Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Monday 16 October 2023 - Thursday 19 October 2023

Virtual Hearing

Name of Registrant:	Nicola Helen Sharp
NMC PIN	09I0553E
Part(s) of the register:	Registered Nurse – Learning Disabilities (19 October 2009)
Relevant Location:	Lincolnshire
Type of case:	Misconduct
Panel members:	Simon Banton (Chair, Lay member) Carol Porteous (Registrant member) Hannah Harvey (Registrant member)
Legal Assessor:	Michael Hosford-Tanner
Hearings Coordinator:	Amie Budgen
Nursing and Midwifery Council:	Represented by Simon Gruchy, Case Presenter
Ms Sharp:	Not present and not represented
Facts proved:	Charges 1, 2a, 2b and 3
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Sharp was not in attendance and that the Notice of Hearing letter had been sent to Ms Sharp's registered email address by secure email on 22 August 2023.

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

The panel accepted the advice of the legal assessor.

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

In the light of all of the information available, the panel was satisfied that Ms Sharp 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 Ms Sharp

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

Mr Gruchy referred the panel to an email from Ms Sharp dated 13 October 2023 which included stated the following:

'Thank you for the invitation to the hearing but i (sic) *won't be able to attend the hearing as I will be away on holiday. I won't be back in England until November 4th…Furthermore I have asked for no further contact from the NMC who have taken me to hell and back over the last 4 years.'.*

Mr Gruchy invited the panel to take the view that Ms Sharp has voluntarily absented herself in the light of the email dated 13 October 2023.

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 Ms Sharp. In reaching this decision, the panel has considered the submissions of Mr Gruchy, the email from Ms Sharp dated 13 October 2023, 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:

- Ms Sharp sent an email on 13 October 2023 stating that she will not be attending the hearing and that she does not wish to be contacted by the NMC, therefore the panel took the view that Ms Sharp has voluntarily absented herself;
- No application for an adjournment has been made by Ms Sharp at all, nor in the email dated 13 October 2023;
- There is no reason to suppose that adjourning would secure her attendance at some future date;

- Seven witnesses are scheduled to attend the hearing today, tomorrow and the day after to give live evidence;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019, as well as in 2023;
- 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 Ms Sharp in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Ms Sharp at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her 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 Ms Sharp's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

'That you, a registered nurse:

1) *On 19 October 2019, you incorrectly administered 2.5ml of morphine to Patient A when 2.5mg of morphine was prescribed.*

2) *On 19 October 2019:*

   a) failed to make a record of the administration of morphine and/or midazolam in Patient A's care notes;
   b) failed to record your reason for administrating morphine and/or midazolam in Patient A's care notes.

3) *On 24 March 2023, administered 19 units of insulin to Patient B, instead of the prescribed dose of 4 units of insulin.*

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

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

At the outset of the hearing, Mr Gruchy made a request that this case be held partly in private on the basis that proper exploration of Ms Sharp's case involves reference to the details of her private life, as well as… [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Having heard that there will be reference to Ms Sharp's private life, as well as…[PRIVATE], the panel determined to hear parts of the hearing in private, as and when such issues are raised, in order to preserve the details of Ms Sharp's private life.

Decision and reasons on application to admit written statements as evidence

The panel heard an application made by Mr Gruchy under Rule 31 to allow the written statements of all of the witnesses into evidence. All witnesses were scheduled to attend

the hearing to provide oral evidence between days 1-3, however Mr Gruchy invited the panel to consider that the comprehensive written statements of all of the witnesses are sufficient and can be used as evidence.

Furthermore, Mr Gruchy informed the panel that three of the witnesses are family members of Patient A and therefore, inviting them to provide oral live evidence at the hearing may cause them distress as they will be revisiting circumstances surrounding Patient A's death. The NMC, at the request of the panel today, made sufficient efforts to ensure that witnesses 1-3 had a choice as to whether they wish to attend the hearing to provide oral live evidence, or if they are content to submit their written statements as their evidence. Witness 1 indicated that they would prefer to submit their written statements as evidence instead of providing oral evidence at the hearing. Witness 1 had also spoken to witnesses 2 and 3, who indicated that they would also prefer this.

