Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 25 April 2022 – Friday, 29 April 2022
&
Thursday, 5 May 2022

Hybrid Meeting held at 2 Stratford Place, Montfichet Road, London, E20 1EJ (Day 1 and Day 2), with all other days held virtually

Name of registrant:	**Leslie Patrick Aldridge**
NMC PIN:	80C0024E
Part(s) of the register:	Registered Nurse – Sub-part 1 Adult Nursing – June 2981 Registered Nurse – Sub-part 2 Adult Nursing – April 2993
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Bernard Herdan (Chair, Lay member) Anne Phillimore (Lay member) Susan Tokley (Registrant member)
Legal Assessor:	David Marshall
Hearings Coordinator:	Philip Austin
Facts proved:	Charges 1a, 1b, 1c(i), 1c(ii), 1c(iv), 1c(v), 1d, 1e(i), 1e(ii), 1e(iii), 1f, 1g, 1h, 2a (i), 2a(ii), 2b, 3, 4, 5, 6, 7, 8 and 9
Facts not proved:	Charges 1c(iii) and 1i
Fitness to practise:	Currently Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel received information and advice from the legal assessor concerning service of the notice of meeting.

The notice of meeting was sent by the Nursing and Midwifery Council's ("NMC") case officer in a secure and encrypted fashion to Mr Aldridge's email as shown on the NMC register on 1 March 2022. The NMC case officer had also sent the notice of meeting to a secondary email address used by Mr Aldridge to correspond with the NMC. The panel noted that the statutory instrument in place allows for electronic service of the notice of meeting to be deemed reasonable in the current circumstances, involving Covid-19.

The panel was aware that as this matter is being considered at a meeting, Mr Aldridge would not be able to attend. However, Mr Aldridge had been sent all of the evidence relating to this matter, and was informed that this meeting would take place on or after 6 April 2022. Mr Aldridge was also asked to provide comment no later than 30 March 2022 by using the response form attached to the notice of meeting, if he had anything that he wanted the panel to take account of in considering this matter.

The panel noted that the NMC has received no response from Mr Aldridge in relation to the notice of meeting. Mr Aldridge was previously represented by the Royal College of Nursing in this case, but representation was withdrawn in an email dated 20 June 2018 which stated:

> "*I am instructed that Mr Aldridge disengages from the NMC procedure as he intends to retire from nursing. Any prior consent to contact 3rd parties is hereby withdrawn, so please ensure that your file is marked appropriately. He does not consent to the NMC's contacting him save contact that you are required to make by law.*
>
> *With that, I no longer act for Mr Aldridge so please remove my name as representative*"[sic].

In taking account of the above, the panel considered Mr Aldridge to have expressed a desire, through the last act of his representative, to disengage from proceedings with the NMC. Mr Aldridge had also indicated that he intends to retire from nursing, and requested that he only be contacted insofar as the NMC's statutory obligations.

Mr Aldridge had been asked by the NMC if he would prefer this case to be considered at a hearing. However, Mr Aldridge did not respond to that request, nor object to this case being held as a substantive meeting.

Therefore, the panel was satisfied that referring this matter to a hearing would not serve any useful purpose, as it determined that Mr Aldridge would be highly unlikely to attend that in any event.

The panel was of the view that it had all the necessary information before it to reach a decision on this matter. It decided that it would be able to consider this matter solely based on the documentary and video evidence it had received.

The panel determined that this case could be properly dealt with by way of a meeting.

The panel noted that the notice of meeting had been served on 1 March 2022, which was more than 28 days before this meeting. The panel was satisfied that there was good service of the notice of meeting in accordance with Rules 11A and 34 of the Fitness to Practise Rules 2004 (as amended) ("the Rules").

Details of charge

That you a registered nurse:

1. While working the night shift 16-17 August 2015 at HMP Winchester:

    a) Did not elicit a verbal response from Prisoner A when visiting him in his cell at approximately 21:22 on 16 August 2015.

b) Did not take further steps to rouse Prisoner A during the visit to his cell at approximately 21:22.

c) Failed to appropriately assess Prisoner A when you were unable to rouse him in that you did not:

i. Assess his consciousness level; and/or
ii. Take his blood pressure; and/or
iii. Take his pulse rate; and/or
iv. Look at his pupils; and/or
v. Check his respiratory rate.

d) Did not recognise or consider that Prisoner A was showing signs of an overdose/opioid toxicity.

e) Did not take appropriate steps to mitigate the effects of a suspected overdose such as:

i. Administering Naloxone.
ii. Providing Oxygen therapy.
iii. Arranging a Transfer to hospital.

f) Did not return to Prisoner A's cell later in the shift to conduct observations

g) Recorded in Prisoner A's medication/prescription chart that you had administered Liquid Diazepam at 21:30 on 16 August 2015 when you had not.

h) Recorded in Prisoner A's Patient Record at 22:34 that you had administered Prisoner A's prescribed medication when you had not.

i) Your conduct at Charge 1g) and/or 1h) above was dishonest in that you knew you had not administered the medication to Prisoner A.

2. On 18 August 2015:

   a) Made a statement to the police in which you said and it was recorded that:

      i. "*I ensured that [Prisoner A] took the diazepam, he swallowed it in front of me*" when this did not happen.

      ii. "*I also recorded that I had observed him later, I am not sure when I observed him but it would have been about midnight*" when you had not returned to Prisoner A's cell.

   b) Signed a Statement of Truth confirming the accuracy of the statement you had given to the police which you knew to be untrue.

3. Your conduct at Charge 2 a)i and b was dishonest in that you knew you had not administered the medication to Prisoner A.

4. Your conduct at Charge 2 a)ii and b was dishonest in that you knew you had not returned to Prisoner A's cell.

5. Your conduct at 2 b was dishonest in that you sought to mislead a criminal investigation into Prisoner A's death.

6. On 28 August 2015 informed the Head of Healthcare at HMP Winchester that you did not administer medication at approximately 22:00/23:00 but had returned approximately 1 hour later and administered the medication through the inundation point when you had not.

7. Your conduct at Charge 6 was dishonest in that you sought to mislead the Central and North West London NHS Foundation Trust's investigation into events on 16-17 August 2015.

8. Your conduct at Charge 2 and/or Charge 6 demonstrates a lack of candour in that you gave false or misleading accounts when asked about your interactions with Prisoner A on 16-17 August 2015.

9. Your acts and/or omissions set out at any or all of charge 1 contributed to the loss of chance to avert the death of Prisoner A.

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

Submissions from the parties

The panel had sight of the NMC meeting bundle which contained all of the evidence that had been adduced in this case. This included correspondence between the NMC and Mr Aldridge, as well as a written statement of case prepared by the NMC for the purposes of this meeting. Mr Aldridge has not provided any direct evidence or written representations for the panel to take account of.

The following insert is from the NMC's statement of case, setting out the background of this matter, along with written representations of the facts, misconduct, impairment and sanction. The panel were invited to take account of this document in considering the evidence before it.

"THE NURSING AND MIDWIFERY COUNCIL

-and-

LESLIE PATRICK ALDRIDGE

_____

NMC's

STATEMENT OF CASE

_____

Preliminary

1) *Any and all references to the 'Registrant', 'Les, 'Leslie' and 'Mr Aldridge are to Leslie Patrick Aldridge PIN 80C0024E.*

2) *The Panel is reminded that the burden of proving the facts is on the NMC and that the standard of proof is the balance of probabilities. In other words is it more likely than not that the allegation occurred as alleged.*

Allegation

That you a registered nurse:

1. *While working the night shift 16-17 August 2015 at HMP Winchester:*

    a) *Did not elicit a verbal response from Prisoner A when visiting him in his cell at approximately 21:22 on 16 August 2015.*

    b) *Did not take further steps to rouse Prisoner A during the visit to his cell at approximately 21:22.*

    c) *Failed to appropriately assess Prisoner A when you were unable to rouse him in that you did not:*

        i. *Assess his consciousness level; and/or*

        ii. *Take his blood pressure; and/or*

        iii. *Take his pulse rate; and/or*

        iv. *Look at his pupils; and/or*

        v. *Check his respiratory rate.*

d) Did not recognise or consider that Prisoner A was showing signs of an overdose/opioid toxicity.

e) Did not take appropriate steps to mitigate the effects of a suspected overdose such as:

i. Administering Naloxone.

ii. Providing Oxygen therapy.

iii. Arranging a Transfer to hospital.

f) Did not return to Prisoner A's cell later in the shift to conduct observations

g) Recorded in Prisoner A's medication/prescription chart that you had administered Liquid Diazepam at 21:30 on 16 August 2015 when you had not.

h) Recorded in Prisoner A's Patient Record at 22:34 that you had administered Prisoner A's prescribed medication when you had not.

i) Your conduct at Charge 1g) and/or 1h) above was dishonest in that you knew you had not administered the medication to Prisoner A.

