Decision and reasons on application to amend the charge (1)

The panel heard an application made by Mr Brahimi, on behalf of the NMC, to amend the wording of charge 2.

The proposed amendment was to amend the wording of charge 2 to instead say:

'That you, a registered nurse;

Whilst working a shift at Stepping Hill Hospital;

2) *On or around ~~5 February~~* ***20 January*** *2010, when requested, did not pass a call buzzer/bell to Patient Y.'*

Mr Brahimi submitted that this was purely a typographical error. He referred the panel to exhibit [Witness 1]/3 in which Mr Skrbina makes clear that the date of the incident in question was 20 January 2010. It was submitted by Mr Brahimi that the proposed amendment above would provide clarity and more accurately reflect the evidence.

Mr Brahimi reminded the panel that Mr Skrbina has chosen not to engage with these proceedings, and consequently he has forfeited his opportunity to respond to this application. He submitted that the amendment as applied for would not cause any injustice or unfairness towards Mr Skrbina, and it is purely an amendment based on the evidence he has already been served.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Skrbina and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit hearsay evidence (1)

The panel heard an application made by Mr Brahimi under Rule 31 to admit a number of documents containing hearsay evidence. He provided written submissions which are as follows:

'***Statutory Hearsay Guidance***

1. *The fitness to practice panel is entitled to hear evidence pursuant to Rule 31 of the Nursing and Midwifery Council (Fitness to Practice) Rules 2004:*

   31 (1) Upon receiving the advice of the legal assessor, and subject only to the
   requirements of relevance and fairness, a Practice Committee considering an
   allegation may admit oral, documentary or other evidence, whether or not such
   evidence would be admissible in civil proceedings (in the appropriate Court in
   that part of the United Kingdom in which the hearing takes place).

NMC Hearsay Guidance

2. *The panel is also assisted by guidance provided by the NMC Fitness to Practice Library, where hearsay is further explored under reference DMA-6:*

‘In general terms, hearsay is any evidence which is not given orally by a witness with direct experience of the matter they are giving evidence about, and which is being given to prove an issue in dispute.

Evidence given by telephone and video link is not hearsay evidence. To the extent that there are limitations on evidence given by remote means that is a matter of weight (see above).

Most commonly, hearsay evidence will involve a witness reporting what they were told about something in issue by another individual who is not themselves a witness, or a statement being placed before a panel without the maker of the statement giving oral evidence.

Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn’t ‘demonstrably reliable’ and not capable of being tested.

Hearsay statements will usually carry less weight than oral evidence because it cannot be tested. Hearsay evidence may also be inadmissible where the weight which could be given to it in the circumstances of the case is zero, even where there is other evidence that could ‘corroborate’ (or support) it. Although it’s not possible to provide a complete list of situations where this could happen, one example is where the evidence of a crucial witness is hearsay, and the fact that the nurse, midwife or nursing associate can’t challenge it is so unfair that nothing else in the hearing process can avoid the unfairness.’

Case Law Hearsay Guidance

3. *NMC submit there is no unfairness to the Registrant by having the evidence placed within the bundle and put before the Panel as this would not be in line with best practice or the relevant authorities such as Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin) at paragraph 58 where it set out that the Panel should have been provided at the fact-finding stage with all of the documents which the Claimant (the NMC) had submitted. Also, paragraph 59, which explains that the decision on admissibility was a judgement for the Panel to make, not the legal assessor or the case presenter. In the absence of the Appellant the only proper way for the Panel to judge the relevance and admissibility of the statements was to read them for themselves. So essentially the Panel have to see what it is they're being asked to adjudicate on. The Panel cannot be expected to judge the relevance and fairness of evidence if they cannot see it for themselves, otherwise the Panel would be relying on a generalised description from Counsel and placing reliance on Counsel's interpretation, which is wholly wrong as Counsel is not the Judge of fact.*

4. *If the Panel refuse the hearsay application, it is submitted that as a professional Panel, you would be able to put it out of your mind as the Panel are not a jury but are adjudicators on what to admit. It is submitted that the Panel are required to consider the merits of the evidence and decide whether to formally admit the evidence, to accept it into the evidence the Panel take into account when they retire. The case of El Karout v NMC (2020) EWHC 3079 adopts the principles of Ogbonna (2010) EWCA Civ 1216 and Thorneycroft, and makes clear the need for a Panel to undertake a careful balancing exercise before admitting hearsay evidence, especially in a case where the evidence is the sole or decisive evidence on an allegation. The key issue in all cases is one of*

"fairness". If the Panel decide to admit the hearsay evidence, then the Panel can determine what weight to attach to that evidence.

Submissions:

Charge 1

5. *The evidence relied upon by the NMC for this charge includes the witness statement of [Witness 1] who at paragraph 17 exhibits [Witness 1]/2 & [Witness 1]/3*
   The registrant accepts administering the injection intramuscularly and mitigates this by stating that he was not provided with support. The evidence for this charge is not sole and decisive – we have evidence of a complaint and a response from the registrant admitting the action, although he does deny any wrongdoing due to a lack of support. There is no suggestion of fabrication. The charge is serious as it involves a medication error, however the misconduct stems from over 13 years ago and a finding of this charge alone may not have an impact on the overall outcome of the registrant's case or career. The NMC has evidence of admission – it would be disproportionate to call the actual patient as a witness.

Charge 2 (with new amendment of 20th January 2010)

6. *The evidence relied upon by the NMC for this charge includes the witness statement of [Witness 1] who at paragraph 18 exhibits [Witness 1]/2 & [Witness 1]/3 The registrant accepts that he did not pass the buzzer to the patient as he was busy. The evidence in this charge is not sole and decisive, we have evidence of a complaint and a response from the registrant admitting the action, although he does deny wrongdoing*

due to being busy on the ward. There is no suggestion of fabrication. The charge is serious as it involves a medication error, however the misconduct stems from over 13 years ago and a finding of this charge alone may not have an impact on the overall outcome of the registrant's case or career. The NMC has evidence of admission – it would be disproportionate to call the actual patient as witness.

Charge 11

7. *The evidence of [Witness 4] from para 34-38 is not sole and decisive – the evidence corroborated by [Witness 5] was is [sic] a direct eye witness. She confirms the conversation between the registrant and Patient C and that the registrant did not in fact escalate the matter to the Nurse in Charge... Furthermore, the registrant has provided a response to these allegations in his Response to the Incidents at Leighton Mid Cheshire Trust dated 08/03/2019. Where he states that this incident would not have occurred had male and female staff members been placed on the ward. The registrant does not challenge the fact that he did not escalate this incident to the nurse in charge despite providing a detailed response and account of the incident. This is a serious charge and will have an impact on impairment as it involves deliberately disregarding a patient's request and their dignity. The NMC have direct eye-witness evidence and a written response of the incident it would be disproportionate to request the patient to give evidence. The registrant has been served all of the evidence well in advance of the hearing and in the case management form, the registrant is fully aware of the evidence the NMC intend to rely upon and the registrant was informed that a hearsay application would be made regarding the evidence relating to charge 11.*

Charge 12

8. *The hearsay evidence is contained in the witness statement of [Witness 4] where she makes reference to a conversation at paragraphs 42-43 of her witness statement and in paragraph 10 of her supplementary witness statement. This evidence is not sole and decisive firstly the lack of medication administration is corroborated in]Witness 4]/04 which shows on page 162 (pdf) (same as [Witness 4]/09) that the patient was not administered Oramorph between 10a.m and 10p.m. despite being prescribed it every 4 hours. Secondly there is [Witness 4]/8 which is an email from [Witness 4] to [Another Colleague] 02/03/2019 where the witness [Witness 4] makes reference to Patient D stating that registrant refused to give her Oramorph. 'Bed three said he refused to give her Oramorph and said she was to ask the night staff as it would help her sleep, but she is pxd it 4 hourly and had only had it at 10a.m.' The registrant denies refusing to administer the medication to the patient. In his response he states that the patient refused the medication as they stated they were not in pain when he asked. The registrant has not expressly stated that the allegation by [Witness 4] is fabricated but sets out his version of the incident and expressly denies the allegation. This is an extremely serious charge if found proves demonstrates a deliberate refusal to administer medication when requested by a patient. If found proved this will have an adverse impact on the registrant's nursing career. The NMC did not consider it proportionate to call the patient in this case.*

Charges 13, 14 and 15

9. *The hearsay evidence can be found in paragraphs 50-51 of [Witness 4] witness statement as she relays a conversation where Patient E informed*

her that the registrant had refused to assist her to the toilet and denied the patient's request to help her get out of bed. This evidence is not sole and decisive the registrant in his response dated 08/03/2019 at paragraph 7 accepts that he did not assist the patient as he states 'I followed the physio's protocol and repeated to the patient that I could not let her walk until after assessment by the physio. The complainant needs to be asked why did she allow the patient to walk before the physio's assessment…' [Witness 4]/5 at page 173 includes a record in the daily summary of care where [Witness 4] has recorded the patient's complaints. The NMC did try and obtain the physio book however were unsuccessful with this PIW [Post Investigation Work]. The witness [Witness 4] is clear in paragraph 53 that the patient did not require a physio assessment and that a nurse could have made the assessment. There is no suggestion of fabrication. The NMC did not consider it proportionate to pursue a witness statement form a vulnerable patient when we have an admission from the registrant regarding the non assistance and a witness statement from an RGN confirming that the patient did not require physiotherapy assessments. As stated, we were unable to obtain the physio book. This is a serious charge relating to a pattern of deliberately failing to assist patients. If found proved it will have an adverse impact on the registrant's career. The issues relating to charge will focus more so on whether the registrant should have left the patient in bed, fail to actually conduct his own assessment and incorrectly tell the patient she needed a physiotherapy assessment. The evidence of [Witness 4] is that the patient did not require an assessment and the registrant was merely trying to avoid a task. When looking at the patient notes [Witness 4]/5 page 174 (pdf) the registrant at 5p.m. on 02/03/2018 records that the patient is not fit for discharge until reviewed by a physiotherapist where as a at 2a.m [Witness 4] assist the patient to the toilet by walking her there. There is an argument that the refusal to assist

the patient to the toilet and the physiotherapy assessment are not linked, the registrant could have helped this patient.

