Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
07-10 June 2021

Nursing and Midwifery Council
Virtual Hearing

Name of registrant:	Michala Jayne Clair Gough
NMC PIN:	08F0768E
Part(s) of the register:	Nursing – sub part 1 RNA: Registered Nurse – Adult – 11 November 2008
Area of registered address:	Birmingham
Type of case:	Misconduct
Panel members:	Nick Cook (Chair, Lay member) Terry Shipperley (Registrant member) Derek McFaull (Lay member)
Legal Assessor:	Andrew Young
Panel Secretary:	Amira Ahmed
Nursing and Midwifery Council:	Represented by Callum Munday, Case Presenter
Miss Gough:	Not present and not represented
Facts proved:	All
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Gough was not in attendance and that the Notice of Hearing letter had been sent to Miss Gough's registered email address on 04 May 2021.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and venue of the hearing and, amongst other things, information about Miss Gough's right to attend, to be represented and to call evidence, as well as the panel's power to proceed in her absence.

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

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Gough 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 Miss Gough

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

Mr Munday submitted that there had been no engagement at all by Miss Gough with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her 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'*.

The panel has decided to proceed in the absence of Miss Gough. In reaching this decision, the panel has considered the submissions of Mr Munday and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that no application for an adjournment has been made by Miss Gough; she has not engaged with the NMC and has not responded to any of the emails sent to her about this hearing; Miss Gough indicated at her disciplinary meeting that she would not attend any NMC proceedings. There is no reason to suppose that adjourning would secure her attendance at some future date and there is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Gough in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

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

Details of charge (as amended)

That you, a registered nurse:

1. On 13 June 2019, failed to administer three packets of Aymes shakes which had been prescribed to one or more of the Residents identified in Schedule 1;

2. On 13 June 2019 recorded on the MAR ~~charges~~ **charts** of one or more of the Residents identified in Schedule 1 that you had administered medication **or supplements** to them when this was not correct;

3. Your actions at Charge 2 were dishonest as you knew that you had disposed of the medication **or supplements** and had sought to mislead your colleagues into believing that medication **or supplements** had been administered;

4. On 14 June 2019 failed to administer one or more of the following medications **or supplements** which had been prescribed to one or more of the Residents identified in Schedule 1:

a. *Fluoxetine;*
b. *Sertraline;*
c. *Citalopram;*
d. *Escitalopram;*
e. *Risperidone;*
f. *Ferrous sulphate;*
g. *Cyanocobalamin;*
h. *Fultium;*
i. *Folic acid;*
j. *Paracetamol;*
k. *Amoxicillin;*
l. *Docusate sodium;*
m. *Ispaghula Husk;*

n. *Laxido Orange;*

o. *Mesalazine;*

p. *Ranitidine;*

q. *Oxybutynin;*

r. *Pregabalin;*

s. *Gabapentin;*

t. *Carbamazepine;*

u. *Ramipril;*

v. *Digoxin;*

w. *Amlodipine;*

x. *Aspirin;*

y. *Bisoprolol;*

z. *Nebivolol;*

aa. *Enalapril;*

bb. ,*Furosemide;*

cc. *Tildiem;*

dd. *Memantine;*

ee. *Co-careldopa;*

ff. *Exemestane;*

gg. *Cellusvisc;*

hh. *Carmellose;*,

ii. *Baclofen;*

jj. *Ad Cal;*

kk. *Calcium carbonate;*

ll. *Carbocisteine;*

mm. *Tiotropium;*

nn. *Apixaban;*

oo. *Clopidogrel;*,

pp. *Aymes shakes;*

qq. *Forti crème;*

rr. *Fortisip;*

5. On 14 June 2019 recorded on the MAR ~~charges~~ **charts** of one or more of the Residents identified in Schedule 1 that you had administered medication **or supplements** to them when this was not correct;

6. Your actions at Charge 5 were dishonest as you knew that you had disposed of the medication **or supplements** and had sought to mislead your colleagues into believing that medication **or supplements** had been administered;

