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

**Substantive Hearing**
**22 February – 3 March, 23 April, 26 - 28 July 2021**

Virtual Hearing

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| **Name of registrant:** | **Derek Phinn** |
| **NMC PIN:** | 83H0091S |
| **Part(s) of the register:** | Registered Nurse – sub part 2<br>General (Level 2) Nursing – 9 March 1985 |
| **Area of registered address:** | Dundee |
| **Type of case:** | Misconduct |
| **Panel members:** | Nicola Jackson (Chair, lay member)<br>Martin Bryceland (Registrant member)<br>Ian Dawes (Lay member) |
| **Legal Assessor:** | Alain Gogarty |
| **Panel Secretary:** | Tara Hoole (22 February – 3 March, 23 April 2021)<br>Leigham Malcolm (26 – 27 July 2021) |
| **Nursing and Midwifery Council:** | Represented by Yusuf Segovia, Case Presenter |
| **Mr Phinn:** | Not present or represented in absence |
| **Facts proved:** | Charges 1a), 1b), 1c), 1d)i,1d)iii, 2a), 2b), 2c)ii, 2c)iii, 2c)iv, 2c)v, 2e)i, 2e)ii, 3a)i, 3a)ii.a**,** 3a)ii.b, 4a), 4b), 4c)i, 4c)ii, 4c)iii, 5, 6 and 7 |
| **Facts not proved:** | Charges 1d)ii, 2c)i, 2d)i, 2d)ii, 2d)iii, 2f), and 2g) |

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| **Fitness to practise:** | Impaired |
| **Sanction:** | Striking-Off Order |
| **Interim order:** | Interim Suspension Order 18 months |

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Mr Phinn was not in attendance and that the Notice of Hearing had been sent to Mr Phinn's registered email address as shown on the electronic register on 17 December 2020.

Mr Segovia, 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 charges, the time, dates and venue of the hearing and, amongst other things, information about Mr Phinn's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

The panel noted that Mr Phinn was notified by email on 11 January 2021, that the hearing venue was changed to a virtual hearing in response to the updated government guidance regarding the Covid-19 pandemic. This email contained a link to the virtual hearing.

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

The panel next considered whether it should proceed in the absence of Mr Phinn. It had regard to Rule 21 and heard the submissions of Mr Segovia who invited the panel to proceed in the absence of Mr Phinn. He submitted that this was a case where it could be said that Mr Phinn had voluntarily absented himself.

Mr Segovia referred the panel to an email dated 12 October 2020 from Mr Phinn (in response to an email from the NMC) in which he states: *'I am sorry but I shall not be attending at any time… I am sure the committee will manage to come to the right decision without me.'* In a further email dated 14 January 2021, again in response to an email from the NMC, Mr Phinn stated '*I will not be joining this [hearing] at any time'*.

Mr Segovia submitted that there had been limited engagement by Mr Phinn with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted 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 and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

The panel has decided to proceed in the absence of Mr Phinn. In reaching this decision, the panel has considered the submissions of Mr Segovia, the email correspondence from Mr Phinn, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision *Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Phinn;
- Mr Phinn responded to the Notice of Hearing and confirmed that he would not be attending the hearing. He indicated that he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure Mr Phinn's attendance at some future date;
- Two witnesses are instructed to appear today to give evidence, twelve others are due to provide evidence this week;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events alleged to have occurred in 2017;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events;
- There is a strong public interest in the expeditious disposal of the case; and
- It may also be in Mr Phinn's interest for these matters to come to a conclusion.

There is some disadvantage to Mr Phinn in proceeding in his absence. Although the evidence upon which the NMC relies has been sent to him at his registered email address, he has made no response to the allegations. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Phinn's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and not to provide evidence or make submissions on his own behalf.

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

**Details of charge**

That you, a registered nurse:-

Ballumbie Court Care Home

1. On 6/7 February 2017:-

    a) Covertly administered medication to Resident A. **Found proved.**

    b) Failed to check a resident who had fallen out of bed (Resident B). **Found proved.**

    c) Requested care assistants to manually lift Resident B back into bed. **Found proved.**

    d) Following Resident B's fall at 'b)', failed to:-

        i. Complete a Datix **Found proved.**

        ii. Complete a risk assessment **Found not proved.**

        iii. Update Resident B's care plan **Found proved.**

Moss Park Care Home

2. Around 21 to 23 May 2017:-

    a) Did not assist care assistants with the personal care of residents. **Found proved.**

    b) Referred to a resident as a 'screamer' or words to this effect. **Found proved.**

c) With respect to Resident C failed to:-

   i. Ensure the syringe driver remained connected **Found not proved.**
   ii. Ensure the syringe driver administered medication at the correct infusion rate **Found proved.**

   iii. Complete the syringe driver chart **Found proved.**

   iv. Ensure checks on the syringe driver were undertaken **Found proved.**

   v. Document that the syringe driver had become disconnected **Found proved.**

d) Asked carers to write entries in the 'Night Checks Records' for residents that did not reflect the care given, around:

   i. 11pm **Found not proved.**

   ii. 1am **Found not proved.**

   iii. 3am **Found not proved.**

e) Signed the 'Night Check Record' dated 21 May 2017 for residents to indicate that you had carried out checks, around:

   i. 11pm **Found proved.**

   ii. 1am **Found proved.**

f) Your action at 'd' was dishonest in that you knew that no member of staff had checked on residents around any of the times listed at 'i)-iii)'. **Found not proved.**

g) Your action at ‘e’ was dishonest in that you had not checked on residents around either of the times listed at ‘i)-ii)’. **Found not proved.**

Harestane Nursing Home

3. On 12/13 July 2017:-

a) With respect to Resident D:-

i. Around 11pm administered a second evening dose of Trazodone and Simvastatin. **Found proved.**

ii. Following the error at ‘i’ failed to:-

a) Undertake observations **Found proved.**

b) Call a General Practitioner for advice **Found proved.**

South Grange Care Home

4. With respect to Resident E:-

a) On 25 November 2017 administered a second morning dose of medications. **Found proved.**

b) Recorded the dose at ‘a)’ as having been administered on 26 November 2017. **Found proved.**

c) Failed to

i. Identify **Found proved.**

ii. Report **Found proved.**

iii. Escalate **Found proved.**

the second dose at ‘a)’.

5. On 7 December 2017 failed to administer 75mg Aspirin to Resident G. **Found proved.**

6. On 22 November 2017 were verbally and/or physically aggressive to Resident F. **Found proved.**

7. Around 19/20 November 2017 were verbally and/or physically aggressive to Colleague A. **Found proved.**

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

**Decision and reasons on application to admit further evidence**

During Ms 9's oral evidence she made reference to a 'reflective accounts form' completed by Mr Phinn in relation to charge 3.

The panel considered that this may be information which was relevant to the case.

Mr Segovia made an application to admit this document into evidence under Rule 31 of the Rules as it was clearly relevant. He submitted that the document may assist the NMC's case but that it may also be of benefit to Mr Phinn.

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 determined that the document was clearly relevant as it related directly to an incident detailed in charge 3. The panel considered that there would be no prejudice to Mr Phinn or the NMC in admitting this document into evidence.

The panel therefore decided to admit the 'reflective accounts form' into evidence.

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

Prior to hearing the application to admit the written witness statement of Ms 13, Mr Segovia made a request that this part of the hearing be held in private on the basis that it involved reference to Ms 13's health. The application was made pursuant to Rule 19 of 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.

The panel determined to hear matters relating to Ms 13's health in private session in order to protect her right to privacy.

**Decision and reasons on application to admit written witness statements of Ms 13**

The panel heard an application made by Mr Segovia under Rule 31 to admit the written statement of Ms 13 into evidence. Ms 13 was not available to join the virtual hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to provide oral evidence [private].

Mr Segovia acknowledged that fairness was the key issue in whether the panel accepted Ms 13's written statements into evidence. Mr Segovia highlighted the factors identified in the case of *Thorneycroft v NMC [2014]* EWHC 1565 (Admin).

Mr Segovia submitted that Ms 13's evidence was clearly relevant to one aspect of this case (her evidence directly relates to the incidents at South Grange Care Home) and that it would not be unfair to admit her evidence as her account can be tested by questioning other witnesses. Further, he submitted that it is not the sole or decisive evidence with the exception of charge 5, although charge 5 is supported by documentary evidence. He submitted that the panel could determine the matter of what weight to attach to Ms 13's evidence when it came to determine the facts of the case.

Mr Segovia submitted that the panel had evidence before it which related to Ms 13's medical condition. He accepted that this was not independent medical evidence but that it was clear that Ms 13 has a diagnosis which affected her ability to provide oral evidence to the panel at this hearing. He submitted that the evidence before the panel provided a good reason for Ms 13's non-attendance at the hearing.

Mr Segovia highlighted that, despite knowledge of the nature of the evidence to be given by Ms 13, Mr Phinn made the decision not to attend this hearing and had not provided any written representations. On this basis Mr Segovia made the submission that there was limited prejudice and no lack of fairness to Mr Phinn in allowing Ms 13's written statement into evidence.

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. He also drew the panel's attention to the matters identified in the cases of *GMC v Hyatt [2018]* EWCA Civ 2796 and *Thorneycroft*.