2. On 18 August 2015:

a) Made a statement to the police in which you said and it was recorded that:

i. "I ensured that [Prisoner A] took the diazepam, he swallowed it in front of me" when this did not happen.

ii. "I also recorded that I had observed him later, I am not sure when I observed him but it would have been about midnight" when you had not returned to Prisoner A's cell.

b) Signed a Statement of Truth confirming the accuracy of the statement you had given to the police which you knew to be untrue.

3. Your conduct at Charge 2 a)i and b was dishonest in that you knew you had not administered the medication to Prisoner A.

4. Your conduct at Charge 2 a)ii and b was dishonest in that you knew you had not returned to Prisoner A's cell.

5. Your conduct at 2 b was dishonest in that you sought to mislead a criminal investigation into Prisoner A's death.

6. On 28 August 2015 informed the Head of Healthcare at HMP Winchester that you did not administer medication at approximately 22:00/23:00 but had returned approximately 1hour later and administered the medication through the inundation point when you had not.

7. Your conduct at Charge 6 was dishonest in that you sought to mislead the Central and North West London NHS Foundation Trust's investigation into events on 16-17 August 2015.

8. Your conduct at Charge 2 and/or Charge 6 demonstrates a lack of candour in that you gave false or misleading accounts when asked about your interactions with Prisoner A on 16-17 August 2015.

9. Your acts and/or omissions set out at any or all of charge 1 contributed to the loss of chance to avert the death of Prisoner A.

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

Facts

3) The NMC received a referral about Mr Aldridge's fitness to practise on 2 October 2015 from the Head of Healthcare, Central and North West London NHS Foundation Trust ('the Trust'). At the time of the concerns raised in the referral, the

Registrant was working as a staff nurse for the Integrated Substance Misuse Service ('ISMS') at HMP/YOI Winchester ('the Prison').

The regulatory concerns identified and investigated by the NMC and referred to the Fitness to Practice Committee by the Case Examiners are as follows:

1. Failure to adequately monitor and escalate deteriorating patients in relation to:

1.1. Prisoner A on 16 and 17 August 2015;

2. Providing misleading information, with associated dishonesty, by:

2.1. Stating that you had administered medication to Prisoner A when you had in fact not;

2.2. Stating that you had gone back to check on Prisoner A when you had in fact not;

2.3. Stating that you had seen Prisoner A during the early hours of 17 August 2015 when you had in fact not;

7. Inadequate record keeping practice.

The Registrant

4) *Mr Aldridge joined the Register in 1981 and started working at the Trust in 1992. He began working at the Prison as part of the ISMS in October 2013.*

Background

5) *Prisoner A was receiving treatment from the ISMS for substance misuse issues. The treatment included administration of diazepam and methadone. On 16 August 2015, staffing issues resulted in prisoners being locked in their cells for longer than usual. Prisoner A was due to receive diazepam twice a day, but because of the extended time locked in the cell, there was a delay in administering this. The task of administering the second dose was therefore handed over to the night shift. Mr Aldridge was working on the night shift and attended Prisoner A's cell at around 21:22, accompanied by prison officers. It is alleged that Mr Aldridge did not*

administer Patient A's diazepam, and instead rolled Prisoner A, who was snoring, onto his side. Mr Aldridge recorded that he had administered diazepam to Prisoner A on System One, the electronic record. He did not return to Prisoner A during the night shift. Prisoner A was found dead in his cell the following morning.

6) *The police investigated the matter of Prisoner A's death. However Mr Aldridge was not charged or cautioned in respect of any offence arising out of Prisoner A's death.*

7) *The pathologist's conclusion was that Prisoner A's death was due to the toxic effects of methadone. He found no significant natural disease or any sigsn of injury no any other apparent cause for death.*

Charges

8) *The panel is referred to the attached evidence matrix which should be considered alongside the submissions made below.*

Charge 1 While working the night shift 16-17 August 2015 at HMP Winchester:

9) *It is submitted that there is no dispute that Mr Aldridge was working on the night shift 16-17 August 2015, at HMP Winchester. Indeed at Exhibit [PRIVATE] Mr Aldridge confirms he was at the prison at the relevant time. As [Ms 1] notes at paragraph 6 of her witness statement:*

The Registrant's role was to provide a high quality nursing assessment and treatment service to prisoners, ensuring that healthcare needs are identified and met, and any risks addressed. As a Band 5 nurse, he would have been expected to work with a high degree of autonomy and professional accountability, which was likely to include working alone at times.

10) *The Registrant's job description and person specification can be found at [PRIVATE] Appendix 1 and 2 respectively.*

Charge 1a) Did not elicit a verbal response from Prisoner A when visiting him in his cell at approximately 21:22 on 16 August 2015.

11) Mr Aldridge attend Prisoner A's cell accompanied by prison officers [Mr 2], [Mr 3] and [Mr 4]. The CCTV at Exhibit [PRIVATE] shows that the Registrant attended the cell at 21:22.

12) The CCTV shows Mr Aldridge entering the cell with one prison officer identified as [Mr 4]. [Mr 3] remained outside the cell door (paragraph 4 of [Mr 3's] statement and Exhibit [PRIVATE]). [Mr 2] stood in the doorway but moved further into the cell for approximately 5 seconds.

13) At Exhibit [PRIVATE] [Mr 2] notes: Prisoner A was snoring very loudly and didn't wake up when his name was said a few times'.

14) [Ms 5] at paragraph 12 onwards of her witness statement recalls a face-to-face meeting she had with Mr Aldridge on 8 September 2015. At paragraph 12.c.i. she notes: 'Mr Aldridge said that he had called Prisoner A's name but got no response'.

15) In his evidence to the Inquest Mr Aldridge was asked by the coroner: 'Did he appear to rouse at all? Did he appear to come out of sleep?' to which Mr Aldridge answered 'No, no' (page 1063 line 5-6).

16) [Ms 6] in her expert report concludes at paragraph 10.7: It is my opinion that failure to illicit a verbal response in this scenario fell far below the standard of care expected of a reasonably competent registered nurse.

Charge 1b) Did not take further steps to rouse Prisoner A during the visit to his cell at approximately 21:22.

17) [Mr 2] notes at paragraph 6e of his statement that 'I remember Mr Aldridge at one point saying words to the effect of "I won't try and wake him so I won't give him his meds"'. At Exhibit [PRIVATE] he recalls that 'I don't think Prisoner A woke up at all'.

18) In his evidence to the Inquest, Mr Aldridge was asked: 'And did he appear to rouse at all? Did he appear to come out of sleep?'. He answered: 'No, no'. (page 1063 Line 5-6). The evidence suggests that Mr Aldridge turned Prisoner A on to his side but did no more than this.

19) *[Ms 5] in her evidence to the Corner suggested that a nurse could give someone 'a little bit of a shake' conducted a 'pain test where you can pinch the individual to see if they respond to stimuli' (page 1171 L25 onwards). [Dr 7] agreed that it would have been reasonable in the context to have conducted a the 'pinch test' (page 1190 L29 onwards)*

20) *[Ms 6] notes at paragraph 10.7 that in her opinion a prisoner, 'lying on his back, snoring loudly and did not wake or rouse on turning the light on or to verbal stimuli…..would be unusual in a patient who has been subject to extended hours locked in his cell and who is undergoing drug detoxification'.*

Charge 1c) Failed to appropriately assess Prisoner A when you were unable to rouse him in that you did not:

i. Assess his consciousness level; and/or

ii. Take his blood pressure; and/or

iii. Take his pulse rate; and/or

iv. Look at his pupils; and/or

v. Check his respiratory rate.

21) *The evidence before the panel is that on entering the cell Prison A was lying on his back, snoring loudly and did not wake or rouse in response to the light being turned on or to his name being called. [Ms 6] in her expert report notes at paragraph 11.3.1 that: 'Prisoner A did not rouse, even when rolled onto his side. It is my experience that this would be unusual in a patient who has been subject to extended hours locked in his cell and who is undergoing drug detoxification. It is my opinion that Prisoner A had a reduced conscious level and, as such, opioid toxicity should have been suspected at this point'.*

22) *At paragraph 11.3.2 [Ms 6] notes:*

Any reasonably competent nurse would, in my opinion, have attempted to rouse [Prisoner A] and gain a verbal response from him. Had he failed to rouse, any

reasonably competent nurse would have looked for signs of overdose, including an assessment of conscious level using a recognised scale, such as the Glasgow Coma Scale, and a physical assessment of pupil responses, blood pressure, respiratory rate and pulse rate. [Dr 8] confirmed that the prison used the National Early Warning Signs assessment tool and I would have expected Nurse Aldridge to use this tool prior to leaving the cell.