7. On 17 June 2019 failed to administer one or more of the following medications **or supplements** which had been prescribed to one or more of the Residents identified in Schedule 1:

a. *Fluoxetine;*
b. *Sertraline;*
c. *Citalopram;*
d. *Escitalopram;*
e. *Risperidone;*
f. *Ferrous sulphate;*
g. *Cyanocobalamin;*
h. *Fultium;*
i. *Folic acid;*
j. *Paracetamol;*
k. *Amoxicillin;*
l. *Docusate sodium;*
m. *Ispaghula Husk;*
n. *Laxido Orange;*
o. *Mesalazine;*
p. *Ranitidine;*
q. *Oxybutynin;*
r. *Pregabalin;*
s. *Gabapentin;*

t. *Carbamazepine;*

u. *Ramipril;*

v. *Digoxin;*

w. *Amlodipine*

x. *Aspirin;*

y. *Bisoprolo;*

z. *Nebivolol;*

aa. *Enalapril;*

bb. *Furosemide;*

cc. *Tildiem;*

dd. *Memantine;*,

ee. *Co-careldopa;*

ff. *Exemestane;*

gg. *Cellusvisc;*

hh. *Carmellose;*

ii. *Baclofen;*

jj. *Ad Cal;*

kk. *Calcium carbonate;*

ll. *Carbocisteine;*

mm. *Tiotropium;*

nn. *Apixaban;*

oo. *Clopidogrel;*

pp. *Aymes shakes;*

qq. *Forti crème;*

rr. *Fortisip;*,

8. On 17 June 2019 made inaccurate entries on the MAR charts of one or more of the Residents identified in Schedule 1;

9. Your actions at Charge 8 were dishonest as you knew that you had disposed of the medication **or supplements** and had sought to mislead your colleagues into believing that medication **or supplements** had been administered;

10. Disposed of medication **or supplements** in an unsecured general waste bin on:
a. 13 June 2019;
b. 14 June 2019;
c. 17 June 2019

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

Schedule 1

Resident A
Resident B
Resident C
Resident D
Resident E
Resident F
Resident G
Resident H
Resident I
Resident J
Resident K
Resident L
Resident M
Resident N
Resident O
Resident P
Resident Q

Resident R
Resident S
Resident T
Resident U
Resident V
Resident W
Resident X
Resident Y

Decision and reasons on application to amend the charges

The panel of its own volition decided to amend the wording of charges 2 and 5.

The proposed amendment was to change the typographical error 'MAR charges' to 'MAR charts'. The proposed amendment would provide clarity and more accurately reflect the evidence.

Mr Munday did not oppose this amendment.

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

The panel accordingly amended the charges (2 and 5) to:

> *"2. On 13 June 2019 recorded on the MAR ~~charges~~* ***charts*** *of one or more of the Residents identified in Schedule 1 that you had administered medication to them when this was not correct;*
>
> *5. On 14 June 2019 recorded on the MAR ~~charges~~* ***charts*** *of one or more of the Residents identified in Schedule 1 that you had administered medication to them when this was not correct;"*

Mr Munday before providing his closing submissions to the panel submitted that charges 2, 3 (both parts), 4, 5, 6 (both parts), 7, 9 (both parts) and 10 should be amended to change where it says ‘medication’ to say ‘medications or supplements’ on the basis that supplements were not, strictly speaking, medications but were prescribed for residents for health reasons. Management at Berwood Court Care Home (“the Home”) confirmed that such supplements were deemed as medications for all procedural purposes.

The panel accepted the advice of the legal assessor.

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

Background

The charges arose whilst Miss Gough was employed as a registered nurse by the Home. The NMC received a referral from the Home on 31 July 2019. It is alleged that on three separate dates (13, 14 and 17 June 2019) Miss Gough failed to administer prescribed medications or supplements to up to 25 patients in her care. It is further alleged that Miss Gough had signed patients' medical records (MAR charts) to record that the medication had been given.

