**Nursing and Midwifery Council**
**Fitness to Practise Committee**

**Substantive Hearing**
**13 January 2020 – 21 January 2020**

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

| | |
|---|---|
| **Name of registrant:** | Jose Crujo Repsina Baptista |
| **NMC PIN:** | 16H0439C |
| **Part(s) of the register:** | Registered Nurse – Sub Part 1<br>Mental Health Nursing – 11 January 2012 |
| **Area of registered address:** | Peterborough |
| **Type of case:** | Misconduct |
| **Panel members:** | Barbara Stuart (Chair, Lay member)<br>Peter Wrench (Lay member)<br>Jonathan Coombes (Registrant member) |
| **Legal Assessor:** | John Bromley-Davenport QC |
| **Panel Secretary:** | Akunna Iwuagwu (Days 1 – 3) and Philip Austin (Days 4 – 7) |
| **Nursing and Midwifery Council:** | Represented by Assad Badruddin, Case Presenter |
| **Mr Baptista:** | Not present and not represented |
| **Facts proved:** | Charge 1a–e, 2, 4a–d, 6, 7a–c |
| **Facts not proved:** | Charge 3a–c, 5 |
| **Fitness to practise:** | Currently 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 Baptista was not in attendance and that the Notice of Hearing had been sent to Mr Baptista's registered address by recorded delivery and by first class post on 12 December 2019.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and venue of the hearing and, amongst other things, information about Mr Baptista's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Mr Badruddin, 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.

In the light of all of the information available, the panel was satisfied that Mr Baptista 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 Baptista**

The panel next considered whether it should proceed in the absence of Mr Baptista.

The panel had regard to Rule 21(2), which states:

*'**21.**— (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—*

*(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;*

*(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or*

*(c) may adjourn the hearing and issue directions.'*

Mr Badruddin invited the panel to proceed in the absence of Mr Baptista on the basis that he had voluntarily absented himself. Mr Badruddin drew the panel's attention to correspondence from Mr Baptista, stating that he has disengaged from these proceedings and does not intend to continue practising as a registered nurse in the UK. Mr Badruddin submitted that since the NMC received this correspondence in November 2019, there had been no engagement at all from Mr Baptista. As a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor which included reference to the case of *R. v Jones (Anthony William), (No.2) [2002] UKHL 5.*

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 *Jones.*

The panel noted the correspondence dated 19 November and 20 November 2019, in which Mr Baptista twice states "I hereby inform you that I do not intend to continue with

this process as I do not intend to continue to practice nursing in this country”. It also noted that Mr Baptista has not responded to any of the regular NMC correspondence since 20 November 2019. The panel therefore came to the conclusion Mr Baptista has disengaged from these proceedings, and voluntarily absented himself from this hearing.

The panel has decided to proceed in the absence of Mr Baptista. In reaching this decision, the panel has considered the submissions of the case presenter, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *Jones*. It has 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 Baptista;
- Mr Baptista has not engaged with the NMC since 20 November 2019 and has not responded to any of the letters or emails sent to him about this hearing;
- Mr Baptista has indicated that he has disengaged from these proceedings, and has no intention of nursing again in the UK. The panel therefore considered that there is no reason to suppose that adjourning would secure his attendance at some future date;
- Two witnesses are attending to give oral evidence to the panel today; six more are also scheduled to attend to give oral 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 2017;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

Despite proceeding in his absence, the panel had a response bundle provided to it containing Mr Baptista's written responses to the NMC's concerns, which were sent by him prior to his disengagement. As Mr Baptista had given those responses, the panel was satisfied that it would be able to test the evidence given by the NMC's witnesses, making an allowance for the fact that they will not be tested in cross examination as neither Mr Baptista nor a legal representative has attended on his behalf.

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

**Details of charge (Amended):**

*That you a registered nurse, whilst employed at United Lincolnshire Hospitals NHS Trust:*

*1) On 7 April 2017, in relation to Patient A:*

*a) Did not administer prescribed insulin to Patient A;*
*b) Incorrectly recorded/signed that you had administered prescribed insulin to Patient A;*
*c) Altered the time you recorded the administration of insulin;*
*d) Did not check Patient A's blood glucose level;*
*e) Incorrectly recorded that Patient A's blood glucose level was 7.4 mmols;*

*2) Your actions in one or more of charges 1 b), 1c) & 1 e) were dishonest, in that you knowingly recorded false entries in Patient A's records, in an attempt to conceal your errors;*

*3) On 14 October 2017, in relation to Patient C:*

*a) Incorrectly administered Patient C's morning dose of furosemide medication via the oral route;*
*b) Administered the incorrect dose of Patient C's morning furosemide medication;*
*c) You did not administer Patient C's lunch time dose of furosemide medication;*

*4) On 19 October 2017, in relation to Patient B:*

*a) Incorrectly administered a dose of 0.5 mg of Lorazepam to Patient B;*

*b) Incorrectly administered the Lorazepam via the oral route;*

*c) Retrospectively recorded that the Lorazepam had been administered at 07:55;*

*d) Did not make clear that your entry was retrospective;*

*5) Your actions in charge 4 c) and/or 4 d) above were dishonest in that you knowingly recorded false entries into Patient B's records in an attempt to conceal your errors;*

*6) On an unknown date between 19 December 2016 and 23 March 2018, you undertook IV cannulation on one or more patients, when you lacked the assessed competency to do so;*

*7) On 11 October 2017:*

*a) Inserted a nasogastric tube into a Patient, when you lacked the assessed competency to do so;*

*b) Gave water via the oral route to the Patient who was nil-by-mouth;*

*c) Blew air into the Patient's stomach whilst listening via a stethoscope;*

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

**Application to amend the charges**

The panel heard an application made by Mr Badruddin, to amend the wording of charges 2 and 7b). This application was pursuant to Rule 28 of the Rules.

Mr Badruddin invited the panel to amend charge 2 due to a typographical error. He also invited the panel to amend charge 7b), in order to clarify the precise nature of the allegation in relation to "a particular patient".

Original Charge:

> *2) Your actions in on or more of charges 1b), 1c) & 1e) were dishonest, in that you knowingly recorded false entries in Patient A's records, in an attempt to conceal your errors;*

Proposed amendment:

> *2) Your actions in on**e** or more of charges 1b), 1c) & 1e) were dishonest, in that you knowingly recorded false entries in Patient A's records, in an attempt to conceal your errors;*

Original Charge:

> *7) On 11 October 2017:*
>
> > *b) Gave water via the oral route to a Patient who was nil-by-mouth;*

Proposed amendment:

> *7) On 11 October 2017:*

*b) Gave water via the oral route to ~~a~~* ***the*** *Patient who was nil-by-mouth;*

The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

*28.— (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—*

*(a) the charge set out in the notice of hearing; or*

*(b) the facts set out in the charge, on which the allegation is based,*

*unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.*

*(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.*

The panel noted that the proposed amendment to charge 2 was simply to address a typographical error and that the charge would not make sense without this amendment being made. It also noted that the proposed amendment to charge 7b) was to limit the scope of the charge to an already identified patient.

