Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 22 February – Tuesday 1 March 2022

Virtual Hearing

Name of registrant:	**Ramnarain Sowky**	
NMC PIN:	76B5518E	
Part(s) of the register:	RN3: Mental Health Nurse - December 1976) RN1: Adult Nurse - August 1979)	
Area of registered address:	East Sussex	
Type of case:	Misconduct	
Panel members:	Sue Heads Jonathan Coombes Barry Greene	(Chair, Lay member) (Registrant member) (Lay member)
Legal Assessor:	Paul Housego	
Hearings Coordinator:	Sharmilla Nanan	
Nursing and Midwifery Council:	Represented by Tope Adeyemi, Case Presenter	
Mr Sowky:	Not present and not represented at the hearing	
Facts proved:	Charges 1)b), 1)c), 1)d), 4), 5)	
Facts not proved:	Charges 1)a), 2), 3)	
Fitness to practise:	Impaired	
Sanction:	**Conditions of practice order (12 months)**	
Interim order:	**Interim conditions of practice order (18 months)**	

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Sowky was not in attendance and that the Notice of Hearing letter had been sent to Mr Sowky's registered email address on 9 December 2021.

Ms Adeyemi, 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 venue of the hearing and, amongst other things, information about Mr Sowky'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 Sowky 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 Sowky

The panel next considered whether it should proceed in the absence of Mr Sowky. It had regard to Rule 21 and heard the submissions of Ms Adeyemi who invited the panel to continue in the absence of Mr Sowky. She submitted that Mr Sowky had voluntarily absented himself.

Ms Adeyemi referred the panel to the documentation from Mr Sowky which included a telephone note dated 7 February 2022 which states that he is content for hearing to proceed in his absence.

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 Mr Sowky. In reaching this decision, the panel has considered the submissions of Ms Adeyemi, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5 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 Sowky;
- Mr Sowky 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;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A number of witnesses are due to attend the hearing today to give live evidence and others are due to attend this week;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in October 2016 and September 2017;
- 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 Sowky 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 has made no response to the allegations. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Sowky's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge

That you a registered nurse:

1) On 28 October 2016:

a) Administered Patient A's medication to Patient B; **(NOT PROVED)**
b) Signed Patient A's medication chart to indicate that Patient A had received medication; **(PROVED)**
c) Failed to ensure Patient A received their medication; **(PROVED)**
d) Failed to sign Patient B's medication chart to indicate Patient B had received any medication; **(PROVED)**

2) Failed to report that you had made a medication administration error. **(NOT PROVED)**

3) Acted dishonestly in that you sought to conceal that you had administered Patient A's medication to Patient B as set out in charge 1(a). **(NOT PROVED)**

4) Failed to dispose of medications according to local administration medication and destruction policy and/or Safe Storage, Control and Administration of Medicines Policy. **(PROVED)**

5) On 19 September 2017 failed to maintain safe staffing levels. **(PROVED)**

AND in light of the above, your fitness to practise is impaired by reason 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 Adeyemi on behalf of the NMC.

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

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: Previously employed by Priory Hospital Burgess Hill (the Priory) as a staff nurse on the Michael Shepherd Ward (the Ward) and

worked with Mr Sowky on 28 October 2016.

- Witness 2: Previously employed by the Priory as a support worker on the Ward and worked with Mr Sowky on 28 October 2016.

- Witness 3: Previously employed by the Priory as a lead nurse and conducted the investigation for the incident on 28 October 2016.

- Witness 4: Previously employed by the Priory as a healthcare worker on the Ward and worked with Mr Sowky on 19 September 2017.

- Witness 5: Previously employed by the Priory as a ward manager and acting manager for the Ward. Interviewed Mr Sowky as part of the Priory's investigation.

- Witness 6: Employed by the Priory as an agency nurse at the time of the incident and worked with Mr Sowky on 19 September 2017.

Background

Mr Sowky has been a registered nurse since 1976. The charges are in relation to two separate unrelated incidents which occurred in October 2016 and September 2017 respectively. Both incidents occurred whilst Mr Sowky was employed as at the Dene Hospital in West Sussex which is now known as the Priory Hospital Burgess Hill (the Priory). He started his employment at the Priory in 2009 and by 2016 he was a Band 5 staff nurse.