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

The panel gave the application in regard to Witnesses 1, 2 and 3 serious consideration. The panel noted that Witness 1, 2 and 3's statement had been prepared in anticipation of being used in these proceedings and was signed by them. Further, the panel considered that witnesses 1, 2 and 3 may be caused emotional distress if they were required to join the hearing and give oral live evidence relating to the death of Patient A.

The panel found that witnesses 4, 5, 6 and 7 have all provided comprehensive written statements which the panel determined are sufficient to rely on as their evidence, instead of inviting them to provide oral live evidence.

The panel considered that as Ms Sharp had been provided with a copy of all of the witnesses' written statements and, as the panel had already determined that Ms Sharp

had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine the witnesses in any case. Further, the panel determined that the written statements of all of the witnesses can be used as sufficient evidence in these proceedings. The panel was of the view that it did not propose to ask any questions of the witnesses as their statements were clear and supported by contemporaneous documentation, which had also been sent to Ms Sharp.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence, the comprehensive written statements of all seven of the witnesses scheduled to attend the hearing to provide oral live evidence. It would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

Ms Sharp was referred to the NMC on 23 October 2019 by Lincolnshire Police. Ms Sharp started working at Howson Care Centre (the Home) as a Band 5 Nurse in February 2019. The alleged facts are as follows:

On Saturday 19 October 2019, Ms Sharp was working a 12.5-hour shift at the Home. Patient A was receiving end of life care at the Home and had been prescribed 2.5mg – 5 mg of morphine for pain relief. During the course of 19 October 2019, members of Patient A's family, who were visiting her at the Home, noticed that Patient A was in pain. A healthcare assistant informed Ms Sharp that Patient A's family had requested pain management for Patient A. Ms Sharp administered 2.5mls of morphine, which amounted to 25mgs, up to ten times the prescribed dose, at around 1530 on 19 October 2019. Patient A died shortly after.

Ms Sharp failed to record in Patient A's daily progress notes either the administration of the medication to Patient A on 19 October 2019, or the reasons for administering it.

Witness 4 attended the Home to verify Patient A's death in the early hours of 20 October 2019. Witness 4 had concerns about discrepancies she had found in Patient A's paperwork, as well as the amount of morphine which was signed for and administered by Ms Sharp in the Controlled Drugs Book. Witness 4 called the police to inform them of the concerns.

Ms Sharp was suspended from working at the Home and a police investigation commenced in relation to Patient A's death. Police attended Ms Sharp's home to try and arrange a voluntary interview under caution. Ms Sharp was arrested and subsequently released after almost two days in custody, with strict bail conditions, while the police awaited the toxicology report.

In March 2020, Lincolnshire Police advised that they would not be taking the criminal case against Ms Sharp any further, as they had determined that there was no realistic prospect of her conviction.

The coroner's investigation into Patient A's death, commenced on 31 October 2019. The inquest opened on 13 January 2020. The coroner's inquest hearing took place on 15 April 2021. The medical cause of death was found to be *"effects of morphine"* and the conclusion of the coroner as to Patient A's death was *"misadventure."*

In August 2020 Ms Sharp started working at Drovers Call Care Home (the Home 2). Ms Sharp left the Home 2 on 24 March 2023 following a medication administration error that day, where she had administered 19 Units of insulin to a patient instead of the 4 Units that had been prescribed.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all of the written statements of the witnesses as evidence in this case, together with the submissions made by Mr Gruchy on behalf of the NMC.

Mr Gruchy submitted that the written evidence from witnesses 1, 2, 3, 4, 5, 6 and 7 are credible reports regarding the circumstances surrounding both events.

The panel has drawn no adverse inference from the non-attendance of Ms Sharp.

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 received written statements as evidence from the following witnesses:

- Witness 1: A relative of Patient A.
- Witness 2: A relative of Patient A.
- Witness 3: A relative of Patient A.
- Witness 4: The Doctor who was called to confirm the death of Patient A.
- Witness 5: Health Care Assistant (HCA) at the Home.
- Witness 6: Deputy manager of the Home.
- Witness 7: Health Care Assistant (HCA) at the Home 2.

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

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

Charge 1

"That you, a registered nurse:

1) On 19 October 2019, you incorrectly administered 2.5ml of morphine to Patient A when 2.5mg of morphine was prescribed."