The panel had regard to the principles to be considered when determining an application to admit hearsay evidence as laid out in the case of *Thorneycroft* at Paragraph 45 which states:

> *'45. For the purposes of this appeal, the relevant principles which emerge from the authorities are these:*
>
> *1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.*
>
> *1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.*
>
> *1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.*

*1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.'*

The panel gave the application in regard to Ms 13 serious consideration. The panel noted that Ms 13's statements had been prepared in anticipation of being used in these proceedings and contained the paragraph '*This statement … is true to the best of my information, knowledge and belief*' and was signed by her.

The panel considered that Ms 13's evidence is clearly relevant. The panel was satisfied that her evidence was not the sole or decisive evidence in respect of the charges with the exception of charge 5. In the panel's view her evidence is supported by the evidence of other witnesses and the documentary evidence provided which can be tested accordingly by the panel. In respect of charge 5 there is documentary evidence which the panel can take into consideration when it makes its determination on this charge.

In respect of the '*good and cogent reason*' for Ms 13's non-attendance, the panel was satisfied that there was a good reason for her non-attendance albeit that it is not supported by detailed and current medical evidence.

The panel considered that as Mr Phinn had been provided with a copy of Ms 13's statement and, as the panel had already determined that Mr Phinn had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered that Ms 13 is an experienced nurse who has provided the panel with the benefit of her experience in a fair and balanced way. Ms 13's role was that of an investigator into the issues which arose at South Grange Care Home. The issues she speaks to have not been contested by Mr Phinn and there does not appear to be any 'bad blood' between Ms 13 and Mr Phinn.

In these circumstances, the panel came to the view that the written statements of Ms 13 were relevant to the proceedings and it would be fair to accept them into evidence.

The panel determined it would give what it deemed appropriate weight to Ms 13's evidence once it had heard and evaluated all of the evidence before it.

**Adjournment**

Mr Segovia advised the panel that under Rule 32 (5) the panel should consider whether to make an interim order given that the hearing is going to adjourn part-heard. He advised that this was not necessary in this case as there was an interim order already in place on Mr Phinn's practice.

The panel noted Mr Segovia's submission and determined that it was not necessary for it to make an interim order in this case.

The panel formally adjourned the hearing on 3 March 2021 to a date to be determined.

Resumed Hearing

The panel resumed on Day 9 – 23 April 2021. Mr Phinn was not in attendance.

**Notice of Hearing**

Mr Segovia highlighted to the panel an email, dated 22 March 2021, which was sent to Mr Phinn's email address, attached to that email was a letter also dated 22 March 2021 which set out that on Friday 23 April 2021 (and future dates) that there would be a virtual resuming hearing for this case. The letter also set out the details for joining the virtual hearing.

The panel accepted that advice of the legal assessor.

The panel was satisfied that Mr Phinn has been served with the Notice of this resuming hearing in accordance with the requirements of the Rules.

**Proceeding in absence**

Mr Segovia highlighted an email dated 14 April 2021 sent to Mr Phinn which asked him to advise if he would be attending the resuming hearing on 23 April 2021 and asked whether he would be content for the hearing to proceed in his absence.

Mr Phinn's response was three words: *'not attending*' and '*yes'*. Mr Segovia submitted that this indicated that Mr Phinn had voluntarily absented himself from the hearing today. He submitted there was a clear indication from Mr Phinn that the panel should proceed in Mr Phinn's absence and that there was no reason to believe that an adjournment would secure his attendance.

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 *Jones* and *Adeogba*.

The panel considered the interpretation by the NMC of the email of 14 April 2021 received from Mr Phinn in response to the NMC's enquiry as to whether he would attend, and if not if he was happy for the hearing to proceed in his absence. The panel decided that it was reasonable to conclude that Mr Phinn was confirming that he did not wish to attend but was content for the hearing to proceed in his absence. The panel noted that there had been no application to adjourn this hearing. In addition Mr Phinn had not attended the previous hearing and in an email dated 14 January 2021 had stated that he would not be joining the hearing at any time.

The panel further considered that there is a public interest in hearings proceeding expeditiously and that this may also be in Mr Phinn's interest.

The panel therefore proceeded and handed down its decision on facts.

**Decision and reasons on facts**

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

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

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Ms 1: Branch Manager for the Dundee branch for Newcross Healthcare at the time of the

incident. Ms 1 was involved in the investigation into the complaints raised.

- Ms 2: Registered Nurse and Manager at Ballumbie Court Care Home at the time of the incidents.
- Ms 3: Care Home Manager at Moss Park Care Home at the time of the incidents.
- Ms 4: Healthcare Assistant at Moss Park Care Home at the time of the incidents.
- Ms 5: Senior Care Worker at Moss Park Care Home at the time of the incidents.
- Ms 6: Team Leader and Senior Carer at Harestane Nursing Home at the time of the incidents.
- Ms 7: Care Officer at Harestane Nursing Home at the time of the incidents.
- Ms 8: Registered Nurse and Care Home Manager at Harestane Nursing Home.
- Ms 9: Clinical Governance – Senior Lead Nurse for Newcross Healthcare Solutions.
- Ms 10: Registered Nurse working at South Grange Care Home at the time of the incidents.

- Ms 11: Care Assistant at South Grange Care Home at the time of the incident.

- Ms 12: Staff Nurse working at South Grange Care Home at the time of the incident.

- Colleague A: Senior Care Assistant and Practitioner at South Grange Care Home.

The panel also accepted into evidence the written witness statement of Ms 13: Registered Nurse and Deputy Manager of South Grange Care Home at the time of the incident.

**Background**

The NMC received a referral on 14 July 2017 regarding Mr Phinn's fitness to practise. Mr Phinn was employed as an agency nurse by Newcross Healthcare (the Agency) at this time.

The charges relate to concerns raised regarding incidents involving Mr Phinn's work as a nurse at four separate care homes over the course of 2017. In February 2017 Mr Phinn was working as an agency nurse at Ballumbie Court Care Home (Ballumbie). In May 2017 Mr Phinn was working as an agency nurse at Moss Park Care Home (Moss Park). In July 2017 Mr Phinn was working as an agency nurse at Harestane Care Home (Harestane).

In November/December 2017 Mr Phinn was working as a staff nurse at South Grange Care Home (South Grange).

The concerns identified relate to medication errors, failures to follow proper policies and procedures, as well as concerns regarding Mr Phinn's behaviour towards colleagues and residents.

The Agency investigated the concerns raised by Ballumbie (which resulted in a first written warning to Mr Phinn in April 2017) and by Moss Park (which resulted in a final written warning in June 2017).

Before making any findings on the facts, the panel accepted the advice of the legal assessor who referred it to the cases of *Re H and others (minors) (Sexual Abuse: Standard Approof)* [1996] AC563, *Pope v The General Dental Council [2015]* EWHC 278 (Admin), *Fish v The General Medical Council [2012]* EWHC 1269 (Admin), *Lawrance v General Medical Council [2015]* EWHC 586 (Admin), *Casey v The General Medical Council [2011]* NIQB 95, *Moseka v Nursing and Midwifery Council [2014]* EWHC 846 (Admin) and *Ivey v Genting Casinos [2017]* UKSC 67.

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 considered the evidence of the witnesses and made the following conclusions:

Ms 1: The panel considered the evidence of Ms 1 to be clear, concise and credible. She did her best to assist the panel but was limited in terms of the evidence she could provide as she was not a direct witness to any of the incidents. Her oral evidence was consistent with her written evidence and she was able to talk the panel through the disciplinary procedure.

Ms 2: The panel considered the evidence of Ms 2 to be of limited reliability. She did her best to assist the panel and admitted when she did not know. Ms 2 had limited

recollection of the events. She relied heavily on the documentation before her. The panel noted Ms 2 was not a direct witness to the incidents but she was able to assist the panel in regards to the relevant policy and procedures which should have been followed.

Ms 3: The panel considered the evidence of Ms 3 to be credible. She was not a direct witness to all events, rather she detailed what the carers had reported to her and so her evidence was somewhat limited in its reliability in regards to charge 2a) and 2b). The panel considered her to be a fair and balanced witness. Her evidence regarding charges 2c)i-v was both credible and reliable. She was able to give detailed evidence in respect of charges 2c)i-v regarding the syringe driver.

Ms 4: The panel considered Ms 4 to be a credible and reliable witness. Her oral evidence differed slightly from her written witness statement but the panel considered this was to add context rather than an elaboration and was not inconsistent with her written evidence. The panel considered that Ms 4 was clear in what she heard, she was fair and helpful.

Ms 5: The panel considered the evidence of Ms 5 to be confused, faded and at times contradictory. Ms 5 was clear in some aspects, in particular regarding where she could identify her signature and she was consistent in what she could remember. However, the panel considered that she did not have a clear memory of events and her oral evidence often differed significantly from her witness statement. The panel therefore considered that, whilst she tried to assist the panel, Ms 5’s evidence was of limited reliability.

Ms 6: The panel considered Ms 6 to be a credible and reliable witness. Her oral evidence was consistent with her written witness statement. She had a very good recollection of events and was fair to Mr Phinn. She limited her evidence to what she knew and was able to explain the handwritten amendment to her statement.

Ms 7: The panel considered the evidence of Ms 7 to be credible and reliable. She was fair and consistent with her witness statement. However she did not have a good recall of the events. Ms 7 did her best to assist the panel.

Ms 8: The panel considered the evidence of Ms 8 to be credible and reliable. She had a good recollection of events and was able to bring in additional detail. Ms 8 accepted and corrected where there were errors in her statement. She went into more depth in some matters, offering explanations of policy and procedures, the panel considered this to be genuine recall and found it to be helpful.