23) *[Ms 6] concludes at paragraph 11.3.4: It is my opinion that Nurse Aldridge did not act as required. When Nurse Aldridge failed to rouse Prisoner A, he repositioned him; he stated that the checked his pulse rate prior to leaving the cell, although this was not documented or witnessed by the officers. In my opinion, failure to elicit a verbal response and to conduct a full physical assessment (including conscious level, heart rate, blood pressure and pupil reaction) falls below the required standards of care.*

24) *The panel is also referred to [Dr 7's] evidence at the Inquest and in particular page 1206 line 23 onwards:*

We have heard that Mr Aldridge was, in fact, trained to recognise the symptoms of potential methadone toxicity and seek medical assistance or administer naloxone. How would you describe Mr Aldridge's failure in those circumstances even to take a blood pressure or measure his respiratory rate?
I think it's a significant failure.

25) *[Ms 5] at Exhibit [PRIVATE] notes: The patient's presentation and current stabilising status would have warranted further clinical observations which were not undertaken. Further when questioned by [Ms 1] (Exhibit [PRIVATE], Notes from investigation meeting Wednesday 11 November 2015, page 2) [Ms 5] is asked and responds:*

[Ms 1] What would a nurse on night duty be expected to do in order to know the patient is ok/safe in the cell?

[Ms 5] We would get the medication. If the patient did not respond when we tried to wake them – we would look for overdose signs and then decide what action to take for example to do observations again, a nurse would give the

medication later. We would try awakened the person, would try and reason with the person.

26) *The evidence of the prison officers who accompanied Mr Aldridge to the cell is that save for turning Prisoner A on to this side, the Registrant did nothing further. At Exhibit [PRIVATE] [Mr 2] is asked 'Did you see/remember the nurse taking any clinical observations such as a pulse?' he responds 'Not that I'm aware'. [Mr 3] likewise is asked at interview 'Did you see/remember the nurse taking any clinical observations such as a pulse?' to which he responds 'no' (Exhibit [PRIVATE]).*

27) *Mr Aldridge claims to have taken Prisoner A's pulse but this was not recorded in any of Prisoner A's medical records or witnessed by the officers accompanying him. The CCTV evidence shows that Mr Aldridge was in the cell for approximately 40 seconds and it is therefore submitted that carrying out any or all these observations, including taking an accurate pulse, as well as turning Prisoner A on to his side would not have been possible in such a short space of time.*

Charge 1d Did not recognise or consider that Prisoner A was showing signs of an overdose/opioid toxicity.

28) *Mr Aldridge was trained in the symptoms and signs of overdose, as confirmed by him at the Inquest (page 1082 L4-5).*

29) *[Dr 7] is asked in questioning at the Inquest about whether the 'nurse should have been very concerned of overdose' to which she responds 'mm-hmm' (page 1206 L5).*

30) *[Ms 5] notes in her interview with [Ms 1] (Exhibit [PRIVATE]) that 'if the patient did not respond when we tried to wake them – we would look for overdose signs and then decide what action to take'.*

31) *[Ms 6] notes at paragraph 10.8 that Nurse Aldridge should, in my opinion, have considered opioid toxicity as a potential risk from the outset. At paragraph 11.3.2. she further states 'had he failed to rouse any reasonably competent nurse would have looked for signs of overdose, including an assessment of conscious level*

using a recognised scale, such as the Glasgow Coma Scale, and a physical assessment of pupil responses, blood pressure, respiratory rate and pulse rate'.

Charge 1e Did not take appropriate steps to mitigate the effects of a suspected overdose such as:

i. Administering Naloxone.

ii. Providing Oxygen therapy.

iii. Arranging a Transfer to hospital.

32) [Ms 6] in her report notes at paragraph 11.3.3.:

All prison nursing staff have access to emergency equipment and would be trained in its use. Naloxone was available in the emergency bag and [Dr 8] confirmed that nurses were trained to administer this. In my experience, oxygen is also always available. In my opinion, oxygen therapy, naloxone administration and a transfer to hospital were mandated in this scenario.

33) There is no evidence to suggest any of the steps at 1e) i, ii or iii were taken by Mr Aldridge. The prison officer's accounts, as well as that of Mr Aldridge himself do not detail him administering naloxone and/or providing oxygen therapy and or arranging a transfer to hospital.

Charge 1f Did not return to Prisoner A's cell later in the shift to conduct observations.

34) The CCTV shows that the Registrant did not return to Prisoner A's cell for the remainder of the shift. He therefore could not have conducted any further observations of Prisoner A.

35) [Dr 7], a Consultant Psychiatrist notes in her report that 'If Mr Aldridge had carried out further observations (or indeed gone back to the cell to give the diazepam) when [Prisoner A] was found snoring and unrousable in the cell on 16 August 2015 then it is also possible that the death could have been averted".

36) [Ms 5] at paragraph 12 onwards of her statement, details a face-to-face meeting she had with Mr Aldridge on 8 September 2015. At that meeting she put to Mr Aldridge the inconsistencies in the accounts he had given about his interaction with Prisoner A on the night shift 16-17 August 2015. When faced with the inconsistencies in his story he said that he had been confused and he agreed that he had not returned to Prisoner A's cell on a second occasion, as he had suggested on 28 August 2015.

37) Finally, in his evidence at the Inquest Mr Aldridge confirmed that he had not returned to the cell following his initial visit with the prison officers at 21:22 (page 1068 L30-331):

30 Q. So to be clear, after 21.22 you didn't return to the cell? That's what you say?

31 A. Yes that's right, sir.

Charge 1g Recorded in Prisoner A's medication/prescription chart that you had administered Liquid Diazepam at 21:30 on 16 August 2015 when you had not.

38) The Panel's attention is drawn to Exhibit [PRIVATE], Appendix 36 which is Prisoner A's Medication and Administration Record Chart. It can be seen that on 16 August liquid diazepam 10mgs is recorded to have been administered at 21:30 by the Registrant.

39) However, [Mr 2] notes at paragraph 6e of his statement and in Exhibit [PRIVATE] and [PRIVATE] that no medication was administered.

40) [Ms 1] reports at paragraph 12 that in her interview with the Registrant on 15 October 2015 he stated 'that he did not give any medication to Prisoner A as he was not 'rousable'.

41) When questioned by the Coroner at the inquest into Prisoner A's death as to whether he gave Prisoner A the diazepam he responded 'No I didn't, sir.' [Page 1063, Line 28-29].

Charge 1h Recorded in Prisoner A's Patient Record at 22:34 that you had administered Prisoner A's prescribed medication when you had not.

42) At page 40 of 107 at Appendix 38 of Exhibit [PRIVATE] the panel will see Mr Aldridge's entry at 22:34 on 16 August 2015 in which he records 'prescribed medication given'.

43) As stated above the Registrant on 15 October 2015 confirmed to [Ms 1] 'that he did not give any medication to Prisoner A as he was not 'rousable'.

44) As set out above in response to the Coroner's question as to whether he had administered diazepam to Prisoner A, the Registrant respondent that he had not.

Charge 1i Your conduct at Charge 1g) and/or 1h) above was dishonest in that you knew you had not administered the medication to Prisoner A.

45) By his own admission Mr Aldridge did not administer the diazepam to Prisoner A on his shift 16-17 August 2015.

46) Despite knowing this the Registrant proceeded to complete Prisoner's A's medical records to show that the medication had been administered.

47) It is submitted the Registrants conduct at both 1g) and 1h) was dishonest. In applying the test in Ivey v Genting Casinos (UK) (trading as Cockfords Club) [2017] UKSC 67 the panel need to ascertain (a) what was the defendant's actual state of knowledge or belief as to the facts' and then (b) was his conduct dishonest by the standards of ordinary decent people?

48) It is submitted that as he knew he had not administered the diazepam to Prisoner A because he was 'sleeping' then he knew he should not record it as being administered as nurses are taught about the need to accurately record medication administration. In response to (b) it is submitted that his conduct was dishonest by the standards of ordinary decent people, as in completing the records to indicate medication had been administered he gave the impression that Prisoner A had taken the medication when he had not. It is submitted that ordinary people would consider this to be dishonest in the circumstances.