This charge is found proved.

In reaching its decision, the panel took into account the written statement by Ms Sharp and the comprehensive written statements from Witness 1,Witness 2 and Witness 3 detailing their version of events from the time of the incident with Patient A.

Further, the panel considered the written statement of Witness 4 who was the on-call Doctor who came to the Home to confirm the death of Patient A. The panel considered that Witness 4 provided a detailed account of Patient A's cause of death being linked to an overdose, how she checked the sharps bin to see how much medication had been administered to Patient A, and how she identified concerns with the dosage of controlled drugs which had been administered to Patient A, based on the documentation available.

The panel considered that the concerns of Witness 4, which led to her calling the Police, were supported by the 'Gold standard Framework' document which details the correct doses of morphine, a controlled drug, which should be administered. The panel had regard to the 'Gold Standard Framework' document stating that morphine was allowed to be administered every 2 hours (2.5- 5mg), but no more than 6 doses should be administered within twenty-four hours. Further, the panel considered the 'Copy of the Controlled Drugs Book' page, which indicated that three vials of morphine had been taken

from the controlled drugs cupboard compared to the dose prescribed to Patient A, which would have required only half of one, 5mg vial.

The panel also considered a letter received from Ms Sharp's representative at the Royal College of Nursing (RCN) dated 12 January 2023, which stated that Ms Sharp admits to charge 1 and has detailed this in her written reflective piece dated 29 January 2023, as well as making partial admissions during the Police investigation in 2019.

In light of all of the supporting evidence above, the panel found this charge proved.

Charge 2) a) and Charge 2) b)

"That you, a registered nurse:

2) On 19 October 2019:

   a) failed to make a record of the administration of morphine and/or midazolam in Patient A's care notes;

   b) failed to record your reason for administrating morphine and/or midazolam in Patient A's care notes;"

Charges 2) a) and 2) b) are found proved.

The panel decided to consider charges 2) a) and 2) b) together as it was required to examine the same documentary evidence for both.

In reaching its decision, the panel took into account the written statement from Ms Sharp's representative at the RCN dated 12 January 2023, as well as the written witness statement from Witness 4, and the supporting documents available.

The panel had sight of Patient A's care notes and found no evidence or entry in the notes regarding the morphine and/or midazolam administration on 19 October 2019. Further, the

panel considered closely the ‘Daily Progress Notes’ for Patient A and determined that these documents did not support Ms Sharp’s contention, during the Police investigation, that she had made a record of the administration of morphine and/or midazolam to Patient A. On examination of Patient A’s care notes, nor did the panel find any evidence of Ms Sharp’s reasoning for the morphine and/or midazolam administration.

The panel determined that Ms Sharp had a duty, as a registered nurse, to record in the care notes both the administration and reason for administering morphine and/or midazolam to Patient A.

In light of charge 1 having been found proved and all of the supporting evidence above, the panel found charge 2) a) and charge 2) b) proved.

Charge 3

“That you, a registered nurse:

On 24 March 2023, administered 19 units of insulin to Patient B, instead of the prescribed dose of 4 units of insulin.

This charge is found proved.

In reaching this decision, the panel took into account the comprehensive written witness statement from Witness 7, and the supporting documents available, namely the exhibited note of the discussion between Witness 7 and Ms Sharp on 24 March 2023. Further, the panel consider the Medication Administration Record (MAR) chart where Ms Sharp recorded that she had administered 19 Units of insulin to Patient B on the afternoon of 24 March 2023.
The panel noted that Patient B was on a Diabetes Management Plan which stated the correct and prescribed doses of insulin that needed to be administered at specific times of the day. The panel considered the ‘Terms of Reference for Community Nurse to

Administer Injectable Medication' document which stated that 19 Units of insulin should be administered to Patient B in the morning and 4 Units in the afternoon. The panel had evidence before it that Ms Sharp had administered 19 Units of insulin to Patient B in the afternoon, instead of the prescribed dose of 4 units.

The panel considered the written statement from Witness 7, in which she stated that Ms Sharp had administered an incorrect dose of insulin to Resident B and Ms Sharp had acknowledged this. Ms Sharp's admission was also recorded in a contemporaneous record of a supervision meeting held immediately after the incident. It determined that this can be viewed as Ms Sharp's admission to this charge.