The Priory provided assessment, care and treatment to men and women diagnosed with mental illness.

On 28 October 2016, on the Michael Shepherd Ward (the Ward), which was a female low secure unit, Mr Sowky undertook a shift on the Ward as overtime. It is alleged that while working on the Ward, Mr Sowky administered Patient A's medication to Patient B. On the Ward, medication was administered to patients as directed on the patients' prescription chart, through a hatch, from a locked clinic room. Both Patient A and B were due to be administered medications on a daily basis. Patients A and B used similar names. Staff were assisted by the inclusion of the patients' pictures in the patients' medication charts.

At 9.30am, Mr Sowky was required to accompany another patient to the general hospital following a self-harm incident. He left the Ward and handed over the work of finishing the medication round to Witness 1. Throughout the course of the morning there was concern amongst staff that an error had occurred.

Patient A, whose medication had been signed for as given, stated she had not been given her medication. It was suspected that an error may have occurred. Due to the concerns raised regarding the similarity in names, Witness 1 checked Patient B's medication chart and made some enquiries with other staff present at the time. She noted that there was no record of Patient B receiving her medication but Witness 2, a health care assistant who was observing Patient B on a 1 to 1 basis, informed her that Patient B had been given medication in a medication pot.

The normal presentation of Patient B had changed and after some time Patient B was sent to Princess Royal Hospital (PRH). Patient B returned to the Ward the following day.

Mr Sowky's response to the allegation has varied. In the Priory's investigation he stated that Patient A's medication was dispensed but that she did not take it, and then when he realised that she was the patient with a similar name to another patient he then disposed of the medication in the sink. He noted that it was an oversight and he did not say at handover that Patient A's medication was not administered to her.

On 19 September 2017, Mr Sowky was working on the Ward again. There were five members of staff on duty which included Mr Sowky as the nurse in charge. As the nurse in charge, Mr Sowky was to ensure adequate staffing levels were maintained.

During this shift, Mr Sowky permitted three of the five staff on shift to take their break at the same time from around 4pm to 5pm. He also took his own break during this period. This therefore left one registered nurse, Witness 6, who was working as a locum and was relatively new to the Ward and a supernumerary health care worker, Witness 4, to look after the patients on the Ward. Witness 4 was not to be included in a substantive role as part of the staff, as this was her first shift on the Ward which is why she was supernumerary as per the Priory's policy.

During the period that Witness 6 remained on the Ward on his own as the only registered nurse, Patient Y was trying to get his attention. Patient Y then went to her room and swallowed a plastic knife and began to gag and cough, before going on to start vomiting.

In the Priory's investigation, Mr Sowky stated that he regretted what happened to Patient Y. He believed the Ward to have been adequately staffed. Patient Y had a history of self-harm, and the staffing level was not a causative factor. He stated that her action was a response to not being provided with medication.

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

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

Charge 1)a)

> "That you, a registered nurse, on 28 October 2016:
>
> a) Administered Patient A's medication to Patient B"

This charge is found NOT proved.

In reaching this decision, the panel took into account that the burden of proof rests with the NMC to prove its case on a balance of probabilities. The panel took into consideration that it did not have the relevant medication administration records of either Patient A or Patient B.

The panel noted that in Witness 1's oral evidence, she made the link that the Patient B was administered Patient A's medication, and this was why Patient B's presentation required a referral to the hospital but the panel noted that this was an assumption and that there was no direct evidence which supported this position. The panel bore in mind that it did not know whether medication was erroneously administered to Patient B and if any, what the effects of that had been to Patient B. It also did not know what medication that Patient B should have been administered.

The panel noted that Patient B was told that she had received the wrong medication, and was then not given her own medication, save for a strong tranquilliser, all or any of which may have been related to the changed presentation of Patient B. The panel noted that Witness 1 stated that she assumed that Patient B had been given the medication of Patient A, given the similarity in names. While the similarity of names is relevant, an assumption is not evidence. On the basis of the evidence given to it, the panel decided that the NMC had not proved that on the balance of probabilities there was an erroneous administration of medication to Patient B and was based on an assumption.

The panel noted that in Witness 3's oral evidence she did not know what medications were erroneously administered to Patient B.