Charge 2: On 18 August 2015:

Charge 2a) Made a statement to the police in which you said and it was recorded that:

i. "I ensured that [Prisoner A] took the diazepam, he swallowed it in front of me" when this did not happen.

ii. "I also recorded that I had observed him later, I am not sure when I observed him but it would have been about midnight" when you had not returned to Prisoner A's cell.

49) [Mr 9] visited the Registrant at home on 18 August 2015 at which time he took a witness statement which he produces as Exhibit [PRIVATE]. The panel will see that within that statement the quotations used in the charge are recorded.

50) The Panel have seen the statements of the prison officers and indeed Mr Aldridge's own admission that as Prisoner A was 'asleep' the medication was not administered. Therefore his statement provided to the police was incorrect.

51) Furthermore, the CCTV evidence establishes that Mr Aldridge did not return to Prisoner A's cell for the duration of his shift. Therefore his assertion that he 'observed him' around 'midnight' is also incorrect.

52) The panel are referred to [Ms 5's] statement where she records that Mr Aldridge states that he gave a different account at the outset of the investigation into Prisoner's A death because he had been confused as to which prisoner was being referred to.

53) [Mr 9] records in his statement the information he gave to the Registrant at the time the statement was made and also that the Registrant did not indicate a willingness to delay making a statement to receive any further information.

54) Furthermore, [Ms 10's] evidence is that she contacted Mr Aldridge to inform him that Prisoner A had died and that the police would contact him. There is no evidence to suggest he raised concerns about the identity of who had died or sought further information/clarification.

Charge 2b: Signed a Statement of Truth confirming the accuracy of the statement you had given to the police which you knew to be untrue.

55) [Mr 9] notes that he witnessed Mr Aldridge sign the Statement of Truth as can be seen at Exhibit [PRIVATE].

56) It is the NMC's case that Mr Aldridge knew when signing that statement that the contents were untrue. There is no evidence to suggest that he voiced any reservations about who or what was being discussed with [Mr 9].

57) Furthermore and in this regard, [Mr 10] notes that she had contacted Mr Aldridge to tell him that Prisoner A had died and that the police would contact him. If Mr Aldridge had had any doubts about who was being discussed he could and should have raised this with the police officer and not signed the statement of truth until he was sure about what he was signing.

Charges 3 and 4

10. Your conduct at Charge 2 a)i and b was dishonest in that you knew you had not administered the medication to Prisoner A.

11. Your conduct at Charge 2 a)ii and b was dishonest in that you knew you had not returned to Prisoner A's cell.

58) It is the NMC's submission that Mr Aldridge's conduct at charges 2a)i and 2a)ii was dishonest in that he knew he had not administered medication to Prisoner A and that he had not returned to Prisoner A's cell after visiting it at approximately 21:22.

59) It is submitted that in applying the test in Ivey, the Registrant knew he had not administered the medication as well as that he had not returned to Prisoner A's cell when making the statement to the police. It is submitted that ordinary people would consider this to be dishonest.

Charge 5 Your conduct at charge 2 b was dishonest in that you sought to mislead a criminal investigation into Prisoner A's death.

60) In terms of the conduct at charge 2b) the Registrant has contended that he was not sure which prisoner was being discussed. However the evidence of the police officer is that Mr Aldridge raised no concerns or queries about who was discussed, and as is set out above, he had been contacted by [Ms 10] who informed him who had died and that the police would be coming to see him. If Mr Aldridge had at any point been unclear about who was being discussed he could have sought more information but did not do so.

61) It is submitted that he knew he was giving incorrect information that would lead anyone reading the statement to consider that he had administered the medication and that he had returned at a later point during the shift to check on Prisoner A and that there were no concerns. This would have had an impact on considerations about time of death as well as potential causes. In dishonestly reporting his interactions with Prisoner A to the police, it is submitted he was trying to deflect from the fact he had not administered the medication or appropriately carried out observations on Prisoner A when seeing him at 21:22.

Charge 6: On 28 August 2015 informed the Head of Healthcare at HMP Winchester that you did not administer medication at approximately 22:00/23:00 but had returned approximately 1hour later and administered the medication through the inundation point when you had not.

62) The panel is referred to the witness statement of [Ms 5] and in particular paragraphs 9-12 and Exhibit [PRIVATE] in determining this charge.

63) [Ms 5] recalls a telephone conversation between herself and the Registrant on 28 August 2015. During that telephone call the Registrant informed her that he did not administer medication when the prison officers had been with him at around 22:00/23:00 because Prisoner A was asleep and snoring loudly. The Registrant went on to say that he had returned to the cell, on his own, an hour later and then administered medication through the inundation point.

64) The CCTV shows that after the single attendance of Mr Aldridge with the 3 prison officers at 21:22 he did not return to the cell at any point during the rest of the shift.

Charge 7 Your conduct at Charge 6 was dishonest in that you sought to mislead the Central and North West London NHS Foundation Trust's investigation into events on 16-17 August 2015.

65) [Ms 5] at paragraph 12 onwards of her statement, details a face-to-face meeting she had with Mr Aldridge on 8 September 2015.

66) At that meeting she put to Mr Aldridge the inconsistencies in the accounts he had given about his interaction with Prisoner A on the night shift 16-17 August 2015. When faced with the inconsistencies in his story he 'said that he had been confused and he agreed that he had not returned to Prisoner A's cell on a second occasion, as he had suggested on 28 August 2015.

67) It is the NMC's case that Mr Aldridge was seeking to mislead the investigation by providing an incorrect account of his movements on 16-17 August 2015 because he knew he had not administered the medication to Prisoner A but had recorded he had done so. It was only when the inconsistencies in his story were pointed out and the evidence of the CCTV shown to him, did he admit that he hadn't returned to Prisoner A's cell later on shift. Mr Aldridge states he was confused, but if confused when talking about the death of a patient in your care, it is submitted you would seek clarification and further information.

Charge 8: Your conduct at Charge 2 and/or Charge 6 demonstrates a lack of candour in that you gave false or misleading accounts when asked about your interactions with Prisoner A on 16-17 August 2015.

68) Nurses have a duty to be open and honest with patients, colleagues and employers when things go wrong. After Prisoner A's death was discovered on 17 August 2015 it would have been inevitable that both the prison/healthcare Trust and the police would want to speak to Mr Aldridge especially as all deaths which occur in custody are subject to a coronial enquiry.

69) Instead of telling the truth when first confronted and owning up that he had incorrectly signed medication charts showing medication had been administered, he proceeded to lie until faced with evidence to the contrary. This may well have led to

delays in the investigation and the requirement for further, unnecessary, work to be carried out.

Charge 9 Your acts and/or omissions set out at any or all of charge 1 contributed to the loss of chance to avert the death of Prisoner A.

70) It is the NMC's case that if Mr Aldridge had taken steps to rouse Prisoner A without success he should then have known to consider whether Prisoner A had had an overdose. In helping him to make that judgement call he should have carried out the appropriate observations at charge 1c) which would then have informed his next steps, which the NMC say, were to administer naloxone, provide oxygen and call for an ambulance. The evidence is that Prisoner A was still alive when Mr Aldridge entered the cell but the fact that he did not take the above steps, all of which could be reasonably expected of a registered nurse in Mr Aldridge's position, meant that there was a loss of chance to avert the death of Prisoner A.

71) The panel is referred to [Dr 7's] report for the Corner at Exhibit [PRIVATE] and in particular section 8.4.

72) The panel is also referred to [Dr 7]'s evidence to the Coroner in full but specifically:

You'd have had to call the ambulance. If you'd given him naloxone you'd have had to have called the ambulance.

Q. And then call the ambulance. But all of that is speculation, isn't it?

A. It's certainly speculation about how well the naloxone would have worked, but the combination of naloxone and calling an ambulance would – it certainly have increased the chance of his survival but it wouldn't have been 100% sure that he would have survived, yes. (page 1208 L18 onwards)

73) [Dr 7] is questioned and answers (page 1207 L 16 onwards):

So, overall, doctor, you would agree that Mr Aldridge failed very seriously in his duty of care to Prisoner A

A. I think he did, yes.

Q. Do you have any reason, [Dr 7], to disagree with the proposition that if

Nurse Aldridge had responded according to his training and administered naloxone at 21.23 or, indeed, at any time up until 01.00 hours when the man in the cell next door, it wasn't a cell mate, heard the snoring cease that need not have died?
I think that's possible, yes.