The panel was of the view that such amendments, as applied for, were in the interests of justice. The panel was satisfied that there would be no prejudice to Mr Baptista and no injustice would be caused to either party by the proposed amendments being allowed.

The panel was satisfied that these amendments did not alter the case or the evidence in relation to what Mr Baptista is alleged to have done. It was therefore appropriate for the amendments to be made to ensure clarity, accuracy and fairness.

**Background:**

On 6 July 2017, the NMC received a referral in relation to Mr Baptista. The charges arose whilst he was employed as a Band 5 Staff Nurse by United Lincolnshire Hospitals NHS Trust ("The Trust"), on the Carlton Coleby Ward ("the Ward") at Lincoln County Hospital ("the Hospital").

Mr Baptista first registered as a nurse in the UK on August 2016. He initially applied to the Trust through their overseas recruitment programme, which entails a rigorous selection process and a long period of induction and training should the applicant be successful. However, Mr Baptista was not successful in the recruitment process. On encouragement from Mr 4 who had previously worked with Mr Baptista, he applied directly to the Trust and was recruited onto the Ward. The Ward is a 28 bedded ward and cares for patients with acute respiratory problems.

Following his employment, it was decided that Mr Baptista needed further support and training in relation to medicines management and administration. An action plan was devised by Mr 2 in order to address the concerns identified in relation to Mr Baptista's nursing practise. Mr Baptista was prevented from administration of medication to patients until such time he was assessed as competent. After he had been assessed as competent, Mr Baptista allegedly continued to make medication errors despite being given further training and support.

It is alleged that on 7 April 2017, a concern was raised by Ms 3 that Mr Baptista had failed to check Patient A's blood glucose level and that he had also failed to administer Patient A's prescribed insulin. Patient A was diabetic, and prescribed insulin injections to be administered 4 times a day. It is also alleged that Mr Baptista incorrectly recorded/signed that he had administered the prescribed insulin to Patient A, altered the time of recording said insulin, and incorrectly recorded Patient A's blood glucose level as being 7.4 mmols.

It is alleged that Mr Baptista was dishonest in his actions in incorrectly recording/altering Patient A's records in an attempt to conceal the fact that he had not taken Patient A's blood glucose levels.

Following the concerns raised by Ms 3, Mr Baptista was suspended by the Trust whilst Ms 2 was asked to carry out an investigation. Upon conclusion of the investigation, the decision was made for Mr Baptista to return to work with a new supportive action plan. Mr Baptista returned to work in August 2017.

It is alleged that on 14 October 2017, at around 18:00 hours, Mr Baptista requested assistance from Ms 5 to administer intravenous ("IV") furosemide to Patient C as he was unable to administer IV furosemide to patients. Ms 5 identified that Patient C's prescription required the administration of furosemide to be made at 13:00 hours, which signifies a lunchtime dose, and that this time was significantly later. Ms 5 also identified that the morning medication had been signed as having been administered orally to Patient C by Mr Baptista rather than intravenously as prescribed.

It is alleged that on 19 October 2017, in relation to Patient B, Mr Basptista incorrectly administered 0.5mg of Lorazepam to Patient B via the oral route when the prescription required 1mg of Lorazepam via an intramuscular ("IM") injection. Further, he allegedly then made a retrospective entry in Patient B's records indicating that the Lorazepam had been administered at 07:55 hours, without indicating that the entry had been made retrospectively, as Mr 4 had inspected Patient B's records at around 08:00 hours and noted that there was no such recording. It is therefore alleged that Mr Baptista had failed to adhere to Patient B's prescription and administered the wrong dose of medication via the wrong route.

It is alleged that Mr Baptista was dishonest in his actions in making the alleged retrospective entry in relation to Patient B, in that he sought to conceal the errors he had made.

It is alleged that on an unknown date between 19 December 2016 and 23 March 2018, Mr Baptista undertook an IV cannulation on one or more patients, when he lacked the assessed competency to do so. Dr 7 states that he assisted her by cannulating a patient and did not inform her that he did not possess the relevant competency to undertake IV cannulations.

It is alleged that on 11 October 2011, Dr 6 had been working with Mr Baptista on the Ward and raised further concerns to Mr 4 in relation to Mr Baptista's nursing practise. Dr 6 is alleged to have observed Mr Baptista giving water to a patient who was nil by mouth in order to assist with the insertion of a nasogastric tube. It is alleged that Mr Baptista lacked the required assessed competency in order to insert a nasogastric tube, and that he also blew air into the patient's stomach whilst listening via a stethoscope.

Following this incident, Mr Baptista was suspended from duty pending further investigation and subsequently dismissed.

**Application to hear Dr 7's evidence remotely:**

Mr Badruddin applied under Rule 31 of the Rules for Dr 7 to give her evidence to the panel by video link. He told the panel that Dr 7's health condition prevented her from attending the hearing in person and referred the panel to a letter from Dr 7's consultant confirming this.

Mr Badruddin submitted that Dr 7's evidence was crucial to charge 6 and told the panel that it would be able to view Dr 7 on screen and assess her credibility. He submitted that this would be the fairest way to proceed in allowing Dr 7 to give her evidence in this manner.

The panel accepted the advice of the legal assessor who drew the panel's attention to the case of *Polanski v Conde Nast Publications Ltd [2005] 1 WLR 637*. He advised the panel of the legal test of relevance and fairness to be applied for such an application and referred to Rule 31 of the Rules. The legal assessor identified considerations which the panel may wish to take account of when coming to its decision, the key consideration being fairness to the parties and that a decision to allow video link evidence should not be regarded as routine.

The panel took into account that Dr 7's evidence was relevant to charge 6 in that she was allegedly the direct witness to Mr Baptista undertaking an IV cannulation. The panel also noted that according to his written representations, Mr Baptista does not dispute that he carried out an IV cannulation.

The panel has been provided with evidence of Dr 7's medical condition and the fact she is unable to travel to give evidence in person as a result of this.

The panel did not consider there to be any prejudice to Mr Baptista if Dr 7 were to give her evidence remotely via video link. Mr Baptista had been provided with a copy of Dr 7's witness statement and had chosen voluntarily to absent himself from these

proceedings. Given his absence, he would not be in a position to cross-examine Dr 7 in any event.

In these circumstances, the panel came to the view that it would be fair and relevant to allow Dr 7 to give evidence remotely via video link, but would give what it deemed appropriate weight to that evidence once the panel had heard and evaluated all the evidence before it.

**Decision on the findings on facts and reasons**

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case, together with the oral submissions made by Mr Badruddin. The panel also had regard to the written responses of Mr Baptista.