The panel was of the view that there was no evidence regarding the medication administered to Patient B and noted that no blood tests were taken at the PRH.

The panel took into consideration that other than the similarity of the names of both Patient A and Patient B, it had no other direct evidence to prove this charge. The panel recognised it is possible that Patient B was given the incorrect medication but there is nothing presented in the evidence to prove this to the requisite standard.

The panel therefore determined that there was a lack of evidence and that the evidence presented was not sufficiently persuasive to find this charge proved. The panel therefore concluded; this charge was not proved on the balance of probabilities.

Charge 1)b)

"That you, a registered nurse, on 28 October 2016:

b) Signed Patient A's medication chart to indicate that Patient A had received medication"

This charge is found proved.

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

The panel noted that it did not have the relevant medication administration record of Patient A.

The panel took account of Witness 1's written NMC statement which states:

> *"After Raj had left, I took over administering the medication. Raj had told me that there was only a couple of patients who had not yet been administered their medication; Patient A, however, was insisting to me that she had not been given her medication. The person who was doing the one to one observation of Patient A also said she had not had her medication and two other healthcare assistants on the ward said that Patient A had only just got up. When I looked at Patient A's medication chart, I saw that her morning medication had been signed as given by Raj."*

The panel next considered Witness 1's contemporaneous statement, dated 8 December 2016 which states:

> *"Patient A then came to the hatch for her medication but I told her that she must have already had her medication because it had been signed for whereby she said: 'I haven't had my f**king medication, I was sick of waiting, today isn't a good day for me…"*

The panel took into consideration IRIS report completed by Mr Sowky on 28 October 2016 in which he wrote, *"I did not inform her of my action and also did not inform her (Nurse [Witness 1]) that I have signed the prescription chart of Patient A who did not receive her morning medication".*

The panel considered the information before it and determined that on a balance of probabilities, that it was more likely than not that Mr Sowky had signed Patient A's medication chart to indicate that Patient A had received medication and concluded that this charge was found proved.

Charge 1)c)

> "That you, a registered nurse, on 28 October 2016:
>
> c) Failed to ensure Patient A received their medication"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and the documentary evidence of Witness 3.

The panel bore in mind Witness 1’s written NMC statement which states:

> *“After Raj had left, I took over administering the medication. Raj had told me that there was only a couple of patients who had not yet been administered their medication; Patient A, however, was insisting to me that she had not been given her medication. The person who was doing the one to one observation of Patient A also said she had not had her medication and two other healthcare assistants on the ward said that Patient A had only just got up. When I looked at Patient A’s medication chart, I saw that her morning medication had been signed as given by Raj.”*

The panel took into consideration Witness 1’s contemporaneous statement, dated 8 December 2016 which states:

> *“He [Mr Sowky] had to escort another patient to PRH so RMN [Witness 1] took over from doing medication at approximately 09:45 and RMN [Mr Sowky] reported that there was ‘only 3 patients left to have their medication’ and their charts were on the side in the clinic room. I called each for medication (patient JC, patient SJ and Patient B)”*

The panel was of the view that Witness 1’s written statement was consistent with her oral evidence, in that she explained to the panel that she took over the medication administration round from Mr Sowky when he went to another hospital with a different patient. She told the panel there were only three medication administration charts left over including Patient B. She noted that Patient A came to the hatch and told her that she had not had her medications.

Mr Sowky in a handwritten note dated 28 October 2016, exhibited by Witness 3, states:

> *"He did state he signed for Pat A medication as she had come to the hatch, he dispensed it and then she left without taking the medication. He disposed of the medication down the sink and did not tell anyone he had done this or that he had signed for the medication. "This was my mistake and I did not inform anyone what I had done.""*

The panel took into consideration the evidence before it and it noted that Mr Sowky accepted that he did not tell anyone or record anywhere that Patient A did not have her medication to ensure that she would later receive it. The panel determined that this charge is found proved.

Charge 1)d)

> "That you, a registered nurse, on 28 October 2016:
>
> d) Failed to sign Patient B's medication chart to indicate Patient B had received any medication"

This charge is found proved.

In reaching this decision, the panel took into account of the evidence of Witness 1 and Witness 2.