The panel noted that Ms Sharp had engaged with NMC up until the point of the second incident at the Home 2 on 24 March 2023, after which she stopped working as a registered nurse.

In light of all of the supporting evidence above, the panel found charge 3 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 amounted to misconduct and, if so, whether Ms Sharp'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, recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there was no burden or standard of proof at this stage, and it 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 then go on to decide whether, in all the circumstances, Ms Sharp's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

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.'.*

Mr Gruchy invited the panel to take the view that the facts found proved amount to misconduct. He invited the panel to have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2018)' (the Code) in making its decision.

Mr Gruchy invited the panel to identify the specific, relevant standards that he submitted Ms Sharp had breached, which would lead to her actions amounting to misconduct and he referred the panel to the NMC's published guidance on impairment.

Mr Gruchy moved onto 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. He referred the panel to the cases of '*Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin)'.

Mr Gruchy submitted that three limbs of the *Grant* test were engaged. He submitted that limb 'd' is not engaged as the charges found proved do not relate to dishonesty.

Mr Gruchy invited the panel to consider that Ms Sharp's fitness to practice is impaired on the grounds of public protection and is also in the wider public interest.

In relation to public protection, Mr Gruchy submitted that the incidents were serious in nature, relating to a lack of proper conduct which led to direct, unwarranted harm to Patient A and put Patient B at risk of unwarranted harm. Mr Gruchy invited the panel to consider whether Ms Sharp is liable to repeat the conduct, which was found proved. He submitted that Ms Sharp has not been working as a registered nurse since the date of the second incident relating to the medication administration error with Patient B on 24 March 2023. Further, he informed the panel that Ms Sharp does not wish to be contacted by the NMC, nor has she engaged with the NMC proceedings since the date that the second incident occurred, namely 24 March 2023.

Furthermore, Mr Gruchy submitted that Ms Sharp has not provided the NMC with evidence which can demonstrate her remorse and insight. Mr Gruchy submitted that Ms Sharp has not made any efforts to demonstrate any remediation. Mr Gruchy submitted that, therefore, there is a risk of repetition of the charges found proved and invited the panel to consider that Ms Sharp's fitness to practise is impaired on the ground of public protection.

Mr Gruchy submitted a finding of impairment is also in the wider public interest as a well-informed member of the public would be concerned to learn that Ms Sharp was continuing to work as a registered nurse without any form of restriction in place in light of the seriousness of the charges found proved. He submitted that Ms Sharp's actions breached the Code and have brought the profession into disrepute and, therefore, her fitness to practise is also impaired on public interest grounds.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *Meadow v General Medical Council* [2006] EWCA Civ 1390.

In reaching its decision on misconduct, the panel considered to Ms Sharp's written reflective piece, the written statements of the witnesses and the documentary evidence provided. Further, the panel considered the submissions of Mr Gruchy on behalf of the NMC.

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 Ms Sharp's actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity.

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively.

6 Always practise in line with the best available evidence.

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice.

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:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.

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.

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:

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

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs.

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

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times.

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that the breaches of the Code were a serious departure from the standards expected of a registered nurse and concluded that each of the charges and sub charges found proved amounted to misconduct.

Decision and reasons on impairment

The panel went on to decide if as a result of the misconduct, Ms Sharp's fitness to practise is currently impaired. The panel was aware that the NMC guidance as to whether a nurse's fitness to practise is impaired can be answered by considering whether the nurse can practice kindly, safely and professionally (NMC guidance on Impairment DMA-1).

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional conduct. 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 the trust in the profession of both patients and the public.

The panel went on to consider 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.'*

The panel next had regard to paragraph 76, where Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our finding 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 and/or is liable in the future to be dishonest.'

The panel considered that limbs '*a'-'c'* were engaged. It determined that limb *'d'* was not engaged as the charges found proved were not related to dishonesty.