Charge 16

10. *The hearsay evidence is contained in paragraph 60 where the witness [Witness 4] spoke to the patient's mother who informed her that Patient G was in pain. This is not sole and decisive firstly [Witness 4] had recorded this in her email contained at [Witness 4]/7. 'Bed 2 said he refused to give paracetamol and codeine together and he said she doesn't look in pain so she didn't need it.' Furthermore, the registrant actually admitted to not administering the medication directly to [Witness 4] at paragraph 59 and in his written response where he states 'The patient in 2, again I asked the patient are you in pain. At the time she said "no". As she wasn't showing any symptoms associated with pain and had furthermore refused by saying no, I followed her instructions.' The NMC have not obtained a witness statement from the patient – the registrant accepts that he did not administer the analgesia the issue is whether he is able to make a decision to override a prescription for Codeine (page 179 [Witness 4]/7). It also does not appear that he has recorded a refusal but we can get [Witness 4] to clarify this as her evidence is clear that the registrant should have administered the medication and that the patient was in pain. The registrant is denying the fact that he refused to administer the medication, in fact he states the patient refused. If found proved this charge demonstrates a pattern of misconduct where the registrant refused to provide basic and compulsory levels of care to vulnerable patients. The registrant has been submitted all of this material in advance and informed this is what the NMC would be relying upon.*

> 11. *The registrant was served all documents well in advance of the hearing and informed we would be relying on the evidence at the substantive hearing. The registrant was also informed on Friday 2 June 2023 that the NMC would be applying under rule 31 to adduce hearsay evidence in relation charges 1, 2, 11, 12, 13, 14, 15 & 16.'*

The panel took account of all the evidence before it and the written submissions of Mr Brahimi. It considered each charge in turn:

Charge 1

The panel considered that this is not sole or decisive evidence, as it has the initial contemporaneous complaint from the nursing staff, as well as Mr Skrbina's response as to what occurred at the time. The panel considered that, given the passage of time, it would be inappropriate to locate the patient that made the complaint at the time.

In these circumstances, the panel came to the view that it would be fair and relevant to accept the hearsay evidence relating to charge 1, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Charge 2

For the same reasons as set out in charge 1, the panel considered that it would be fair and relevant to accept the hearsay evidence relating to charge 2, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Charge 11

The panel considered that this is not sole or decisive evidence, as it has the response from Mr Skrbina as to what occurred at the time. It noted that a witness will be giving live evidence in relation to this charge. The panel considered that, given the passage of time, it would be inappropriate to call this particular patient to give evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to accept the hearsay evidence relating to charge 11, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Charge 12

The panel considered that this is not sole or decisive evidence, and that a witness will be giving oral evidence in relation to this charge, who could take the panel through the relevant documents.

In these circumstances, the panel came to the view that it would be fair and relevant to accept the hearsay evidence relating to charge 12, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Charge 13, 14 and 15

The panel considered that this is not sole or decisive evidence, as it has the response from Mr Skrbina as to what occurred at the time. The panel also has contemporaneous documentation from the time of the incident. It considered that it would be inappropriate to seek the patient’s account, considering the passage of time.

In these circumstances, the panel came to the view that it would be fair and relevant to accept the hearsay evidence relating to charges 13, 14 and 15, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Charge 16

The panel considered that this is not sole or decisive evidence, as it has contemporaneous emails from the time of the incident, and the response from Mr Skrbina as to what occurred.

In these circumstances, the panel came to the view that it would be fair and relevant to accept the hearsay evidence relating to charge 16, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit hearsay evidence (2)

The panel heard an application made by Mr Brahimi under Rule 31 to allow the written statement of Witness 7 into evidence. Witness 7 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, involving various attempts by both email and phone, she was unable to be contacted. Mr Brahimi also informed the panel that a witness trace had recently been conducted, but this was unsuccessful.

In the preparation of this hearing, the NMC had indicated to Mr Skrbina that it was the NMC's intention for Witness 7 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 7, Mr Skrbina made the decision not to attend this hearing. On this basis, Mr Brahimi advanced the argument that there was no lack of fairness to Mr Skrbina in allowing Witness 7's hearsay testimony into evidence.

Mr Brahimi submitted that Witness 7's evidence is not sole or decisive, and although her evidence does not go towards the seriousness of the charges, it clarifies administrative

matters relating to the organisation. He submitted that there is no suggestion that Witness 7 would have fabricated her evidence, and it is not challenged by others.

The panel accepted the advice of the legal assessor.

The panel gave the application in regard to Witness 7 serious consideration. The panel noted that Witness 7'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 her.

The panel considered whether Mr Skrbina may be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 7 to that of allowing hearsay testimony into evidence. However, it considered that as Mr Skrbina had been provided with a copy of Witness 7's statement and, as the panel had already determined Mr Skrbina had chosen voluntarily to absent himself from these proceedings, and he would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 7 and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered it important that Witness 7's evidence did not go to any particular charge and related solely to administrative matters relating to the organisation.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Witness 7, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge (2)

The panel heard an application made by Mr Brahimi to amend the wording of charge 3b.

The proposed amendment was to amend the wording of charge 3b to instead say:

> *'Whilst working a shift at Royal Stoke Hospital in the recovery ward on or around 14 March 2017;*
>
> *3) Did not respond appropriately to Patient X's bleeding/deteriorating condition in that you;*
>
> *b) Were unable to open an anaesthetic/oxygen face mask* ***and/or the endobronchial suction****'.*

Mr Brahimi submitted that this amendment can suitably be made as it does not cause any injustice to Mr Skrbina, nor any unfairness. He reminded the panel that the original charge is still present, but there is some ambiguity as to what item it could have related to, based on the evidence heard from the NMC witnesses. He submitted that there has been a previous response from Mr Skrbina, so far as him being unable to open this particular item. He concluded by submitting that this is an addition to charge 3b that does not include any new information or evidence, and it is purely based on what has already been served on Mr Skrbina.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Skrbina and no

injustice would be caused to either party by the proposed amendment being allowed. The panel considered the responses provided by Mr Skrbina during the early stages, in relation to his difficulty with the oxygen mask and the endobronchial suction. It was therefore fair and appropriate to allow the amendment, as applied for, to ensure clarity, accuracy and reflect the evidence that has been heard.

Details of charge (as amended)

That you, a registered nurse;

Whilst working a shift at Stepping Hill Hospital;

1) On or around 25 January 2010, incorrectly administered morphine intra-muscularly to Patient Z. **[PROVED]**

2) On or around 20 January 2010, when requested, did not pass a call buzzer/bell to Patient Y. **[PROVED]**

Whilst working a shift at Royal Stoke Hospital in the recovery ward on or around 14 March 2017;

3) Did not respond appropriately to Patient X's bleeding/deteriorating condition in that you;
    a) Were unable to locate an anaesthetic/oxygen face mask. **[PROVED]**
    b) Were unable to open an anaesthetic/oxygen face mask and/or the endobronchial suction; **[NOT PROVED]**
    c) Did not obtain a new prescription chart. **[PROVED]**
    d) Incorrectly obtained a child health care chart. **[PROVED]**
    e) Did not obtain Fentanyl when instructed to do so. **[PROVED]**

f) Did not obtain a Bbraun set to administer the Hartmanns Solution bag. **[PROVED]**

g) Incorrectly attached the Hartmanns Solution bag to the existing system. **[NOT PROVED]**

4) Whilst working a shift at the Royal Preston Hospital in or around July 2016, incorrectly attached a paracetamol IV infusion to Patient W's arterial line. **[PROVED]**

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

5) During handover to Colleague A/Colleague B;
   a) Inaccurately reported that Patient A was absolutely fine. **[PROVED]**
   b) Inaccurately reported that Patient A had not suffered any bruising around their neck. **[PROVED]**
   c) Did not report that Patient A had suffered some swelling around their neck. **[PROVED]**
   d) Did not report that Patient A had trouble swallowing. **[NOT PROVED]**
   e) Inaccurately reported that Patient B had been talking throughout the shift. **[PROVED]**
   f) Inaccurately reported that Patient B had refused to have their wound dressings changed. **[PROVED]**

6) Your actions in one or more of charges 5 e) & 5 f) above were dishonest, in that you sought to misrepresent that Patient B had refused to have their wound dressings changed. **[PROVED]**

7) Did not administer prescribed Midazolam to Patient B. **[PROVED]**

8) Did not change Patient B's wound dressings. **[PROVED]**

9) Did not record in the daily summary of care that Patient B had refused to have their dressings changed. **[PROVED]**

10) On one or more occasion, refused to change Patient B's wound dressing, after Colleague C requested that you change them. **[PROVED]**

11) Did not inform the nurse in charge that Patient C requested a female nurse to conduct her wash. **[PROVED]**

12) Did not administer Oramorph to Patient D;
    a) At minimum intervals of 4 hours as prescribed. **[NOT PROVED]**
    b) When requested by Patient D as Po Re Nata (PRN). **[PROVED]**

13) Denied Patient E's request to get out of bed. **[PROVED]**

14) Did not conduct a mobility assessment for Patient E. **[PROVED]**

15) Incorrectly told Patient E to remain in bed for a physiotherapy assessment. **[PROVED]**

16) Did not administer codeine to Patient G as prescribed. **[NOT PROVED]**

17) On an unknown date when Patient H requested assistance after soiling themselves, used words to the effect;
    a) "that you were not there to help Patient H" **[PROVED]**
    b) "that Patient H had two hands and could clean himself up" **[PROVED]**
    c) "you would help Patient H on this one occasion only" **[PROVED]**

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

(Throughout this decision, the correct term 'Pro Re Nata' is used).

Background

The charges arose whilst Mr Skrbina was employed as a registered nurse by a number of employers, namely: Stepping Hill Hospital, Royal Stoke Hospital, Royal Preston Hospital and Leighton Mid Cheshire Hospital NHS Foundation Trust (Leighton Hospital).

The allegations relate to a number of clinical practice concerns in respect of multiple patients, and involve medications errors, communication issues, and potential attitudinal concerns in the workplace.

It is also alleged that Mr Skrbina was dishonest in that he sought to misrepresent that Patient B had refused to have their wound dressings changed.

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 Brahimi on behalf of the NMC.

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

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: Head of Clinical Services and Governance; Medacs Healthcare Agency
- Witness 2: Band 6 Theatre Practitioner; Royal Stoke University Hospital
- Witness 3: Band 5 Theatre Practitioner; Royal Preston Hospital
- Witness 4/Colleague A: Former Senior Staff Nurse; Leighton Hospital
- Witness 5/Colleague B: Senior Staff Nurse; Leighton Hospital
- Witness 6/Colleague C: Healthcare Assistant; Leighton Hospital

The panel also took account of the written hearsay evidence by the following witness:

- Witness 7: Ward Manager; Leighton 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 charges and made the following findings.

Charge 1

That you, a registered nurse;

Whilst working a shift at Stepping Hill Hospital;

1) On or around 25 January 2010, incorrectly administered morphine intra-muscularly to Patient Z

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered the written evidence of Witness 1, namely a near contemporaneous complaint form that was submitted by Stepping Hill Hospital, dated 25 January 2010. This form clearly sets out that morphine was incorrectly administered intra-muscularly to Patient Z as opposed to subcutaneously.