74) *In addition the panel are referred to the findings and conclusions of the NMC's expert [Ms 6] and [Dr 11]'s report at Exhibit [PRIVATE].*

Impairment

75) *The panel will be aware that in deciding whether a Registrant's fitness to practise is impaired by reason of misconduct the correct course (per Cheatle v General Medical Council [2009] EWHC 645) is to embark upon a two stage process.*

76) *First, the panel should consider whether the facts found proved amount to misconduct. If the panel determine that the facts found proved amount to misconduct, they should next proceed to decide whether the Registrant's fitness to practise is currently impaired.*

77) *In determining these questions there is no burden or standard of proof, it is entirely a question for the panel's professional judgment (per Council for the Regulation of Health Care Professionals v (1) General Medical Council (2) Biswas [2006] EWHC 464 (Admin)).*

78) *The Panel's overarching objective in reaching a decision is the protection of the public. Public protection is defined as a real risk to patients and/or colleagues and/or other members of the public in the registrant continuing in the role. A vital part of public protection is encouraging people to use the services of nurses and midwives and in doing this, it is important that the Panel recognises its obligation to also uphold public interest. Public Interest includes:*

a) the need to declare and uphold proper standards of conduct and

b) the need to maintain confidence in the profession and also in the NMC as a regulator.

Misconduct

79) The first task for the panel is to decide whether the facts found proved amount to misconduct. It is submitted that if any of the charges are found proved they would amount to misconduct.

80) The starting point for the panel is the definition of misconduct given by Lord Clyde in Roylance v General Medical Council (No 2) [2000] 1 AC 311, a case considered by the Privy Council in 2000. Lord Clyde framed the meaning of misconduct in the following way:

"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of what may often be found by reference to the rules and standards of ordinarily required to be followed by a medical practitioner in the particular circumstances."

81) The description of misconduct in Roylance was expanded upon by Auld LJ in Meadow v General Medical Council [2006] EWCA Civ 1390:

"Serious professional misconduct' is not statutorily defined and is not capable of precise description or delimitation. It may include not only misconduct by a doctor in his clinical practice, but misconduct in the exercise, or professed exercise, of his medical calling in other contexts, such as that here in giving of expert medical evidence before a court. As Lord Clyde might have encapsulated his discussion of the matter in Roylance v Clyde, it must be linked to the practice of medicine or conduct that otherwise brings the profession into disrepute, and it must be serious. As to seriousness, Collins J, in Nandi v General Medical Council [2004] EWHC rightly emphasised, at paragraph 31 of his judgement, the need to give it proper weight, observing that in other contexts it has been referred to as 'conduct which would be regarded as deplorable by fellow practitioners."

82) In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin), Mrs Justice Cox defined it as:

"…conduct falling seriously short of [standards] what the public has a right to expect from a registrant nurse or midwife; hence, I say it is based upon your own expertise."

83) It is submitted that the charges fall squarely within the parameters of the definition of misconduct in Roylance, Meadow, and Grant.

84) Where the acts or omissions of a registered nurse are in question, what would appear proper in the circumstances (per Roylance) can be determined by having reference to the Code of Conduct.

85) It is submitted that, the facts contained within the charges are demonstrative of conduct falling short of the rules and standards expressed in the Code.

86) The Code in place at the time of the conduct charged was the 2015 version, which remained valid until 10 October 2018. The NMC submits that the following parts of the Code are engaged in this case:

1.1 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

2.1 work in partnership with people to make sure you deliver care effectively

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

6.1 make sure that any information or advice given is evidence- based, including information relating to using any healthcare products or services

6.2 maintain the knowledge and skills you need for safe and effective practice

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

8.6 share information to identify and reduce risk

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

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

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

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

13.3 ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence

15.1 only act in an emergency within the limits of your knowledge and competence

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

20.1 keep to and uphold the standards and values set out in the Code

87) *The panel will be mindful however that breaches of the Code do not automatically result in a finding of misconduct.*

88) *It is the NMC's case however that the misconduct captured in the charges is extremely serious and fell below the standard expected of a registered nurse in Mr Aldridge's position, as has been made clear in the expert report of [Ms 6]. There were policies in place covering treatment for substance misuse and how to identify and teat an overdose. In addition Mr Aldridge's training was up to date. Despite this Mr Aldridge's acted in such a way as to put Prisoner A at risk of harm and indeed harm did follow the NMC say, as a result of Mr Aldridge's failure to take the appropriate action.*

89) *Record keeping is a fundamental nursing skill and one which is central to the provision of safe and effective care. Mr Aldridge dishonestly recorded the administration of medication to Prisoner A. He then proceeded to lie about that administration to the police and his employer until presented with evidence to the contrary.*

90) *It is submitted that the conduct contained in the charges amounts to misconduct.*

Current Impairment

91) *The term "impairment of fitness to practise" or current impairment is not defined in the Nursing and Midwifery Order 2001 or The Nursing and Midwifery Council (Fitness to Practice) Rules 2004 (SI2004/1761). The NMC have defined current impairment as 'the suitability of a nurse to remain on the register without restriction.'*

92) *Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain the standards expected of the profession. 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 open and honest. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.*

93) There is judicial guidance as to how a panel should approach the issue of impairment of fitness to practise and it appears in a number of authorities.

94) The starting point for the panel is the comprehensive approach formulated by Dame Janet Smith in her fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011] EWHC 927 (Admin):

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

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

b) Has in the past and/or is liable in the future to bring the profession into disrepute;

c) Has in the past, and/or is liable in the future to breach one of the fundamental tenets of the professions;

d) Has in the past, and/or is liable in the future to act dishonestly." (para 76)

95) It is submitted that limbs a – d are engaged in this case. It is the NMC's case that the Registrant's conduct contributed to the actual harm of Prisoner A and his conduct and in-action in doing so breached a fundamental tenet of the nursing profession.

96) By failing to follow policies and procedures, implemented to mitigate the risk of harm, and as a consequence, taking an unreasonable risk with Prisoner A's safety which the NMC say contributed to Prisoner A's 'loss of chance', the Registrant brought the profession into disrepute.

97) The Registrant's dishonest conduct in falsifying clinical records and his failure to demonstrate the duty of candour when first questioned by the police and his employer not only fulfil limb d) but it is submitted also engage limbs a)-c).

98) *In addition to the questions posed in Grant, the panel should also take into account the observations made by Mr J Silber in the case of Cohen v General Medical Council [2008] EWHC 581:*

"Any approach to the issue of whether a doctor's fitness to practise should be regarded as 'impaired' must take account of 'the need to protect the individual patient, and the collective need to maintain confidence [in the] profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the profession. In my view, at stage 2 when fitness to practise is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor's misconduct, his or her fitness to practise has been impaired. It must not be forgotten that a finding in respect of fitness to practise determines whether sanctions can be imposed: s 35D of the Act." (para 62)

"I must stress that the fact that the stage 2 is separate from stage 1 shows that it was not intended that every case of misconduct found at stage 1 must automatically mean that the practitioner's fitness to practise is impaired." (para 63)

"There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired. Indeed the Rules have been drafted on the basis that the once the Panel has found misconduct, it has to consider as a separate and discreet (sic) exercise whether the practitioner's fitness to practise has been impaired. Indeed s 35D(3) of the Act states that where the Panel finds that the practitioner's fitness to practise is not impaired, 'they may nevertheless give him a warning regarding his future conduct or performance." (para 64)

99) *In respect of Mr Aldridge, the panel may form the view that that the misconduct was an isolated incident in the Cohen sense above, particularly in light of the fact that the Registrant has no previous regulatory concerns. His conduct could be viewed as being a single occurrence restricted to one night shift. However, Mr Aldridge*

went on to mislead and frustrate the police and local investigation to cover up his dishonest record keeping which increases the seriousness of his misconduct. It was also repeated in that he only changed his story when the inconsistencies and discrepancies in his account were put to him.

100) An assessment of current fitness to practise also involves the panel asking the question 'has the registrant taken any steps to remedy her past misconduct? Silber J recognised this in a '3-fold' test in formulated in Cohen when referring to the necessity to determine whether the misconduct of the registrant is remediable, whether it has in fact been remedied and whether it is highly likely to re-occur:

"It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly likely to be repeated." (para 65)

Remediable?