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 who, at the time of the events, were employed in the following roles:

- Ms 1 – Sister in the Out-Patients Department at the Trust appointed to carry out the first internal investigation
- Mr 2 – Clinical Education Nurse at the Trust;
- Ms 3 – Staff Nurse on the Ward;
- Mr 4 – Charge Nurse on the Ward;
- Ms 5 – Deputy Sister on the Ward;
- Dr 6 – Junior Doctor on the Ward;
- Dr 7 – Locum Doctor on the Ward;
- Ms 8 – Ward manager for an Oncology Unit in the Trust appointed to carry out part of the second internal investigation.

The panel first considered the overall credibility and reliability of all of the witnesses it had heard from. In the round, the panel considered all of the NMC witnesses to have attempted to assist it to the best of their knowledge and belief.

The panel found Ms 1 to be a clear, consistent and credible witness when giving her oral evidence. Ms 1 was not a direct witness to any of the alleged events as she was

asked to conduct an internal investigation in relation to the concerns identified in charge 1 and, as such, could only provide limited evidence to the panel. However, she was able to articulate what steps she had taken in conducting her internal investigation and explained her reasoning for this. It found Ms 1 to have been a fair and balanced witness, noting as it did, that she did not bear any ill-will towards Mr Baptista.

The panel found Mr 2 to be a credible and reliable witness. Mr 2 was not able to give any direct evidence in relation to the charges Mr Baptista is faced with as he did not witness any of the alleged events directly. However, Mr 2 was able to provide some helpful information and an insight into the perspective of a clinical educator, particularly in relation to the level of support and training Mr Baptista received during his employment at the Trust.

The panel found Ms 3 to be a helpful, credible and reliable witness who was able to provide additional contextual information requested of her when giving her oral evidence. The panel considered her to have a good recollection of the alleged events, and found her evidence to be of a high standard.

The panel found Mr 4 to be a credible and reliable witness who was consistent with his NMC witness statement. It noted that Mr 4 was able to provide helpful contextual information in relation to the management of the Ward and the duties imposed on staff at around the time of the alleged events. The panel considered Mr 4 to have a good knowledge of the policies in place at the Trust in relation to medicines management and administration, as well as details of any current updates.

The panel found Ms 5 to be an honest and balanced witness. It considered her to have given great thought to the questions asked of her, and to have responded in a measured and articulate manner. Ms 5 was a direct witness to some of the alleged events. The panel did not consider her to bear any ill-will towards Mr Baptista, nor did she attempt to mislead the panel or embellish the evidence she gave. Ms 5 readily accepted that an overseas nurse would not necessarily know whether they would not be

permitted to carry out certain kinds of clinical procedures on the Ward unless they were expressly informed by other staff at the Trust.

The panel found Dr 6 to be an honest witness. It considered her to have given a coherent account of events, although her oral evidence was not always entirely consistent with the documentary evidence she provided. In any event, the panel did not consider Dr 6 to have attempted to mislead it, or embellish her evidence in any way. Dr 6 was able to clarify important aspects of her evidence that needed to be addressed.

The panel found Dr 7 to be an honest and reliable witness who was consistent with her NMC witness statement. The panel noted that Dr 7 was able to give direct evidence in relation to charge 6, and that she appeared to be fair and balanced in giving her account. The panel did not consider Dr 7 to have attempted to embellish her evidence in any way.

The panel found Ms 8 to be an honest, reliable and credible witness. It noted that she was independently instructed to investigate matters that resulted in Mr Baptista being dismissed from the Trust, and that she had no direct involvement with Mr Baptista. The panel considered Ms 8 to be measured and balanced when giving her oral evidence as she accepted when she could not recollect certain points due to the lapse in time since the incidents occurred. She did not attempt to embellish her account.

The panel then considered each charge and made the following findings:

**Charge 1a:**

*1) On 7 April 2017, in relation to Patient A:*

*a) Did not administer prescribed insulin to Patient A;*

**This charge is found proved.**

In reaching this decision, the panel took account of the evidence of Ms 3.

The panel noted from Ms 3's witness statement that "…when I asked [Mr Baptista] if he had remembered to give Patient A her insulin since she was back on the Ward. "Yes" was his reply, and this was overheard by people at the nurse's station…[Patient A] said she hadn't had her lunchtime insulin since returning to the Ward, having had her MRI. Surprised by this I went to Jose and told him about the conversation I had just had with Patient A. He took out the prescription chart and looked at it, muttering under his breath. I could see that he had dated and signed the time of administration on the chart, but he looked shocked. He said "No, no, this is wrong", and started altering the time of administration to the tea-time round which was after 5pm…Jose then started signing in the correct box for tea-time medication round…I then went back to Patient A and asked her if she had been given either her lunchtime or team time insulin, and she said no, Jose had only given her her morning insulin that day"[sic]. This was also supported by other documentary evidence, including Ms 3's contemporaneous note which was made on the day of the alleged incident.

The panel considered Ms 3 to have been sufficiently concerned by the incident for her to have completed a contemporaneous note, which was largely consistent with her NMC witness statement. Ms 3 also recounted her concerns in her interview with Ms 1 on 2 May 2017.

The panel noted that there was evidence before it to suggest that Mr Baptista had administered Patient A's morning dose of insulin on 7 April 2017, and that this was consistent with what she had reported back to Ms 3. However, the panel considered that the mischief identified in this charge related specifically to Patient A's prescribed insulin which was due to be administered at lunchtime and teatime, and that there was no evidence of this having been given.

The panel reminded itself that it had found Ms 3 to have been a helpful, credible and reliable witness. It considered her to have been clear in both her documentary and oral evidence in relation to this incident.

Mr Baptista does not appear to dispute that he did not administer insulin to Patient A as he has not addressed this in his written representations.

In taking account of the above, the panel was satisfied that, on the balance of probabilities, charge 1a is found proved.

**Charge 1b:**

> *1) On 7 April 2017, in relation to Patient A:*
>
> > *b) Incorrectly recorded/signed that you had administered prescribed insulin to Patient A;*

**This charge is found proved.**

In reaching this decision, the panel took account of the evidence of Ms 3.

In her witness statement, Ms 3 stated "I went back and told Jose what [Patient A] had said, and he then scribbled out the whole column he had signed as I watched. I'm not sure if he understood the correct process for making alterations or not, but it appeared to me that he was defacing it so it wasn't legible to hide what he had done. His behaviour was awkward and embarrassed, and when I told him I would need to report this to [Ms 9] he said "Yes you do that then"... Patient A was at risk of becoming unwell without her insulin".

The panel had sight of Patient A's insulin prescription chart and noted that recordings have been scribbled out for the lunchtime period on the date listed as 7 April 2017, and that this is consistent with the evidence the panel had received. Mr Baptista accepts in his written representations to the panel that he had made a mistake in entering these recordings at the wrong time.

In having regard to the above, the panel determined that Mr Baptista was the author of these recordings, and that he had scribbled out these recordings when concerns were first raised.