It is alleged that Miss Gough then inappropriately disposed of the medications or supplements into an unsecure general waste bin, contrary to the Home's prescribed medication disposal policy. Miss Gough's actions came to light on 13 June 2019 as a senior healthcare assistant (Ms 1) discovered medication or supplements in the general waste bin which was unopened and still in date. Ms 1 discussed this with Miss Gough who informed her that the medication or supplements were out of date and that she had found it in the drug trolley and decided that as it was no longer in date and should be discarded. This raised Ms 1's suspicion and the following day she observed Miss Gough and saw her place the bin bag from the drug trolley, into the lounge bin. The lounge bin was checked by Ms 1 and medication or supplements were recovered. The same thing happened on a further date and the matter was subsequently reported to the Home Manager by Ms 1.

At the first meeting with the Home Manager on 19 June 2019, Miss Gough denied the allegations. A further meeting took place the next day on 20 June 2019 and it is then that Miss Gough admitted to falsifying medication administration records and admitted to disposing of prescribed medication or supplements in the unsecured general waste bin. She admitted that she had failed to follow company policies and procedures and on the dates identified, she had not given medication or supplements to patients as required.

It is therefore alleged that Miss Gough was dishonest as she knew that she had disposed of the medication or supplements and had sought to mislead her colleagues into believing that medication or supplements had been administered.

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 Munday on behalf of the NMC.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Ms 1: Senior Healthcare Assistant at the Home at the time of the events.
- Ms 2: Home Manager at the Home at the time of the events.
- Ms 3: Deputy Home Manager at the Home at the time of the events.

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

The panel considered the evidence of the witnesses and reached the following conclusions:

The panel considered the evidence of Ms 1 to be concise and she was able to answer questions that were asked to the best of her ability. The panel found her to be credible and reliable.

The panel found Ms 2 to be professional, confident and clear. The panel noted that she had general good recall and found her to be credible and reliable.

The panel considered Ms 3's evidence to be clear but noted that she was not a key witness to the allegations. It found her evidence credible and reliable.

Before making any findings on fact the panel noted that the eye witness evidence from Ms 1 that the medication was disposed of incorrectly according to the company's policy. The panel also noted that at the Home supplements were treated as medication and should have been disposed of as such.

The panel heard live evidence from Ms 2 and Ms 3 regarding the duties of Miss Gough and also had sight of her job description in which the administration of medication or supplements was a core role. As this is a failure of duty case, the panel was satisfied that Miss Gough had a duty to administer medication or supplements to residents under her care.

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

Charge 1

1. On 13 June 2019, failed to administer three packets of Aymes shakes which had been prescribed to one or more of the Residents identified in Schedule 1;

This charge is found proved.

The panel noted Ms 1's witness statement, contemporaneous statement dated 18 June 2019 and live evidence which were all consistent in that the Aymes shakes were found by her in the general waste bin.

The panel also took account of Miss Gough's admissions in the disciplinary meeting when asked whether she felt that she had failed in her responsibilities as a nurse, she stated yes. She also admitted to placing the medication or supplements in the general waste bin.

Therefore the panel found charge 1 proved as Miss Gough had failed to administer three packets of Aymes shakes which had been prescribed to one or more of the Residents identified in Schedule 1.

Charge 2)

2. On 13 June 2019 recorded on the MAR ~~charges~~ **charts** of one or more of the Residents identified in Schedule 1 that you had administered medication **or supplements** to them when this was not correct;

This charge is found proved.

In reaching this decision, the panel took into account Ms 2's written statement, oral evidence and exhibits which show that Miss Gough did incorrectly record on the MAR charts that she administered the medication or supplements when she did not.

The panel noted that there was evidence from the MAR charts that four residents should have received the Aymes shakes and that three packets having been found disposed of in the bin bag indicated that three out of the four residents did not receive it.

On the balance of probability the panel determined that one or more of the residents identified did not receive the Aymes shakes although in the MAR charts it was recorded that all four residents had received them.

Charge 3)

3. Your actions at Charge 2 were dishonest as you knew that you had disposed of the medication **or supplements** and had sought to mislead your colleagues into believing that medication **or supplements** had been administered;

This charge is found proved.

The panel are satisfied that the medication had not been administered to the residents. The panel took into account the case of *Ivey v. Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 when looking at the issue of dishonesty. It noted that on signing the MAR charts Miss Gough sought to mislead her colleagues into believing that medication or supplements had been administered as prescribed.