101) The NMC submit that the conduct charged is a mix of clinical concerns which would in theory be remediable as well as concerns relating to Mr Aldridge's attitude and dishonesty which, while not impossible, are much more difficult to remediate (Bolton v Law Society [1994] 1 WLR 512).

102) In his police interview, if he had any doubt about who was being discussed he should have asked for further information or indicated he could not remember without returning to the prison and reviewing records. When faced with evidence he had not administered the medication when accompanied by the 3 prison officers at approximately 21:22 he then changes his story to say he returned at a later time to administer the medication instead of admitting he had not administered it. Only when later faced with the CCTV evidence that he never returned to the cell did he concede he had not administered the medication.

103) in General Medical Council v Patel [2018] EWHC 171, His Honour Judge Dight CBE made it clear that any efforts made at remediating misconduct involving dishonesty of far less significance:

"Secondly, where a FTPP considers that fitness to practise is impaired for such reasons, and that a firm declaration of professional standards so as to promote public confidence in that medical practitioner and the profession generally is required, the efforts made by the practitioner to address his problems and to reduce the risk of recurrence of such misconduct in the future may be of far less significance than in other cases, such as those involving clinical errors or incompetence. In the former type of case, the fact that the medical practitioner in question has taken remedial action in relation to his own attitudes and behaviour will not meet the basis of justification on which the FTPP considers that a finding of impairment of fitness to practise should be made. This view is also supported to some degree by the judgment of McCombe J in Azzam at [51] (distinguishing the case before him, which involved clinical errors, in respect of which evidence of remedial steps and improvement was relevant, from a case involving "a rape or misconduct of that kind", in relation to which – by implication – such evidence might be less significant)."

Remedied?

104) *It is submitted that Registrant has not taken steps to remediate his conduct. While the NMC's file shows that a reflective piece was provided to an interim order review panel on 29 March 2017, despite requests to the Registrant's representatives at the time (1 and 20 June 2018) for a copy of that reflective piece, nothing was forthcoming. Then in a letter dated 20 June 2018 the RCN indicated that the Registrant was disengaging form the NMC proceedings as he intended to retire form nursing. As such there has been no response to the NMC's fitness to practice proceedings.*

105) *The panel are therefore invited to consider Mr Aldridge's responses as documented during the Trust, PPO, police investigations as well as his evidence to the Coroner. The transcript of the interview with LW indicates that he acknowledged he "did things wrong that night…but what I don't put my hands up is that there could be a lot of things that went better…" This response focuses on the systems in place rather than his own actions.*

106) It is submitted that the Registrant has not demonstrated any or sufficient insight into the concerns.

107) Furthermore, there has been no evidence provided regarding any further training or references commenting on the standard of Mr Aldridge's nursing care as they relate to the regulatory concerns.

Repetition?

108) It is submitted that there is a real risk of repetition in this case given the absence of sufficient insight and lack of evidence of training or continued clinical practice. Moreover given the dishonesty which is directly linked to his practice and the lack of sufficient insight and training in this regard it is submitted that there remains a risk of repetition of similar concerns if he were to return to unrestricted practice. As such the NMC submits that Mr Aldridge presents a risk to the health, safety and wellbeing of the public.

109) The Panel will be aware that Silber J's '3-fold test' in Cohen is not determinative in assessing the question of impairment in relation to a registrant's fitness to practise.

110) When considering fitness to practise, the panel will also have to consider the 'fundamental public interest considerations' in any assessment of a registrant's impairment, as outlined by Mrs Justice Cox in Grant:

"However, it is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations emphasised at the outset of this section of his judgement at paragraph 62, namely the need to protect the public and the need to declare and uphold proper standards of professional conduct and behaviour so as to maintain public confidence in the profession." (para 71)

"Sales J also referred to the importance of the wider public interest in assessing fitness to practise in Yeong v. GMC [2009] EWHC 1923 (Admin), a case involving a doctor's sexual relationship with a patient. Pointing out that Cohen was concerned with misconduct by a doctor in the form of clinical errors and incompetence, where the question of remedial action taken by the doctor to address his areas of weakness may be highly relevant to the question whether his fitness to practise is

currently impaired, Sales J considered that the facts of Yeong merited a different approach. He upheld the submission of counsel for the GMC that:

"… Where a FTPP considers that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between medical practitioner and patient and thereby undermining public confidence in the medical profession, a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. In such a case, the efforts made by the medical practitioner in question to address his behaviour for the future may carry very much less weight than in a case where the misconduct consists of clinical errors or incompetence." (para 73)

I agree with that analysis and would add this. 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." (para 74)

111) It is submitted that a finding of impairment is in the public interest as public confidence in the nursing profession would be undermined if a finding of impairment was not made given the nature of the charges proved against Mr Aldridge. It is submitted that Mr Aldridge's behaviour fell far below the standards the public would expect of a registered nurse.

112) Furthermore a finding of current impairment is necessary to declare and uphold proper standards of conduct for the profession and in the NMC as regulator. Nurses need to know that it is never acceptable to act dishonestly, especially where is relates directly to their clinical practice and that the duty of candour is fundamental to the relationship of trust between the profession and the public.

113) For the reasons given above it is submitted that a finding of current impairment is necessary in this case to protect the public and because it is in the public interest. It is further submitted that the need to uphold proper professional standards and

public confidence in the nursing profession and the NMC as regulator, would be undermined if a finding of impairment were not made in the particular circumstances of this case.

Sanction

114) The NMC's sanction bid is for a striking-off order.

115) The NMC contends that the behaviour displayed by this Registrant is fundamentally incompatible with him remaining on the Register, especially given the total lack of insight.

116) The NMC proposes the following as aggravating and mitigating factors:

Aggravating

- *No evidence of remediation.*
- *Lack of insight.*
- *Compounded dishonesty.*
- *Actual harm occurred as a result of acts/omissions.*

Mitigating

- *Eventually admitted he had not administered the medication to Prisoner A as recorded.*
- *No previous regulatory findings.*

117) It is submitted that as the Registrant has failed to provide evidence of any remediation or insight there remains a high risk of repetition. Therefore to take no action or to issue a caution order would not be appropriate or proportionate in the circumstances of this case.

118) It is submitted that conditions of practice would not be appropriate in this case. While there are recognisable clinical concerns in terms of identifying and escalating a deteriorating patient, the dishonesty, which in this case is particularly serious as it also breaches the professional duty of candour to be open and honest when things go wrong, means conditions of practice would not be appropriate or proportionate.

Furthermore, the Registrant has not demonstrated a willingness to respond or engage in clinical remediation so it is highly unlikely conditions of practice would be workable in any event.

119) *The NMC submits that a suspension order would not be suitable in this case. While the clinical conduct relating to Prisoner A's care could be said to be limited to a single instance of misconduct the associated dishonesty in his record keeping which he initially maintained when questioned about Prisoner A's care by the police and his employer was protracted and compounded. He had opportunities to seek further and clarifying information and to tell the truth, but only did so when confronted with conflicting evidence. This demonstrates attitudinal problems and a clear departure from the professional duty of candour. While there is no evidence of repetition of behaviour since the incident this could be explained by the fact that the NMC was informed by the RCN, before they came off record, that he was retiring form nursing. Given the lack of insight and remediation the panel cannot, it is submitted, be satisfied that Mr Aldridge does not pose a significant risk of repeating the behaviour demonstrated.*

120) *The NMC is of the view that Mr Aldridge's clinical conduct was serious and caused a loss of chance to Prisoner A for which he has not remediated. Furthermore, his dishonest conduct and behaviour demonstrates a significant departure from the standards expected of a registered nurse, and that the serious breach of a fundamental tenet of the profession is fundamentally incompatible with Mr Aldridge remaining on the NMC's register. To allow him to continue to practise as a registered nurse would undermine public confidence in the profession and in the NMC as a regulatory body.*

121) *Balancing all of these factors, the NMC submit that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters the NMC has identified, in particular Mr Aldridge's dishonesty, and the lack of insight and remediation nothing short of a striking-off order would be sufficient in this case to protect the public. A striking-offer order is also 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 and honesty required of a registered nurse.*

122) In all the circumstances of this case it is submitted that public confidence in nurses could not be maintained if Mr Aldridge was not removed from the register. Furthermore, given the lack of remediation or evidence of a willingness to remediate, a striking-off order is the only sanction sufficient to protect patients and members of the public.

Interim Order Consideration

123) If the Panel decide to impose either a striking off order or a suspension order they are invited to make an interim suspension order for a period of up to 18 months to cover the 28 days before the substantive sanction takes effect and, should the Registrant appeal the decision, the appeal period thereafter.