Ms 9: The panel considered Ms 9 to be a clear, credible and reliable witness. Ms 9 was not a direct witness to any of the incidents however she conducted the investigation and interviewed Mr Phinn regarding the events. She had very good recall and was very knowledgeable. She was fair and balanced in her evidence which was consistent with her written statements. The panel found her evidence to be of great assistance.

Ms 10: The panel considered the evidence of Ms 10 to be clear, credible and reliable. She had a good recall of events and her oral evidence was consistent with her witness statements. It was obvious that Ms 10 knew the resident well and was distressed by the incident she witnessed which led to the clear and detailed recollection of the incident.

Ms 11: The panel considered Ms 11 to be a credible and reliable witness. She was thoughtful and clear in her responses and had a good recollection of events. She was fair and did not elaborate or speculate. It was clear that Ms 11 had no axe to grind with Mr Phinn. She accepted that both parties were at fault in the argument, albeit Colleague A was provoked, and she was clear that Mr Phinn was the instigator.

Ms 12: The panel considered Ms 12 to be a credible and reliable witness. She was fair and confident in her answers and had a good recollection of events but accepted limitations in terms of the time which had elapsed. Her oral evidence was consistent with her written evidence.

Colleague A: The panel considered Colleague A's evidence to be credible and reliable. He had a clear recollection of events, which had obviously had a significant impact on him. His oral evidence was consistent with his witness statement. He was fair to Mr Phinn and accepted his part in the argument. The panel noted that Colleague A was a very experienced senior care assistant who had worked at the relevant home for many years. He said that this was the only time he had ever experienced a registered nurse behaving in that way.

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

Ballumbie Court Care Home

**Charge 1a)**

1. On 6/7 February 2017:-

    a) Covertly administered medication to Resident A.

**This charge is found proved.**

The panel noted that it had not heard direct witness evidence in respect of this charge.

The panel considered the handwritten statements regarding this incident from two healthcare assistants (HCA's) (HCA 1 and HCA 2) who witnessed Mr Phinn administering the medication covertly. These state:

'*This letter is to raise concerns regarding the agency nurse I worked with on Monday the 6th Febuary (sic). I observed him putting medication in cup's of tea…*'

and

*'…regarding the agency nurse on Monday the 6th of February night shift… his mannor (sic) regarding medication was very lax… he was putting it into drinks…*'

In her witness statement Ms 2 states '*I did not witness any of the allegations made against [Mr Phinn] as these were reported to me by the HCA's following the incidents occurred. On the 6th of February 2017, [Mr Phinn] began a night shift, he put a tablet in a drink for a patient who would not take her medicine orally*.'

The panel considered that whilst the evidence of Ms 2 was hearsay it was supported by the handwritten statements of the HCA's.

The panel next considered the email from Mr Phinn to Ms 1 dated 20 February 2017 in response to her email informing him of the complaint from Ballumbie. Mr Phinn stated: *'I gave one resident her medication in tea as she had refused on several occasions to take it from me…*'

In the notes of the investigatory meeting on 1 March 2017 it states '[*Mr Phinn] confirmed that he had given one resident her medication covertly. He had tried to administer her medication a few times, however the resident continued to spit it out… He advised that there was only an inch of tea in her cup, and he crushed the tablet and added to the tea. He claims to have then ensured that one of the carers remained with her until she had drunk it. [Mr Phinn] now recognised that despite him taking these steps, he should not have done this unless this was included in the resident's care plan.*'

In her oral evidence Ms 1 confirmed that Mr Phinn had admitted to giving medication to a resident covertly.

The panel also considered the first written warning dated 21 April 2017 from Ms 1 to Mr Phinn in which it states '*The reason for the warning is that whilst on shift at Ballumbie Court Care Centre… In addition, you admitted to administering medication to one resident covertly*'.

The panel was of the view that Mr Phinn appears to have accepted that he did covertly administer medication.

The panel was satisfied, on the balance of probabilities, that at Ballumbie Court Care Home on 6/7 February 2017, Mr Phinn covertly administered medication to Resident A.

The panel therefore found this charge proved.

**Charge 1b)**

b) Failed to check a resident who had fallen out of bed (Resident B).

**This charge is found proved.**

The panel considered Ms 2's oral and written evidence. She told the panel that it should be normal practice not just good practice to check a resident who had fallen out of bed. She told the panel that she would expect any resident who had fallen to be assessed for injury and for observations to be taken. She said that, as the nurse in charge it would be your duty and responsibility to check a resident who had fallen for any possible harm incurred and deal with any injuries accordingly. She told the panel that the fact that the resident was 'still asleep' should have triggered an assessment as a fall would usually wake someone. She told the panel that she would have completed a structured check of the resident and continued checks throughout the night.

The email from Ballumbie raising this concern on 15 February 2017 stated '*A resident fell out of her bed. [Mr Phinn] advised the carers to check her over and use her quilt to pick her up off the floor. They stated he did not even check her*.' The panel considered this indicated that Mr Phinn knew a check was required but delegated the responsibility.

The panel considered the email from Mr Phinn to Ms 1 dated 20 February 2017 in response to her email informing him of the complaint from Ballumbie. Mr Phinn states: *'I was called because a resident had rolled, not falling out of her bed. The bed in question was set to its lowest setting and there was a thick crash mat on the floor. As far as examining her is concerned I can assure you that due to the height, position and the fact that she was asleep (not unconscious) led me to believe there was no reason for an*

*in-depth examination.'* The panel considered this to be a clear admission by Mr Phinn that he did not carry out an appropriate clinical checks on the resident who had fallen out of bed. The panel were concerned that Mr Phinn had assumed that Resident B was asleep rather than unresponsive as a consequence of this incident.

In the notes of the investigatory meeting on 1 March 2017 it states '[*Mr Phinn] advised that bed was on lowest setting and resident had a crash mat at the side of the bed. He claims that the resident rolled from the bed to the crashmat – which was a "fall" of no more than 6 inches. The resident was asleep when she rolled, and did not wake her up. [Mr Phinn] asked the carers to assist him in lifting her back into bed without waking her. They agreed to do this, and did not suggest getting a hoist to do this.'*

The panel noted that this charge alleges a failure. This requires the NMC to prove that Mr Phinn was under a duty to do that which he is alleged to have failed to have done.

The panel considered that there was a clear duty on Mr Phinn, as the registered nurse on shift, to check a resident who had fallen out of bed and that he failed to do this.

The panel concluded that, on the balance of probability, Mr Phinn failed to check a resident who had fallen out of bed (Resident B). The panel therefore found this charge proved.

**Charge 1c)**

c) Requested care assistants to manually lift Resident B back into bed.

**This charge is found proved.**

The panel considered the handwritten statements regarding this incident from two healthcare assistants (HCA's) (HCA 1 and HCA 2) who witnessed Mr Phinn administering the medication covertly. These state:

'*This letter is to raise concerns regarding the agency nurse I worked with on Monday the 6th Febuary (sic)… when a resident fell out the bed he did not check them over, and told myself and my colleuge (sic) to use our head and roll her on her quilt and pick her up.* '

and

*'…regarding the agency nurse on Monday the 6th of February night shift… he also didnt (sic) follow proper prosedures (sic) when residents had fallen.*'

The panel considered Ms 2's oral and written evidence. Ms 2 told the panel that a hoist should have been used to lift the resident and return her to the bed and that it had been reported to her by HCA 1 and HCA 2 that this was not done. She confirmed in her oral evidence that a quilt should never be used to lift a resident back into bed due to the risk of it failing and subsequent injury to a resident. She told the panel that the mobility care plan referred to the whole body hoist being used which required two people to operate.

In the notes of the investigatory meeting on 1 March 2017 it states '*[Mr Phinn] asked the carers to assist him in lifting her back into bed without waking her. They agreed to do this, and did not suggest getting a hoist to do this.'*

The panel also considered the first written warning dated 21 April 2017 from Ms 1 to Mr Phinn in which it states '*The reason for the warning is that whilst on shift at Ballumbie Court Care Centre on 15th February 2017, you utilised illegal moves in terms of moving and handling, by instructing care staff to lift a resident who had fallen to the floor using her crashmat'*.

The panel concluded, on the basis of the evidence before it, it was more likely than not that Mr Phinn requested care assistants to manually lift Resident B back into bed. The panel therefore found this charge proved.

**Charge 1d)i**

d) Following Resident B's fall at 'b)', failed to:-

i. Complete a Datix

**This charge is found proved.**

The panel considered Ms 2's witness statement in which she states '*Following this [the fall] I would have expected the resident to have been placed on a twenty four-forty eight hours falls observation chart, her falls risk assessment to be updated and a datix to be completed… None of this appears to have been carried out…*'

The panel accepted Ms 2's evidence that there was no evidence of a Datix or incident report following Resident B's fall. The panel considered that it would be expected that a Datix should be completed after such an incident.

The panel noted that Mr Phinn accepted that the fall happened but that in his responses at the investigatory meetings he has indicated that he did not complete checks because he did not think there was a need for in-depth examination.

The panel concluded that it was more likely than not that, following Resident B's fall, Mr Phinn failed to complete a Datix and as the registered nurse it was his duty to do so as set out by Ms 2. The panel therefore found this charge proved.