The panel noted that Patient A was not on the Ward at the time Mr Baptista is alleged to have administered insulin to her, having gone for an MRI scan over the lunchtime period. It was therefore not possible for her to have had this medication administered to her at the time Mr Baptista recorded it to have taken place.

In taking account of the above, the panel was satisfied that, on the balance of probabilities, charge 1b is found proved.

**Charge 1c:**

*1) On 7 April 2017, in relation to Patient A:*

*c) Altered the time you recorded the administration of insulin;*

**This charge is found proved.**

In reaching this decision, the panel reminded itself of the evidence of Ms 3 that Mr Baptista "took out the prescription chart and looked at it, muttering under his breath. I could see that he had dated and signed the time of administration on the chart, but he looked shocked. He said "No, no, this is wrong", and started altering the time of

administration to the tea-time round which was after 5pm…Jose then started signing in the correct box for tea-time medication round…”[sic].

In taking account of Patient A’s insulin prescription chart and Mr Baptista’s admission, in that he accepts he altered the recorded administration of insulin due to an “honest mistake”, the panel was satisfied that charge 1c was found proved to the required standard.

Therefore, the panel was satisfied that charge 1c is found proved.

**Charge 1d:**

> *1) On 7 April 2017, in relation to Patient A:*
>
> > *d) Did not check Patient A’s blood glucose level;*

**This charge is found proved.**

In reaching this decision, the panel took account of the evidence of Ms 1.

In her witness statement, Ms 1 stated “As part of my investigation the data from the blood glucose machine was looked at which confirmed no blood glucose test had been conducted between the times in question…The patient twice said she hadn’t received her insulin and Jose signed to say he’d given it, but later crossed out the blood glucose test result he had recorded and changed the time Jose said that he got confused with the times as in Portugal lunchtime is anytime between 1pm and 5pm…He did say it was a mistake and at no point admitted any deliberate misconduct. He accepted that he had not performed the patient’s blood glucose test and said he was unsure where he had gotten the figure from”.

The panel noted that Mr Baptista had recorded having checked Patient A's blood glucose level three times on 7 April 2017 according to the Blood glucose monitoring chart, however, there was no record on the only recording machine on the Ward of him having checked Patient A's blood glucose level at lunchtime. Indeed, the recording machine on the Ward did show Mr Baptista's name and Patient A's name, however, there was no recording of blood glucose levels having been taken between the hours of 07:40 hours and 17:18 hours.

The panel received evidence to suggest that Patient A was not using her own machine to take her blood glucose levels.

In taking account of the above, the panel was satisfied that, on the balance of probabilities, charge 1d is found proved in relation to the lunchtime reading.

**Charge 1e:**

*1) On 7 April 2017, in relation to Patient A:*

*e) Incorrectly recorded that Patient A's blood glucose level was 7.4 mmols;*

**This charge is found proved.**

In reaching this decision, the panel took account of the evidence of Ms 1.

Having found that Mr Baptista did not check Patient A's blood glucose levels the panel was satisfied that Mr Baptista had made an incorrect entry for Patient A on the Blood glucose monitoring chart on 7 April 2017. The panel noted that this entry had been crossed out in the 'Before lunch' column and Mr Baptista himself could not explain where he got the figure 7.4 mmols from during his interview for the internal

investigation. Mr Baptista appeared to accept that recording this incorrect entry had been a mistake on his part.

Therefore, the panel was satisfied that charge 1e is found proved.

**Charge 2:**

> *2) Your actions in one or more of charges 1 b), 1 c) & 1 e) were dishonest, in that you knowingly recorded false entries in Patient A's records, in an attempt to conceal your errors;*

**This charge is found proved.**

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 3 and Mr 4.

It also took account of the case of *Ivey v Genting Casinos[2017] UKSC 67* in considering whether Mrs McLean had been dishonest in her actions. In particular, it noted in paragraph 74:

> *When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.*

Having found charges 1b and 1c proved, the panel noted that Mr Baptista had recorded/signed an incorrect entry in Patient A's prescription chart and that he later altered the time of this recording/signature after Ms 3 had queried whether he had indeed administered insulin to Patient A.

The panel took account of Ms 3's witness statement, in which she stated "I was concerned by Jose's reaction, as I did not get the impression he had made a genuine mistake, it seemed more like he was covering up…".

The panel took account of Patient A's insulin prescription chart and noted that there were entries recorded when Mr Baptista was purporting to have administered insulin to Patient A and that these had been scribbled out. However, these entries were still legible, and the panel noted that at the time Mr Baptista is recorded as having administered insulin to Patient A at lunchtime, she had not been on the Ward at the time, having been sent for an MRI scan.

When the lunchtime recordings were raised with Mr Baptista, he appeared to accept that his entries had been incorrect, and he began entering his recordings in the teatime slot instead.

The panel reminded itself that it found Ms 3's oral evidence to be helpful, credible and reliable, and that it had also found her to have a good recollection of events. In particular, Ms 3 remembered having gone back to Patient A for a second time to seek clarification on when she had last received a dosage of insulin, and Patient A had been adamant that she had not received one since breakfast. This was consistent with the account detailed in Ms 3's contemporaneous note completed on the same day of the incident. Ms 3 was able to articulate to the panel why she had believed Mr Baptista's behaviour appeared deceitful in that he appeared to be attempting to cover up the original misleading entries. The panel did not consider this to have been a genuine mistake by Mr Baptista, as expressed by him.

The panel was of the view that, at the point Mr Baptista had made an entry in Patient A's insulin prescription chart for having allegedly administered insulin at lunchtime, he was aware that he was making an incorrect entry, and he did this intending to create a misleading impression of the care delivered to Patient A. When this was then raised with him, he attempted to minimise the situation by pretending to have made a mistake as to the time of his recordings, when he had not administered any insulin to Patient A on 7 April 2017.

Having found charge 1e proved, the panel was satisfied that by incorrectly recording Patient A's blood glucose levels as 7.4mmols when he had not conducted a blood glucose test, Mr Baptista was dishonest in his actions. The recording of 7.4mmols was false as the only recording machine on the Ward had not been used by Mr Baptista.

Mr Baptista appeared to accept during the internal investigation that he was not clear where he had got this information from. He could not explain how he had arrived at the figure 7.4mmols, and why he had entered that in Patient A's Blood glucose monitoring chart. The panel was satisfied that Mr Baptista had recorded this information for Patient A to give the impression that Patient A's blood glucose levels had been checked, when he had not conducted this test.

Taking account of the above, the panel determined that, on the balance of probabilities, Mr Baptista would be considered to be dishonest by the standards of ordinary, decent people.

Therefore, the panel found charge 2 proved in respect of charges 1b, 1c and 1e.

**Charge 3a–c:**

*3) On 14 October 2017, in relation to Patient C:*

*a) Incorrectly administered Patient C's morning dose of furosemide medication via the oral route;*
*b) Administered the incorrect dose of Patient C's morning furosemide medication;*
*c) You did not administer Patient C's lunch time dose of furosemide medication;*

**These charges are found NOT proved.**

In reaching this decision, the panel took account of the evidence of Ms 5.