The panel then considered the oral evidence of Witness 1 who confirmed that the agency received the above complaint form regarding the incident with Patient Z. She told the panel that Mr Skrbina should have checked the correct administration route or asked another member of staff if he was unsure before administering the drug to the patient.

Witness 1 confirmed that she was not an eyewitness to the incident and, as such, her evidence was hearsay. However, the panel noted that Witness 1's evidence was not sole

or decisive as it also took into account the response from Mr Skrbina in relation to this incident, within an email dated 11 February 2010, in that he made some admissions:

> *'…on the patient's hand was inserted some type of cannula, which I had never seen before. Therefore, it was obvious to me, in such a situation to ask for help regarding that type of subcutaneous injection administration. But when I asked for clarification of my query, I was ignored by a regular member of staff… I was left on my own to decide what to do and than blamed after my actions… [sic]'*

The panel considered that although Mr Skrbina does not explicitly say that he incorrectly administered morphine intra-muscularly, it is clear from his description that he accepted that he administered the drug intra-muscularly, and not subcutaneously.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that this did occur and the panel finds charge 1 proved.

Charge 2

That you, a registered nurse;

Whilst working a shift at Stepping Hill Hospital;

2) On or around 20 January 2010, when requested, did not pass a call buzzer/bell to Patient Y.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that the evidence for charge 2 is similar to that in charge 1. The panel took account of the near contemporaneous complaint form that was submitted by Stepping Hill Hospital. This form clearly sets out that Patient Y had asked Mr Skbrina to pass her the buzzer, and he had told her that he could not as he was busy attending to other patients.

The panel also considered the response from Mr Skrbina in relation to this incident, in that he made some admissions:

> *'I did not pass the buzzer to a patient, because as stated in original complaint I was busy… The patient was perfectly capable of reaching the buzzer herself…'*

The panel noted that Mr Skrbina's response above to the incident involving Patient Y was very dismissive.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did not pass the buzzer to Patient Y when requested, and the panel finds charge 2 proved.

Charge 3

That you, a registered nurse;

Whilst working a shift at Royal Stoke Hospital in the recovery ward on or around 14 March 2017;

3) Did not respond appropriately to Patient X’s bleeding/deteriorating condition in that you;
   a) Were unable to locate an anaesthetic/oxygen face mask.
   b) Were unable to open an anaesthetic/oxygen face mask and/or the endobronchial suction.
   c) Did not obtain a new prescription chart.
   d) Incorrectly obtained a child health care chart.
   e) Did not obtain Fentanyl when instructed to do so.
   f) Did not obtain a Bbraun set to administer the Hartmann’s Solution bag.
   g) Incorrectly attached the Hartmann’s Solution bag to the existing system.

Charge 3a

In reaching this decision, the panel took into account of the oral and documentary evidence before it.

The panel considered the evidence of Witness 2’s NMC statement, which stated:

> *‘[Mr Skrbina] was asked to get an anaesthetic facemask but [Mr Skrbina] was not able to locate one… I was passing by and was shocked that [Mr Skrbina] had not looked in the drawer located infront of him. I intervened and asked [Mr Skrbina] to look in the top drawer near him… [sic]’*

Witness 2 in her oral evidence also made it clear that Mr Skrbina should have known where the equipment was kept and pre-empted the situation, in the event that he needed to locate it quickly.

The panel took account of Mr Skrbina’s response to the incident, in which he stated:

‘I passed to them an oxygen face mask as soon as was able to find one… I am not a regular member of staff (an agency nurse), who was not there every day so to blame me that I could not find an oxygen mask does not stand…’

The panel considered that Mr Skrbina’s response in relation to the above incident was dismissive and does not hold much weight, when considering other evidence that has been read and heard. The panel noted that there is some ambiguity in the wording relating to an anaesthetic and oxygen face mask, but it did not find Mr Skrbina’s response credible.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina was unable to locate an anaesthetic/oxygen face mask. The panel finds charge 3a proved.

Charge 3b

In reaching this decision, the panel took into account of the oral and documentary evidence before it.

The panel considered the witness statement of Witness 2, in which she stated:

‘He proceeded to pick it one up and attempted to open it. The Patient was struggling to breathe but yet he was not able to open the packaging.’

Witness 2, in her oral evidence, stated that she could understand why it may have been difficult to open the packaging. She said that the equipment was opened eventually but she could not confirm who opened it and conceded that it may have been Mr Skrbina.

The panel also considered the response from Mr Skrbina, who stated:

‘I opened an endobronchial suction, which was not easy to open, due to the nature of the packaging, which even anaesthetist could not open.’

The panel acknowledged the ambiguity in whether it was an anaesthetic/oxygen face mask or an endobronchial suction that could not be opened however, despite this, there was insufficient evidence to indicate that Mr Skrbina had not been able to open the equipment and there is some contradiction between the accounts provided.

Therefore in light of the above, the panel could not see sufficient evidence to find charge 3b proved.

Charge 3c

In reaching this decision, the panel took into account of the oral and documentary evidence before it.

The panel considered the witness statement of Witness 2, in which she stated:

‘I asked [Mr Skrbina] to get a new prescription chart from the pharmacy room as there was only an old one for the patient. A new prescription chart was needed so that fluid could be prescribed for the patient. [Mr Skrbina] proceeded to come back only to state that there weren’t any fluid charts. I informed him that I was aware that there weren’t any fluid charts any more and that I needed a prescription chart.’

The panel accepted Witness 2’s written and oral evidence.

The panel also considered Mr Skrbina’s response to the incident, in that he made some admissions:

'Regarding a prescription chart, yes I could not find it, because it was kept under lock in the cupboard in the clinical room, which I did not know as no one had informed me of its location.

I could not leave the patient unconsciousness on their own and go looking for a new prescription chart. [sic]'

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did not obtain a new prescription chart. The panel finds charge 3c proved.

Charge 3d

In reaching this decision, the panel took into account the oral and documentary evidence before it. It noted that the evidence for charge 3d is similar to that in charge 3c.

The panel considered the witness statement of Witness 2, in which she stated:

'*I informed him that I was aware that there weren't any fluid charts any more and that I needed a prescription chart. He returned with a child health care chart.'*

The panel considered Witness 2's oral evidence in that she described the differences between an adult and child prescription chart, and that it would be clear from the front page that it would state 'adult' or 'child'. She also told the panel that the child's chart had fewer pages than that of an adult's chart.

The panel noted that Mr Skrbina did not provide a response to this particular matter.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did incorrectly obtain a child health care chart. The panel finds charge 3d proved.

Charge 3e

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered the witness statement of Witness 2, in which she stated:

> *'I also asked [Mr Skrbina] to get Fentanyl which he forgot to bring.'*

The panel accepted the written and oral evidence of Witness 2.

The panel considered the response by Mr Skrbina, in which he stated:

> *'About not obtaining Fentanyl when instructed, again I could not leave an unconsciousness patient on their own, when I called for help, I was ignored. [sic]'*

The panel noted that Mr Skrbina partially accepts this as he purports to give reasons for not obtaining the Fentanyl. Given the inconsistencies of Mr Skrbina's response, the panel did not find it credible, when taking into account the other witnesses' evidence both read and heard.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did not obtain Fentanyl when instructed to do so. The panel finds charge 3e proved.

Charge 3f

In reaching this decision, the panel took into account of the oral and documentary evidence before it.

The panel considered the witness statement of Witness 2, in which she stated:

> *'I asked [Mr Skrbina] to run this through a system called a BBraun set but [Mr Skrbina] did not go to get the equipment.'*

The panel accepted the written and oral evidence of Witness 2.

The panel also considered the evidence of Witness 1, who exhibited an email forwarded on by the Deputy Manager, which stated:

> *'I asked him to run it though a BBraun set – he just attached it to the set already there. I asked him to get a Braun pump…'.*

Mr Skrbina also provided a response to the incident, in which he stated:

> *'…at that time an intravenous pump not available. It is important to get an intravenous pump, but if not available what was I supposed to do….'*

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did not obtain a Bbraun set to administer the Hartmanns Solution bag. The panel finds charge 3f proved.

Charge 3g

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered the witness statement of Witness 2, in which she stated:

> *‘He then attached the Hartmanns to the system that had already been running until I had to alert him to get a Braun pump.’*

The panel heard oral evidence from Witness 2, who confirmed that it would not be right to say the Hartmann’s solution was incorrectly attached to the existing system by Mr Skrbina. She explained that this was acceptable practice, although it would be best practice to attach it to an intravenous pump. The panel considered that this does not appear to be a clinical requirement as such, but rather a preference of the department where Mr Skrbina was working.

Mr Skrbina also provided a response to this incident, in which he stated:

> *‘About the Hartmann’s solution, I cannot recall that incident, because in that hospital department agency staff at the time were not allowed to connect any intravenous solutions.’*

Therefore in light of the above, the panel could not find sufficient evidence to suggest that Mr Skrbina had *incorrectly* attached the Hartmann’s solution bag to the existing system, based on the evidence heard. The panel therefore finds charge 3g not proved.

Charge 4

That you, a registered nurse;

Whilst working a shift at Royal Stoke Hospital in the recovery ward on or around 14 March 2017;

4) Whilst working a shift at the Royal Preston Hospital in or around July 2016, incorrectly attached a paracetamol IV infusion to Patient W's arterial line.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel heard oral evidence from Witness 3 in that she was clear that arterial lines are only used for specific reasons, such as checking blood gases and accurate blood pressure, and she was descriptive about how she checked the line and found a line for the administration of paracetamol had been attached to it. The panel considered that her oral evidence was consistent with her witness statement:

> *'An arterial line… is used to accurately measure blood pressured. It is not to be used as a feeding line or a venious line. It is only ever used to extract blood and an infusion or medication infusion drip should never be attached to it… The Two lines also look very different. There are also dressings on the patient which alert the nurse as to which type of line it is. The arterial line has a red port to alert the nurse. This is the standard warning colour that is used on this type of line for all hospitals and a nurse would be expected to be comfortable knowing the difference in lines. [sic]'*

The panel considered that Witness 3 had a clear memory of the incident and described feeling shocked by it, despite her statement being provided some time after the incident happened. The panel noted that not attaching paracetamol (or any other) infusion to an

arterial line is not merely a matter of practice for this particular hospital, rather it is something that every nurse should know.

The panel also noted that Witness 3 said in her oral evidence that she had made a handwritten note of the incident, however she no longer has this. Witness 3 said that she had informed the nurse in charge at the time of the incident. The panel considered Witness 3's evidence to be credible and reliable.