**Charge 1d)ii**

d) Following Resident B's fall at 'b)', failed to:-

ii. Complete a risk assessment

**This charge is found NOT proved.**

The panel considered Ms 2's witness statement in which she states '*Following this [the fall] I would have expected the resident to have been placed on a twenty four-forty eight*

*hours falls observation chart, her falls risk assessment to be updated and a datix to be completed… None of this appears to have been carried out…*'

Whilst the panel accepted that Mr Phinn would have had a duty to update a falls risk assessment, it could find no evidence that there was a falls risk assessment in place for Resident B at the time of the incident. The falls risk assessment for Resident B provided to the panel was dated 2 June 2017.

The panel did not consider, on the basis of the evidence provided, that it would have been Mr Phinn's responsibility to complete a falls risk assessment for Resident B. Further, Mr Phinn could not be expected to update a document which it would appear did not exist at the time.

The panel considered that there was not sufficient evidence to conclude that, following Resident B's fall, Mr Phinn failed to complete a risk assessment. The panel therefore found this charge not proved.

**Charge 1d)iii**

d) Following Resident B's fall at 'b)', failed to:-

iii. Update Resident B's care plan

**This charge is found proved.**

The panel considered Ms 2's witness statement in which she states '*Following this [the fall] I would have expected the resident to have been placed on a twenty four-forty eight hours falls observation chart, her falls risk assessment to be updated and a datix to be completed… None of this appears to have been carried out…*'

The panel noted the care and support plan provided to it was a monthly evaluation dated 1 May 2017.

The panel accepted Ms 2's evidence that there was no record to suggest that Mr Phinn had updated Resident B's care plan after the fall. The panel considered that it would be expected that the care plan should be updated after such an incident by the trained nurse and that Mr Phinn would have been under a duty to do so.

The panel again noted that Mr Phinn had not concluded that an in depth assessment of Resident B was necessary. It therefore concluded that it was more likely than not that, following Resident B's fall, Mr Phinn failed to update Resident B's care plan. The panel therefore found this charge proved.

Moss Park Care Home

**Charge 2a)**

2. Around 21 to 23 May 2017:-

    a) Did not assist care assistants with the personal care of residents.

**This charge is found proved.**

Ms 5 in her written witness statement stated *'[Mr Phinn] refused to assist in any of the cleaning of residents, and he only did one round check on the residents with me at 5am. [Mr Phinn] told me he was only there to do medication rounds and give out medication throughout the night. [Mr Phinn] told me that our main job was to promote sleep not to check them (residents) every 2 hours. He told me that you can open the door a little and smell the piss and shit on a resident'*. This corroborates with her handwritten statement dated 3 June 2017. In her oral evidence she told the panel that Mr Phinn had helped with pad changes for one resident.

Ms 4 in her handwritten statement stated *'Didn't cooperate with the last 2 checks. So I was downstairs on my own checking 16 residents and there were a few pad changes which I struggled to do on my own'.* In her witness statement she stated *'[Mr Phinn] did*

*not help me with any checks on the ground floor during the 2am and 5am rounds. I had to do pad changing for some "double" residents by myself*'. This was corroborated by her oral evidence in which she confirmed that it was usual for the nurse on shift to assist the care assistants with the personal care of residents but that Mr Phinn had not provided this assistance throughout the shift.

The panel noted that Mr Phinn did not assist on several of the rounds and that Ms 4 had to manage several rounds of checks on her own. She told the panel that Mr Phinn did not cooperate with the checks and told the care assistants that he did not think he should be doing them.

The panel considered that the evidence before it demonstrated that Mr Phinn had provided a small amount of minimal personal care to residents and assistance to the care assistants. The witnesses agreed that Mr Phinn had assisted on a couple of occasions during the shift but that they mostly provided the care on their own.

Ms 3 confirmed to the panel that the nurse was expected to provide direct nursing care and supervision of colleagues. She told the panel that she had spoken to Mr Phinn on 22 May 2017 about him not helping the care assistants and Mr Phinn had replied that he '*was just a safe pair of hands and wasn't actually there to do anything*'.

The panel considered that there is a level of care and assistance which is expected of a registered nurse. From the evidence before it the panel concluded that the minimalist level of care and assistance described as being provided by Mr Phinn did not constitute assisting the care assistants with personal care of residents.

The panel concluded that it was more likely than not that, around 21 to 23 May 2017, Mr Phinn did not assist care assistants with the personal care of residents. The panel therefore found this charge proved.

**Charge 2b)**

b) Referred to a resident as a ‘screamer’ or words to this effect.

**This charge is found proved.**

In her oral evidence Ms 4 told the panel that Mr Phinn referred to one of the residents as a ‘screamer’ rather than by their name. Ms 4 clearly recalled this incident and had been upset by his use of inappropriate language towards a resident she knew well and had cared for over several years. This was corroborated by her written witness statements one of which was written on 24 May 2017, the day after the incident.

Ms 3 told the panel that it had been reported to her that Mr Phinn had asked ‘*when is the screamer going to shut up*’. She said that the staff who heard this were really angry and upset by Mr Phinn’s comment.

In an email to the Agency dated 24 May 2017 Ms 3 noted that Mr Phinn ‘*called one of our residents a screamer’*.

The panel considered that the witness evidence of Ms 4 and Ms 3 was clear and consistent throughout. It is clear to the panel that Mr Phinn did refer to a resident as a ‘screamer’. The panel noted that the staff were clearly experienced and were fond of this resident. It had obviously impacted on them such that they recalled the incident in detail during their oral evidence.

The panel concluded that it was more likely than not, that around 21 to 23 May 2017, Mr Phinn referred to a resident as a ‘screamer’ or words to this effect. The panel therefore found this charge proved.

**Charge 2c)i**

c) With respect to Resident C failed to:-

i. Ensure the syringe driver remained connected

**This charge is found NOT proved.**

Ms 3 in her witness statement said in relation to Resident C '*the resident had pulled the [syringe] driver out'*.

The panel considered that for there to have been a failure to ensure the syringe driver remained connected there required to be something Mr Phinn could or should have done to prevent the resident from pulling the driver out. The panel heard no evidence to suggest that this was the case.

The panel had regard to the 'Subcutaneous Medicines Administrations Form' (T34). On 23 May 2017 it is recorded '*pulled out restarted'*.

The panel considered that there was nothing Mr Phinn could have done to prevent Resident C from pulling the syringe driver out.

The panel therefore found this charge not proved.

**Charge 2c)ii**

ii. Ensure the syringe driver administered medication at the correct infusion rate

**This charge is found proved.**

The panel had regard to Ms 3's evidence. She told the panel that when Mr Phinn reinserted the syringe driver to Resident C that he '*started the cycle of medication from the start which meant [Resident C] did not get the proper dose'*. In her oral evidence Ms 3 explained to the panel how the syringe driver worked and that by restarting rather than resuming the cycle the syringe driver would have amended the infusion rate and

Resident C would have received a weaker dose than prescribed as the syringe driver works out the infusion rate over twenty four hours.

Ms 3 explained to the panel that when she started the syringe driver it was delivering 1mg per hour over a twenty four hour period. She told the panel that when she returned the following morning the Resident was only receiving 0.5mg over an hour. This was due to Mr Phinn having restarted the driver rather than resuming it. Ms 3 told the panel that when she returned to work the following morning she had to administer medication to Resident C to counter the effect of the weaker dose.

The panel considered that the evidence of Ms 3 is supported by the T34 form.

The panel concluded that it was more likely than not that, around 21 to 23 May 2017, with respect to Resident C Mr Phinn failed to ensure the syringe driver administered medication at the correct infusion rate. The panel therefore found this charge proved.

**Charge 2c)iii**

iii. Complete the syringe driver chart

**This charge is found proved.**

In Ms 3's evidence (supported by the policy procedure for administering subcutaneous infusions) she told the panel that syringe driver checks should be completed every four hours to check for reddening at the site of the needle, to check for infection and to ensure the resident was not in any pain. She told the panel that she had explained this to Mr Phinn at handover and said that at the same time he should check that the syringe driver was still running, check the volume history and the battery. She said that she had told Mr Phinn that this should all then be marked on the T34 form.

Ms 3 told the panel that when she returned to the home the following shift she checked the T34 form and saw that Mr Phinn had not made any entries.

The panel had regard to the T34 form (syringe driver chart). Mr Phinn's signature does not appear on this form. There is an entry on 22 May 2017 at 19:55 (completed by the day shift) the next entry is not until 23 May 2017 at 08:50 (completed by the following day shift).

The panel considered that any checks conducted by Mr Phinn during the night shift of 22/23 May 2017 should have been recorded on this chart and they are not.

The panel accepted Ms 3's evidence which is supported by the T34 form provided. The panel concluded that it was more likely than not that, around 21 to 23 May 2017, with respect to Resident C Mr Phinn failed to complete the syringe driver chart. The panel therefore found this charge proved.

**Charge 2c)iv**

iv. Ensure checks on the syringe driver were undertaken

**This charge is found proved.**

The panel considered the evidence as detailed at charge 2c)iii. It concluded that, given the lack of any entries in the T34 form during Mr Phinn's shift there was no evidence that Mr Phinn had checked Resident C's syringe driver.

The panel concluded that it was more likely than not that, around 21 to 23 May 2017, with respect to Resident C Mr Phinn failed to ensure checks on the syringe driver were undertaken. The panel therefore found this charge proved.