In Ms 5's NMC witness statement, she states "On 14 October 2017 Jose came to me in the evening after 6pm when I was doing some of the patients' intravenous medications (IV) and asked if I could give an IV medication to one of his patients, as he wasn't competent in this procedure at the time. When I looked at the MAR chart I noted that patient had been due this medication at 1pm. The medication was frusemide, and I was aware that if I administered it so late the patient would need to get up to urinate throughout the night. I reminded Jose that he needed to tell us if a patient on his medications round was due IV medicine so that we could assist straight away. While I was looking at the MAR chart I noticed that Jose had signed for the patient's morning dose of frusemide. When I questioned him about this he shrugged and said he had given it. I asked how and he said that he couldn't tell it was IV and gave it orally"[sic].

The panel considered there to be very limited evidence in relation to this charge.

The panel noted that it had not been provided with Patient C's MAR chart, and this was how Ms 5 had been able to identify these concerns. The panel also noted that Mr

Baptista was not questioned in relation to this alleged incident during his interview for the internal investigation, nor has he seemingly addressed this in his written responses to the NMC.

Therefore, in the absence of any supporting evidence, the panel could not be satisfied that there was sufficient evidence before it to suggest that Mr Baptista had administered Patient C's morning dose of furosemide incorrectly, both through the alleged method he used and the amount administered; nor could it be satisfied that he did not administer Patient C's lunchtime dose.

In taking account of the above, the panel found charges 3a, 3b and 3c not proved.

**Charge 4a–d:**

*4) On 19 October 2017, in relation to Patient B:*

*a) Incorrectly administered a dose of 0.5 mg of Lorazepam to Patient B;*
*b) Incorrectly administered the Lorazepam via the oral route;*
*c) Retrospectively recorded that the Lorazepam had been administered at 07:55;*
*d) Did not make clear that your entry was retrospective;*

**These charges are found proved.**

In reaching this decision, the panel took account of the evidence of Mr 4.

In Mr 4's NMC witness statement, it is stated "When I checked the patient's notes, at about 08:20 a.m, I noticed lorazepam had been prescribed by [Dr 10] earlier than morning as an intramuscular (IM) dose…I noticed that Patient B's prescription chart was blank; there was no entry indicating that lorazepam had been administered that

morning. If medication had been administered, I would expect the prescription chart to have been timed, dated and signed by the nurse who administered the medication. When one of the doctors attended the ward later that morning, I went back to the notes as I wished to discuss Patient B further. When I checked Patient B's notes at that time, I discovered that Jose had documented 0.5 milligrams of lorazepam having been administered orally at 07:55am. This was the incorrect dose and incorrect route of administration. There was nothing on the record to indicate that he had gone back and made this entry later on the patient's prescription chart"[sic].

The panel had sight of Patient B's prescription chart for 19 October 2017. This confirmed that Dr 10 had prescribed 1 milligram of lorazepam to be administered to Patient B and that the route of administration should be IM. The panel noted that Mr Baptista has signed Patient B's prescription chart as having given 0.5 milligrams of lorazepam orally to Patient B at 07.55 hours on 19 October 2017, and that this was consistent with his responses in his interview for the internal investigation in which he accepted that he made errors and apologised.

In taking account of the above, the panel was satisfied that Mr Baptista had administered the incorrect amount of lorazepam to Patient B via an incorrect route.

The panel also noted that Mr 4 had stated in his NMC witness statement that he is "100% sure" there was no entry for lorazepam on this date when he first checked Patient B's prescription chart. However, Mr 4 gave oral evidence to the panel that upon returning to this within an hour, an entry had been made by Mr Baptista recording his administration. The panel reminded itself that it had found Mr 4 to be a credible and reliable witness when giving his oral evidence, and that he had been clear on policies in place at the Trust in respect of medicines management. He had explained that due to a previous Care Quality Commission ("CQC") inspection in March 2017 highlighting that there had been no policy covering lorazepam administration, any issue with this medication had been on his radar.

The panel noted that there was no indication that this entry had been made retrospectively by Mr Baptista. However, the panel was satisfied that on the clear and consistent evidence provided by Mr 4, on the balance of probabilities, Mr Baptista had made a retrospective entry in Patient B's notes as having administered lorazepam at 07:55 hours, without indicating that this entry had been made retrospectively. Having received evidence to suggest that this entry had been recorded within an hour of Mr 4 returning to view Patient B's prescription chart, the panel decided that it would consider to what extent this impacted upon the care delivered to Patient B at the misconduct stage of this hearing.

Therefore, the panel found charges 4a, 4b, 4c and 4d proved.

**Charge 5:**

> *5) Your actions in charge 4 c) and/or 4 d) above were dishonest in that you knowingly recorded false entries into Patient B's records in an attempt to conceal your errors;*

**This charge is found NOT proved.**

The panel had regard to the case of *Ivey v Genting Casinos[2017]* in considering whether Mr Baptista's actions in updating Patient B's prescription chart retrospectively without indicating such a recording was retrospective could be perceived as dishonest.

The panel noted that Mr Baptista had recorded himself as having administered the incorrect amount of lorazepam to Patient B via an incorrect route. His retrospective entry came within an hour of Mr 4 returning to view Patient B's prescription chart and, unlike his conduct in charge 1, there was no evidence to suggest that Mr Baptista was

attempting to conceal any of his actions by scribbling through and/or altering previous entries.

The panel determined that it could not be satisfied that Mr Baptista had been dishonest in his actions in entering these recordings retrospectively, and in not indicating that these entries were retrospective.

Therefore, the panel found charge 5 not proved in respect of charge 4c and 4d.

**Charge 6:**

> *6) On an unknown date between 19 December 2016 and 23 March 2018, you undertook IV cannulation on one or more patients, when you lacked the assessed competency to do so;*

**This charge is found proved.**

In reaching this decision, the panel took account of the evidence of Dr 7.

In Dr 7’s NMC witness statement, it is stated “I recall the incident. The patient required antibiotics and needed a new cannula in order to receive these. Jose was assisting me with the procedure as the patient was very agitated and I recall looking at one of the patient’s arms whilst Jose looked at the other. Both of us were looking for a position where a cannula could be inserted. The patient was agitated and this was making them difficult to cannulate. I remember Jose identifying a vein and volunteering to insert the cannula. At this time, I was unaware that Jose did not possess the cannulation competency package for the Trust, and I said to go ahead. Jose inserted the cannula…There was a conversation a few hours later between myself and another doctor on the ward, where I had been asked how the cannulation had gone. I said that Jose had carried out the cannulation…It was then that Charge Nurse [Mr 4] highlighted

to me that Jose was not cannula competent. At no time before, during or after the procedure did Jose tell me that he had not completed the correct competency package for inserting cannulas. If I had been aware of this, I would not have allowed him to carry out the procedure and would have cannulated the patient myself".