The panel also considered Witness 1's witness statement, in which she stated:

> *'I was notified when Lancashire Teaching Hospitals NHS Trust restricted him in July 2018 when he was working for them. After some investigation it was discovered that their objections related to an incident in 2016 (date unspecified) when [Mr Skrbina] had attached a paracetamol IV infusion to a port on the arterial line as opposed to the intended venous cannula.'*

The panel also took account of Mr Skrbina's response to the incident:

> *'I cannot recall that, but again agency staff at that theatre department at the time were not allowed to administer any kind of intravenous fluids or connect any kind of intravenous fluids…'*

The panel considered that Mr Skrbina's response does not seem credible nor reliable considering the other evidence it has seen and heard.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina incorrectly attached a paracetamol IV infusion to Patient W's arterial line. The panel finds charge 4 proved.

Charge 5

That you, a registered nurse;

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

5) During handover to Colleague A/Colleague B;
   a) Inaccurately reported that Patient A was absolutely fine.
   b) Inaccurately reported that Patient A had not suffered any bruising around their neck.
   c) Did not report that Patient A had suffered some swelling around their neck.
   d) Did not report that Patient A had trouble swallowing.
   e) Inaccurately reported that Patient B had been talking throughout the shift.
   f) Inaccurately reported that Patient B had refused to have their wound dressings changed.

Charge 5a

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that Witness 4 and Witness 5 gave clear oral accounts about their recollection of this incident involving Patient A and corroborated each other's evidence. Their oral evidence is also consistent with their witness statements.

Witness 4 in her witness statement said:

> *'When I had come on duty, the senior Nurse on the day shift [Colleague D], had told me prior to handover that I needed to keep a close eye on Patient A*

as she had significant bruising and swelling around the neck…. When I later received a handover from [Mr Skrbina] at the Doctor's desk, he stated…she was absolutely fine… I proceeded to check on Patient A and alarmingly found extensive amounts of bruising. I also found some swelling which looked concerning…'

Witness 5 in her witness statement said:

'During the handover [Mr Skrbina] said that this patient was fine. I remember asking him if she had any bruising and he said, "No, there was no bruising". I said again to him, "Are you sure because I know that she has been back to theatre today?" but he was insistent that that she had no bruising.'

The panel considered that it is clear from the evidence that Mr Skrbina did inaccurately report that Patient A was 'absolutely fine' and both Witness 4 and 5 were clear that those were the words he used during handover. However, when Witness 4 and Witness 5 went to check on Patient A, they could see that she was in a bad way, which further indicates the inaccuracies from Mr Skrbina's account.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina had inaccurately reported that Patient A was absolutely fine. The panel finds charge 5a proved.

Charge 5b

In reaching this decision, the panel took into account the oral and documentary evidence before it, especially that considered in deciding charge 5a.

The panel considered that Witness 4 and Witness 5 gave clear oral accounts about their recollection of this incident involving Patient A and corroborated each other's evidence. Their oral evidence is also consistent with their witness statements.

Witness 4 in her witness statement said:

> *'When I had come on duty, the senior Nurse on the day shift [Colleague D], had told me prior to handover that I needed to keep a close eye on Patient A as she had significant bruising and swelling around the neck…. I proceeded to check on Patient A and alarmingly found extensive amounts of bruising…'*

Witness 5 in her witness statement said:

> *'I recall that when [Witness 4] and I first came on shift, [Colleague D] had told us to keep an eye on this lady as she had a lot of bruising…There was significant bruising on this lady's neck…'.*

The panel noted that Mr Skrbina had reported there was no bruising to Patient A's neck.

The panel considered that Colleague D told both Witness 4 and 5 about the bruising on Patient A's neck. The panel considered that the bruising would have been clearly visible, from both Witness 4 and 5's accounts.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina had inaccurately reported that Patient A did not have any bruising around her neck. The panel finds charge 5b proved.

Charge 5c

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that Witness 4 and Witness 5 gave clear oral accounts about their recollection of this incident involving Patient A and corroborated each other's evidence. Their oral evidence is also consistent with their witness statements.

Witness 4 in her statement said:

> *'I also found some swelling which looked concerning… I could not understand how [Mr Skrbina] had not seen the extensive bruising or swelling. If the swelling had remained unnoticed, it could have caused a large haematoma…'*

The panel noted Mr Skrbina's response to the above incident, in which he accepted this is what had happened, as he raised the question of how he was supposed to report something he did not know about. The panel considered that it was clear Mr Skrbina did not spend much time with Patient A during his shift and therefore did not notice the swelling.

The panel also heard evidence from Witness 4 and 5 that there was some swelling to Patient A's neck, which was seen as typical by the doctors on shift of a patient undergoing such surgery, and she was to be monitored.

The panel considered that Colleague D told both Witness 4 and 5 about the swelling on Patient A's neck. The panel considered that the swelling would have been clearly visible, from both Witness 4 and 5's accounts.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did not report that Patient A had suffered some swelling around her neck. The panel finds charge 5c proved.

Charge 5d

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that Witness 4 and Witness 5 gave clear oral accounts about their recollection of this incident involving Patient A and corroborated each other's evidence. Their oral evidence is also consistent with their witness statements.

Witness 5 in her witness statement said:

> *'…she said that she was having trouble swallowing.'*

The panel considered the oral evidence of Witness 5 who said that Patient A having trouble swallowing could have been something that arose recently, so it may not have been something that Mr Skrbina would have been expected to report.

The panel considered that from the invasive procedure Patient A had, swelling and bruising would have been expected following this, and a possible side effect may have been trouble swallowing. It is not clear whether Mr Skrbina would have been expected to know about this patient having trouble swallowing and it is unclear whether the patient had told him this directly during his shift. It noted that this would have been difficult to know about, unless Mr Skrbina was told directly.

Therefore in light of the above, the panel found insufficient evidence to find charge 5d proved.

Charge 5e

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that Witness 4, Witness 5 and Witness 6 gave clear oral accounts about their recollection of this incident involving Patient B and corroborated each other's evidence. Their oral evidence is also consistent with their witness statements.

The panel heard direct evidence from all three witnesses that Patient B was in a comatose state and was nonverbal, indicating that he was not able to have a conversation. These witnesses spoke about their knowledge of Patient B, and how they had cared for him on the days leading up to the incident, and they were familiar with his presentation. There was evidence heard that Patient B was rapidly declining in health, and died soon afterwards.

Witness 4 and 5 described how surprised they were to hear during the handover takeover from Mr Skrbina that Patient B had been talking to him throughout his shift and refusing care, which contradicts their own understanding of Patient B's state of health at that time.

The panel considered Witness 4's witness statement, in which she stated:

> *'Patient B, was an end of life care patient and was in an extremely bad state… When [Mr Skrbina] had provided me with the verbal handover for Patient B, he had stated Patient B was talking throughout the day and was refusing dressing changes... [Mr Skrbina] had also strangely noted a completely different account on the daily summary of care. He had noted that Patient B was in a 'comotose' state during the entirety of the shift [sic].'*

The panel also considered Witness 5's witness statement, in which she stated:

> *'At this stage [Patient B] was no longer able to communicate with us…When I questioned this [Mr Skrbina] told me that [Patient B] said he was in too much pain and didn't want it doing. I queried whether [Patient B] was talking and able to give instructions and [Mr Skrbina] told me Yes he had told him that he didn't want them doing and he had been talking to him throughout the day. [sic]'*

Witness 6 corroborated the above in her oral evidence and in her witness statement:

> *'He was very poorly and was basically in a comatose state. He certainly wasn't speaking although if you moved him he made groans.'*

Mr Skrbina's statement in the care notes for Patient B contradicted what he told Witness 4 and 5 during handover:

> *'Mostly in comotosed state. No verbal or other signs of discomfort or pain present… [sic]'*

The panel considered that it was highly unlikely that a conversation or any meaningful verbal exchange took place between Mr Skrbina and Patient B. It considered that Mr Skrbina's response was not credible.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina inaccurately reported that Patient B had been talking throughout the shift. The panel finds charge 5e proved.

Charge 5f

In reaching this decision, the panel took into account the oral and documentary evidence before it.

For the same reasons as above, and on the balance of probabilities, it is more likely than not that Mr Skrbina inaccurately reported that Patient B had refused to have their wound dressings changed. The panel finds charge 5f proved.

Charge 6

That you, a registered nurse;

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

6) Your actions in one or more of charges 5 e) & 5 f) above were dishonest, in that you sought to misrepresent that Patient B had refused to have their wound dressings changed.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that Mr Skrbina clearly documented that Patient B was in a comatose state as highlighted in charge 5e. However, Mr Skrbina told Witness 4 and 5 during handover that Patient B was speaking and refusing his dressing changes. The panel considered that Mr Skrbina knew that this was untrue, and the reason was likely to conceal that he should have spent more time with Patient B during his shift, and changed

his dressings as was required. Patient B was in a very poor state after Mr Skrbina's shift and his dressings should have been changed, as they were on every shift.

The panel took account of Witness 6's evidence that she had prompted Mr Skrbina on three or four occasions during his shift to change Patient B's dressings, and he had responded by saying that he was busy and that it could wait. The panel accepted this evidence. This indicates that he was misrepresenting what was happening in order to conceal that he was not providing the necessary care to Patient B. Witness 6 indicated a clear pattern of behaviour by Mr Skrbina throughout his shift, in that he was dismissive regarding Patient B's dressings.

The panel considered that it has heard evidence from witnesses that Mr Skrbina wanted to leave handover as soon as possible so he could return home. It is clear from the evidence before the panel that Mr Skrbina had recognised he had not undertaken what was required of him during his shift for a vulnerable patient, and sought to conceal this by inventing an implausible refusal from a patient who Mr Skrbina himself stated was comatose.

The panel considered that ordinary decent people would find this to be dishonest. Therefore the panel found Mr Skrbina's actions in charges 5e and 5f to be dishonest, in that he intentionally misrepresented at handover that Patient B had refused to have their wound dressings changed to try to excuse his lack of care for Patient B, described in the findings about charge 8. The panel finds charge 6 proved.

Charge 7

That you, a registered nurse;

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

7) Did not administer prescribed Midazolam to Patient B.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

Witness 4 in her oral evidence confirmed that Patient B had been prescribed Midazolam and that Mr Skrbina had not administered it to him. She also confirms this in her witness statement:

> *'For Patient B, he had also been prescribed Midazolam…. It was prescribed to aid Patient B's end of life care. [Mr Skrbina] had failed to administer this completely.'*

The panel considered the prescription chart for Patient B, and it is clear that no Midazolam had been administered to Patient B during his shift, and there was a large gap in administration, despite it having been administered on the days before and after Mr Skrbina was on shift. Witness 4 confirmed that Patient B was administered the medication during the early hours of 2 March and then there was nothing recorded until 3 March.