Witness 1 said in her contemporaneous statement, dated 8 December 2016, that "*When I called for Patient B she said that she had had her medication and her observing nurse HCW [Witness 2] also said that she had had her medication already but this was not signed for.*"

Witness 2 stated in her NMC witness statement that *“the registrant gave Patient B her medication in a little plastic pot”* and in her undated contemporaneous statement she said that *“The nurse then administered Patient (A) medication to which she took all from a little pot.”* The panel noted that in Witness 2’s oral evidence that she confirmed that this was the patient that she was providing one to one care for, now known as Patient B.

The panel also noted that in Witness 2’s undated contemporaneous statement she said *“The nurse who was administering the medication gave my 1-1 patient [B] a brown inhaler which I believed belonged to another patient [A] with the same name as patient [B] although this isn’t patient [B] chisten [sic] name it is her preferred name.”*

The panel concluded that on the balance of probabilities and on the basis of the evidence before it, this charge is found proved.

Charge 2)

> “That you, a registered nurse, failed to report that you had made a medication administration error”

This charge is found NOT proved.

The panel was of the view that charge 2 was not clearly drafted and did not specify which medication administration error it referred to. The panel noted that in the NMC’s summing up, it was submitted that this charge was in relation to charge to 1)a), where it was alleged that Mr Sowky administered Patient A’s medication to Patient B. The panel did not find charge 1)a) proved and subsequently, concluded that this charge cannot be found proved.

The panel noted Mr Sowky first knew of the errors relating to charges 1)b), 1)c) and d), when he was informed of them whilst at the hospital with another patient, as indicated in the investigation interview dated 11 November 2016. Mr Sowky stated *“I was at the hospital and they contacted me about this but don’t recall.”* The panel was of the view that even if charge 2 related to charges 1)b), 1)c) or d), it would still have found charge 2 not proved because it cannot be a failure to report a medication administration error of which you are unaware, and that there was not sufficient evidence that Mr Sowky was aware of his error before being informed of it by others.

Charge 3)

> “That you, a registered nurse, acted dishonestly in that you sought to conceal that you had administered Patient A’s medication to Patient B as set out in charge 1(a)”

This charge is found NOT proved.

As this charge is founded on charge 1)a) it cannot be not proved, as charge 1)a) was found not proved.

Consequently, the panel determined that this charge is not proved.

Charge 4)

> “That you, a registered nurse, failed to dispose of medications according to local administration medication and destruction policy and/or Safe Storage, Control and Administration of Medicines Policy.”

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence exhibited by Witness 3.

The panel took into consideration the IRIS report completed by Mr Sowky on 28 October 2016 in which he wrote, *"I threw the partially dispensed medication down the sink."*

The panel next considered the investigation interview with Mr Sowky dated 11 November 2016. The panel noted that Mr Sowky said in the interview *"… so to prevent the medication being given to someone else I chucked it down the sink and signed the medication for the first patient."*

In the same interview, when asked what time he threw the medication in the sink he clarified:

> *"I don't know before I left , I chucked it in the sink and then I left. I forgot to sign for medication to say I didn't give to her... I was at the hospital and they contacted me about this but don't recall."*

In a letter from Mr Sowky to the Priory dated 26 November 2011, he states *"I was not prepared to commit a mistake, so I chucked the tablets down the sink and signed the medication for the first Patient".*

The panel considered the Priory's 'Safe Storage, Control and Administration of Medicines Policy', undated, which states:

> *"Medicines prepared for administration, which are not required, should be placed in the sharps bin, with the exception of Cyctotoxic drugs or vaccines, which must be disposed of by a pharmacist."*

The panel considered the evidence outlined above and determined that this charge is found proved.

Charge 5)

> "That you, a registered nurse, on 19 September 2017 failed to maintain safe staffing levels"

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 4, 5 and 6.

The panel noted that in Witness 4's oral evidence she stated that this was her first shift on the Ward as a supernumerary support worker.

The panel noted that in Witness 5's oral evidence, she stated that there was an issue with breaks as they had been lengthened (so making the scheduling of breaks problematic, as people did not want to start breaks early in the shift).