The panel noted that Dr 7 only alleges that Mr Baptista assisted her with the cannulation of one patient, and that she would have prevented him from being involved had she had known that Mr Baptista had not completed the Trust's competency assessment to perform this task. The panel noted that in his interview for the internal investigation, Mr Baptista appears to accept that he was not permitted to perform a cannulation having not completed the Trust's competency pack.

In taking account of the above, the panel was satisfied that on the balance of probabilities, Mr Baptista did undertake an IV cannulation of a patient when he had not been assessed as competent to do so.

Therefore, the panel found charge 6 proved.

**Charge 7a–c:**

*7) On 11 October 2017:*

*a) Inserted a nasogastric tube into a Patient, when you lacked the assessed competency to do so;*
*b) Gave water via the oral route to the Patient who was nil-by-mouth;*
*c) Blew air into the Patient's stomach whilst listening via a stethoscope;*

**These charges are found proved.**

In reaching this decision, the panel took account of the evidence of Ms 5, Dr 6 and Ms 8.

In Dr 6's NMC witness statement, it is stated "I was asked by the Registrar to insert an NG [nasogastric] tube for the patient, who I am aware was nil by mouth. As far as I can remember, Jose had asked if he could observe the procedure – he certainly was not there to perform it…The patient started to experience some discomfort making insertion of the tube difficult so I decided to stop the procedure to give the patient a short break…At this time, Jose took the NG tube straight out of my hands. There was a cup containing some water within the room and Jose gave this to the patient and instructed him to hold it in his mouth whilst he attempted to pass the tube. This is a technique that can be used however, on a patient who is nil by mouth with problems swallowing it can be risky as it can cause the patient to aspirate. Jose inserted the NG tube very quickly. I was quite shocked by Jose's actions. At no point had I asked him to assist. I also had no time to object before Jose had snatched the tube out of my hands and inserted it…He touched my stethoscope which was around my neck at the time and said "use this, you listen and I'll pump air in, if you hear the air then you know it is in the right place", or words to that effect. This is known as a "whoosh test". I explained to Jose that I was familiar with this technique but it was no longer an accepted practice in the UK. I made it very clear to Jose that he was not to inject air into the NG tube and I am sure I said this more than once. He ignored me and proceeded to do it regardless"[sic].

The panel also had sight of Ms 5's witness statement, which was supportive of Dr 6's account. In her NMC witness statement, Ms 5 had stated "On 11 October 2017 the dietician approached me to discuss concerns about Jose, as [Dr 6] had advised her that she witnessed Jose gave water to a patient who was nil by mouth to help them swallow a nasogastric tube. Jose had apparently carried out an incorrect procedure by blowing air into the patient's stomach. I spoke to [Dr 6] to confirm what had happened, then I asked to speak to Jose privately in the office. Jose was angry that the doctor hadn't spoken to him directly and wanted to go and confront [Dr 6]. I can remember him throwing his arms up in the air and saying "that's how we do it in Portugal" and "I have

been nursing for 30 years". I gave Jose a copy of the policy and guidelines for nasogastric intubation and asked him to take them home to read…Jose didn't seem to understand the importance of what he had done and how this could have affected the patient".

At the time of the alleged incident, the panel noted that Mr Baptista had not been formally assessed by the Trust as having the required competency to perform an NG tube insertion. Whilst the panel received evidence to suggest that there was no formal assessment available for such a procedure in the Trust's competency pack, the panel had regard to the oral evidence of Ms 8, who had stated that Mr Baptista would have been obligated to observe other staff conducting the procedure, prior to attempting to do this himself.

The panel reminded itself that it had found Dr 6 to be an honest witness, although not entirely consistent with the documentary evidence she had provided. However, the panel had considered her to be clear in some aspects of her oral evidence due to its "shocking" nature. Dr 6 was the more senior member of staff at the alleged incident, but she recalls how Mr Baptista gave this little regard, and attempted to insert the NG tube despite Dr 6 telling him not to do so on more than one occasion.

The panel noted that Mr Baptista does admit giving the patient a "sip" of water whilst he inserted the NG tube, but he initially claimed that he was not aware that the patient was nil by mouth.

In taking account of the above, the panel was satisfied on the balance of probabilities that Mr Baptista did insert an NG tube when he lacked the assessed competency to do so, that he gave water to a patient orally who was nil by mouth and that he blew air into the patient's stomach whilst listening via a stethoscope.

Therefore, the panel found charges 7a, 7b and 7c proved.

**Submissions on misconduct and impairment:**

Having announced its finding on all the facts, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mr Baptista'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.

In his submissions, Mr Badruddin invited the panel to take the view that Mr Baptista's actions amounted to breaches of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) ("the Code"). He then directed the panel to specific paragraphs and identified where, in the NMC's view, Mr Baptista's actions amounted to misconduct.

Mr Badruddin referred the panel to the case of *Roylance v GMC (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 Badruddin submitted that Mr Baptista's conduct fell far below the standards expected of a registered nurse in the circumstances of this case. He submitted that his failure to administer insulin to Patient A at the allotted time exposed her to a significant risk of harm. In proceeding to falsify the administration of insulin and in recording an entry for Patient A's blood glucose levels that he knew to be incorrect, Mr Baptista's honesty, integrity and trustworthiness has been brought into question. Mr Badruddin submitted that as Mr Baptista's dishonesty is directly linked to his clinical nursing practice, this could have impacted upon the care delivered to Patient A by other staff, as other practitioners could have been misled to believe that insulin had been administered to Patient A and that her blood glucose levels had been checked when they had not.

Mr Badruddin further submitted that in knowingly administering an incorrect dose of lorazepam via an incorrect route, Mr Baptista exposed Patient B to a risk of

unwarranted harm. By not indicating that he had also made a retrospective entry in relation to this administration, there was potential for Patient B to have received a further dosage of lorazepam, subsequent to the 0.5mg that Mr Baptista had already administered.

Mr Badruddin submitted that there is some evidence before the panel to suggest that Mr Baptista had attempted to operate outside of his scope on more than one occasion, in conducting clinical procedures he had not been assessed as competent in by the Trust. Mr Baptista also used a procedure which was no longer accepted practices in the UK, despite a more senior colleague telling him to refrain from using the technique.

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

Mr Badruddin submitted that Mr Baptista had placed multiple patients in his care at a clear risk of harm, and that his actions had brought the nursing profession into disrepute. He also submitted that any charges relating to dishonesty are serious and can often be more difficult to remediate than clinical nursing concerns.

Mr Badruddin invited the panel to consider whether there are any attitudinal and behavioural concerns identified in this case, taken in context with the amount of support Mr Baptista received from the Trust. Mr Badruddin submitted that Mr Baptista was supernumerary for significant periods of time during his employment as a registered nurse at the Trust, and that he was assisted by clinical education nurses, along with his mentor and Ward Manager.