**Charge 2c)v**

v. Document that the syringe driver had become disconnected

**This charge is found proved.**

In her evidence to the panel Ms 3 confirmed that she had recorded that the syringe driver had become disconnected when she restarted the driver at 08:00 on 23 May 2017. Again, the panel noted that there were no entries made by Mr Phinn in the T34 form for Resident C.

The panel concluded that it was more likely than not that, around 21 to 23 May 2017, with respect to Resident C Mr Phinn failed to document that the syringe driver had become disconnected. The panel therefore found this charge proved.

**Charge 2d)**

d) Asked carers to write entries in the 'Night Checks Records' for residents that did not reflect the care given, around:

i. 11pm

ii. 1am

iii. 3am

**This charge is found NOT proved.**

The panel considered charges 2d)i, 2d)ii and 2d)iii together.

The panel had regard to Ms 4's oral and written evidence and the night check record for 22 May 2017. She was clear that Mr Phinn asked her to change the times of the night checks from 11pm, 1am, 3am and 5am to 12am, 2am and 5am. She told the panel that Mr Phinn had said to 'miss out' the 11pm check and instead to do checks at 12am, 2am and 5am but to sign as if they had done the 11pm, 1am and 3am checks. Ms 4 was

consistent in her oral and written evidence. She told the panel that she was uncomfortable in being asked to change the times and record these incorrectly so she checked on the residents at the normal time as well as the times Mr Phinn had told her to.

Ms 5's handwritten statement dated 3 June 2017 also mentions that Mr Phinn asked them to change their night checks from 11pm, 1am, 3am and 5am to midnight, 2am and 5am and to fill in the night book as if they had done the two hourly checks. In her oral evidence Ms 5 was not able to remember this clearly. When questioned, Ms 5 confirmed that the times written on the night check form for 21 May 2017 were the times she had checked the residents.

The panel considered that it appeared that Mr Phinn had asked carers to change the time of the night checks to 12am, 2am and 5am but to record it at as if they had completed the checks at 11pm, 1am and 3am. The carers complied with this instructions but also provided care in between these times as recorded on the Night Check Records.

Given that the carers provided the care given to residents at the times recorded in the 'Night Checks Records' the panel determined that it could not find any part of this charge proved as the entries did reflect the care given. The panel therefore found charges 2d)i, 2d)ii and 2d)iii not proved

**Charge 2e)**

e) Signed the 'Night Check Record' dated 21 May 2017 for residents to indicate that you had carried out checks, around:

i. 11pm
ii. 1am

**This charge is found proved.**

The panel considered charges 2e)i, and 2e)ii together.

The panel had regard to the Night Check Record dated 21 May 2017. It clearly shows at 11pm and 1am. The record was initialled to indicate that these checks were carried out by “DP” and another member of staff at 11pm and 1am.

The panel noted that Mr Phinn was the nurse on duty on this shift and considered that it was a reasonable inference that the DP at 11pm and 1am were his initials. Further, the panel had regard to other documentation which Mr Phinn has initialled and considered that his initials on these were similar to the initials at 11pm and 1am.

The panel therefore concluded that it was more likely than not that Mr Phinn had signed the ‘Night Check Record’ dated 21 May 2017 for residents to indicate that he had carried out checks, around 11pm and 1am.

The panel therefore found this charge proved.

**Charge 2f)**

f) Your action at ‘d’ was dishonest in that you knew that no member of staff had checked on residents around any of the times listed at ‘i)-iii)’.

**This charge is found NOT proved.**

Given the panel’s finding that charge 2d) was not proved, there remains no factual basis upon which a finding of dishonesty can be made. The evidence established that the entries at 11pm, 1am, and 3am did in fact reflect the care given. Further, the evidence does not establish that Mr Phinn knew no members of staff had checked on residents at any of the material times. In addition, it cannot be established on the evidence that Mr Phinn was not aware that staff did check residents at times outside of those set by him.

Clearly Mr Phinn could not be aware because the staff did indeed conduct checks of the residents.

The panel therefore found this charge not proved.

**Charge 2g)**

g) Your action at ‘e’ was dishonest in that you had not checked on residents around either of the times listed at ‘i)-ii)’.

**This charge is found NOT proved.**

The panel again had regard to the Night Check Record dated 21 May 2017. It clearly shows at 11pm and 1am that the records were initialled by “DP” and another member of staff. The panel has already determined that Mr Phinn initialled the chart for these times.

The panel next considered the witness evidence of Ms 5 who told the panel that the initialling at the 9pm check was hers. However, she told the panel that she was certain that the initials at 11pm and 1am, despite having the same initials, were not hers. The panel noted that the 9pm checks contain two sets of the same initials but that these could be different. Ms 5 told the panel that the other initials were that of another care assistant. Ms 5 was therefore unable to tell the panel whether Mr Phinn had conducted the checks at 11pm and 1am as recorded on the Night Check Record. Ms 5 also told the panel that she did not know if Mr Phinn had conducted the checks as she would have been in another part of the home.

The panel considered that Ms 5’s evidence was confused and her recollection was faded. However, she was adamant that the initials at 11pm and 1am were not hers. The panel therefore concluded there was no evidence to suggest that Mr Phinn had not checked on the residents as he had signed for on the Night Check Records.

In its consideration of this dishonesty charge the panel accepted the advice of the legal assessor that the test to be applied is that set out at paragraph 74 in the case of *Ivey*.

For the reasons set out above the panel considered that the NMC has not discharged the burden of proof in relation to this charge. The panel therefore decided that there is no basis for making a finding of dishonesty. The panel found this charge not proved.

Harestane Nursing Home

**Charge 3a)i**

3. On 12/13 July 2017:-

    a) With respect to Resident D:-

        i. Around 11pm administered a second evening dose of Trazodone and Simvastatin.

**This charge is found proved.**

In reaching this decision, the panel took into account Ms 8, Ms 6 and Ms 7's oral and written evidence. The panel also had sight of the incident report form dated 13 July 2017, Resident D's MAR chart for 12/13 July 2017, photocopies of the blister packs of Resident D's prescribed Trazodone and Simvastatin, the disciplinary meeting notes, dated 22 August 2017, and the disciplinary letter dated 23 August 2017.

Ms 8 explained to the panel that Resident D liked to know the people who administered her medication and because of this, she had been given her evening medication (Trazodone and Simvastatin) by a care officer at 8pm before they finished their shift. She told the panel that this had been recorded on the MAR chart for Resident D. Ms 8 said that Mr Phinn had then given Resident D another dose of her medication at 11pm despite Resident D saying that she had already had her medication. Ms 8 said that this

was brought to the attention of the day staff at handover by Mr Phinn. The day staff then informed Ms 8 who spoke with Resident D. Resident D confirmed that she had received a second dose of the medication from Mr Phinn. Resident D had been upset by the incident.

Ms 6 told the panel that Mr Phinn had told her and Ms 7 at the handover on the morning of 13 July 2017 that he had made an error and that he had given Resident D a second dose of her evening medication, despite later remembering that he had been told she had received her medication at 8pm. Ms 6 said that he could not explain why he had done it and admitted that he should have checked the MAR chart before he dispensed the tablets. He told her that Resident D had been fine overnight and that he had kept a close eye on her. This is supported by a contemporaneous record dated 14 July 2017 and signed by Ms 6.

Ms 7 confirmed that Mr Phinn had told her and Ms 6 at handover that he had made a medication error with Resident D. Ms 7 spoke about it to Resident D who was worried and upset because '*she knows what medication she takes and when'*. Ms 7 reported the incident to Ms 8 and wrote up an incident report.

In the records of the disciplinary hearing it is recorded by Ms 1, that Mr Phinn admitted that he had administered a second dose of evening medication to Resident D. He said that he had apologised to Resident D and that he had checked on her hourly to ensure that there were no ill-effects, however he did not record these checks.

The panel considered that the evidence before it supports the charge. The evidence from Ms 8, Ms 6 and Ms 7 was clear and consistent with the contemporaneous records. Further Mr Phinn admitted the medication error in a disciplinary hearing.

The panel concluded that it was more likely than not that on 12/13 July 2017, at around 11pm, in respect to Resident D, Mr Phinn administered a second evening dose of Trazodone and Simvastatin.

The panel therefore found this charge proved.

**Charge 3a)ii.a)**

ii. Following the error at 'i' failed to:-

a) Undertake observations

**This charge is found proved.**

In reaching this decision, the panel took into account Ms 8's oral and written evidence. The panel also had sight of Resident D's daily notes and MAR chart for 12/13 July 2017, the disciplinary meeting notes, dated 22 August 2017, and the disciplinary letter dated 23 August 2017.

The panel had regard to the notes of the disciplinary meeting on 22 August 2017. In these Mr Phinn said that he carried out observations, but not vital signs as he did not think this necessary. He said that he had gone into Resident D's room every hour to check her breathing. When asked if he documented this he said he could not remember.

The panel had regard to Resident D's daily notes which have no record of any observations on the night of 12/13 July 2017. The only entry by Mr Phinn reads *'[Resident D] has been fine. Settled after feed finished and appears to have settled well. No issues'*.

Ms 8 told the panel Mr Phinn should have undertaken observations of Resident D following the medication error as per the medication policy which was attached to each resident's MAR chart. The panel noted the policy is clear in relation to the steps which must be followed by the nurse in the event of a drug error which include '*Take vital signs for the client'* and '*Monitor and observe the client closely over 24-48 hours*'.

The panel considered that the policy makes it clear that Mr Phinn had a duty to undertake observations of Resident D following the medication error. The panel could see no record of any formal comprehensive observations of Resident D in the daily notes or on the MAR chart for 12/13 July 2017.