The panel took into consideration Witness 6's oral evidence. He told the panel that he was new to the Ward and unfamiliar with the Ward. He also told the panel that Mr Sowky knew that he was new to the Ward as they had only been introduced to each other at the start of the shift. He stated that early in the shift he drew Mr Sowky's attention to the scheduling of three staff members being on break simultaneously and that this would leave the Ward understaffed. Witness 6 stated that this was ignored by Mr Sowky.

The panel considered the Investigation Meeting Notes dated 27 September 2017, exhibited by both Witness 3 and Witness 5. In the interview, Mr Sowky stated:

> *"Staff are stretched and there are limited staff numbers. I know that from my memory we had people going out to various appointments and people requested their break at certain times. No one wants their break at 10.00am so this was really difficult. I only had a 45 minute break and I went*

downstairs for fresh air and came back. There were 2 people on the ward: [Witness 6], [Witness 4] (not in numbers) and [Colleague A] was on the ward at that time. [Colleague A] was on duty…

[Witness 6] had a break earlier on, I didn't have one, that girl must have been on her break too –[Colleague B]"

The panel noted that there was no local policy from the Priory in relation to what constitutes safe staffing levels on the Ward.

The panel bore in mind that there was one registered nurse on the Ward who was new and unfamiliar to the Ward. It noted that there was also a new support worker on the Ward who was supernumerary and so did not count towards the staffing numbers to support the Ward. It noted that the Ward is a high dependency ward where the patients are at risk to themselves and each other. The panel was of the view that one registered nurse to manage between 8-16 patients in different rooms on the Ward was inappropriate and unsafe. Further, it considered that it was Mr Sowky's responsibility as the nurse in charge of that shift to maintain safe staffing levels on the Ward and that he was aware of the issue with the break coverage for staff. The panel noted that it did not have any information that Mr Sowky raised or escalated this to another member of staff for assistance.

The panel was of the view that the self-harm incident where a patient swallowed a knife was not relevant to the charge nor was the total number of staff on the Ward that day. It noted there had been other incidents of self-harm on the Ward and that Mr Sowky had not raised concerns of the Ward's staffing levels prior to this incident. Patient Y had a tendency to self-harm by swallowing and had unrestricted access to the kitchen from which it appeared that she earlier taken the plastic knife.

The panel decided that leaving one qualified nurse and a supernumerary health care worker on the Ward was unsatisfactory in this instance. The panel therefore determined that this charge is found 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 Sowky'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 Sowky's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Adeyemi referred the panel 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 Adeyemi 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.

Ms Adeyemi identified the specific, relevant, standards where Mr Sowky's actions amounted to misconduct. She submitted the panel must determine if Mr Sowky's failings are serious and also whether his failings are a departure from the Code.

Submissions on impairment

Ms Adeyemi 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).

Ms Adeyemi submitted that charge 1)b) and d) relate to record keeping in that Mr Sowky failed to indicate which medications had been given to patients. She outlined the importance of accurate record keeping to the panel and that the failures in these charges led to confusion on the part of Mr Sowky's colleagues as to what medication had been administered. She submitted that charge 1)c) related to Mr Sowky's failure to ensure that Patient A received their medication and that this failure was a fundamental feature of ensuring that proper standards of care are adhered to. In respect of charge 4, Ms Adeyemi submitted that Mr Sowky's failure to dispose of medication in accordance with the Priory's local policy posed a number of risks and she outlined the concerns to the panel. Ms Adeyemi addressed the panel on charge 5, which relates Mr Sowky's failure to maintain safe staffing levels and outlined the panel's findings. She submitted that Mr Sowky's conduct in respect of all of the charges found proved amounted to misconduct.

Ms Adeyemi addressed the panel in relation to Mr Sowky's insight. She noted the apologies that he has made for his failings and that while his remorse is highly relevant and positive, she submitted that it is insufficient in itself to establish remediation. Further, she submitted that there is no evidence before the panel of any active steps taken by Mr Sowky to remediate or reflect on his conduct. There is also no evidence of any further

training undertaken by Mr Sowky in the relevant areas. She noted that these events took place some time ago and submitted that Mr Sowky has not assured the panel that he has in some way or another bridged the gap in his knowledge. She invited the panel to determine that Mr Sowky's fitness to practise is currently impaired.