Witness 4 stated that Patient B required Midazolam roughly 30 minutes before he needed his dressings changed, in order to ease his pain. It is clear that there was an expectation from Mr Skrbina to administer Midazolam for Patient B, when looking at the prescription chart on the days before and after the incident.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did not administer prescribed Midazolam to Patient B. The panel finds charge 7 proved.

Charge 8

That you, a registered nurse;

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

8) Did not change Patient B's wound dressings.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

Witness 5 was clear and descriptive in her oral evidence about Patient B's condition at the time. In her witness statement she said:

> *'Night staff would change [Patient B] dressings as needed but always at the end of the shift so he was comfortable as it may be late morning before the day staff could get to him… When we received handover from [Mr Skrbina] in relation to Patient B [Mr Skrbina] said he hadn't changed his dressing. This really surprised us as we knew how bad the wound was leaking… When [Witness 4] and I went in to see [Patient B] we were both shocked and disgusted to see the state he was in. His dressing was wet and badly stained and there was an unpleasant smell… the bed was saturated.'*

Witness 4 in her witness statement said:

> *'When I returned to his room later to undertake a more detailed check, I was shocked to find Patient B laying down on the bed swimming in blood. It was disgusting… [Mr Skrbina] should have recognised that this was an end of life care patient and that the upmost respect should have been provided to him at all costs. He definitely should not have been subjected to such neglect… I asked one of the Healthcare Assistants [Witness 6] why Patient B had not been changed the previous day to which she replied that she had prompted [Mr Skrbina] on four occasions to change him. [Mr Skrbina] proceeded to inform her 'no, no, he is fine'. She further stated that [Mr Skrbina] had refused to change Patient B despite recording to the contrary.'*

The panel also took account of Mr Skrbina's response, and his own admissions, in which he stated:

> *'I didn't change the patient's head dressing because when I went to the patient, I told him that I needed to change his dressing, he emphatically said NO. Clearly he wanted to be left in peace and comfort without been harassed in his final hours. To have forcibly changed his dressing against his wishes would have caused totally unnecessary distress, and even worse, avoidable pain.'*

The panel had heard evidence that Patient B was in a comatose state and was nonverbal. Mr Skrbina had also recorded this in Patient B's notes, which contradicts his own account of the incident, and the panel found this affected the credibility of Mr Skrbina's evidence.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did not change Patient B's wound dressings. The panel finds charge 8 proved.

Charge 9

That you, a registered nurse;

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

9) Did not record in the daily summary of care that Patient B had refused to have their dressings changed.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it. Notably, the absence of an entry from Mr Skrbina in the patient's notes, stating that he had attempted to change Patient B's wound dressing but it had been Patient B's instruction that he not do so.

The panel considered that, given its previous findings in charge 8, it also finds charge 9 proved.

Charge 10

That you, a registered nurse;

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

10) On one or more occasion, refused to change Patient B's wound dressing, after Colleague C requested that you change them.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered that, given its previous findings in charge 8, it also finds charge 10 proved.

Charge 11

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

11) Did not inform the nurse in charge that Patient C requested a female nurse to conduct her wash.

This charge is found proved.

In reaching this decision, the panel took into account all the oral and documentary evidence before it.

The panel considered Witness 5's witness statement, which said:

‘She told us that [Mr Skrbina] and another male nurse had arrived to give her a wash and she had refused and said that she wanted to have a female nurse. [Mr Skrbina] had told her that that was not possible as they were all busy and some were on their breaks so they were going to give her a wash... It is always the patient’s choice to ask for a female nurse, it does happen on the ward… He could have reported her wishes to [Colleague D] as the Nurse in Charge and she would have found a way round it.’

Witness 4 also reported the above in her witness statement:

‘Patient C stated that she informed [Mr Skrbina] that she would prefer to be washed by a female nurse to which [Mr Skrbina] replied that if she wanted a wash today then it would have to be by him as everyone else was either away or busy... Patients are allowed to request female Nurses if they wish to do so. [Mr Skrbina] should have told [Colleague D], the nurse in charge on the day shift, and she would have found someone else to do it.’

The panel also took account of Witness 4’s contemporaneous email to the ward manager, dated 20 March 2019:

‘A number of patients have complained one being [Patient C] saying that [Mr Skrbina]… had wash her this morning and had been very sharp with her, even when she asked for a female nurse… [sic]’

The panel accepted the written and oral evidence of Witness 4.

Mr Skrbina also provided a response to the above incident, in which he made some admissions:

‘When the patient complained that she didn’t want to be washed by two male staff, I politely informed the patient that a female member of staff was on her break. I gave her the options, she could either wait until that person was available or carry on and let us do it now, she chose the latter.’

It is clear from the evidence above that Mr Skrbina did not inform the nurse in charge about Patient C’s request, despite it being her right to choose a female member of staff to conduct her wash. Mr Skrbina’s response was dismissive, in that he was not taking into account Patient C’s preferences at the time, when it was clear to the panel that the situation should have been referred to those in charge of the ward.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did not inform the nurse in charge that Patient C requested a female nurse to conduct her wash. The panel finds charge 11 proved.

Charge 12

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

12) Did not administer Oramorph to Patient D;
   a) At minimum intervals of 4 hours as prescribed.
   b) When requested by Patient D as Pro Re Nata (PRN).

Charge 12a

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered Witness 4’s witness statement, which said:

> *‘Patient D, required pain relief medication (Oramorphe) every four hours. [Mr Skrbina] refused to administer two doses of the medication and instead told her that she would have to wait until the night staff came on duty… Patient D had been prescribed the medication and it was completely unacceptable for [Mr Skrbina] to go against her prescription… [sic]’*

The panel took account of Mr Skrbina’s response to the above incident:

> *‘The patient in 3 wasn’t refused pain killers, because when I asked “are you in pain”, she said no. I always ask patients are they in pain or not before I administer any analgesia…’*

The panel considered that Mr Skrbina clearly did not administer the medication at four-hour intervals, but from looking at the drug chart, it appears that the Oramorph was not prescribed for Patient D as such a requirement. It considered that the four-hour intervals appeared to be what nurses on shift administered for Patient D, but this was not required by the prescription, as it does not require administration at intervals of four hours, but administration as the patient’s needs dictate.

Therefore in light of the above, the panel finds charge 12a not proved.

Charge 12b

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel noted that the Oramorph was prescribed Pro Re Nata (PRN) for Patient D, indicating that it could be administered as and when Patient D required it.

The panel considered Witness 4's witness statement, which said:

'Patient D, required pain relief medication (Oramorphe) every four hours. [Mr Skrbina] refused to administer two doses of the medication and instead told her that she would have to wait until the night staff came on duty… When I attended to Patient D, I found her to be rolling around in pain and gave her the dose she needed. [sic]'

Witness 4 also confirmed the above during her oral evidence and in her contemporaneous email to the ward manager, dated 20 March 2019.

The panel also took account of Patient D's drug chart, which clearly states that Oramorph was not administered to Patient D for a 12-hour period whilst Mr Skrbina was on shift.

Mr Skrbina, in his local response, said:

'Opioids are not toffees, so any such medications must be administered with caution and only when required or in the case of conscious patients when they are requested.'

The panel considered that it is clear Patient D had requested this medication of Mr Skrbina but he did not administer it to her when she had requested it, and resulted in the patient being in significant pain and discomfort.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did not administer Oramorph to Patient D when requested by Patient D. The panel finds charge 12b proved.

Charges 13, 14 and 15

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

13) Denied Patient E's request to get out of bed.
14) Did not conduct a mobility assessment for Patient E.
15) Incorrectly told Patient E to remain in bed for a physiotherapy assessment.

These charges are found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered all three charges cumulatively as they are linked to the same event. Patient E, at the time, was due to be discharged from Leighton Hospital, back to her care home.

Witness 4's witness statement said:

> *'Patient E was due to be discharged back to her care home and was going to be discharged on that day. Whilst I was on shift… I noticed Patient E using her zimmer frame to walk herself through the bathroom…. She proceeded to inform me that she was ready to go home and was extremely upset about [Mr Skrbina] behaviour on that shift. She had asked [Mr Skrbina] to allow her to get out of bed to walk but [Mr Skrbina] had consistently denied her requests to get out of bed. Instead he told her to stay in bed and wait for physiotherapy. Patient E did not require a physiotherapy assessment, a nurse was able to make the assessment…'*

Witness 4 also confirmed the above in her contemporaneous email to the ward manager, dated 20 March 2019.

The panel took account of Patient E's daily summary of care notes, in that it was documented:

> *'Pt has stated she asked 4 times to get up, but was refused and told she couldn't walk and needed physio by staff nurse…'*

Mr Skrbina also provided a response to the above incidents, in that he made some admissions:

> *'I followed the physio's protocol and repeated to the patient that I could not let her walk until after assessment by the physio…'*

The panel noted in Patient E's care notes that a physio's assessment was necessary before her discharge from hospital to a care home, but was not related to her treatment or activities on the ward.

The panel considered that from the evidence above, it is clear that Mr Skrbina refused Patient E's repeated requests to get out of bed. It is clear that there was an expectation of nurses on the ward to undertake their own mobility assessments for patients. Witness 4 said that *'The physiotherapy team were always telling us to do a nursing assessment first and only to call them if we needed them. I could see that she was mobile enough to be discharged.'* Witness 4 had also seen Patient E walking unaided around the ward and to the bathroom, and reported Patient E being upset about the situation.

The panel noted the absence of the physiotherapy book as part of the evidence, but it felt there was sufficient evidence to find these charges proved.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina denied Patient E's request to get out of bed, did not conduct a mobility assessment for Patient E and incorrectly told Patient E to remain in bed for a physiotherapy assessment. The panel finds charge 13, 14 and 15 proved.

Charge 16

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

16) Did not administer codeine to Patient G as prescribed.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel considered Witness 4's witness statement, which said:

> *'At handover, [Mr Skrbina] had told me that he had only given her paracetamol not codeine as well, which she was prescribed, as he didn't think she was in that much pain and in any event she been on and off the ward all day… [sic].'*

Witness 4 repeated the above during her oral evidence to the panel, and said that Patient G's mother had come to them requesting pain relief for the patient, as she had not been administered any all day.

Mr Skrbina, in Patient G's notes, had documented a score of '2' which, from the evidence heard, meant that Patient G was in a degree of pain and he had recorded in the notes that analgesia had been administered.