The panel considered the factors set out in the case of *Cohen* and considered whether Ms Sharp's misconduct is such that it could be remedied. The panel took into account all of the evidence before it, including Ms Sharp's written reflective pieces in relation to the incident that occurred at the Home, the letter from Ms Sharp's representative at the RCN dated 12 January 2023, and the email from Ms Sharp dated 13 October 2023 which stated the following:

'I really cannot cope with anything more to do with the NMC or nursing…[PRIVATE]…*I would be and am completely embarrassed to be classed as a nurse. Furthermore, I have asked for no further contact from the NMC who have taken me to hell and back over the last 4 years.'*

Further, the panel considered the comprehensive written statements by all of the witnesses. The panel also had regard to the submissions made Mr Gruchy, when determining whether Ms Sharp has addressed her misconduct.

The panel determined that Patient A was caused direct unwarranted harm and Patient B was put at an unwarranted risk of harm as a result of Ms Sharp's misconduct. It determined that Ms Sharp's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel concluded that confidence in the nursing profession would be undermined if a finding of impairment was not made.

In relation to insight, the panel considered that Ms Sharp has not demonstrated any understanding of how her actions caused Patient A direct, unwarranted harm and could have put Patient B at an unwarranted risk of serious harm. Further, Ms Sharp has not demonstrated an understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession. Therefore, the panel was of the view that Ms Sharp has not demonstrated any insight or remorse in relation to her actions, nor has Ms Sharp evidenced any measures she has taken to strengthen her practise.

In all the circumstances, the panel determined that Ms Sharp has not demonstrated any insight into the seriousness of her misconduct.

The panel took into account that Ms Sharp was engaging but has stopped engaging with the NMC in relation to these proceedings since the 24 March 2023 when the second incident occurred with Patient B at the Home 2.

The panel noted that Ms Sharp made partial admissions during the Police investigation in relation to the incident which occurred on 19 October 2019 with Patient A, and that her RCN representative stated that she admitted to the charges relating to medication administration errors with Patient B on 24 March 2023. However, the panel determined that in the light of Ms Sharp's non engagement with the NMC since 24 March 2023 and that she has not demonstrated any remorse, insight or any measures she has taken to strengthen her practise, there is a risk of repetition of the charges found proved. Consequently, the panel 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 wellbeing 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 also required due to the risk of repetition of the charges found proved and the consequential risk of harm to patients/residents in Ms Sharp's care. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment was not made in this case in light of the seriousness of the charges found proved, and therefore the panel found that Ms Sharp's fitness to practise is also impaired on the ground of the wider public interest.

Having regard to all of the above, the panel has determined that Ms Sharp's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Ms Sharp off the register. The effect of this order is that the NMC register will show that Ms Sharp 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, notably the FTP-3 '*Guidance regarding serious concerns'* and the SAN-2 *'Considering sanction for serious cases'* guidance.

Submissions on sanction

Mr Gruchy invited the panel to impose a striking-off order or at least a suspension order, as it found Ms Sharp's fitness to practise currently impaired. Mr Gruchy referred the panel to the NMC Guidance SAN-1 in respect of the factors to consider before deciding on sanction.

Mr Gruchy outlined aggravating and mitigating features affecting the case. He submitted that it is the NMC's position that a substantive striking-off order is necessary on the grounds of public protection and in the wider public interest.

In relation to public protection, Mr Gruchy submitted that the charges found proved are serious in nature, relating to Ms Sharp's medication administration errors, which caused Patient A direct unwarranted harm and put Patient B an unwarranted risk of harm. Mr Gruchy submitted that Ms Sharp has not engaged with the NMC proceedings since the day of the second incident on 24 March 2023, and has not provided evidence to demonstrate her insight, remorse or strengthened practice since then.

Mr Gruchy informed the panel that Ms Sharp is currently subject to an interim conditions of practice order, and was so at the time of the second incident with Patient B on 24 March 2023.

Mr Gruchy submitted that the risk of repetition and risk of harm to the public in light of Ms Sharp being involved in a second incident on 24 March 2023 whilst subject to an interim conditions of practice order, and her lack of remediation cannot be addressed with a caution order, conditions of practice order, nor a suspension order. Further, Mr Gruchy referred the panel to the email which Ms Sharp sent on 13 October 2023 again, which stated the following:

> *'…I really cannot cope with anything more to do with the NMC or nursing…*[PRIVATE]*…I would be and am completely embarrassed to be classed as a nurse. Furthermore, I have asked for no further contact from the NMC who have taken me to hell and back over the last 4 years.'.*

Mr Gruchy submitted that the imposition of a substantive striking-off order is also otherwise in the wider public interest to maintain public confidence in the profession. He submitted that a well-informed member of the public would be concerned to learn that Ms

Sharp was continuing to work as a registered nurse on the NMC register in light of the seriousness of the charges found proved.