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, *Spencer v General Osteopathic Council* [2012] EWHC 3147 (Admin), *Calhaem, R (on the application of) v General Medical Council* [2007] EWHC 2606, *(Administration) Cohen v GMC* [2008] EWHC 581 (Admin), *CHRE v (1) NMC (2) Grant* [2011] EWHC 927, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

The panel considered each of the charges found proved in turn as to whether Mr Sowky's actions amounted to serious professional misconduct.

The panel considered charges 1)b), 1)c), 1)d) and 4) together, as to whether the facts found proved amount to misconduct. The panel considered that the actions of Mr Sowky in the charges found proved at charge 1 were inadvertent and not deliberate. It noted that Mr Sowky's action, which was found proved at charge 4, was deliberate. It noted that Mr Sowky's conduct in these charges related to a single event of medication administration during one drug round, which was interrupted as Mr Sowky had to escort a patient to another hospital. The panel took into consideration that as Mr Sowky was taken away from the drug round, he did not have the opportunity to identify and rectify his errors. It noted that Mr Sowky worked for another year after this incident with no further issues in relation to medication administration. The panel considered that other nursing professionals would not consider Mr Sowky's failings in these charges serious enough to amount to professional misconduct. The panel concluded that whilst Mr Sowky's failings in these

charges, on a single occasion, are serious they are not sufficiently serious to result in a finding of professional misconduct.

The panel next considered charge 5. The panel noted that the Ward is a high dependency ward with vulnerable patients, and it noted that Mr Sowky, as the nurse in charge of the shift, had the responsibility to ensure that safe staffing levels were maintained on the Ward. The panel was of the view that it is a basic principle for the nurse in charge to ensure that there is enough staff on the ward to secure patient safety. The panel took into consideration that Mr Sowky was an experienced mental health nurse. The panel took into consideration that Mr Sowky chose to take his own break at a time when he had released other staff members on the Ward to take their own break. The panel noted that this left a registered locum nurse and a supernumerary healthcare worker on the Ward. The panel was of the view that it was Mr Sowky taking his own break which left the Ward critically understaffed.

Consequently, the panel was of the view that Mr Sowky's actions in this charge are serious and were a deliberate decision, despite being warned by Witness 6 of the risk of leaving the Ward in this position. The panel was of the view that other nursing professionals would consider leaving one registered nurse on this ward inappropriate and unreasonable particularly given the vulnerability of the patients on the Ward. The panel noted that even if Witness 6 had not warned Mr Sowky of the risks of leaving the Ward critically understaffed, he should have been of aware of those risks anyway. The panel concluded that this made Mr Sowky's actions all the more concerning.

The panel decided that Mr Sowky's actions in charge 5 amount to misconduct, as alleged. The incident with Patient Y was not a reason the panel found that this was misconduct: it was the reason the understaffing came to attention. It was not part of the NMC's case that the incident resulted from understaffing. However, it is self-evident that there is great risk to patients whose mental health is such that they are present in the Ward (having been sectioned) if the Ward is understaffed. It is also self-evident that it was understaffed on this

occasion, and that this was the result of Mr Sowky's scheduling of breaks, including taking his own, having released others.

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 Sowky's actions in charge 5 did fall significantly short of the standards expected of a registered nurse, and that Mr Sowky's actions amounted to a breach of the Code. Specifically:

> ***'8 Work co-operatively***
> *To achieve this, you must:*
> *8.5 work with colleagues to preserve the safety of those receiving care*
>
> ***20 Uphold the reputation of your profession at all times***
> *To achieve this, you must:*
> *20.1 keep to and uphold the standards and values set out in the Code*
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people*
> *20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*
>
> ***25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system***
> *To achieve this, you must:*
> *25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel found that Mr Sowky's actions did fall seriously short of the conduct and standards expected of a qualified nurse and amounted to misconduct in relation to charge 5 only.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Sowky'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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) ...'*

The panel finds limbs a), b) and c) of the Grant test engaged. The panel finds that patients were put at risk of harm as a result of Mr Sowky's misconduct. Mr Sowky's misconduct had breached the fundamental tenets of the nursing profession and so brought its reputation into disrepute.