The panel considered that there is an element of Patient G's prescription chart missing in the NMC's bundle, as there was no administration information for the date in question, only 6 and 7 March. It noted that there was some confusion and a lack of consistency between the documentary evidence and Witness 4's witness statement.

Therefore in light of the above, the panel could not find sufficient evidence before it to find charge 16 proved.

Charge 17

Whilst working a shift on Ward 18 at Leighton Mid Cheshire Hospital NHS Foundation Trust on 2 March 2019;

17) On an unknown date when Patient H requested assistance after soiling themselves, used words to the effect;

a) "that you were not there to help Patient H".
b) "that Patient H had two hands and could clean himself up".
c) "you would help Patient H on this one occasion only".

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it.

The panel heard compelling oral evidence from Witness 5, in that she was clear about what she heard Mr Skrbina say to Patient H, and where this happened. She told the panel that she was shocked by Mr Skrbina's comments.

Witness 5 was a direct eyewitness and had a clear recollection of the incidents. Her oral evidence was consistent with her witness statement, which said:

> *'I heard [Mr Skrbina] talking loudly and refusing to help the patient who had soiled himself… I heard [Mr Skrbina] saying several times that he was not there to help him and that he had two hands and he could clean himself up. I was disgusted to hear him speaking to a patient like that and I went over to him and said that the patient was asking for help due to his condition and that he should not be talking to him like that. [Mr Skrbina] said he would help him on this one occasion only…'*

The panel considered that Witness 5's evidence held greater weight, and she was detailed in her recollection and the impact that this event had had on her. The panel considered that Witness 5 was a clear and credible witness.

The panel also heard evidence from Witness 5 and Witness 6 regarding Mr Skrbina's general character and his attitude. Witness 5 in her statement said:

> *'…I would say that this was a good example of the way [Mr Skrbina] talked to patients, he was often short with them and abrupt.'*

The panel also took account of Mr Skrbina's response to the incident:

> *'Regarding that I refused to assist to the patient after soiling themselves, that patient vehemently refused a male nurse, in which case I had stepped back and called for help when my female colleague was available.'*

The panel did not consider Mr Skrbina's response to be credible nor reliable based on the compelling evidence it has heard and read from other witnesses.

Therefore in light of the above, and on the balance of probabilities, it is more likely than not that Mr Skrbina did make the comments to Patient H, as charged. The panel finds charge 17 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 Skrbina'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 Skrbina's fitness to practise is currently impaired as a result of that misconduct.

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect,*

involving some act or omission which falls short of what would be proper in the circumstances.'

Submissions on misconduct

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

Mr Brahimi provided written submissions on misconduct, which are as follows:

'***Misconduct***

1. *Misconduct is a matter for the Panel's professional judgment. The leading case is Roylance v GMC [2000] 1 AC 311 which says:*

   "misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of proprietary may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."

2. *In Calhaem v GMC [2007] EWHC 2006 (Admin) Mr Justice Jackson commented on the definition of misconduct and he stated:*

   'it connotes a serious breach which indicates that the doctor's fitness to practise is impaired.'

3. *Mr Justice Collins in Nandi v GMC [2004] EWHC 2317 (Admin) stated that:*

   "the adjective 'serious' must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners."

4. *Although the following charges were not proven:*

   Charges 3(b), 3(g), 5(d), 12(a) and 16;

5. *The NMC submit that the remainder of other charges being found proved, amount to misconduct. The following submissions are collectively made in respect of the proved charges:*

   a. *The Registrant has demonstrated that he is unable to correctly administer drugs to a number of patients. Not only did this include incorrectly administering morphine intramuscularly but also wrongly using the arterial line for drug infusion. Some of this conduct was described as potentially dangerous and this conduct connotes a serious breach in the form of misconduct.*

   b. *The Registrant has demonstrated a lack of care to patients and that he is disinclined to effectively carry out his nursing role. The Panel has found him refusing to provide a buzzer to a patient, appropriately respond to a bleeding and deteriorating patient, ignore their choice for a wash and make rude remarks when they requested help. Some of these acts alone, not to mention collectively, are acts or omissions which fall short of what would be proper in the circumstances.*

c. The Registrant has failed to note the status of patients within their medical records, namely the daily summary of care, which is information that other staff members act upon. The recording of such vital information is a standard ordinarily required to be followed by a medical practitioner.

d. The Registrant's handover and reporting of patients has been found to be inaccurate. This is a concern where not only the patients are put in a position of potential harm, but other staff members are also put in a difficult position of handling risk. This conduct is made worse where the defendant has been dishonest in deliberately misrepresented the state of certain patients. Such conduct would be regarded as deplorable by fellow practitioners.

6. The NMC say that the following parts of The Code have been breached, but of course the Panel is able to consider any other parts as it sees fit (note that it is the 2015 version of the Code that applies in this case):

1 Treat people as individuals and uphold their dignity
2 Listen to people and respond to their preferences and concerns;
4 Act in the best interests of people at all times;
5 Respect people's right to privacy and confidentiality;
7 Communicate early;
8 Work cooperatively;
9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues;
11 Be accountable for your decisions to delegate tasks and duties to other people;

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

20 Uphold the reputation of your profession at all times;

21 Uphold your position as a registered nurse, midwife or nursing associate;

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system.

7. *Overall, the NMC further submits that the Registrant's actions as proven fall far short of what would be expected of a Registered Nurse. The public would expect that the profession will have staff that uphold a professional reputation. The Panel may find that most in breach are that of "1" and "20" above. The Registrant has clearly put into question the safety and integrity of patients and this will have an overall effect of the public's trust in the medical profession. The Registrant has also put his own practice into question where he has been found proven of serious form of dishonesty, namely misrepresenting his communication with patients.*

8. *The NMC therefore invite the Panel to find misconduct.*

Registrant's latest position

9. *The Registrant was not present or represented throughout the hearing. The Registrant did produce a bundle of 335 pages that the Panel may take into consideration when deciding on misconduct and impairment.*

10. *The NMC would submit that the majority of these documents are heavily outdated. It is difficult to address an attitudinal concern such as dishonesty and the Registrant has not attended or at least provided an up-to-date reflective document and/or insight into these allegations. The*

NMC would submit that these documents are insufficient to argue against the finding of misconduct and impairment.'

Submissions on impairment

Mr Brahimi moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Brahimi provided written submissions on impairment, which are as follows:

'***Impairment***

11. *Current impairment is not defined in the Nursing and Midwifery Order of the Rules. The NMC have defined fitness to practise as the suitability to remain on the register without restriction.*

12. *The Panel may be assisted by the questions posed by Dame Janet Smith in her Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011] EWHC 927 (Admin):*

"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:

(i) Has in the past, and/or is liable in the future to act as so as to put a resident or residents at unwarranted risk of harm;

(ii) Has in the past, and/or is she liable in the future to bring the profession into disrepute;

(iii) Has in the past, and/or is she liable in the future to breach one of the fundamental tenets of the profession;

(iv) Has in the past, and/or is she liable in the future to act dishonestly."

13. *As further stated at paragraph 74 of Grant, the Panel should:*

    "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.

14. *The NMC say that the Registrant is impaired and that all four limbs of Grant are engaged in this case.*

15. *The first limb is engaged as a result of the Registrant putting staff in unwarranted risks of harm. The Panel have accepted the evidence in respect of the charges proven and it follows that individuals were put at risk of harm where (but not limited to):*

    a. *The Registrant's behaviour put more than one patient at risk of harm and this is made more significant where some were particularly vulnerable patients;*

b. Some of the misconduct could have been avoided but the Registrant ignored patient requests and failed communicate which shows a liability of similar mistakes in the future.

16. The second limb is engaged as a result of the Registrant's behaviour, as found proven, plainly brings the profession into disrepute:

a. It is unacceptable that any individual engages in such behaviour and repeats it over a period of time. Members of public may be discouraged from seeking medical assistance as their view may be that they will not be in a safe environment where there is a lack of care and respect from staff. This behaviour has plainly brough the profession into disrepute.

17. The third limb is engaged, where the Registrant has plainly breached fundamental tenets of the profession in numerous areas of the Code of Conduct as referred to above, but in particular:

a. Treat people as individuals and uphold their dignity (1.1 and 1.3);
b. Listen to people and respond to their preference and concerns (2.4 and 2.6);
c. Uphold the reputation of your profession at all times (20.2 and 20.6);

18. The fourth limb is engaged as a result of the Registrant's having been found proven of acting dishonestly. The Panel have accepted that the Registrant did misrepresent the true status of patients (but not limited to):

a. This kind of behaviour presents a risk to patients because their misrepresented state may mean that they receive insufficient care;

b. *The medical professional is also put into question where agencies, such as those in these proceedings, may be less inclined to hire genuine people as a result of being concerned with possible risks, as heard in these proceedings. The Panel will recall that some agencies had their instructions ceased from*
hospitals as a result of the Registrant's misconduct. Dishonestly is a difficult
behaviour to tackle and where there is insufficient material to say this has been addressed, the Registrant is liable in the future to act dishonestly.

19. *As further stated at paragraph 74 of Grant, the Panel should:*

"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."

20. *The NMC submit that there is a serious departure from the standards expected of a nurse and that the behaviour is incompatible with ongoing registration. The Panel should consider impairment on the following grounds:*

21. Public protection

a. *There is a real risk of harm in this instance where multiple patients have been subject to the Registrant's inaccurate, incorrect and dishonest care. The Panel has heard that some of this conduct affected the level of care*

patients were receiving, some of which needed urgent action in response to their deteriorating state.

b. *There is a risk of repetition given there are at least 10 patients (proven charges) and this happened over a period of time. Subcategorised are multiple incidents from more than one patient, demonstrating that there is no isolated incident but an individual who appears to have shown behaviour that was repeated until he was brought to the attention of the regulatory body.*

22. Otherwise in the public interest

a. *A member of public's confidence in the medical profession would be deeply undermined as, upon learning about these charges, they would have doubts about how medical professionals behave within the workplace, in particular questioning the level of care that vulnerable patients receive. The Registrant's behaviour towards a healthy work ethic, as seen in the evidence, suggest that there are fundamentally harmful and underlying attitudinal concerns. Any patient, including those most vulnerable such as end of life, should be protected from the fear of being mistreated and insufficiently looked after. Overall, the honesty and integrity of the medical profession has been challenged and evidently been put into disrepute.*

23. As such the NMC invite the Panel to find that the Registrant is currently impaired.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v GMC and Nandi v GMC.*

Decision and reasons on misconduct

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

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

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

2 Listen to people and respond to their preferences and concerns
To achieve this, you must:
2.1 *work in partnership with people to make sure you deliver care effectively*
2.2 *recognise and respect the contribution that people can make to their own health and wellbeing*
2.5 *respect, support and document a person's right to accept or refuse care and treatment*
2.6 *recognise when people are anxious or in distress and respond compassionately and politely*

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.2 *recognise and respond compassionately to the needs of those who are in the last few days and hours of life*

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 *balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*

8 Work co-operatively

To achieve this, you must:

8.2 *maintain effective communication with colleagues*

8.3 *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

8.6 *share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

To achieve this, you must:

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

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

To achieve this, you must:

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

19.2 *take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures*

19.3 *keep to and promote recommended practice in relation to controlling and preventing infection*

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

20 ***Uphold the reputation of your profession at all times***

To achieve this, you must:

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

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

20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 *identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'*

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

The panel considered each of the charges found proved in turn, in respect of each hospital:

Stepping Hill Hospital – Charges 1 and 2

Charge 1

The panel considered this action to amount to misconduct, and that there could have been serious consequences, when taking into account the risk posed to the patient. The panel considered that Mr Skrbina made a decision at the time that the medication should be administered intra-muscularly when, to his knowledge, it was not prescribed in that manner. He also acknowledged in his local response that the medication should have been administered subcutaneously, and the patient had also told him this. The panel heard evidence that the medication can be absorbed much quicker by administering it intra-muscularly, which increases the possibility of harm, as Morphine is a powerful drug. The panel decided that Mr Skrbina's actions in charge 1 amounted to misconduct.