Mr Gruchy submitted that in all the circumstances, it is the NMC's position that a substantive striking-off order is the only sanction which is appropriate and capable of protecting the public and maintaining public confidence in this case.

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

Decision and reasons on sanction

Having found Ms Sharp'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:

- Ms Sharp's actions caused Patient A direct and serious unwarranted harm and there was a risk of unwarranted harm to Patient B;
- Ms Sharp has not demonstrated any insight or remorse into her failings since the second incident with Patient B occurred on 24 March 2023 and very limited remorse with regards to the harm caused to Patient A on 19 October 2019;
- There is no evidence of any up-to-date, relevant training Ms Sharp has undertaken to strengthen her current practice, or any indication that she intends to do so;
- Ms Sharp's attitude with regards to her misconduct and her current view of the NMC and nursing.

The panel also took into account the following mitigating features:

- Ms Sharp's partial admissions to the serious medication error, following the death of Patient A, which occurred on 19 October 2019.

The panel considered that the aggravating factors greatly outweighed the mitigating feature.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Sharp'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 Ms Sharp'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 Ms Sharp's registration would be a sufficient and appropriate response. The misconduct identified in this case caused Patient A direct unwarranted harm and put Patient B at an unwarranted risk of harm. The panel considered that whist the clinical concerns had the potential to be addressed through conditions of practice, both the fact that the second incident with Patient B on 24 March 2023 occurred whilst Ms Sharp was subject to an interim conditions of practice order and the seriousness of the charges found proved, indicate that the imposition of a conditions of practice order is unlikely to protect the public. Further, the panel considered that Ms Sharp has not provided any evidence to demonstrate her insight, she has not shown any remediation, nor has she demonstrated how these

concerns can or have been addressed since they occurred, indicating that Ms Sharp wishes nothing to do with nursing or the NMC.

In all the circumstances, the panel is of the view that there are no practical or workable conditions that could be formulated and that the placing of conditions on Ms Sharp's registration would not adequately address the seriousness of this case and would not protect the public or the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse.

The panel has no evidence before it to suggest that Ms Sharp has taken steps to strengthen her practice and strong indications that she has no intention of doing so or engaging with the NMC. The panel noted that Ms Sharp has had ample opportunities since the death of Patient A on 19 October 2019, to make improvements or developments within her career and provide evidence of this to the NMC but has failed to do so. After initial engagement with the NMC, Ms Sharp has disengaged totally since the second medication error on 24 March 2023. The panel further considered the contents of her email dated 13 October 2023, noting that Ms Sharp stated that she does not wish to work as a registered nurse, nor engage further with the NMC proceedings.

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?'*

Ms Sharp's actions were a significant departure from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that its findings demonstrate that Ms Sharp's actions were serious and to allow her 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. The panel had regard to the effect of Ms Sharp's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves. The panel concluded that nothing short of this would be sufficient in this case on the grounds of both public protection and public interest and in upholding proper standards of professional conduct.

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. Again, the panel noted that Ms Sharp has disengaged with the NMC in relation to these proceedings which involved serious charges, since the time of the second incident on 24 March 2023.

The panel considered that the serious breaches of fundamental tenets of the profession, greatly aggravated by the lack of remorse and total disengagement from nursing and the NMC following the second medication error on 24 March 2023, are fundamentally incompatible with Ms Sharp remaining on the register and make a suspension order inappropriate. The panel determined that a member of the public will have a serious

concern about Ms Sharp continuing as a registered nurse due to the concerns raised against her and the lack of insight into her failings.

This decision will be confirmed to Ms Sharp 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 Ms Sharp'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 submissions made by Mr Gruchy. He submitted that it is necessary to impose an interim suspension order for a period of 18 months to cover the appeal period on the grounds of public protection and in the wider public interest.

Decision and reasons on interim order

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

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

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

That concludes this determination.