Regarding insight, the panel considered that Mr Sowky did not accept his failings during the Priory's investigation in relation to charge 5. It noted in the Priory's local investigation, Mr Sowky said that it was the change in the break system which led to the understaffing issues on the shift but did not acknowledge his own actions on the shift. He also said in the Priory's local investigation that he considered that there were *'adequate'* staff on the Ward. The panel considered a letter from Mr Sowky to the Priory dated 26 November 2011, in which he said

“The ward was adequately staffed in my view at that particular time. The supernumary [sic] nurse was supporting S/N Witness 6. HCW Colleague B could have been called if the situation warranted extra staff… I conclude the gravity of my mistake is comparatively of a lesser degree to the refusal of medication… I am aware of the risk on an acute ward of volatile clients.”

The panel noted that Mr Sowky attempted to deflect blame onto his colleague, Witness 6, and has maintained this position after the Priory’s hearing and appeal process. The panel took into consideration that he had not reflected how he could have avoided leaving the Ward understaffed so placing patients and the remaining staff on the ward at risk.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Sowky’s has taken steps to strengthen his practice. The panel took into account that it has no reflective piece to consider. The panel took into consideration the training certificates dated between 2018 and 2019 but noted that there were no certificates which directly addressed the concerns of charge 5 which the panel found to be misconduct.

However, the panel is of the view that there is a risk of repetition based on the lack of information the panel had in relation to Mr Sowky’s insight. The panel determined that vulnerable patients could be put at risk, because of the risk of repetition and the panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

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

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

(For the avoidance of doubt, had the panel found the charges 1)b), c), d) and 4) to be misconduct, the panel would not have found Mr Sowky's fitness to practise impaired now, by reason of those charges. This is not only because was it an isolated incident in a 35 year career, but also because he worked at the Priory for a further year without any other incident occurring.)

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Mr Sowky's name on the NMC register will show that he is subject to a conditions of practice order and anyone who enquires about his registration will be informed of this order.

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 Adeyemi provided the panel with information in relation to Mr Sowky's subsequent employment history following the events outlined in the charges. She noted that in February 2018 he began working at Hanover Care, in a care home. In Hanover Care's feedback, it noted that it had no concerns in relation to Mr Sowky's working as a nurse in charge or his leadership skills. She noted that he moved to work in another home, Ferndale Nursing Home, where he was employed as a night nurse. She noted the feedback from both of these care homes was largely positive.

Ms Adeyemi told the panel that Mr Sowky had most recently been employed by Asher Nursing Home. She noted that this care home sent a referral to the NMC in 2019 regarding several allegations relating to Mr Sowky's nursing practice. She informed the panel that as a result of this referral, Mr Sowky is currently subject to an interim suspension order for 18 months, which she noted has been extended by the High Court until August 2022. She stated that Mr Sowky is currently working in retail.

Ms Adeyemi reminded the panel that the aim of a sanction was not to punish a registrant. She noted that while Mr Sowky failed to maintain safe staffing levels, he had gone onto work successfully and without issue at other care homes but that he has demonstrated no insight or leadership since. Further, she submitted that there is a concern that any learning cannot be sustained as Mr Sowky may not understand the issues or risks to patients following any decisions he makes when leading a shift.

Ms Adeyemi outlined to the panel the mitigating and aggravating features of the case. She invited the panel to take into account that a further referral to the NMC has been made in relation to Mr Sowky's practice which she submitted suggests that he is a risk to the public. She submitted that it was a matter for the panel to determine what the most appropriate sanction is in this case.

The legal assessor advised the panel that sanctions were not intended to be punitive although that might be their effect. They were to protect the public, and to uphold professional standards and the reputations of the profession and its regulator. They must be proportionate and related to the matters found proved. The process to be followed was as outlined in the SG. The consideration of sanction was always to start at the lowest and move up until the appropriate sanction was arrived at.

The legal assessor advised that the panel must focus on the matter it found to be misconduct, which was in the management of nurses. The panel would have to consider, if no lesser sanction was appropriate, whether conditions of practice related to management would address the risk identified in its determination on impairment. The panel would also bear in mind that at the end of a suspension a nurse automatically practised unrestricted.