The panel also noted that a decent/ordinary person would find this to be dishonest as it was Miss Gough's duty to record accurate information and she would have known that her actions were dishonest at the time. It further noted the investigation meeting minutes on 22 July 2019 in which she was asked whether she was willing to admit signing for medication she had not given was fraud and she answered yes.

The panel therefore found charge 3 proved.

Charge 4)

4. On 14 June 2019 failed to administer one or more of the following medications **or supplements** which had been prescribed to one or more of the Residents identified in Schedule 1:

This charge is found proved.

The panel noted Ms 1's contemporaneous statement dated 18 June 2019 which was confirmed in the notes of the investigation meeting dated 22 July 2019, her oral evidence and written statement. It also noted all of the medications in schedule 1 and Miss Gough's admission at the investigation meeting (CM/28) and disciplinary meeting (LB/6) to failing to administer the medications or supplements that were identified.

The panel concluded that it found charge 4 proved as the evidence has shown that 44 different drugs and supplements were not administered to up to 25 patients.

Charge 5)

5. On 14 June 2019 recorded on the MAR ~~charges~~ **charts** of one or more of the Residents identified in Schedule 1 that you had administered medication **or supplements** to them when this was not correct;

This charge is found proved.

The panel had sight of the MAR charts (CM/3) and noted that they clearly indicate that Miss Gough had recorded that she had administered the medication or supplements on 14 June 2019 when she did not. The panel noted the admissions to this by Miss Gough in both the investigation meeting and disciplinary hearing.

The panel also noted the images taken that were exhibited of the discarded medication or supplements recovered by Ms 1 from the general waste bin. It determined that charge 5 was therefore found proved.

Charge 6)

6. Your actions at Charge 5 were dishonest as you knew that you had disposed of the medication **or supplements** and had sought to mislead your colleagues into believing that medication **or supplements** had been administered;

This charge is found proved.

The panel are satisfied that the medication had not been administered to the residents on 14 June 2019. The panel took into account the case of *Ivey v. Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67 when looking at the issue of dishonesty. It noted that on signing the MAR charts Miss Gough sought to mislead her colleagues into believing that medication or supplements had been administered as prescribed.

The panel also noted that a decent/ordinary person would find this to be dishonest as it was Miss Gough's duty to record accurate information and she would have known that her actions were dishonest at the time. It further noted the investigation meeting minutes on 22 July 2019 in which she was asked whether she was willing to admit signing for medication she had not given was fraud and she answered yes.

The panel therefore found charge 6 proved.

Charge 7)

7. On 17 June 2019 failed to administer one or more of the following medications **or supplements** which had been prescribed to one or more of the Residents identified in Schedule 1:

This charge is found proved.

The panel noted Ms 1's contemporaneous statement dated 18 June 2019 which was confirmed in the notes of the investigation meeting dated 22 July 2019, her oral evidence and written statement. It also noted all of the medications in schedule 1 and Miss Gough's

admission at the investigation meeting (CM/28) and disciplinary meeting (LB/6) to failing to administer the medications or supplements that were identified.

The panel concluded that it found charge 7 proved as the evidence has shown that 44 different drugs and supplements were not administered to up to 25 patients.

Charge 8)

8. On 17 June 2019 made inaccurate entries on the MAR charts of one or more of the Residents identified in Schedule 1;

This charge is found proved.

The panel had sight of the MAR charts (CM/3) and noted that they clearly indicate that Miss Gough had recorded that she had administered the medication or supplements on 17 June 2019 when she did not. The panel noted the admissions to this by Miss Gough in both the investigation meeting and disciplinary hearing.

The panel also noted the images taken that were exhibited of the discarded medication or supplements recovered by Ms 1 from the general waste bin. It determined that charge 8 was therefore found proved.

Charge 9)

9. Your actions at Charge 8 were dishonest as you knew that you had disposed of the medication **or supplements** and had sought to mislead your colleagues into believing that medication **or supplements** had been administered;

This charge is found proved.

The panel are satisfied that the medication had not been administered to the residents on 14 June 2019. The panel took into account the case of *Ivey v. Genting Casinos (UK) Ltd*

t/a Crockfords [2017] UKSC 67 when looking at the issue of dishonesty. It noted that on signing the MAR charts Miss Gough sought to mislead her colleagues into believing that medication or supplements had been administered as prescribed.