124) If the Panel determine that Conditions of Practice is the appropriate sanction in this case then the panel is invited to impose an interim conditions of practice order for a period of up to 18 months for the same reasons provided above.

125) If a panel conclude that to take no further action or a caution order is appropriate and proportionate that the NMC make no application for an interim order." [sic].

Here ends the NMC's statement of case.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took account of all the documentary and video evidence adduced in this case. It heard and accepted the advice of the legal assessor.

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 noted that Mr Aldridge has not provided any admissions to the charges.

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

Charge 1a

1. While working the night shift 16-17 August 2015 at HMP Winchester:

    a) Did not elicit a verbal response from Prisoner A when visiting him in his cell at approximately 21:22 on 16 August 2015.

This charge is found proved.

In reaching this decision, the panel took account of Mr 2, Ms 5 and Ms 12's evidence.

The panel took the view that the allegation was that Mr Aldridge did not obtain a verbal response from Prisoner A.

The panel noted that Mr Aldridge was the registered nurse on shift at the time, as confirmed by himself and other witnesses working on the night shift of 16/17 August 2015. Mr Aldridge was the clinician in charge of Prisoner A's care.

The panel had sight of the CCTV footage, which showed that Mr Aldridge attended Prisoner A's cell at approximately 21:22 hours on this shift, in the accompaniment of three prison officers. In his initial statement, taken some time in August 2015 after the incident, Mr 2 had stated:

> "*I, [Mr 3], [Mr 4] and Nurse Les Aldridge went to [Prisoner A's cell] to administer medication. Prisoner A was snoring very loudly and didn't wake up when his name was said a few times. The nurse entered the cell, the nurse turned him onto his right hand side so that would help his snoring. This did help and he was breathing, what sounded like normal…*".

This version of events was consistent with the account provided by Mr 2 in his interview with Ms 1 on 15 November 2015:

> "*We opened the door and the first thing I notice was that he was snoring badly. Prisoner A was on his back and Les put him on his right hand side so he was facing the wall. I think someone helped him but it wasn't me. He then started breathing normally*.

The panel noted that all the evidence is demonstrative of Prisoner A not having woken up at any point when Mr Aldridge, Mr 2, Mr 3 and Mr 4 entered his cell. Furthermore, Mr Aldridge appears to accept that he did not elicit a verbal response from Prisoner A as he was of the view that Prisoner A was asleep at the time.

The panel concluded that Mr Aldridge had not elicited a verbal response from Prisoner A in the circumstances of this case.

Accordingly, the panel found charge 1a proved.

Charge 1b)

b) Did not take further steps to rouse Prisoner A during the visit to his cell at approximately 21:22.

This charge is found proved.

In reaching this decision, the panel took account of Ms 5, Ms 6, Dr 7 and Ms 12's evidence, as well as Mr Aldridge's evidence at the Coroner's inquest.

The panel noted that Prisoner A's name was called a few times when staff were in his cell at approximately 21:22 hours, but this did not elicit a verbal response from him. Aside from this, the panel noted that there is no other evidence to suggest that Mr Aldridge, or anyone else for that matter, took any other steps to rouse Prisoner A.

The panel noted from the transcript of the Coroner's inquest, the following dialogue between the Coroner and Mr Aldridge:

> "*Q. And so given that training, when you saw Prisoner A that evening on 16 August did it not occur to you that you should wake him to check that he was fit enough to continue without further observations?*
>
> *A. No sir, I didn't. I had taken it that this gentleman, it was normal sleep time…*".
>
> *…*
>
> *Q. So we heard from [Ms 5] yesterday that one possible approach would be to apply a pinch test, some pain, on to see if he reacted to that. Would you agree that that would be a reasonable thing to do in that context?*
>
> *A. Yes, I would agree. Yes…*".

In taking account of the above, Mr Aldridge appeared to accept that it would have been appropriate to conduct a 'pinch test' to see if Prisoner A would have responded to stimuli, as previously indicated by Ms 5 and Dr 7. However, this was not done at approximately 21:22 hours, or at any other time during the night shift of 16/17 August 2015, as Mr Aldridge did not return to Prisoner A's cell after that point.

Furthermore, the evidence suggested that it did not occur to Mr Aldridge to wake Prisoner A up at 21:22 hours, as he considered it to be '*normal sleep time*'.

Therefore, it was clear to the panel that Mr Aldridge did not take further steps to rouse Prisoner A during the visit to his cell at approximately 21:22 hours.

Accordingly, the panel found charge 1b proved.

Charge 1c)

c) Failed to appropriately assess Prisoner A when you were unable to rouse him in that you did not:

i. Assess his consciousness level; and/or
ii. Take his blood pressure; and/or
iii. Take his pulse rate; and/or
iv. Look at his pupils; and/or
v. Check his respiratory rate.

Charges 1c(i), 1c(ii), 1c(iv) and 1c(v) are found proved. Charge 1c(iii) is found not proved.

In reaching this decision, the panel took account of Mr 2, Ms 5, Ms 6 and Ms 12's evidence.

In considering this charge, the panel was of the view that in order for Mr Aldridge to have '*failed*' to do something, there must have been a duty imposed on him to act in a certain way. As the registered nurse on duty, and the clinician assigned to Prisoner A's cell, the panel was of the view that there would have been a duty imposed on Mr Aldridge to appropriately assess Prisoner A when he was unable to rouse him, especially having regard to his history and vulnerabilities.

The panel had regard to Ms 6's expert witness report, which states:

> "*Nurse Aldridge should, in my opinion, have considered opioid toxicity as a potential risk from the outset. He should have looked for signs of overdose, including an assessment of conscious level using a recognised scale such as the Glasgow Coma Scale (contained within the local prescribing policy (paragraph 6.3.9)), and should have carried out a physical assessment of pupil responses, blood pressure, respiratory rate and pulse rate…*
>
> *Any reasonably competent nurse would, in my opinion, have attempted to rouse Prisoner A and gain a verbal response from him. Had he failed to rouse, any reasonably competent nurse would have looked for signs of overdose, including an*

assessment of conscious level using a recognised scale, such as the Glasgow Coma Scale, and a physical assessment of pupil responses, blood pressure, respiratory rate and pulse rate. [Dr 8] confirmed that the prison used the National Early Warning Signs assessment tool and I would have expected Nurse Aldridge to use this tool prior to leaving the cell...

In my opinion, failure to elicit a verbal response and to conduct a full physical assessment (including conscious level, heart rate, blood pressure and pupil reaction) falls below the required standards of care. Failure to conduct an assessment and to act accordingly (i.e. administer oxygen, naloxone and arrange a hospital transfer), in my opinion, constituted an omission of care..."[sic].

The panel noted from the expert witness report of Ms 6 that she would have expected Mr Aldridge to appropriately assess Prisoner A in the particular circumstances of this case, Prisoner A being a drug addict, being treated with Methadone. As a registered nurse experienced in the treatment of recovering drug addicts, he would have been aware of the risks of the Methadone treatment that had been prescribed. Mr Aldridge does not claim to have carried out any observations relating to Prisoner A's consciousness level, blood pressure, pupils or respiratory rate. Mr Aldridge said he did not consider Prisoner A to be showing any signs of deterioration. The panel considered this to be further supported by the fact that no observations had been recorded by Mr Aldridge in Prisoner A's clinical notes, specifically relating to his consciousness level, blood pressure, pulse rate ("PR"), pupils or respiratory rate for the night shift of 16/17 August 2015. Further, Mr 2 did not recall Mr Aldridge conducting any observations on Prisoner A in his interview with Ms 1 on 15 November 2015; he also made no mention of having witnessed Mr Aldridge carry out any assessments of Prisoner A in his contemporaneous statement approximately dated August 2015.