The panel concluded that it was more likely than not that on 12/13 July 2017 following the medication error described at charge 3a)i Mr Phinn failed to undertake observations of Resident D.

The panel therefore found this charge proved.

**Charge 3a)ii.b)**

ii. Following the error at 'i' failed to:-

b) Call a General Practitioner for advice

**This charge is found proved.**

In reaching this decision, the panel took into account Ms 8, Ms 6 and Ms 7's oral and written evidence. The panel also had sight of the incident report form dated 13 July 2017, Resident D's daily notes for 12/13 July 2017, the disciplinary meeting notes, dated 22 August 2017, and the disciplinary letter dated 23 August 2017.

The panel had regard to the notes of the disciplinary meeting on 22 August 2017. In these Mr Phinn said that his previous experience of the out of hour's service was that they would only advise to take observations. He said that if Resident D had felt any ill-effects she would have told him. When questioned about the potential side-effects of the medications he answered that in his opinion there was nothing to worry him enough to call someone.

Ms 8 told the panel that Mr Phinn should have contacted the General Practitioner (GP) following the medication error as per the medication policy which was attached to each resident's MAR chart. The panel noted the policy is clear in relation to the steps which must be followed by the nurse in the event of a drug error which include '*Report to GP immediately and receive further instruction of action to be taken'*. Ms 8 confirmed that there would have been an out of hour's GP available to call for any reason including for medication errors.

The panel considered that Ms 8's evidence along with the policy made it clear that Mr Phinn had a duty to contact the GP following the medication error and that he failed to do this. Ms MV's evidence supported this, she confirmed that she would expect a GP to be contacted following any medication administration error.

The panel concluded that it was more likely than not that on 12/13 July 2017 following the medication error described at charge 3a)i Mr Phinn failed to call a GP for advice.

The panel therefore found this charge proved.

South Grange Care Home

**Charge 4a)**

4. With respect to Resident E:-

    a) On 25 November 2017 administered a second morning dose of medications.

**This charge is found proved.**

In reaching this decision, the panel took into account Ms 12 and Ms 13's oral and written evidence. The panel also had regard to the MAR chart for Resident E on 25 and 26 November 2017, the near miss report and the notes of the investigatory meeting with Mr Phinn on 31 November 2017.

Ms 12 told the panel that she remembered handing over to Mr Phinn that she had given him a copy of the MAR chart showing all of the medications she had administered on 25 November 2017, including the morning medication at 6am. When she returned for her shift that evening Mr Phinn handed over to her. The MAR chart had already been signed by him for the following day's morning medications. Ms 12 told the panel that she was concerned by this, she had withheld the medication from Resident E and informed the manager. A medication check was then carried out and it became apparent that Resident E had received a double dose. Ms 12 completed a near miss report.

The near miss report, dated 26 November 2017, records that *'[Mr Phinn] administered the [morning medication] to Resident E on the morning of the 25th of November but signed it off on the [MAR chart] on the morning of the 26th of November. This is because the medication had been administered already by the night nurse. Double dose of the above medication was given to the resident that morning on the 25th November. On the morning of the 26th of November myself, the night nurse [Ms 12] was going to administer the medication to the resident at 06:30am when I noticed the signature already in the box for the 26th November, so I withheld the medication. I also asked [Mr Phinn] that morning if he had administered medication to Resident E on the morning of the 25th he stated yes…*'

The panel accepted that the MAR chart for Resident E shows that Mr Phinn administered a second dose of the morning medication on 25 November 2017.

The panel noted the minutes of the investigatory meeting held on 31 November 2017 between Ms 13 and Mr Phinn. Mr Phinn was asked if he recalled the incident and he stated that he did not as one day runs into the next. He told Ms 13 that he did not recall the incident at all.

In the minutes from a further investigatory meeting on 1 December 2017 Mr Phinn said that he was confused and could not recall the incident.

Ms 13 confirmed this in her evidence to the panel.

The panel considered that Ms 12 and Ms 13 were credible witnesses who were able to interpret and explain the MAR charts to the panel. Further, their evidence is backed up by contemporaneous evidence. The panel noted Mr Phinn's denial that he gave Resident E a second dose but concluded that his denial was based on his inability to remember the incident.

The panel concluded that it was more likely than not that, with respect to Resident E, on 25 November 2017 Mr Phinn administered a second morning dose of medications.

The panel therefore found this charge proved.

**Charge 4b)**

b) Recorded the dose at 'a)' as having been administered on 26 November 2017.

**This charge is found proved.**

In reaching this decision, the panel took into account its findings at charge 4a) along with the MAR chart for Resident E from 25/26 November 2017.

The panel considered that the signature in the MAR chart on 26 November 2017 appeared to be Mr Phinn's. The panel concluded that it was more likely than not that, with respect to Resident E, on 25 November 2017 Mr Phinn recorded the dose at charge 4a) as having been administered on 26 November 2017.

The panel therefore found this charge proved.

**Charge 4c)**

c) Failed to

i. Identify

the second dose at ‘a)’.

**This charge is found proved.**

In reaching this decision, the panel took into account the Safe Management of Medication document and Ms 13’s written witness statement.

Having taken into consideration the legal assessor’s advice regarding the weighing of hearsay evidence, the panel decided it could give considerable weight to Ms 13’s evidence.

Under ‘Drug Administration’ in the Safe Management of Medication document it specifies that when administering medication the person administering the medication needs to check – resident ready, MAR, Pharmacy label, confirm identity, administer medicine. This should all be done and the MAR chart only signed when the person is fully satisfied that the criteria have been met and that they have witnessed the resident take the medication.

The panel concluded that, because Mr Phinn administered a second dose of Resident E’s morning medication as found at charge 4a), he cannot have followed the criteria set out before he administered the medication.

The panel noted Ms 13’s written witness statement which stated *‘Don’t think [Mr Phinn] realised he’d given Resident E a double dose, as he had signed the wrong date on the MAR sheet. If he had realised he’d given a resident a double dose of medication I would have expected it to be reported to me or the head of unit. It should have been recorded on the medication errors, incidents and near misses report and entered on the clinical governance database. The GP would then have been alerted and we would take*

*direction from the GP on what they wanted us to do. After this the resident and the family should be informed*.'

The panel concluded that it was more likely than not that Mr Phinn failed to identify the second dose described at charge 4a).

The panel therefore found this charge proved.

**Charge 4c)**

c) Failed to

ii. Report

the second dose at 'a)'.

**This charge is found proved.**

The panel noted its finding that Mr Phinn failed to identify the second dose of the morning medication to Resident E.

It further noted that there is no evidence that Mr Phinn reported this. It was discovered and reported by Ms 12.

The panel concluded that it was more likely than not that Mr Phinn failed to report the second dose described at charge 4a).

The panel therefore found this charge proved.

**Charge 4c)**

c) Failed to

iii. Escalate

the second dose at ‘a)’.

**This charge is found proved.**

The panel noted its findings that Mr Phinn failed to identify or report the second dose of the morning medication to Resident E.

It further noted that there is no evidence that Mr Phinn escalated this.

The panel concluded that it was more likely than not that Mr Phinn failed to escalate the second dose described at charge 4a).

The panel therefore found this charge proved.

**Charge 5**

5. On 7 December 2017 failed to administer 75mg Aspirin to Resident G.

**This charge is found proved.**

In reaching this decision, the panel took into account Ms 13’s evidence and the MAR chart for Resident G dated 7 December 2017.

In her written NMC witness statement Ms 13 states: *‘There was a further medication error on 7 December 2017, Derek didn't administer or sign Resident G’s MAR sheet. He didn't administer the medication which was one 75 mg Asprin (sic) and the MAR chart reflects this as the box for this date is blank and the amount listed in the box for the following day is twenty eight. The error occurred on the medication changeover day which takes place every twenty eight days. If he had administered the Asprin (sic) as*

*prescribed he should have written twenty seven in the 7 December 2017 box on the MAR chart to reflect that being the number of tablets left. There was no harm to the resident and no risk to him not having been administered the asprin (sic).'*

The panel had regard to Resident G's MAR chart. From this it can be seen that 'DP' has signed for other medications on that morning's medication round. The panel noted that the box for Aspirin in the morning, as directed on the MAR chart, is blank. The following day the Aspirin is signed for as administered as given and a count of 27 is recorded afterwards. This indicates that the dose on the previous day had not been administered.

The panel considered there to be clear evidence that Mr Phinn did not administer Aspirin to Resident G on 7 December 2017.

It accepted Ms 13's investigation which is supported by the MAR chart for Resident G.

The panel concluded that it was more likely than not that Mr Phinn failed to administer 75mg Aspirin to Resident G on 7 December 2017.

The panel therefore found this charge proved.

**Charge 6**

6. On 22 November 2017 were verbally and/or physically aggressive to Resident F.

**This charge is found proved.**

In reaching this decision, the panel took into account Ms 10's written and oral evidence, her contemporaneous, signed statement dated 22 November 2017 and the investigatory meeting notes of 29 November 2017.