The panel also noted that a decent/ordinary person would find this to be dishonest as it was Miss Gough's duty to record accurate information and she would have known that her actions were dishonest at the time. It further noted the investigation meeting minutes on 22 July 2019 in which she was asked whether she was willing to admit signing for medication she had not given was fraud and she answered yes.

The panel therefore found charge 9 proved.

Charge 10)

10. Disposed of medication **or supplements** in an unsecured general waste bin on:
a. 13 June 2019;
b. 14 June 2019;
c. 17 June 2019

The panel took account of the written and oral evidence provided by Ms 1. It found that as the nutritional supplement of Aymes shakes were treated, in the Home, as clinical medication they should have been disposed of according to the Home's medication management policy on 13 June 2019, but were instead disposed of in an unsecured general waste bin. The panel also found that on 14 and 17 June 2019 much of the medication and supplements prescribed for the residents identified in schedule 1 were also disposed of in an unsecured general waste bin.

Therefore the panel found charge 10 proved in its entirety.

Submissions on misconduct

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

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

Mr Munday submitted that there was a real risk of harm to patients and that Miss Gough's actions did fall significantly short of that expected of a registered nurse. He explained that she deprived vulnerable residents of important medication including, antibiotics and blood thinners heightening the risk of stroke and other diseases.

Submissions on impairment

Mr Munday 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Munday submitted that that a finding of current impairment is required in order to protect the public and to maintain public confidence in the professions.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

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

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

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

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

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…

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 Miss Gough was in breach of all the above areas of the Code.

The panel also found that Miss Gough had failed to administer medication or supplements to a large number of vulnerable patients on more than one occasion. Miss Gough then went on to dishonestly falsify residents' records in an attempt to deceive others into

believing that those medicines or supplements had been administered. Furthermore in an effort to conceal her deception she placed dangerous and harmful medication into a general waste bin, accessible to residents and members of the public alike. The panel considered these actions fell seriously short of the standards required of a registered nurse, presented a real risk of serious harm to residents and amounted to serious misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.’*

The panel found that residents were put at risk as a result of Miss Gough’s misconduct. Miss Gough’s misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Furthermore the panel found that Miss Gough had acted dishonestly and it was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. The panel had no evidence before it to believe that this conduct would not be repeated in the future.

Regarding insight, the panel considered that it heard no evidence in regards to remorse or remediation from Miss Gough and only very limited evidence of insight from what was said by Miss Gough at her disciplinary meeting at the Home. The panel noted that she has not engaged with the NMC proceedings at all. The panel therefore determined that there is a

risk of repetition. The panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel 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 Miss Gough's fitness to practise impaired on the grounds of public interest.

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

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

Submissions on sanction

Mr Munday submitted that there were two stages of dishonesty in this case. He explained that Ms Gough concealed not giving the drugs to the residents and then falsified the MAR charts. Mr Munday outlined a number of mitigating and aggravating features in this case.

He indicated that the panel should consider the need for proportionality, balancing the needs of Miss Gough against the requirement to protect the public as well as upholding public confidence in the regulatory process. He submitted that the most appropriate sanction in this case is a striking off order due to the seriousness of the facts found proved.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Ms Gough's conduct created a direct risk of harm to vulnerable residents;
- Her dishonest actions were repeated on three days over a five day period;
- The unsafe disposal of medications potentially putting residents and others at risk;
- Ms Gough's serious attitudinal issues by attempting to cover up actions by falsifying records.

The panel also took into account the following mitigating feature:

- Ms Gough was previously very well thought of at the Home as a caring and competent nurse.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Gough'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 Miss Gough'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 Miss Gough's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and the lack of engagement by Miss Gough. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Gough's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The 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 Miss Gough's actions and her failure to engage with the regulatory process or to show any remediation, remorse or further insight is fundamentally incompatible with her remaining on the register.

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

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

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

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

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

This will be confirmed to Miss Gough in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Munday. He submitted that an 18 months interim suspension order would be appropriate in this case and would be in line with other findings made by the panel.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the 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 therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination