Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 22 August 2022 – Friday 26 August 2022

Virtual Hearing

Name of registrant:	**David John Martyn**
NMC PIN:	08I2147E
Part(s) of the register:	RNA, Registered Nurse – Adult September 2008
Relevant Location:	Lancashire
Type of case:	Misconduct
Panel members:	David Evans (Chair, Lay member) Mary Jane Scattergood (Registrant member) Alison Hayle (Lay member)
Legal Assessor:	John Bromley Davenport QC
Hearings Coordinator:	Emma Bland
Nursing and Midwifery Council:	Represented by Jessica Ward, Case Presenter
Mr Martyn:	Not present and unrepresented
Facts proved:	Charges 1, 2, 4 (1) a – c, 4 (2), 4 (3), 5 (1) – (6), and 6 (1) – (2)
Facts not proved:	Charges 3 a - b
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 Martyn was not in attendance and that the Notice of Hearing letter had been sent to Mr Martyn's registered email address on 19 July 2022.

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

The panel accepted the advice of the legal assessor.

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

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

The panel next considered whether it should proceed in the absence of Mr Martyn. It had regard to Rule 21 and heard the submissions of Ms Ward.

Mr Martyn had previously engaged with the NMC and stated that he would attend the hearing. However, [PRIVATE], he informed the NMC by email that he could no longer attend. In fairness to Mr Martyn, the hearing was adjourned on Monday 22 August 2022 to allow sufficient time for the NMC to contact Mr Martyn and invite him to consider his options, namely, whether he wanted to apply for an adjournment or whether he was content for the hearing to proceed in his absence.

Ms Ward referred the panel to an email from Mr Martyn dated 22 August 2022 at 17:41 hours which stated, *'Please send my apologies to the panel. Please go ahead with the case'*. In light of this email communication, Ms Ward invited the panel to continue in the absence of Mr Martyn. Ms Ward submitted that Mr Martyn had voluntarily absented himself.

The panel accepted the advice of the legal assessor.

The panel has decided to proceed in the absence of Mr Martyn. In reaching this decision, the panel has considered the submissions of Ms Ward, an email from Mr Martyn dated 22 August 2022, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Martyn;
- Mr Martyn has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- Mr Martyn has stated *'Please go ahead with the case'* in his email to the NMC dated 22 August 2022;
- Two witnesses are arranged to attend the hearing to give live evidence;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Martyn in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email address, 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 Martyn's decisions to absent himself from the hearing, to not request an adjournment, waive his rights to attend, and/or be represented, and to not provide further 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 Martyn. The panel will draw no adverse inference from Mr Martyn's absence in its findings of fact.

Decision and reasons on the joinder application pursuant to Rule 29

Ms Ward, on behalf of the NMC, made an application for charges stemming from two separate referrals to the NMC to be heard together. The application was made pursuant to Rule 29(3) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules):

Joinder

29.

> *(2) The Fitness to Practise Committee may consider one or more categories of allegation against a registrant provided always that an allegation relating to a conviction or caution is heard after any allegation of misconduct has been heard and determined.*
>
> *(3) Where –*
>
> > *(a) an allegation has been referred to the Fitness to Practise Committee;*
> > *(b) that allegation has not yet been heard; and*
> > *(c) a new allegation which is of a similar kind or is founded on the same facts is received by the Council,*
>
> *that Committee may consider the new allegation at the same time as the original allegation, notwithstanding that such new allegation has not been included in the notice of hearing.*

The panel accepted the advice of the legal assessor.

The panel was satisfied that it would not cause Mr Martyn any prejudice if the two cases were joined together and further noted that Mr Martyn had consented for the cases to be joined before the start of this hearing. Therefore, the panel determined to hear charges stemming from two separate referrals together (NMC case references 077582 and 075784).

Details of charge

That you, a registered nurse, whilst working at the Mance Nursing Home [the "Home"]

1. On the 6th December 2019, omitted to provide an injection of 40mg/0.8 ml of Adalimumab to Patient A

2. Despite this omission, you recorded in Patient A's MAR that you had given her the injection.

3. Your action at 2 was dishonest in that
   (a) You purported to record a successful injection in the MAR record.
   (b) You knew that you had not provided such an injection

4. In or about April 2020, failed to exit the covid insulation unit by the dirty exit and instead returned to the Home by the clean entrance thereby exposing others to the risk of contamination.

5. On the 7th April 2020, failed to follow the Home's Covid 19 infection control policy [the "policy"] whilst in the covid insulation unit

   (1) you omitted to wear the relevant PPE, namely

      (a) An apron
      (b) Gloves
      (c) Hair covering.

   (2) Entered into residents' rooms without the protective clothing at (1)

   (3) Carried clinical waste and/or a commode without the protective clothing at (1)

(4) Omitted to change your clothes and/or wash your hands after (3) and before returning to the care of residents.

6. On the 9th April 2020, contrary to the policy

(1) Entered the covid insulation unit without PPE clothing.
(2) Gave care to individual residents without wearing PPE clothing.
(3) Handled a bed pan without gloves.
(4) Were in the process of leaving the covid insulation unit by the clean entrance when countermanded not to do so.
(5) Colleague 1 had to re-educate you in your obligations to comply with all the requirements to wear PPE, obligations you undertook not to breach again.

7. On the 10th April, notwithstanding 6 (5) and contrary to policy

(1) You deliberately and/or wilfully and/or negligently entered the covid insulation unit without PPE clothing.

(2) Left the unit by the clean entrance thereby exposing others to the risk of cross contamination

And in the light of the above, your fitness to practise is impaired by virtue of your misconduct.

Decision and reasons on application to amend the charge

Following the conclusion of oral witness evidence, the panel heard an application made by Ms Ward, on behalf of the NMC, to amend the wording of a number of charges.

It was submitted by Ms Ward that the following proposed amendments would provide clarity and more accurately reflect the evidence:

That you, a registered nurse, whilst working at the Mance Nursing Home [the "Home"]

1. On the 6th December 2019, omitted to provide an injection of 40mg/0.8 ml of Adalimumab to patient A.

2. Despite this omission, you recorded in Patient A's MAR that you had given her the injection.

3. Your action at 2 was dishonest in that

   (a) You purported to record a successful injection in the MAR record.

   (b) You knew that you had not provided such an injection

~~4. In or about April 2020, failed to exit the covid insulation unit by the dirty exit and instead returned to the Home by the clean entrance thereby exposing others to the risk of contamination.~~

4. **Between 1st and 9th April 2020** ~~On the 7th April 2020~~ **on one or more occasions**, failed to follow the Home's Covid 19 infection control policy [the "policy"] whilst in the covid insulation unit

   (1) you omitted to wear the relevant PPE, namely

      (a) An apron

      (b) Gloves

      (c) Hair covering.

   (2) ~~Entered into residents' rooms without the protective clothing at (1)~~

   (3) Carried clinical waste ~~and/or a commode~~ without the protective clothing at (1)

   (4) Omitted to change your clothes and/or wash your hands after (3) and before returning to the care of residents.

5. On the 9th April 2020, contrary to the policy

(1) Failed to exit the covid insulation unit by the dirty exit and instead returned to the Home by the clean entrance thereby exposing others to the risk of contamination

(2) Entered the covid insulation unit without PPE clothing.

(3) Gave care to individual residents without wearing PPE clothing.

(4) Handled a bed pan **/commode pot** without gloves.

(5) Were in the process of leaving the covid insulation unit by the clean entrance when countermanded not to do so.

(6) Colleague 1 had to re-educate you in your obligations to comply with all the requirements to wear PPE, obligations you undertook not to breach again.

6. On the 10th April, notwithstanding **5 (6)** and contrary to policy

(1) You deliberately and/or wilfully and/or negligently entered the covid insulation unit without PPE clothing.
(2) Left the unit by the clean entrance thereby exposing others to the risk of cross contamination

And in the light of the above, your fitness to practise is impaired by virtue of your misconduct.

The panel accepted the advice of the legal assessor.

The panel determined to allow the application to amend the charges.

The amended details of charges

The amended details of charges are as follows:

That you, a registered nurse, whilst working at the Mance Nursing Home [the “Home”]

1. On the 6th December 2019, omitted to provide an injection of 40mg/0.8 ml of Adalimumab to patient A.

2. Despite this omission, you recorded in Patient A’s MAR that you had given her the injection.

3. Your action at 2 was dishonest in that
   (a) You purported to record a successful injection in the MAR record.
   (b) You knew that you had not provided such an injection

4. Between 1st and 9th April 2020on one or more occasions, failed to follow the Home’s Covid 19 infection control policy [the “policy”] whilst in the covid insulation unit
   (1) you omitted to wear the relevant PPE, namely
      (a) An apron
      (b) Gloves
      (c) Hair covering.

   (2) Carried clinical waste without the protective clothing at (1)

   (3) Omitted to change your clothes and/or wash your hands after (2) and before returning to the care of residents.

5. On the 9th April 2020, contrary to the policy

(1) Failed to exit the covid insulation unit by the dirty exit and instead returned to the Home by the clean entrance thereby exposing others to the risk of contamination
(2) Entered the covid insulation unit without PPE clothing.
(3) Gave care to individual residents without wearing PPE clothing.
(4) Handled a bed pan/commode pot without gloves.
(5) Were in the process of leaving the covid insulation unit by the clean entrance when countermanded not to do so.
(6) Colleague 1 had to re-educate you in your obligations to comply with all the requirements to wear PPE, obligations you undertook not to breach again.

6. On the 10th April, notwithstanding 5 (6) and contrary to policy

(1) You deliberately and/or wilfully and/or negligently entered the covid insulation unit without PPE clothing.
(2) Left the unit by the clean entrance thereby exposing others to the risk of cross contamination

And in the light of the above, your fitness to practise is impaired by virtue of your misconduct.

Decision and reasons on facts

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

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will

be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Home Manager of Manse Nursing Home at the time the allegations arose;

- Witness 2: Clinical Lead and Deputy Manager of Manse Nursing Home at the time the allegations arose.

Background

The charges arose whilst Mr Martyn was employed as a registered nurse by Manse Nursing Home ('the Home'). Mr Martyn started working for the nursing home on 13 October 2019.

The NMC received two separate referrals regarding the nursing practice of Mr Martyn. One of the referrals reported an incident whereby Mr Martyn is alleged to have failed to administer medication to a patient. It was further alleged that Mr Martyn had completed the MAR chart to show that the medication had been administered, when in fact it had not. An additional regulatory concern of dishonesty was also raised.

A further referral was received which alleged that Mr Martyn failed to adhere to the Home's infection prevention and control policies during the first national lockdown of the COVID-19 pandemic. It was alleged that Mr Martyn had failed to wear adequate personal protective equipment (PPE) and follow infection prevention and control procedures on a number of occasions despite intervention and instruction from other members of staff.

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 both the NMC and Mr Martyn.

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

Charge 1

"That you, a registered nurse, whilst working at the Mance Nursing Home

1. On the 6th December 2019, omitted to provide an injection of 40mg/0.8 ml of Adalimumab to patient A."

This charge is found proved.

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

In particular, the panel had regard to a copy of the original MAR chart and noted that the drug stated in Charge 1, Adalimumab, appeared to have been mis-spelled as "*Adalimub*". However, the panel observed that its dosage of "*40mg /0.8ml*" was specific and had been correctly stated, alongside the description that it was "*one syringe*" that was "*stored in fridge*". The panel was satisfied that this entry on the MAR chart referred to the administration of Adalimumab to Patient A.

The panel also noted the written evidence of Witness 1 who stated that she had viewed CCTV footage from 6 December 2019 whereby Mr Martyn was seen going to the fridge, taking "*the medication out, put it on the side, opened the box, took out the injection, got the instruction booklet out, stood over and read the instructions, turned it over, folded it up, put it back in the box and put it all back in the fridge*".

The panel also considered the written evidence of Witness 2 who also observed CCTV footage of Mr Martyn removing the medication from the fridge, reading the instructions, and then replacing it back into the fridge. The panel also considered the oral evidence of Witness 2 who stated that when Mr Martyn was informed of the CCTV recording from the day in question during a local level meeting, he simply conceded words to the effect of "*Oh, I didn't give it then*".

The panel also had regard to the written reflection of Mr Martyn which described the medication omission on 6 December 2019. The panel noted that Mr Martyn had made admissions at local level, whereby he states that "*being tired*" and coming across a "*urine specimen in the fridge were at some point contributing factors for me missing the injection, I admit it's my responsibility that the error occurred*". Witness 2, when questioned by the panel, said that he did not see Mr Martyn remove anything from the fridge other than the medication.

In light of the evidence outlined above, the panel determined that Charge 1 is proved.

Charge 2)

"That you, a registered nurse, whilst working at the Mance Nursing Home

2. Despite this omission, you recorded in Patient A's MAR that you had given her the injection"

This charge is found proved.

In reaching this decision, the panel took into account a copy of the signed MAR chart, which included the initials of Mr Martyn. The panel also considered the oral witness evidence of Witness 1 and Witness 2 who both stated that the MAR chart shows the initials of Mr Martyn and further confirmed that he was on duty at the time.

In light of the documentary and oral evidence of two witnesses, the panel determined that Mr Martyn signed the MAR chart to indicate that the medication had been administered.

Charge 3) (a) and (b)

"That you, a registered nurse, whilst working at the Mance Nursing Home…

3. Your action at 2 was dishonest in that

(a) You purported to record a successful injection in the MAR record.
(b) You knew that you had not provided such an injection".

These charges are found NOT proved.

The panel had regard to the advice of the legal assessor in considering the issue of dishonesty. The panel firstly considered what had taken place, namely, that Mr Martyn had signed his initials and recorded that an injection had been administered on Patient A's MAR chart, when in fact, this was not done. The panel next considered the state of mind of Mr Martyn at the time of signing the MAR chart and his motive for doing so. Lastly, taking these factors together, the panel went on to determine whether a reasonable person would consider this to be dishonest.

The panel also carefully considered the documentary and oral evidence. The panel determined there was no information before it to indicate why Mr Martyn signed the MAR chart, nor any information to indicate his state of mind at the time or his motive for doing so. The panel determined that there may be alternative reasons other than dishonesty as to why Mr Martyn signed the MAR chart, including poor clinical practice, signing in error or by mistake, confusion and possible forgetfulness, all of which fall short of wilful dishonesty.

The panel determined that the NMC have failed to provide sufficient evidence as to the state of mind of Mr Martyn at the time he signed the MAR chart. The panel concluded that the signature of the MAR chart, alongside the limited evidence of Witness 1 and Witness 2 was insufficient to support a finding of dishonesty.

Charge 4) (1) (a-c)

"That you, a registered nurse, whilst working at the Mance Nursing Home

4. Between 1st and 9th April 2020 on one or more occasions, failed to follow the Home's Covid 19 infection control policy [the "policy"] whilst in the covid insulation unit

(1) you omitted to wear the relevant PPE, namely

(a) An apron

(b) Gloves

(c) Hair covering.

These charges are found proved.

The panel had regard to the oral evidence of Witness 1, who outlined the considerable efforts that were made at the beginning of the COVID-19 pandemic to train all staff in the proper use of PPE to enable effective barrier nursing, alongside the provision of substantial PPE. The panel also considered the Home's COVID-19 workflow policy document which incorporates NHS infection and prevention control guidance, which places Mr Martyn under a duty to wear PPE when indicated by the policy.

The panel also considered the oral evidence of Witness 1 and 2 who had viewed CCTV footage of Mr Martyn conducting his nursing tasks within the isolation unit without PPE. The panel were also provided with still images taken from the CCTV which both witnesses confirmed were of Mr Martyn working within the isolation unit, without PPE.

The panel also noted admissions made at local level by Mr Martyn in a reflective statement dated 10 April 2020:

> *'I didn't have full PPE on and I admit my mistake. I was seen on CCTV being monitored. My line manager challenged me and I apologised. I fully regret this'*

In light of the evidence outlined above, these charges are found proved.

Charge 4) (2)

"That you, a registered nurse, whilst working at the Mance Nursing Home

4 Between 1st and 9th April 2020on one or more occasions, failed to follow the Home's Covid 19 infection control policy [the "policy"] whilst in the covid insulation unit

(2) Carried clinical waste without the protective clothing at (1)"

This charge is found proved.

The panel considered the oral evidence of witness 1 who stated that she saw Mr Martyn carrying clinical waste contained in plastic bags without PPE.

The panel also noted still images from CCTV that witnesses 1 and 2 confirmed show Mr Martyn handling clinical waste bags without gloves, apron or a mask. Both witnesses were able to attest that these images were taken sometime between 1 April 2020 and 9 April 2020.

In light of the evidence outlined above, these charges are found proved.

Charge 4) (3)

"That you, a registered nurse, whilst working at the Mance Nursing Home

4 Between 1st and 9th April 2020 on one or more occasions, failed to follow the Home's Covid 19 infection control policy [the "policy"] whilst in the covid insulation unit

(3) Omitted to change your clothes and/or wash your hands after (2) and before returning to the care of residents.

This charge is found proved.

The panel carefully considered the documentary and oral evidence before it.

The panel noted from the evidence of both Witness 1 and 2 that, on the CCTV footage, they had seen that Mr Martyn failed to wear PPE whilst handling clinical waste and a commode pot, thereby contaminating his clothing and failed to change his clothes or wash his hands before returning to the care of residents.

Charge 5) (1)

"That you, a registered nurse, whilst working at the Mance Nursing Home

5. On the 9th April 2020, contrary to the policy

(1) Failed to exit the covid insulation unit by the dirty exit and instead returned to the Home by the clean entrance thereby exposing others to the risk of contamination; and

This charge is found proved.

The panel considered the statement of Witness 1 which supported this charge and stated, "*The first time the registrant was in the COVID unit he came of the unit the wrong way*". The panel also considered an Investigation Plan document dated 9 April 2020 in which Witness 1 recorded her "*disbelief that [Mr Martyn] had deliberately flouted the protocol for entering the unit and not wearing the correct PPE all staff had been involved in daily meetings…. And the actions that we were taking as a home to implement a solid COVID-19 infection control policy and building flow*". Witness 1 also states, "*DM assured me that it would not happen again*".

In light of the statement of Witness 1, her oral evidence and contemporaneous evidence in the form of an Investigation Plan document dated 9 April 2020, the panel determined that this charge is proved.

Charge 5) (2)

"That you, a registered nurse, whilst working at the Mance Nursing Home

5. On the 9th April 2020, contrary to the policy

(2) Entered the covid insulation unit without PPE clothing

This charge is found proved

The panel took into account the evidence at Charge 5 (1) above and also Mr Martyn's written admissions at local level dated 10 April 2020 where he accepts that he did not wear PPE clothing.

In light of this evidence, the panel determined that this charge is found proved.

Charge 5) (3)

"That you, a registered nurse, whilst working at the Mance Nursing Home

5 On the 9th April 2020, contrary to the policy

(3) Gave care to individual residents without wearing PPE clothing.

This charge is found proved.

The panel considered the written reflective piece of Mr Martyn at local level dated 10 April 2020 where he accepts that he did not wear PPE clothing: "*I didn't have full PPE on and I admit my mistake*". It noted that his written statement recorded, "*I attended to a buzzer*". The panel therefore concluded that he gave care to individual residents without wearing PPE clothing.

In light of this evidence, the panel determined that this charge is found proved.

Charge 5) (4)

"That you, a registered nurse, whilst working at the Mance Nursing Home

5 On the 9th April 2020, contrary to the policy

(4) Handled a bed pan/commode pot without gloves.

This charge is found proved.

The panel considered the Investigation Plan document dated 9 April 2020 and noted that one of the concerns that was addressed related to Martyn *"handling contaminated equipment without PPE"*. The panel further noted that the dismissal letter of Mr Martyn dated 11 April 2020 referred to a concern that Mr Martyn *"handled a bed pan without*

gloves", which was also discussed during local level meetings on 9 April 2020 and 10 April 2020.

The panel also had sight of a still image from CCTV which witnesses 1 and 2 state shows Mr Martyn handling a commode pot without gloves.

In light of this contemporaneous documentary evidence, alongside CCTV still images, the panel find this charge proved.

Charge 5) (5)

"That you, a registered nurse, whilst working at the Mance Nursing Home

5. On the 9th April 2020, contrary to the policy

(5) Were in the process of leaving the covid insulation unit by the clean entrance when countermanded not to do so.

This charge is found proved.

The panel considered the statement of Witness 1 which stated, "*Even after speaking to the registrant he still entered the COVID area again*". During her oral evidence, Witness 1 clarified that Mr Martyn was not forbidden from entering the COVID-19 isolation area, however, he had exited this area using the wrong entrance.

The panel also noted the dismissal letter of Mr Martyn dated 11 April 2020, which stated the following concern in relation to his nursing practice: "*Failed to follow the clean route as instructed by management and colleagues*".

In light of the evidence outlined above, the panel find this charge proved.

Charge 5) (6)

"That you, a registered nurse, whilst working at the Mance Nursing Home

5). On the 9th April 2020, contrary to the policy

(6). Colleague 1 had to re-educate you in your obligations to comply with all the requirements to wear PPE, obligations you undertook not to breach again.

This charge is found proved.

The panel considered the documentary evidence before it. It had regard to the following section of the Investigation Plan document dated 9 April 2020 which stated:

"3. DM was taken through step by step the process of the isolation unit and PPE requirements in its minutia and advised that further breaches would not be accepted.

4.Finally we discussed the implications of cross contamination to service users

DM assured me that it would not happen again"

The panel also noted the dismissal letter of Mr Martyn dated 11 April 2020 in which Witness 1 describes a meeting that had taken place on 9 April 2020 where "*the full infection control protocol, procedure …was reiterated along with rationale…*"

The panel also took into account the written reflection of Mr Martyn dated 10 April 2020, in which he accepts that he did not wear the required PPE: *"I didn't have full PPE on and I admit my mistake. I was seen on CCTV…My Line Manager challenged me and I apologised".*

In light of the evidence outlined above, the panel is satisfied that this charge is proved.

Charge 6) (1)

"That you, a registered nurse, whilst working at the Mance Nursing Home

6. On the 10th April, notwithstanding 5 (6) and contrary to policy

(1) You deliberately and/or wilfully and/or negligently entered the covid insulation unit without PPE clothing.

This charge is found proved.

The panel considered the oral evidence of Witness 1 who stated that she had explained the COVID-19 infection prevention and control process and protocols to Mr Martyn again. She explained that Mr Martyn confirmed that he understood them. She then returned to her upstairs office where she was living at the time and it was later reported to her that Mr Martyn had breached the process and protocols again "*hours after [she] had spoken to him*". The panel also considered the admissions Mr Martyn made in his reflective piece dated 10 April 2020 at local level.

The panel is satisfied that Mr Martyn's actions were "*deliberate*" and "*wilful*" due to the documented discussions and re-training that had taken place shortly before these events.

In light of the evidence outlined above, the panel is satisfied that this charge is proved.

Charge 6) (2)

"That you, a registered nurse, whilst working at the Mance Nursing Home

6. On the 10th April, notwithstanding 5 (6) and contrary to policy

(2) Left the unit by the clean entrance thereby exposing others to the risk of cross contamination

This charge is found proved.

The panel considered the documentary and oral evidence before it. The panel had regard to the Investigation Plan document dated 9 April 2020 which stated that Witness 1 had *"reviewed CCTV footage"* which *"confirmed [Mr Martyn] had again entered the unit without PPE and left the unit by the clean entrance therefore cross contaminating the nursing home".*

In light of the evidence outlined above, the panel is satisfied that this charge is proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Martyn's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

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.'*

Ms Ward reminded the panel of the two-stage test it must consider. She 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.

The relevant standards of propriety within the Code were identified by Ms Ward. She stated that the panel must be satisfied that the actions of Mr Martyn fall "*seriously below that expected of a registered nurse*". She submitted that Mr Martyn's actions constituted a serious departure from a number of standards within the code, including specific standards within parts 1, 10, 13,14 and 19.

Ms Ward also drew the panel's attention to the COVID-19 Workflow Policy of the Home and a second policy document from the Home which emphasises infection control practices.

Ms Ward addressed the incident in December 2019 whereby Mr Martyn failed to administer medication to Patient A. She stated that Patient A relied upon Mr Martyn as a nurse on duty to provide medication [PRIVATE]. Ms Ward submitted there was a real risk of harm from Mr Martyn's omission which was worsened by Mr Martyn maintaining that he had given the medication. It was only when he was informed of the CCTV findings and the hospital confirmation that only one injection had been dispensed, that Mr Martyn then accepted that he must not have administered the medication.

Ms Ward referred the panel's attention to Mr Martyn's reflective piece which was produced at local level. She acknowledged that he provides his thoughts and feelings about the incident. However, she submitted that he fails to fully acknowledge that he completed the MAR chart without administering the medication and failed to provide a full explanation for this.

Ms Ward also addressed the incidents in April 2020 where Mr Martyn was found to have breached the Home's COVID-19 infection policies. She noted that Mr Martyn was providing care to highly vulnerable service users in the isolation part of the home in the wider context of the early months of the COVD 19 pandemic. Ms Ward submitted that in failing to follow policy a number of times despite intervention from colleagues, Mr Martyn failed to ensure that cross contamination could not occur. She referred to the evidence of both witnesses, who emphasised the importance of compliance with infection control procedures, including the use of PPE. Ms Ward submitted that the repetition of the behaviour on 10 April 2020 demonstrates a deliberate refusal to ensure that cross contamination could not happen. She submitted that consequently, there was a real risk of harm to service users.

Ms Ward concluded by inviting the panel to find that Mr Martyn's actions amounted to misconduct.

Submissions on impairment

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

Ms Ward invited the panel to find that Mr Martyn's fitness to practice is currently impaired. She reminded the panel that "*impairment*" is defined as: "*suitability to remain on the register without restriction*". She referred to the case of *Meadows v GMC* [2206] EWCA Civ 1390 and noted that the purpose of any finding of impairment is "*not to punish a registrant for past wrong doings but rather to protect the public from acts and omissions of those who are not fit to practice*". Ms Ward also referred to the case of Grant, where the Court emphasised "*the fundamental need to protect the public and declare and uphold proper standards of conduct*".

Ms Ward submitted that public protection and public interest considerations were engaged by the circumstances of this case. Addressing public protection concerns, Ms Ward submitted that the failure to administer medication to Patient A and repeated non-compliance with COVID -19 infection control procedures, placed residents and colleagues at a serious risk of harm. She acknowledged that the reflective piece of Mr Martyn accepts that he had no wish to cause harm to service users or colleagues. However, Ms Ward submitted that he failed to take full accountability for his failures as he also refers to staffing levels, issues with PPE and what he regards as conflicting Department of Health guidance, thereby demonstrating a lack of insight into his actions and the risks posed.

Ms Ward submitted that the public would be concerned by the circumstances of the case and further noted that public confidence would be adversely affected if the regulator did not take appropriate action and referred to the case of *Grant.*

Applying the test of current impairment from the case of *Cohen*, Ms Ward submitted that a capacity for remediation potentially existed in the circumstances of this case through training and education. Addressing the second limb of the test, Ms Ward submitted that the conduct had not been remediated. She reminded the panel that Mr Martyn made admissions at local level, but disputed the charges to the NMC. Ms Ward noted that Mr Martyn has failed to provide a further reflective piece to the NMC during the course of its investigation and there is no other evidence of training or education that he has

undertaken since the incidents. As such, Ms Ward submitted that the conduct was not remediated.

Addressing the last limb of the test, Ms Ward submitted that there is a likelihood of repetition of this type of conduct due to the lack of insight Mr Martyn has shown.

In concluding, Ms Ward submitted that the facts found proved amount to misconduct and that a finding of impairment is required for public protection and further, to protect the public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

> *'<u>1 Treat people as individuals and uphold their dignity</u>*
>
> > *To achieve this, you must:*
> > *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 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.4 take account of your own personal safety as well as the safety of people in your care

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

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

> *19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*
>
> *19.3 keep to and promote recommended practice in relation to controlling and preventing infection.*
>
> *19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, it found that Mr Martyn had failed to administer medication to a resident and had also signed the MAR chart to indicate that he had, alongside numerous and repeated incidents of non-compliance with COVID-19 infection control policies. When considered collectively, the panel determined that failure to administer medication and exposure of service users to infection were very serious breaches of the Code which placed service users, colleagues and himself at a real risk of harm.

The panel noted that Mr Martyn had failed to administer the medication but had signed the MAR chart to indicate that he had done so. The panel considered that this medication and record-keeping error was exacerbated by Mr Martyn's continued insistence to colleagues that he had administered the medication. He only accepted that the medication was not administered when he was presented with cogent evidence to the contrary, namely, CCTV recordings and confirmation from the hospital that only one syringe was provided.

The panel also determined that Mr Martyn had repeatedly failed to follow COVID-19 infection prevention and control policies, despite intervention and training from colleagues.

The panel noted that the COVID-19 pandemic was at an early stage in April 2020. However, it noted that infection prevention and control practices are a long-standing and fundamental part of nursing and that special isolation measures had been introduced into the home in February 2020, and those policies should have been adhered to. The panel regarded the policy and instructions around wearing PPE in particular, to be clear. It also noted that this had been explained to Mr Martyn a number of times by his colleagues. It did not accept Mr Martyn's view that there was "*conflicting advice around matters of PPE*" from the Department of Health and other bodies, as stated in his reflective piece dated 10 April 2020.

The panel determined that Mr Martyn's conduct constituted a serious departure of the conduct and standards expected of a nurse and does amount to serious professional misconduct.

Decision and reasons on impairment

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

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

In this regard the panel considered the 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;

The panel determined that limbs a – c are engaged in this case. It considered that patients were put at a risk of harm as a result of Mr Martyn's clinical failings, namely, his failure to administer medication and his failure in record keeping. The panel noted records of Mr Martyn's early training at the Home which indicated that he was competent to administer medication, and considered the incident in question in December 2020 to be poor clinical practice. The panel also noted further clinical errors by Mr Martyn in his repeated failure to comply with COVID-19 infection control policies despite a number of interventions from his colleagues. The panel determined that this placed vulnerable patients at significant risk of

harm from a novel virus for which there was no treatment. The panel was deeply concerned by the apparent lack of insight of Mr Martyn.

The panel bore in mind the case of *Cohen v General Medical Council,* in which the court set out three factors which it described as being '*highly relevant'* to the determination of the question of current impairment:

(a) Whether the conduct that led to the charge(s) is easily remediable?
(b) Whether it has been remedied?
(c) Whether it is highly unlikely to be repeated?

The panel considered that the clinical failings in this case are potentially capable of remediation through training and education. However, the panel noted that Mr Martyn had repeatedly breached COVID-19 infection prevention and control policies despite a number of serious interventions and documented discussions with colleagues. The panel was concerned that this may indicate an attitudinal problem and resistance in implementing corrective training on the part of Mr Martyn.

The panel considered whether Mr Martyn had taken steps to address the failings in his practice. The panel noted that, after his dismissal, Mr Martyn had accessed an online training course from the Home. However, there was a lack of detail about the course content and whether any assessment was undertaken and the panel therefore determined that this was insufficient to remediate the shortcomings identified. It further noted that Mr Martyn had not provided an updated reflective piece to the NMC during the course of its investigation. The panel was of the view that two reflective pieces provided at local level expressed some regret, but were very limited and did not outline what could have been differently and failed to demonstrate insight.

In addition, Mr Martyn has not provided evidence of any further training undertaken reflection, or remediation. In this regard, the panel determined that Mr Martyn has not

demonstrated development of any insight since the incidents. The panel also bore in mind that Mr Martyn’s non-compliance with COVID-19 infection prevention and control policies were repeated, despite intervention.

In the absence of any strengthened practice through training or insight, the panel determined that there is a risk of repetition should Mr Martyn practise unrestricted. As such, it concluded 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.

In this regard, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It considered that an informed member of the public, aware of the misconduct in this case, would be appalled if a finding of current impairment were not made. The panel therefore also finds Mr Martyn’s fitness to practise impaired on public interest grounds.

Sanction

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

Ms Ward informed the panel that in the Notice of Hearing, dated 19 July 2022, the NMC had advised Mr Martyn that it would seek the imposition of a strike off order if it found Mr Martyn's fitness to practise currently impaired.

Ms Ward invited the panel to impose a striking off order and outlined a number of aggravating and mitigating factors. She then considered each form of sanction in turn, starting with the least restrictive first. In summary, she submitted that no further action or a caution order would not be appropriate in the circumstances of this case due to the demonstrable risk of harm to the public. She noted that these forms of sanction would be insufficient to protect the public. Ms Ward also stated that a conditions of practice order would be inappropriate due to evidence of an attitudinal problem and Mr Martyn's unwillingness to respond to training, as demonstrated by the warning and instruction he was given on 9 April 2020 with regard to wearing PPE, and a repetition of his actions on 10 April 2020. She further noted the absence of further training undertaken by Mr Martyn since the incident and his limited insight, which would also mean that a conditions of practice order was inappropriate.

Ms Ward submitted that a suspension order would also be inappropriate given that non-compliance with infection prevention and control policy was not a single incident of misconduct, but was in fact repeated. She also noted that there was evidence to suggest an attitudinal issue.

Turning to the most restrictive sanction, Ms Ward submitted that a striking-off order was the only form of sanction available which appropriately balances the right of the registrant and the need to protect the public and uphold confidence in the profession. She noted that the facts found proved in the case are numerous and repeated, involving a failure to put patient safety first and exposing patients to a risk of serious harm.

Ms Ward reminded the panel that the facts found proved demonstrate poor clinical practice, a failure to provide medication and a failure in record keeping. She also addressed the incidents of April 2020. She submitted that the home had prepared well for the COVID-19 pandemic and implemented measures to ensure patient safety. She noted that the Home's policies were sensible and easy to follow. Notwithstanding this, Mr Martyn failed to follow guidance and in doing so risked exposing patients to COVID-19. Ms Ward submitted that the actions of Mr Martyn are worsened by his conduct on 10 April 2020, as he was corrected and informed of the correct process a day earlier on 9 April 2020. Ms Ward submitted that his continued deliberate failure to ensure patient safety indicates that the only appropriate order is strike off.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr Martyn'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 Sanctions Guidance (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:

- The lack of insight shown by Mr Martyn;
- Repetition of his non-compliance with infection control and prevention procedures even after being instructed to comply;
- His conduct put patients and other staff at a risk of serious harm; and
- His repeated and deliberate disregard and breach of infection control guidance during a pandemic and national lockdown

The panel also took into account the following mitigating features:

- Mr Martyn's registration has been subject to an interim suspension order which has limited his opportunity to practise, but not limited his opportunity to reflect or undertake training.

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 Mr Martyn'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 Martyn'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 Martyn'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 facts found proved in this case.

The panel noted that wearing of PPE is a fundamental part of nursing care, which includes interacting with patients without the risk of cross-exposure to viral and bacterial infections. In light of Mr Martyn's deliberate disregard of infection prevention and control guidance and training, his repeated behaviour in not wearing appropriate PPE and apparent attitudinal issues, the panel determined that it would be difficult to incorporate infection control as a developmental goal in conditions of practice. The panel noted that there was

no evidence of Mr Martyn's positive response to training. To the contrary, the panel was mindful of evidence which documented repetition of the misconduct even after intervention and training from his manager. For these reasons, the panel was satisfied that the misconduct identified in this case was not something that can be addressed through conditions of practice.

Furthermore, the panel concluded that the placing of conditions on Mr Martyn's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel noted that the facts found proved were not a single incident of misconduct, rather, the actions of Mr Martyn in failing to follow infection prevention and control policy despite intervention from colleagues, was deliberate and repeated. The panel considered that Mr Martyn demonstrated an attitudinal problem in light of his repeated failure to follow policy, training and warnings from colleagues with regard to wearing PPE, alongside his questioning with his manager of his duty to comply with procedures. Furthermore, the panel noted that Mr Martyn, after being reprimanded for not wearing PPE, gave assurances to his managers of his intention to comply, providing further evidence of his attitudinal problem when he failed to do so.

The panel determined that a deep-seated attitudinal problem is also evidenced by Mr Martyn's unwillingness to accept that he had failed to administer medication when first confronted, alongside his inability to provide any explanation or insight when he finally admitted the error when clear evidence to the contrary was referred to.

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 Martyn's actions is fundamentally incompatible with Mr Martyn 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?*

The panel considered the charges found proved in relation to medication administration and record-keeping that took place in December 2019, and the repeated failures to follow infection prevention and control policies in April 2020. With regard to the medication error, Mr Martyn's actions caused the panel concern because of the manner in which he responded to the error and his lack of insight into its consequences. In particular, with regard to the PPE failures, the panel was mindful of the wider context that existed in April 2020. It noted that Mr Martyn's deliberate and repeated failure to adhere to the requirement to wear PPE took place during a pandemic of a novel virus, COVID-19, for

which there was no treatment at that time, and during a national lockdown. The panel also acknowledged that the Home had been implementing infection control procedures since February 2020. The panel noted that Mr Martyn was a primary health care provider to highly vulnerable service users who resided at the closed-environment care facility, which was their home. The panel noted that these service users were exposed to a risk of transmission of COVID-19 in this context by virtue of Mr Martyn's refusal to wear PPE.

The panel was also deeply concerned to find that Mr Martyn's non-compliance with the Home's infection and prevention control policies was repeated, in spite of comprehensive group training, daily meetings, and formal individual discussions from senior colleagues. The panel determined that Mr Martyn's persistent non-compliance indicated a wider attitudinal issue on his part in implementing corrections to his nursing practice, namely, the clear and fundamental requirement to wear PPE.

The panel was also mindful that nurses are role models to colleagues. The panel noted the extreme importance of nurses adhering to infection prevention and control measures at this time, in this type of healthcare setting which provided care to highly vulnerable service-users.

It is the panel's view that the matters described above, raise serious fundamental questions about Mr Martyn's professionalism.

The panel was mindful of the acute public protection issues that were raised by the circumstances of this case. The panel also considered that the public interest was engaged to a high degree. The panel was of the view that a well-informed member of the public, familiar with the details of this case, would find it difficult to reconcile Mr Martyn's actions with his remaining on the register.

Mr Martyn'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 Martyn's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mr Martyn in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Ward. She submitted that an interim order is necessary to protect the public and is otherwise in the public interest. Ms Ward submitted that an interim suspension order for a period of 18 months is necessary to cover any possible appeal period. She submitted that an interim suspension order would

be appropriate as it would be consistent with the panel's decision to impose the substantive striking-off order.

The panel heard and 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 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 sufficient time for an appeal to be made by Mr Martyn, should he wish to do so.

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

That concludes this determination.