Charge 2

The panel considered that the result of not passing the call buzzer to the patient would have meant that they could not have called for assistance if they needed it. The panel noted that there is not much information about the circumstances of this incident provided by the NMC, apart from Mr Skrbina stating that he was busy at the time. The panel decided that, when considering the charge individually, Mr Skrbina's actions in charge 2 did not amount to misconduct.

Royal Stoke Hospital – Charges 3a, 3c, 3d, 3e, 3f

The panel considered that the charges indicated a lack of competence by Mr Skrbina. However, it did not consider that the individual sub charges would be sufficiently serious to amount to misconduct, and that they furthermore took place in the context of a one-off incident.

Royal Preston Hospital – Charge 4

The panel considered the oral evidence heard by the witnesses, who were clear that an arterial line should never be used as a medication port, and should only be used for measuring blood gases and accurate blood pressure. The panel heard evidence that an arterial line had a red port, so it would have been obvious that it should not have been used, and that all nurses should know this. The panel considered that this action could have had serious consequences for the patient, had it not been acted on immediately by another staff nurse at the time. Mr Skrbina did not appear to recognise what had gone wrong at the time. The panel decided that Mr Skrbina's action in charge 4 did amount to serious misconduct, because of the potentially adverse consequences to the patient.

Leighton Hospital – Charge 5 onwards

Charge 5

The panel noted that charge 5 related to two patients; Patient A and Patient B. It considered that it is serious to inaccurately report a patient's condition to other colleagues, as they would need to have been clear on what had occurred on the previous shift once they had taken over, in order to provide the appropriate level of care. The panel heard evidence that witnesses were shocked by what they saw in relation to both patient's conditions, and could not reconcile this with Mr Skrbina's handover. The panel considered that the incidents relating to Patient A and Patient B were intrinsically linked, and amounted to misconduct.

The panel particularly considered charges 5e and 5f, in respect of Patient B. The panel was of the view that these actions amounted to serious misconduct, as Mr Skrbina had given the wrong impression to his colleagues during handover about this patient's condition. Patient B was a vulnerable patient on an end of life pathway, and Mr Skrbina had presented a scenario that was not true, which is indicative of a lack of care and professionalism. This would have presented a risk of harm to Patient B.

The panel decided that Mr Skrbina's actions in charge 5 did amount to misconduct, and also amounted to serious misconduct for charges 5e and 5f.

Charge 6

The panel considered that dishonesty is difficult to address and indicates potential attitudinal issues. It is clear from the evidence that Mr Skrbina sought to conceal his errors by misreporting Patients B's condition to his colleagues for his own gain; either to leave his shift early or conceal that he hadn't cared for this patient as he should have done. The panel reminded itself that Patient B was a nonverbal, vulnerable patient who was on an end of life pathway. It considered that Mr Skrbina's actions could have had serious consequences for the patient, and he did not follow his duty of candour because he concealed his lack of care for the patient. The panel decided that Mr Skrbina's actions in charge 6 did amount to serious misconduct.

Charges 7, 8, 9 and 10

The panel acknowledged that all of these charges are intrinsically linked. Mr Skrbina did not change Patient B's wound dressings, and had he done so, he would have needed to administer the necessary medication around 30 minutes before his dressings were changed, to ease the patient's pain. The panel heard detailed evidence from witnesses that Patient B was found in a poor state following Mr Skrbina's shift, as Patient B's dressings had clearly not been changed. The panel considered that this is indicative of Mr Skrbina's lack of care and professionalism towards a vulnerable patient. Witness 6 also told the panel that she prompted Mr Skrbina to change the wound dressings on multiple occasions, but that he still failed to do so. Mr Skrbina knew that Patient B was in a comatose state, and he had even reported this in the care notes, so it was clear that he was aware Patient B was nonverbal and not in a position to refuse to have his dressings changed. The panel decided that Mr Skrbina's actions in charge 6 did amount to misconduct.

Charge 11

The panel heard evidence heard that it was the patient's right to request a female staff member to undertake her wash. She was instead washed by two male nurses, one being Mr Skrbina, and that she had reluctantly chosen this when given limited options by Mr Skrbina, the only other choice being to remain unwashed. This was not any real choice at all. The panel considered that Mr Skrbina should have informed the nurse in charge about the patient's request, and the situation could have been resolved. The patient's request was clearly denied, and so she was left with no option and was washed by two males when she was clear that she did not want this. The panel heard evidence that the patient was unhappy about the situation, and it was clear that her request was not respected. The panel decided that Mr Skrbina's actions in charge 11 did amount to misconduct.

Charge 12b

The panel considered that this patient had requested pain relief, as it was prescribed PRN, and Mr Skrbina had clearly denied this request and told her that she had to wait until the night shift started. The panel considered that there was no reason as to why he could not have administered it when she indicated she needed it. The panel heard evidence from witnesses, who described finding the patient rolling around in pain when they came on shift. The panel decided that Mr Skrbina's actions in charge 12b did amount to misconduct.

Charges 13, 14 and 15

The panel considered that all of these charges are linked to the same incident. The patient in question had made repeated requests to get out of bed. However, the panel found insufficient detail as to why the patient needed to get out of bed in order to determine that this amounted to misconduct, in the circumstances of the case.

Charge 17

The panel considered that Mr Skrbina had a duty of care, and the manner in which he responded to a request of a vulnerable patient who needed assistance was unacceptable. It is clear from the evidence that the patient had asked for help, and witnesses had reported feeling shocked by Mr Skrbina's unkind and uncompassionate response to this patient. The panel decided that Mr Skrbina's actions in charge 17 did amount to misconduct.

The panel decided that there are numerous examples of misconduct present in this case, some classed as serious misconduct, and these are indicative of Mr Skrbina's lack of care and professionalism towards multiple patients, as well as a distinct pattern of behaviour. The panel considered that, taken cumulatively, this paints a picture of indifference and

lack of care Mr Skrbina had for patients, over a significant period of time, and across multiple hospitals. Therefore, the panel found that Mr Skrbina's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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.'

The panel considered that all four limbs of *Grant* are engaged in this case. The panel finds that patients were put at an unwarranted risk of (and actually suffered) harm as a result of Mr Skrbina's misconduct. Mr Skrbina's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel took account of the large bundle of documents provided by Mr Skrbina, although he has not been in attendance to take the panel through these documents. It acknowledged some positive testimonials within the bundle, which makes clear that Mr Skrbina has had periods of good practice. However, the references and testimonials provided predate some of the charges in this case, and it is unclear whether these particular members of staff have sufficient knowledge of Mr Skrbina's overall practice, and

nothing before the panel that indicates any feedback obtained from patients he has cared for in regards to this case. Mr Skrbina may sometimes have been a good nurse does not diminish the seriousness of the occasions when he was not.

The panel also took account of Mr Skrbina's CPD and training certificates, however some of these are also historic documents that predate the charges, and the most recent certificates are dated 2020.

The panel considered that it has had no evidence of remorse, insight or reflection about the incidents from Mr Skrbina. When the incidents were raised as complaints locally, Mr Skrbina's responses appeared to be rude, defensive and dismissive of legitimate patient concerns. The panel could not find any evidence of acceptance or apologies made by Mr Skrbina in respect of his actions, nor any indication as to how he has improved his practice since. There is no evidence before the panel that Mr Skrbina has any understanding of his actions and the impact they may have had on patients, colleagues and the wider public. The panel therefore considered that, in the absence of the above, there remains a risk of harm and a risk of repetition.

The panel also considered the element of dishonesty that has been found proved. Dishonesty is very serious and more difficult to address, and it is also indicative of attitudinal issues. There was nothing before the panel to indicate that Mr Skrbina had accepted his dishonesty, which remains un-remediated. In all the circumstances, the panel considered that there was an unacceptable risk of repetition if Mr Skrbina's fitness to practise was not found impaired.

Therefore, in light of the above, the panel therefore decided 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 determined that a finding of impairment on public interest grounds is required. The panel considered that a well-informed member of the public would be shocked to hear about Mr Skrbina's actions. To not find Mr Skrbina impaired on the grounds of public interests, when considering that he has not sought to address the issues or strengthen his practice, would not be acceptable in the circumstances. The panel also considered the evidence of Witness 1, in that that Mr Skrbina had also been barred from working in 10 different hospitals and/or trusts. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Skrbina's fitness to practise impaired on the grounds of public interest.

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

Agreed Removal Application and Recommendation

Following the announcement of the panel's findings on impairment, Mr Brahimi informed the panel that Mr Skrbina had submitted an application for agreed removal from the NMC register. He provided the panel with a copy of this application and the supporting documentation.

The panel accepted the advice of the legal assessor.

The panel recommended that the Assistant Registrar refused the application. It then adjourned the hearing, so a decision could be made by the Assistant Registrar on the agreed removal application.

Agreed Removal Refused

The panel noted that the application for agreed removal was refused by the Assistant Registrar of the NMC on 13 June 2023. This decision was announced by the Chair of the panel on 13 June 2023.

The panel then proceeded to the sanction stage.

Sanction

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

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Brahimi informed the panel that in the Notice of Hearing, dated 3 May 2023, the NMC had advised Mr Skrbina that it would seek the imposition of a 12-month suspension

order/striking-off order if it found his fitness to practise currently impaired. The NMC are applying for a striking-off order at this stage.