The panel considered Ms 10 to be a credible witness who clearly remembered this incident. She had found it concerning and had raised it immediately with the Home

Manager. She told the panel that the staff had been escorting residents back to their rooms after tea time and she had been walking behind Mr Phinn who was taking Resident F back to their room. Resident F was in a wheelchair. As she walked past she heard Resident F shout. She said that Mr Phinn had been about to leave the room but that he turned and went back into the room, she described seeing Mr Phinn, through the open door, go right up to Resident F and, facing him with one hand on either side of Resident F's wheelchair, push him across the length of the room. She told the panel that she hear Mr Phinn shout something like 'what did you say to me'. She described Mr Phinn as being completely in Resident F's face and Resident F looking scared. She told the panel that Mr Phinn was being quite menacing.

Ms 10 told the panel that she challenged Mr Phinn immediately. At first Mr Phinn had said it was just banter but Ms 10 described him becoming aggressive with her. She said she just told him again and again to get out of the room. She spoke with Resident F and asked if he was OK, to which his response was 'no'. She said that Resident F was not injured but that he was shaken up and she had provided reassurance to him before going to report it to the Home Manager.

Ms 10 provided that panel with some background on Resident F. She said that she knew him quite well, that he had a brain injury and could be quite cheeky and enjoyed a bit of banter. It was clear to the panel from Ms 10's evidence that it was well known by the staff that Resident F's behaviour could be challenging but that there were ways of dealing with this in an appropriate way and not in the manner described. The panel recognised that Ms 10 had obviously found the incident upsetting as did the resident.

In her oral evidence Ms 10 was consistent with her NMC statement and the statement she wrote shortly after the incident. She described and demonstrated for the panel the manner in which Mr Phinn had 'thumped' his hands down on Resident F's wheelchair before pushing it across the room with some force. She described the room in detail and said that the wheelchair had made contact with the wall. The panel considered that the action as detailed by Ms 10 could be described as physical aggression and that Mr Phinn did not have to have made physical contact with Resident F for this to have been physically aggressive.

The panel had regard to the investigatory meeting notes of 29 November 2017. It is recorded that in this meeting the incident was put to Mr Phinn who responded that it had all been part of the banter between Resident F and himself. He denied that he had acted in an aggressive manner towards Resident F. He said that he had been taken aback by Ms 10's reaction. When asked if he could appreciate how Ms 10 may have felt seeing this and thinking that it was inappropriate behaviour, Mr Phinn responded 'yes I do'.

The panel accepted Ms 10's evidence which was clear and consistent. She told the panel what she witnessed Mr Phinn doing and that Resident F was shaken and 'not ok'.

In all the circumstances the panel concluded that on 22 November 2017 Mr Phinn was verbally and physically aggressive to Resident F.

The panel therefore found this charge proved.

**Charge 7**

7. Around 19/20 November 2017 were verbally and/or physically aggressive to Colleague A.

**This charge is found proved.**

In reaching this decision, the panel took into account Ms 11's and Colleague A's oral and written evidence along with the notes of the investigatory meeting with Ms 13 on 29 November 2017.

The panel considered Colleague A's evidence. Colleague A had a detailed recollection of an incident which had clearly had a significant impact on him. He described the incident: '*I was carrying out fire training with staff at about tea time, which I had permission from the home manager to do. I heard [Mr Phinn] shouting up the corridor*

*"you guys dining room now" we were doing the training at the desk in the corridor. I told him "we're just finishing and I have permission to do this". He just walked away then came back, he was about halfway down the corridor from us he shouted "who the hell do you think told me". He just kept walking towards me, he looked very aggressive and walking firmly up the corridor. I was standing in the corridor and his aggression was directed at me not the girls on the training. He came right up to to my face at this point and his nose was about touching my nose. He was shouting in my face "I told you dining room now" I had to physically put my hand on his shoulder and say to him twice to back off my space. I felt fearful for myself… I did feel like he was going to physically harm me.'*

The panel noted that Colleague A's handwritten local statement dated 20 November 2017 and the handwritten NMC statement dated 20 April 2018 both corroborate the details of the incident as Colleague A described in his oral evidence to the panel NMC witness statement dated 30 September 2019. His local statement confirms the date as being 17 November 2017.

Colleague A told the panel that it had been the worst experience in his time working at South Grange. He said he had never been spoken to like that by a registered nurse before and he had worked at South Grange for a significant period of time. He said that he had reported the matter immediately to the home manager and that this had been the only time he had felt fearful when working on the floor. Colleague A told the panel that Mr Phinn had given an apology but that he did not feel like it was genuine, rather he felt like it had been an explanation of what was going on in Mr Phinn's life.

The panel next considered Ms 11's evidence. Ms 11 was a direct witness to the event. Ms 11 describes the incident in a similar way to Colleague A. She told the panel that Mr Phinn was '*very angry'* that when Colleague A told him he had permission to deliver training Mr Phinn said '*I don't care, I'm your boss'* and said '*you're a bastard'* under his breath as he walked away. She told the panel that the argument continued and Mr Phinn was angry and in Colleague A's face. She described Colleague A as being very upset and having looked scared. She told the panel that she had felt frightened by Mr Phinn's abusive and intimidating behaviour and had thought he was going to hit

Colleague A. She confirmed that Mr Phinn had apologised for the incident a couple of weeks later. Ms 11 confirmed that she reported the incident to the home manager that day. The panel noted that Ms 11's evidence was corroborated by a handwritten statement dated 17 November 2017 detailing the incident (as described above) on that day.

The panel considered that there was compelling evidence from witnesses which confirm that Mr Phinn acted in a verbally and physically aggressive way towards Colleague A. The panel noted that Mr Phinn was shouting at Colleague A and got very close to him, invading his personal space. The panel was clear that Mr Phinn had been the instigator in this incident.

Colleague A told the panel that he felt scared and intimidated by Mr Phinn's behaviour and the panel considered that the behaviour described would amount to verbally and physically aggressive behaviour.

Ms 13's written witness statement dated 20 April 2018 stated in relation to the investigatory meeting of 29 November 2017 '*I was a bit nervous about the meeting. [Mr Phinn] could be very defensive and I wasn't sure how he would take it. He was fine at the meeting, but denied much of what was alleged'*.

The panel noted that this alleged incident was put to Mr Phinn in the investigatory meeting on 29 November 2017 by Ms 13. The notes from this meeting record Mr Phinn's view of the incident. Mr Phinn accepted there was an incident which '*got out of hand'*. He denied that he shouted at Colleague A and said that Colleague A '*kept challenging me'.* When asked if he got in Colleague A's face in an intimidating manner Mr Phinn replied that he '*couldn't intimidate a fly'* adding that he and Colleague A had spoken since and were now getting on well. He concluded by saying that he apologised to everyone involved.

The panel noted Mr Phinn's acceptance that he needed to apologise to Colleague A and Ms 11. It considered that this implied that Mr Phinn recognised his behaviour was unacceptable.

The panel also noted that this was an incident between a registered nurse and a senior carer and was cognisant of the power imbalances that come with the relationship between the two roles. Ms 11 had told the panel that there was a feeling that the nurses did not always respect the views of the care assistants.

The panel was satisfied that there was evidence of an incident in which Mr Phinn acted in a verbally and physically aggressive way towards Colleague A. Ms 11 and Colleague A told the panel that Mr Phinn had been angry, was shouting and standing very close, “nose-to-nose”, with Colleague A. They described variously feeling scared, intimidated and fearful. This was clearly an incident which had left its mark on both Colleague A and Ms 11.

The panel finally considered whether to amend this charge. The evidence before the panel is clear that it relates to an incident between Mr Phinn and Colleague A on 17 November 2017. There is no other mention of any other similar incident. The panel concluded that the incident in question must be that of 17 November 2017. The panel considered that whilst it was pushing the boundaries of being around 19/20 November 2017, 17 November was within a couple of days of the dates in the charge and it was clear that this was the incident being referred to. The panel therefore did not see a need to amend the charge.

The panel therefore concluded that around 19/20 November 2017, specifically 17 November 2017, Mr Phinn was verbally and physically aggressive to Colleague A.

The panel therefore found this charge proved.

**Adjournment**

Mr Segovia reminded the panel that under Rule 32 (5) the panel should consider whether to make an interim order. He advised that this was not necessary in this case

as there was an interim order already in place on Mr Phinn's practice which covered the period past the scheduled resuming dates.

The panel accepted the advice of the legal assessor.

The panel noted Mr Segovia's submission and determined that it was not necessary for it to make an interim order at this stage.

Resumed Hearing

The panel resumed on 26 July 2021. Mr Phinn was not in attendance.

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Mr Phinn was not in attendance and that the Notice of Hearing had been sent to Mr Phinn's registered email address as shown on the electronic register on 22 March 2021.

Mr Segovia, 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 date and time of the virtual resuming hearing as well as the details to join the meeting. In the light of all of the information available, the panel was satisfied that Mr Phinn 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 Phinn**

The panel next considered whether it should proceed in the absence of Mr Phinn. It had regard to Rule 21 and heard the submissions of Mr Segovia who invited the panel to proceed in the absence of Mr Phinn. He submitted that this was a case where it could be said that Mr Phinn had voluntarily absented himself.