Mr Badruddin submitted that Mr Baptista had demonstrated limited insight up to the point he disengaged from the NMC. He reminded the panel that Mr Baptista had accepted making some errors during the interview at the internal investigation, although he denied acting dishonestly. Mr Baptista has not sought to develop his insight, nor has he demonstrated any meaningful remediation or remorse into the regulatory concerns as he does not appear to appreciate the seriousness of his actions. Instead, Mr Baptista relied on the fact that he was an experienced registered nurse in his home country of Portugal. Mr Badruddin submitted that these are all relevant to the consideration of whether Mr Baptista is likely to repeat such actions.

In addressing the public interest element of this case, Mr Badruddin submitted that public confidence in the nursing profession and in the NMC as its regulator would be undermined if a finding of impairment were not made. He submitted that a fully informed member of the public would expect registered nurses to maintain honesty and integrity at all times, act in accordance with the Code and adhere to a particular Trust's policy and procedures.

In light of the above, Mr Badruddin invited the panel to find that Mr Baptista's fitness to practise as a registered nurse is currently impaired on public protection and public interest grounds.

The panel has accepted the advice of the legal assessor which included reference to a number of judgments, specifically, *Roylance* and *Grant*.

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

**Decision on misconduct**

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

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that Mr Baptista's actions did fall significantly short of the standards expected of a registered nurse, and it considered his actions to have amounted to multiple breaches 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

**8 Work co-operatively**

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

**13 Recognise and work within the limits of your competence**

To achieve this, you must, as appropriate:
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

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

To achieve this, you must:

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

**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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people".

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, in these circumstances, the panel decided that Mr Baptista's actions in each of the charges found proved fell seriously short of the standards expected so as to justify a finding of misconduct.

In respect of charge 1, the panel considered Mr Baptista to have exposed Patient A to a significant risk of harm by not administering her insulin at the times prescribed. By incorrectly recording that he had administered a dose of insulin to Patient A at lunchtime, he had given the impression that care had been delivered to her when it had not. When challenged, Mr Baptista amended Patient A's insulin prescription chart on two separate occasions. The panel noted that Mr Baptista also incorrectly recorded Patient A's blood glucose levels as being 7.4mmol when he had not checked her blood glucose level at all. In taking account of the above, the panel determined that Mr Baptista's actions identified individually in charges 1a–e, as well as taken together, were so serious so as to amount to misconduct.

In respect of charge 2, the panel considered 'honesty' 'trust' and 'integrity' to form parts of the bedrock of the nursing profession. The panel was of the view that in being dishonest, Mr Baptista had breached a fundamental tenet of the nursing profession. The panel noted that dishonesty in a regulatory context is often regarded as serious, although there are different levels of seriousness on a spectrum of dishonesty. Mr Baptista had been found to have acted dishonestly in making false entries on both Patient A's insulin prescription chart and Blood glucose monitoring chart. Mr Baptista's dishonest actions had the potential to mislead colleagues which could have had serious ramifications for Patient A's wellbeing, as they were directly linked to the care provided to her. The panel therefore considered Mr Baptista's dishonesty to be at the high end of the spectrum of dishonesty, and considered his actions in charge 2 to be so serious so as to amount to misconduct.

In respect of charge 4, the panel considered Mr Baptista to have exposed Patient B to a significant risk of harm in not following the prescription given by the doctor and by not indicating that a retrospective entry had been made in Patient B's records. It noted that Mr Baptista administered the wrong amount of lorazepam to Patient B, and administered it via the wrong route. If Mr Baptista had any concerns regarding the prescription, the panel was of the view that he should have contacted a more senior colleague for advice and support. The panel did not think it was appropriate for Mr Baptista to change the dosage and the route of administration independently as he is not a registered nurse prescriber. By not indicating that an entry was made retrospectively, there was potential for lorazepam to have been administered twice to Patient B. The panel noted that registered nurses are expected to make recordings contemporaneously, or as close to the time of administration as possible. As Mr Baptista had failed to do this, other registered nurses could have sought to administer the medication to Patient B, not knowing that he had already received 0.5mg of lorazepam. Therefore, the panel determined that Mr Baptista's actions identified in charge 4 were so serious so as to amount to misconduct.

In respect of charge 6, by undertaking an IV cannulation on a patient when Mr Baptista had not been assessed as competent to do so, he was acting outside the scope of his approved clinical practice. The panel noted that the mischief identified in this charge does not suggest that Mr Baptista did not have the clinical competence to perform this procedure; it is more that he was not permitted to perform it at this time, having not been assessed as competent. Mr Baptista had accepted in his written responses to the NMC that he was aware of the Trust's requirement for him to be assessed, but he decided to cannulate the patient regardless. Therefore, the panel determined that Mr Baptista's actions identified in charge 6 were so serious so as to amount to misconduct.

In respect of charge 7, the panel considered Mr Baptista to have put the patient, who was nil by mouth, at significant risk of harm by giving water. He also attempted to carry out a procedure which is no longer accepted practice in the UK, despite a more senior colleague telling him to stop. The panel considered Mr Baptista to have acted outside

the scope of his clinical practice as he inserted an NG tube, when he lacked the assessed competence to do so, as he had not satisfied the Trust's requirements before he was able to perform this procedure. In acting in this way, the panel was of the view that Mr Baptista had shown little regard for the patient's wellbeing. Therefore, the panel determined that Mr Baptista's actions identified in charge 7 were so serious so as to amount to misconduct.

The panel found that all of Mr Baptista's actions fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct. It determined that other members of the nursing profession would consider Mr Baptista's clinical and behavioural conduct to be deplorable, and that to characterise his actions as anything other than misconduct would fail to declare and uphold proper standards of conduct and behaviour on the part of a registered nurse.

**Decision on impairment**

The panel next went on to decide if, as a result of this misconduct, Mr Baptista'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 and to maintain professional boundaries. 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 judgement of Mrs Justice Cox in the case of *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.

Mrs Justice Cox went on to say in Paragraph 76:

> I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

> 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 found that all of the limbs above are engaged in this case.

The panel noted that the concerns identified in this case relate to Mr Baptista's clinical nursing practice, as well as his professional conduct. There is no evidence before the panel of any patient suffering actual harm as a result of Mr Baptista's actions, although the panel considered there to have been a serious risk of harm in his repeated refusal to follow the Trust's policies and procedures.

In assessing Mr Baptista's current level of insight, the panel had regard to the written responses he had sent to the NMC prior to disengaging. It considered Mr Baptista to have demonstrated limited insight and remorse into his misconduct as he does not appear to accept full responsibility for the extent of his actions.

The panel noted that Mr Baptista did acknowledge making some errors to both the NMC and the Trust, however, he denied acting in a dishonest manner, and does not appear to appreciate the impact all of his actions could have had on patients, colleagues, and the nursing profession. It therefore considered him to be attempting to minimise his misconduct. Mr Baptista appeared to conduct himself on the basis that he knew what was best for patients, as he relied on the fact that he had been a registered nurse in Portugal for 30 years prior to coming to the UK. Mr Baptista therefore showed little regard for needing to prove to colleagues that he was competent to perform nursing tasks, despite having had large periods of support and supervised nursing practice after having made a number of clinical errors. As Mr Baptista has disengaged from the NMC as of 20 November 2019, there was no evidence of him having reflected further.