The legal assessor referred to the submissions of Ms Adeyemi concerning subsequent referrals to the NMC about the practice of Mr Sowky after leaving his employment at the Priory. The legal assessor advised that these allegations can have no relevance to the question of the sanction appropriate to this case. He advised that any risk identified from subsequent matters is being addressed in those other proceedings. He advised that it would be an error of law, as well as unfair, to impose a sanction that was in any sense influenced by later matters. These had not been put before the panel. They had not been tested in a hearing. They had not been found proved. An interim order is imposed because a risk is identified and needs to be addressed before the substantive hearing of those allegations, not because something has been found proved, found to be misconduct and a finding of current impairment made in respect of the matters found to be misconduct. To take the subsequent allegations into account in imposing sanction would be to punish Mr Sowky for something he had not been found to have done, which had not been found to have been misconduct, and in respect of which it had not been judged that his fitness to practise was impaired. The sanction decision on one matter was not a risk assessment for another. The legal assessor advised that it would be an error of law to conflate later assessments of risk arising from subsequent allegations with sanction for a matter found proved. In any event, there was no risk to the public as Mr Sowky was subject to an

interim suspension order in respect of those other matters. The panel knew that the interim suspension order was extended by the High Court until August 2022, and would be reviewed before then. That reviewing panel would have sight of the decision of this panel. That, he advised, was the correct order of things. A subsequent panel reviewing the interim order would make its decision based on the allegations which had been made subsequent to the matters found proved by this panel and that panel could take into account the findings of fact of this panel, and its conclusion on impairment, in assessing whether there was credible evidence of risk to the public from those subsequent allegations.

The legal assessor advised that the findings in other cases that the length of an interim suspension was relevant to a sanctions decision (*General Medical Council v Ahmed* [2022] EWHC 403 (Admin) and *Kamberova v Nursing and Midwifery Council* [2016] EWHC 2955 (Admin)) related only to an interim suspension imposed in respect of the allegations found proved for which the sanction was being imposed.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr Sowky'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:

- Mr Sowky has not demonstrated any insight into his misconduct and has attempted to deflect blame onto others
- Particularly vulnerable patients were put at risk of harm

The panel also took into account the following mitigating features:

- Mr Sowky's personal circumstances which include health concerns and family concerns
- Practising for 35 years with no previous concerns

The panel noted the positive references provided by two of his subsequent employers but decided to discount this information given that further allegations about Mr Sowky's nursing practice have been made to the NMC.

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

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 Sowky'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 Sowky's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 Sowky's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

The panel had regard to the fact that these incidents happened a long time ago. It noted that prior to this incident, Mr Sowky has had an unblemished career of 35 years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, Mr Sowky should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mr Sowky's case because a suspension order would expire at the end of the period and would not address the issues identified in this matter as the conditions of practice order does.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must restrict your practice to that of a Band 5 nurse, not as the nurse in charge of a shift, and without authority or responsibility for staffing levels on any ward or other nursing environment.

2. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

3. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

4. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).
   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
   e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

5. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

6. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months. The panel considered that this provided Mr Sowky with adequate time to reflect on his nursing practice and strengthen his nursing practice.

Before the order expires, a panel will hold a review hearing to see how well Mr Sowky has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

In making this decision, the panel noted the NMC's sanction bid of a 9-12 months suspension order in the Notice of Hearing letter to Mr Sowky, dated 9 December 2021. However, the panel determined that this was not appropriate given that not all the charges were found proved or amounted to misconduct.

Any future panel reviewing this case would be assisted by:

- A reflective piece using a recognised model such as Gibbs Model of Reflection addressing the event found proved of misconduct.
- Positive references from Mr Sowky's line manager or supervisor which detail his current work practices.
- Mr Sowky's engagement and attendance at any future hearing.

This will be confirmed to Mr Sowky in writing.

Interim order

As the conditions of practice 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 Sowky's own interest until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Adeyemi. She submitted that the conditions of practice order will not come into effect until 28 days after the panel's decision has been sent to Mr Sowky. She noted that he has the right to appeal and if in the event he chooses to exercise this right, the substantive order will not take effect until the conclusion of that appeal. Further, she submitted that any existing interim order could fall away, or it could be reviewed and removed. She invited the panel to consider imposing an interim order.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months as it noted that any existing interim orders may fall away given any changes in risk. It also noted the need to protect the public if Mr Sowky intended to appeal the decision made at this hearing.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mr Sowky is sent the decision of this hearing in writing.

That concludes this determination.