Mr Segovia informed the panel that Mr Phinn had been provided with a transcript of proceedings from 22 February – 3 March and 23 April 2021 and that Mr Phinn had sent the NMC an email on 25 May 2021 stating:

> *"I am going through the latest transcript and am very disappointed in missing statements I made regarding several incidents.*
>
> *It will take me a while but I am very unhappy that I am not being heard and my views are not heard.*
>
> *For instance, in the issue at Ballumbie and covert medication, this was done but only because HCAs advised that other staff did this. While I admit I should have taken the time to read her care plan there were other things going on in the ward and this person due to her disruptive condition was not allowing myself and others attend to matters.*
>
> *Again, Ballumbie and the lady falling from bed. She did not fall she slide from one level to another and due to her history of similar there was a mattress on the floor to prevent/minimise potential injuries.*
>
> *These are as far as I have managed to get and am sure you can understand my disappointment, I am not being represented in any kind of manner.*
>
> *I will continue to read these remarks but wish others to know that I want my side heard."*

Mr Segovia also referred the panel to the NMC's response to this email dated 26 May 2021 in which Mr Phinn was encouraged to attend this resuming hearing so that he

could put his views to the panel. Within the email the NMC Case officer also stated *"Please let me know if there are any specific statement that you would like me to ensure that the panel has access to at your resuming hearing."*

Mr Segovia informed the panel that Mr Phinn had not provided a statement or any new information. He submitted that given Mr Phinn's limited engagement with the NMC in relation to these proceedings there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted 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 and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

The panel decided to proceed in the absence of Mr Phinn. In reaching this decision, the panel considered the submissions of Mr Segovia, the email correspondence from Mr Phinn, and the advice of the legal assessor. It had particular regard to the factors set out in the decision *Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties.

The panel took account of an earlier email dated 12 October 2020 from Mr Phinn (in response to an email from the NMC) in which he stated: *'I am sorry but I shall not be attending at any time… I am sure the committee will manage to come to the right decision without me.'* In addition the panel noted a further email dated 14 January 2021, again in response to an email from the NMC, Mr Phinn stated '*I will not be joining this [hearing] at any time'*.

The panel noted that:

- No application for an adjournment has been made by Mr Phinn;
- No new information has been provided by Mr Phinn;

- There is no reason to suppose that adjourning would secure Mr Phinn's attendance at some future date;
- There is a strong public interest in the expeditious disposal of the case; and
- It may also be in Mr Phinn's interest for these matters to come to a conclusion.

In view of the fact that there had been no change of circumstances since the hearing adjourned on 23 April 2021, the panel decided that it was fair, appropriate and proportionate to proceed in the absence of Mr Phinn.

**Fitness to practise**

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Phinn'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 without restriction.

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

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

**Submissions on misconduct and impairment**

Mr Segovia identified the specific, relevant standards of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) where Mr Phinn's actions amounted to misconduct. He submitted that the concerns around Mr Phinn's practice were wide ranging, occurred in four different settings, and continued throughout most of 2017. On this basis Mr Segovia invited the panel to take the view that the facts found proved amount to misconduct.

Mr Segovia 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. This included reference to the caseof *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Segovia, highlighted to the panel that the facts found proved included aggressive behaviour towards a patient and a colleague as well as conduct which exposed patients to risk of harm. He submitted that Mr Phinn's aggressive conduct was particularly worrying. Mr Segovia submitted that in this case limbs a, b, and c of the Grant test were engaged.

Mr Segovia submitted that on the whole, looking at the facts cumulatively, Mr Phinn's misconduct fell short of the standards expected of a registered nurse. He therefore invited the panel to find that, taken together, Mr Phinn's breaches of the Code, in the absence of sufficient insight and remediation, amount to current impairment.

**Decision and reasons on misconduct**

The panel accepted the advice of the legal assessor which included reference to *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

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

***1 Treat people as individuals and uphold their dignity***

*To achieve this, you must:*

*1.1 treat people with kindness, respect and compassion*

*1.2 make sure you deliver the fundamentals of care effectively*

*1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay, and*

*1.5 respect and uphold people's human rights*

***8 Work cooperatively***

*To achieve this, you must:*

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

*8.2 maintain effective communication with colleagues*

*8.5 work with colleagues to preserve the safety of those receiving care*

***10 Keep clear and accurate records relevant to your practice***

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

*To achieve this, you must:*

*10.1 complete all 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*

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

*To achieve this, you must:*

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

*13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment*

***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*

***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*

*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*

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the concerns in this case were serious and covered a range of basic nursing responsibilities.

The panel bore in mind that the facts found proved included repeated medicines management and administration issues, repeated drug errors, the failure to escalate a patient to the GP, as well as behavioural concerns. The issues spanned from February 2017 to December 2017 and with this in mind the panel considered the facts found proven in this case to represent a pattern of sustained misconduct. Particularly concerning were Mr Phinn's aggressive behaviour towards a patient and a colleague as well as the delivery of care, and continued medicines management issues.

The panel considered that any nurse would find Mr Phinn's misconduct deplorable, in particular Mr Phinn's behaviour towards his colleges and patients. The panel reached

the view that Mr Phinn's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

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

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *…*

The panel finds that patients were put at risk of physical and emotional harm as a result of Mr Phinn's misconduct. Mr Phinn's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case is capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Phinn has remedied his practice.

In addition to repeated medicines management and administration issues, repeated drug errors, the failure to escalate a patient to the GP, there was evidence before the panel of unacceptable behaviour. It has been found proven that Mr Phinn was verbally and physically aggressive.

While Mr Phinn's misconduct is remediable, the panel considered any remediation to begin with insight. Notwithstanding any admissions made at the disciplinary hearing, the panel concluded that there was no evidence of any insight or remediation. Further, there was nothing before the panel to suggest that Mr Phinn was at all remorseful.

The panel considered limbs a, b, and c of the Grant test to be engaged in this case. Given the absence of any significant insight and remediation the panel is of the view that there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

Due to the number and range of concerns in this case the panel determined that a finding of impairment on public interest grounds is required. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Phinn's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Phinn'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 Mr Phinn off the register. The effect of this order is that the NMC register will show that Mr Phinn has been struck-off the register.

**Submissions on sanction**

Mr Segovia informed the panel that in the Notice of Hearing, dated 17 December 2020, the NMC had advised Mr Phinn that it would seek a striking-off order if the panel were to find his fitness to practise currently impaired.

Mr Segovia informed the panel that in August 2017 Mr Phinn was made subject to an interim conditions of practice order which was changed to an interim suspension order in December 2017. From that time Mr Phinn has been unable to practise as a nurse. Therefore, he will not have been able to remediate his misconduct by demonstrating safe and effective practice as a registered nurse during the suspension period. However, the panel also took into account that Mr Phinn has not provided any evidence of remediation addressing the relevant issues from any other setting or working environment.

Mr Segovia highlighted the following aggravating factors in Mr Phinn's case:

- The absence of insight, remediation or remorse;
- Pattern of sustained and wide ranging misconduct;
- Serious case involving basic nursing responsibilities;
- Patients exposed to potential risk of harm;
- Mr Phinn's breach of a position of trust.

Mr Segovia submitted that there was no evidence of any mitigation.

In the circumstances of this case, Mr Segovia invited the panel to strike Mr Phinn's name from the NMC Register.

**Decision and reasons on sanction**

Having found Mr Phinn'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.

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

by the NMC. The panel accepted the advice of the legal assessor. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The absence of insight, remediation or remorse;
- Pattern of misconduct over a sustained period of time;
- The misconduct occurred across four different care homes;
- Patients were exposed to a risk of harm;
- Mr Phinn's misconduct involved vulnerable patients as well as his colleagues.

The panel was not provided with any evidence from Mr Phinn that could be considered as mitigation. However, the panel took account of the interview notes from July 2017, which were admitted into evidence, and included reference to difficult personal circumstances and financial stressors which Mr Phinn was experiencing at the time.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the public protection issues identified. 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 Mr Phinn's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Phinn's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Phinn's registration would be a sufficient and appropriate response. The panel was of the view that conditions of practice could be formulated to address the clinical issues raised in

this case, albeit recognising that the behavioural issues found proved could be more challenging to address. However, considering Mr Phinn's lack of engagement and insight, the panel could not be satisfied that he would be willing or able to comply with any conditions imposed. The panel concluded that the placing of conditions on Mr Phinn's registration would not protect the public nor would it adequately address the seriousness of his misconduct and meet the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel decided that Mr Phinn's misconduct was not a single instance, as it was repeated across four care homes over a period of 11 months. The panel also had concerns around Mr Phinn's behaviour towards vulnerable patients and to colleagues. Further, there was no evidence before the panel that Mr Phinn had insight into the concerns. While a suspension order would protect the public, the conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Phinn's actions is fundamentally incompatible with Mr Phinn remaining on the register.

The panel considered Mr Phinn's lack of meaningful engagement with the NMC as his regulator, along with his failure to take responsibility for his past actions, suggested that he is unlikely to begin to remediate his misconduct in the future. There was nothing before the panel to suggest that a further period of suspension would serve any useful purpose. The panel determined that a suspension order would only undermine public

confidence in the NMC as a regulator and would not be sufficient to meet the public interest.

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?*

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

Whilst a striking-off order is not the only order that would protect the public, the panel consider that it is needed to address the public interest in the particular circumstances of this case. Public confidence in the nursing profession and in the NMC as its regulator would be undermined if a striking-off order was not made.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to all of Mr Phinn's actions the panel concluded that nothing short of a striking-off order would be sufficient in this case.

The panel considered that this striking-off 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.

**Interim order**

The striking-off order cannot take effect until the end of the 28-day appeal period, or if an appeal is lodged then until that appeal is disposed of. The panel therefore considered whether an interim order is required. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Phinn's own interest. The panel took account of the submissions of Mr Segovia on behalf of the NMC and accepted the advice of the legal assessor.

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

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

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

That concludes this determination.