The panel had regard to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)*, and considered whether the concerns identified in Mr Baptista's nursing practice are capable of remediation, whether they have been remediated, and whether there is a risk of repetition of similar concerns occurring at some point in the future.

Whilst the panel noted that concerns relating to dishonesty and attitudinal shortcomings are often more difficult to remediate than clinical nursing concerns, it considered Mr Baptista's misconduct to be possibly capable of remediation, albeit the misconduct is serious. However, the panel determined that no evidence had been provided by Mr Baptista to demonstrate that he had remediated any of the concerns identified or that he was willing to do so. Mr Baptista has now disengaged from the NMC and has stated that he does not intend to work as a registered nurse in the UK in future.

The panel had not been provided with any recent testimonials by Mr Baptista to suggest that he is a safe and effective nursing practitioner.

In light of the above, the panel had no evidence before it to allay its concerns that Mr Baptista would currently pose a risk to patient safety. In absence of any evidence to the contrary, the panel considered there to be a real risk of repetition of Mr Baptista's

misconduct and a risk of unwarranted harm to patients in his care should he be permitted to practice as a registered nurse in future without some form of restriction. Therefore, 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 are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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 considered there to be a high public interest in the consideration of this case. It was of the view that a fully informed member of the public would be seriously concerned by Mr Baptista's professional conduct in being dishonest in a professional context, acting outside the scope of his assessed clinical competence, as well as his clinical nursing failures. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

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

**Determination on sanction:**

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

In reaching its decision on sanction, the panel considered all of the evidence before it, along with the submissions of Mr Badruddin, on behalf of the NMC.

Mr Badruddin invited the panel to impose a suspension order for 12 months, subject to a review before expiry. He submitted that whilst Mr Baptista's misconduct is serious, his actions are not completely incapable of remediation.

Mr Badruddin reminded the panel that it had found that Mr Baptista to have offered limited insight into his misconduct, and had found him to have lacked appreciation for the severity of the actions. He further submitted that Mr Baptista's misconduct could be suggestive of him having a more deep-seated attitudinal issue.

Mr Badruddin took the panel through the aggravating and mitigating factors he considered to be engaged in this case. He submitted that whilst a striking-off order would not be disproportionate in these circumstances, in the NMC's view, a suspension order would be the most proportionate sanction in the circumstances of this case.

Mr Badruddin submitted that this would provide Mr Baptista with an opportunity to reflect, remediate, and consider his next steps in respect of his nursing career.

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

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 Sanctions Guidance ("SG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

As regards aggravating factors, the panel has considered the following as relevant:

- Mr Baptista exposed multiple patients to a significant risk of harm.
- Mr Baptista was found to have acted dishonestly, which is directly linked to his clinical nursing practice.
- Mr Baptista showed little regard for the advice of senior colleagues, as well as the Trust's policies and procedures.
- Mr Baptista had made a wide range of clinical errors despite being given extended periods of support and supervised practice at the Trust.
- Mr Baptista has offered limited insight, remorse and remediation in relation to the misconduct identified.

As regards mitigating factors, the panel has considered the following as relevant:

- Mr Baptista acknowledged making some errors in his written responses to the NMC.

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.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 was of the view that Mr Baptista's misconduct was not at the lower end of the spectrum of fitness to practise and determined 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 a conditions of practice order on Mr Baptista's nursing registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel considered the misconduct identified to be serious, specifically in respect of Mr Baptista's dishonesty, as well as his acting outside the scope of his approved level of clinical competence. It noted that whilst there were clinical failings identified in Mr Baptista's nursing practice, he had already had an extensive period of support and supervised practice offered to him by the Trust. Mr Baptista had also shown a disregard for the opinion of more senior colleagues, along with the Trust's own policies and procedures on more than one occasion. The panel therefore considered Mr Baptista's behavioural concerns to be directly linked to his clinical nursing practice.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the misconduct in this case. Mr Baptista has made no attempt to remediate his misconduct, nor demonstrated any willingness to return to the nursing profession in the UK. In taking account of the above, the panel determined that placing a conditions of practice order on Mr Baptista's nursing registration would not adequately address the seriousness of this case, nor would it sufficiently protect the public, or satisfy the public interest considerations.

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

The panel noted that this was not a single instance of misconduct. It also had some evidence before it of Mr Baptista having demonstrated behaviour which indicated a deep-seated attitudinal concern. Mr Baptista had exposed patients to a significant risk of harm by acting in a dishonest manner, and by acting outside the scope of his approved competence when he was aware that he did not have the authority to do so.

The panel found that Mr Baptista had offered limited insight, remorse and remediation for his misconduct, despite having a substantial amount of time to reflect on his actions. Whilst Mr Baptista has stated that he does not wish to return to the nursing profession in the UK, the panel considered there to be a real risk of repetition should Mr Baptista change his mind and look to return to nursing practice.

Taking account of the above, the panel determined that Mr Baptista's conduct was a significant departure from the standards expected of a registered nurse. His actions, constituted a serious breach of fundamental tenets of the nursing profession. Given his limited insight and lack of remediation, and his disengagement from the regulatory process, they are fundamentally incompatible with Mr Baptista remaining on the NMC register. The panel was of the view that the findings in this particular case demonstrate that Mr Baptista's unprofessional attitude, behaviour and actions were serious in exposing patients to a significant risk of unwarranted harm, and it considered that allowing him to maintain ongoing NMC registration would put the public at a continued risk of harm, and undermine public confidence in the profession and in the NMC as a regulatory body.

The panel noted that a registered nurse who has been found to have acted dishonestly runs a risk of being removed from the NMC register. However, this risk is reduced should a registrant demonstrate a high level of insight, remorse, or remediation into their misconduct. None of these have been demonstrated sufficiently by Mr Baptista despite having ample opportunity to do so, as he has chosen to disengage with the NMC.

The panel noted that there were serious breaches of multiple standards of the Code, a breach of fundamental tenets of the nursing profession, and a breach of Mr Baptista's professional duty of candour in this case.

Considering all of these factors, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular, the effect of Mr Baptista's actions in bringing the nursing profession into disrepute by adversely affecting the public's view of how registered nurses should conduct themselves, 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.

**Determination on Interim Order**

The panel has considered the submissions made by Mr Badruddin that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest. He invited the panel to impose an interim suspension order for 18 months.

The panel accepted the advice of the legal assessor.

The panel had regard to the seriousness of the facts found proved, and the reasons set out in its decision for the substantive order. The panel decided that an interim suspension order is necessary for the protection of the public and it is otherwise in the public interest. To conclude otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.