Mr Brahimi provided written submissions on sanction, which are as follows:

1) *'The Panel have now reached a stage of finding misconduct in respect of the Registrant's behaviour and have concluded that his fitness to practice is currently impaired. The Panel should therefore consider what sanction is appropriate to address:*

   a. *The proven charges, including charge 6 with a finding of dishonesty.*

2. *The Panel should first take into account relevant factors before deciding on sanction, as set out by the NMC Fitness to Practice Library guidance SAN-1:*

3. *Proportionality*

   a. *Finding a fair balance between Registrant's rights and the overarching objective of public protection;*
   b. *To not go further than it needs to, the Panel should think about what action it needs to take to tackle the reasons why the Registrant is not currently fit to practise;*
   c. *The Panel should consider whether the sanction with the least impact on the nurse practise would be enough to achieve public protection, looking at the reasons why the nurse isn't currently fit to practise and any aggravating or mitigating features.*

4. ***Aggravating features***

a. Abuse of position of trust;

b. There were varied incidents;

c. Conduct put patients at risk of harm;

d. Striking lack of insight from the Registrant as to these concerns;

e. No up-to-date reflective documentation.

5. Mitigating features

a. Registrant's bundle with certificates and references.

6. Previous interim order and their effect on sanctions

a. The Registrant has not been subject to an Interim Order.

7. Previous fitness to practice history

a. Referral for failing to practice competently in 2009:

i. "That you, whilst working as a registered nurse at University Hospital of South Manchester from February 2003 over a period of five years, failed to practice competently in accordance with the Nursing and Midwifery Council Code"

ii. The investigating committee found no case to answer however the Panel also decided to keep a record of the matter for 3 years so if another allegation was made within that period, then the allegation would have reopened.

Sanctions available

8. *NMC submit that taking no action and a caution order are not suitable options for this case due to the number and variety of concerns. Guidance is found at SAN-3a and 3b.*

    a. *Taking no action: this would not be an appropriate course of action as the regulatory concern of dishonest behaviour is serious and other charge involves risk of harm to residents given the scenarios found proven in this case. The public protection and public interest elements in this case are such that taking no action would not be the appropriate response;*

    b. *Caution Order: similarly, a Caution Order is also not suitable as this is a sanction aimed at misconduct that is at the lower end of the spectrum. In this case the concern involved public safety and public interest. Given the concerns, a more effective sanction is required.*

9. *With regards to a conditions of practice order (COPO), the NMC submit that this option does not adequately address and reflect upon the number of breaches in this case. NMC guidance is found at reference SAN-3c.*

    a. *It is always difficult to formulate or consider such conditions that effectively deal with dishonest behaviour, which is an attitudinal problem in this case.*

    b. *The level of concern in this case would require a higher level of sanction than a COPO. The guidelines refer to "When conditions of practice are appropriate" and the Panel may find that these conditions are not met.*

    c. *Some of the regulatory concerns in this case focus upon a number of clinical failures which are linked to fundamental*

areas of nursing practice. Measurable, workable and appropriate conditions can be put into place to address the clinical failures, however a COPO would not suitably address the dishonesty charge or the attitudinal and behavioural concerns demonstrated by the Registrant towards patients.

10. *The NMC submit the Registrant's actions do warrant a suspension order but this would not be sufficient. Suspension guidance is found at reference SAN-3d, and includes some of the following (but not limited to):*

    a. *"Key things to weigh up before imposing this order include:*

        - *whether the seriousness of the case require temporary removal from the register?*

    b. *"Use the checklist below as a guide to help decide whether it's appropriate or not. This list is not exhaustive:*

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

    c. *The seriousness of the regulatory concerns does warrant a temporary removal from the Register; however, the Registrant's actions are not isolated but in fact a pattern of misconduct over a significant number of years and involve serious mistreatment and neglect towards multiple patients.*

    d. *The NMC submit that a suspension order will not address the concerns in this case or proportionately provide for an appropriate response to such serious charges.*

11. *The NMC submit that a striking off order is appropriate in this case. The Panel may be assisted by guidance provided at reference SAN-3e. The NMC make the following submissions in response to the guidance:*

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

        i. *The NMC submit that yes, they do. The charges found proven are those in the higher category of seriousness as per the guidance. There has been limited insight into these incidents and therefore not only is the misconduct itself raising fundamental questions about the Registrant's professionalism, but also the point that he has provided no explanation in addressing these concerns.*

    b. *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*

        i. *The NMC submit that no, it cannot. There has been repeated conduct of similar nature, involving multiple patients. The public would be deeply concerned that the Registrant be allowed to remain on the register, in particular when taking into account the lack of insight.*

    c. *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

i. The NMC submit that yes, it is. As outlined in the guidance Panels "…will very often find that in cases of this kind, the only proportionate sanction will be to remove the nurse, midwife or nursing associate from the register". There is no further evidence that the Panel has read or seen which would justify pointing to a less severe sanction. A member of would not only not understand why a less sever sanction is imposed but most likely not accept that it would be a true and proportionate measure in response to the proven charges.

d. Given that the charges involve dishonesty, the Panel will also be assisted with guidance at reference SAN-2. This guidance says "In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve…" – the NMC would repeat the aggravating features above when assessing this guidance and further add:

i. Deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients;
ii. Vulnerable victims;
iii. Direct risk to patients.

e. Where the dishonesty charge has been found proven, it is linked directly to the Registrant's clinical practice and to the neglect of a vulnerable end of life patient. A striking off order should then be

considered proportionate as the misconduct will raise fundamental questions surrounding the Registrant's trustworthiness & professionalism. Ultimately his actions will be considered incompatible with continued registration.

Sanction request:

12. *The concerns in this case may be described as being attitudinal in nature and, therefore difficult to remediate. For all the reasons previously argued, the NMC submit that the appropriate sanction in this case is a:*

Striking-off Order

13. *The NMC have sought to assist the Panel by going through each of the possible sanctions and when weighing the evidence against the set guidance, it is justified that there be a striking-off order. When assessing the dishonest misconduct by the Registrant, it can be argued that this is behaviour that would be difficult to remediate through any form of training, character references or certificates. This is an attitudinal concern where the Registrant should be persuasively showing he has recognised his errors and corrected them. The Registrant has failed to do this. This sanction would reflect that the conduct of the Registrant has been properly addressed and maintain trust with the public that the NMC do take such allegations seriously and will take swift and appropriate action.*

14. *The NMC respect that the Panel is entirely at liberty to proceed as they deem most suitable for this case.'*

Decision and reasons on sanction

Having found Mr Skrbina'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:

- An abuse of a position of trust notably affecting very vulnerable patients and demonstrating the lack of care for them by Mr Skrbina.
- There were varied incidents over a significant period of time and within a number of organisations.
- Mr Skrbina's conduct put patients at risk of harm, and caused actual harm.
- No up-to-date reflections, training certificates or references despite there being no interim order in operation which would have prevented him from working.
- The vulnerability of patients and the lack of care demonstrated by Mr Skrbina.
- Mr Skrbina's rude and dismissive responses to the allegations in which no insight or remorse was demonstrated, and furthermore where he sought to deflect blame on others.

The panel also took into account the following mitigating features:

- Mr Skrbina provided a response bundle, which demonstrates instances of good practice at times.

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

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

The panel next considered whether placing conditions of practice on Mr Skrbina's registration would be a sufficient and appropriate response. The panel was of the view that conditions of practice could be formulated to address solely clinical practice concerns, but those concerns were largely due to attitudinal issues, and it would be difficult to formulate such conditions that would address the attitudinal concerns and dishonesty found. The panel considered that there would be no workable conditions that could be formulated that would address the seriousness of the concerns, given the nature of the charges in this case. There was no suggestion that Mr Skrbina would even comply with a conditions of practice order, when considering the nature of his responses to the concerns. Furthermore, the panel concluded that the placing of conditions on Mr Skrbina's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel considered that a suspension order would protect the public for a period of time, but it would not mark the seriousness of the concerns found proved, nor would it be in the public interest. The panel considered that these are wide ranging concerns that occurred over a significant period of time, and within a number of organisations. The panel also heard evidence that Mr Skrbina has been barred from 10 hospitals/trusts.

When considering the NMC's guidance above, the panel considered that this is not a single incident of misconduct, that there is evidence of attitudinal issues present, and a lack of insight demonstrated by Mr Skrbina. As such, the risk of harm and the risk of repetition remains high. The panel did not have any information regarding a repeat of his behaviour since the incidents. However, the panel has no information as to whether Mr Skrbina was working as a nurse since.

The panel considered that there has been no evidence of insight, remorse or reflection demonstrated by Mr Skrbina regarding these incidents, and the impact they could have had (and did have) on patients, colleagues and the public. There is no evidence that Mr Skrbina has attempted to strengthen his practice. The panel considered that Mr Skrbina's responses to the concerns were rude and dismissive, and there was no evidence that he took any responsibility or apologised. Mr Skrbina had demonstrated a pattern of behaviour within a number of organisations, and a lack of care and professionalism for particularly vulnerable patients.

The panel also considered the dishonesty that was found in this case was at the higher end of the scale as it misrepresented the situation of a patient who was unable to speak for himself. The panel noted that, although it is difficult to address, there has been no information before it to suggest Mr Skrbina has made any attempts to do so. It took

account of the case of *Parkinson v Nursing and Midwifery Council* [2010] EWHC 1898 (Admin), namely paragraph 18, which stated:

> *"18. A nurse found to have acted dishonestly is always going to be at severe risk of having his or her name erased from the register. A nurse who has acted dishonestly, who does not appear before the Panel either personally or by solicitors or counsel to demonstrate remorse, a realisation that the conduct criticised was dishonest, and an undertaking that there will be no repetition, effectively forfeits the small chance of persuading the Panel to adopt a lenient or merciful outcome and to suspend for a period rather than to direct erasure."…*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Skrbina's actions is fundamentally incompatible with him remaining on the register.

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

Finally, in looking at a striking-off order, 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?*

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

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

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

This will be confirmed to Mr Skrbina in writing.

Interim order

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

Submissions on interim order

The panel took account of the written submissions provided by Mr Brahimi:

'***Interim order under Rule 24 (14) to cover possible appeal***

15. Should the Panel make an order as to sanction beyond that of a caution, the NMC would invite that there be an interim order for a period of 18 months. The Panel will appreciate that the decision on sanction will not take effect until at least 28 days. The period of 18 months would therefore be sufficient should an appeal be lodged by the Registrant. The request and grounds argued for why an interim order is required would be the same as those previously presented at the misconduct and impairment stage. The Panel may agree that having no interim order would not be reflective of their finding that a sanction is required, beyond a caution.'

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28-day appeal period.

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

That concludes this determination.