The panel noted that Mr Aldridge does contest the allegation of not taking Prisoner A's pulse rate when he was in the cell with him. Mr Aldridge was said to have been in Prisoner A's cell for approximately 40 seconds, and that includes turning Prisoner A onto his side with the help of one of the prison officers. In Mr 2's notes of the interview with Ms 1, dated 15 November 2015, he was asked "*Did you see/remember the nurse taking any clinical observations such as a pulse?*" and he responded by saying "*Not that I'm aware*". Whilst

the panel was able to rely on Mr 2's evidence in support of much of this charge, it was not satisfied from the totality of the evidence before it that Mr Aldridge had failed to take Prisoner A's pulse rate. It noted from the transcript of the Coroner's inquest that Mr Aldridge said:

> "*A. …I felt his pulse at the time. I decided to turn him on his side to aid his breathing…*
>
> *Q. So why did you take his pulse?*
>
> *A. Because I suppose in a way perhaps it's another Navy thing of mine that every patient I go and see, I always take their pulse or – because that gives me a good idea. Prisoner A looked well perfused. In fact he looked, he had good colour, he wasn't cyanosed at his ears or his mouth and he was, so I wasn't concerned about Prisoner A…*
>
> *Q. So you, as a matter of custom or usage, whatever, you took his pulse?*
>
> *A. I took his pulse but I have to say that I didn't record his pulse. I took his pulse as a sort of – I was asked several months after, I did take his pulse and somebody has asked me what that pulse was and I said that it was regular, it was strong and it wasn't, he didn't seem, not that I knew about the [inaudible] because he didn't, but he didn't seem tachycardic to me at that time. He wasn't showing any other, or visual looking at him, any other visual symptoms.*
>
> *Q. So why take it? Why take his pulse if you're not recording it?*
>
> *A. Because if the pulse had been alarming to me it would have initiated me to do other checks on him. That is my underlying thoughts…*".

The panel concluded that it would have been entirely possible for Mr Aldridge to have been able to take Prisoner A's pulse rate during the period of time he was in Prisoner A's cell. Even though there was no pulse rate reading recorded in Prisoner A's clinical records, the panel noted that this is not to say that Mr Aldridge did not conduct this assessment.

The panel was aware that throughout the investigation into Prisoner A's death, that being the internal investigation, the police investigation, the expert witness interviews and the Coroner's inquest, Mr Aldridge had maintained that he had taken Prisoner A's pulse rate. The panel considered Mr Aldridge to have been consistent in his evidence that he had taken Prisoner A's pulse rate when he was in his cell, and the panel was not satisfied that the NMC had been able to discharge its burden of proof in respect of this charge.

Therefore, the panel found that Mr Aldridge had failed to appropriately assess Prisoner A when he was unable to rouse him as he did not assess his consciousness level, take his blood pressure, look at his pupils, or check his respiratory rate. The panel did not find Mr Aldridge to have failed to take Prisoner A's pulse rate when he was unable to rouse him.

Accordingly, the panel found charges 1c(i), 1c(ii), 1c(iv) and 1c(v) proved. The panel found charge 1c(iii) not proved.

Charge 1d)

d) Did not recognise or consider that Prisoner A was showing signs of an overdose/opioid toxicity.

This charge is found proved.

In reaching this decision, the panel took account of Ms 5, Ms 6, Dr 7, Dr 11 and Ms 12's evidence.

The panel had regard to the expert witness report of Dr 7, who stated:

"***7.2 Compliance with guidelines:***

7.2.1 The DH guidance (2006) state that the signs of opiate overdose which would include methadone overdose include constricted (pinned) pupils (although dilation can occur), respiratory depression/cyanosis, sweating, hypotension and bradycardia, and unconsciousness. Snoring and laboured breathing generally is also often described as a sign of methadone overdose

(Caplehorn 2002). a nurse such as Mr Aldridge who was experienced in the management of substance misuse will be expected to know these.

7.3 Comments: *Mr Aldridge could have noted that Prisoner A was snoring heavily and had a reduced level of consciousness (he could not be woken). If he had noted this and realised its significance then this may have prompted him to go back and observe Prisoner A later in the night. It is not clear whether he knew about the high PR reading earlier that day. Again if he had that may have prompted him to go back and observe Prisoner A again…*".

The panel also had sight of the policy titled 'Protocol for Prescribing for Drug and Alcohol Dependency in HMP/ YOI Winchester' ("the Policy"), which states:

"***Fatalities from Methadone poisoning have been reported at doses as low as 20mg (Humeniuk et al 2000).*** *Non-opiate-dependent individuals are at risk from doses as low as this, and the risk is exacerbated when the simultaneous prescription of a Benzodiazepine is necessary. Methadone deaths tend to occur on the second or third day of treatment as a result of cumulative toxicity. These deaths occur as a consequence of inadequate assessment, failure to confirm previous opiate use by clinical testing for drugs, failure to confirm dependence (such as treatment in the absence of withdrawal symptoms) and a lack of monitoring…*

It needs to be remembered that there is an increased risk of death during induction of Methadone treatment. With Methadone, toxicity is delayed. At least several hours after exposure, and often, after several days of treatment. Therefore it is essential that the patient is fully assessed and observed during this process of induction...".

The panel was concerned that Mr Aldridge did not appear to recognise or consider the situation in the context of the treatment that was being delivered to Prisoner A. Prisoner A was being administered methadone as part of the drug detoxification programme, and his dosage had recently been increased towards the top end of what was allowed to be given. Furthermore, Prisoner A was on the fourth/fifth day of the drug detoxification programme, and had entered a phase known as 'the danger period' for such treatment.

As the registered nurse on shift, Mr Aldridge would have been expected to know that this was a high risk period for Prisoner A, and he did not appear to align Prisoner A's presentation to any sort of deterioration. Mr Aldridge said in his evidence to the Coroner, that he told the prison officers:

> "*I wouldn't even try to medicate him because he's sedated…*"

Mr Aldridge had considered Prisoner A to be sedated, and he did not think Prisoner A's presentation was out of the ordinary, as he thought it reasonable for him to be asleep at approximately 21:22 hours.

The panel noted that Ms 6 would have considered the presentation of Prisoner A to be unusual in the circumstances, given that he had not had his additional dose of diazepam medication. She had stated in her expert witness report that:

> "*On entering Prisoner A cell, he observed that Prisoner A was lying on his back, snoring loudly and did not wake or rouse on turning the light on or to verbal stimuli. It is my opinion that this would be unusual in a patient who has been subject to extended hours locked in his cell and who is undergoing drug detoxification. As a substance misuse nurse, Nurse Aldridge should have been aware that an inability to sleep, agitation and reliance on medication are known responses from patients undergoing drug stabilisation and that drowsiness is a sign of overdose (as described in the Central and North West London protocol at section 6.3)…*"[sic].

The panel was of the view that Mr Aldridge had failed to consider Patient A's clinical history and particular vulnerabilities in being administered methadone.

Therefore, in taking account of all the above, the panel was satisfied that Mr Aldridge did not recognise or consider that Prisoner A was showing signs of an overdose/opioid toxicity

Accordingly, the panel found charge 1d proved.

Charge 1e)

e) Did not take appropriate steps to mitigate the effects of a suspected overdose such as:

i. Administering Naloxone.
ii. Providing Oxygen therapy.
iii. Arranging a Transfer to hospital.

These charges are found proved

In reaching this decision, the panel took account of Mr 2, Mr 3, Ms 6 and Ms 13's evidence, as well as Mr Aldridge's evidence at the Coroner's inquest.

The panel had regard to the expert witness report of Ms 6, who stated:

> "*10.10 Nurses in prison do not have on site doctor cover during the night and are expected to act as the first line emergency response, following emergency protocols and escalating care as required. Nurse Aldridge would have been conversant with these responsibilities. [Dr 8] confirmed that the staff were trained to assess and manage emergency situations using the National Early Warning Signs assessment template. Naloxone was available in the emergency bags and could be administered by nurses to reverse any signs of opioid toxicity. They followed the Department of Health guidelines for the administration of naloxone…*
>
> *11.3.3 All prison nursing staff have access to emergency equipment and would be trained in its use. Naloxone was available in the emergency bag and [Dr 8] confirmed that nurses were trained to administer this. In my experience, oxygen is also always available. In my opinion, oxygen therapy, naloxone administration and a transfer to hospital were mandated in this scenario…*".

Again, the panel also had sight of the Policy which confirmed:

"*Naloxone 400 micrograms/ml is available in the Emergency drug cupboard to manage opioid overuse. The dose of between 400 – 800 micrograms should be administered intramuscularly whilst emergency medical care is sought*…".

The panel noted that no subsequent actions had been recorded by Mr Aldridge in Prisoner A's clinical notes, specifically relating to him administering Naloxone, providing oxygen therapy, or arranging a transfer to hospital on the night shift of 16/17 August 2015. It reminded itself that the CCTV footage does not show Mr Aldridge returning to Prisoner A's cell during the night shift of 16/17 August 2015. Mr Aldridge believed Prisoner A was sedated, and was not showing any signs of deterioration. Therefore, Mr Aldridge was of the opinion that no further treatment would have been needed for Prisoner A.

In taking account of the above, the panel was satisfied that Mr Aldridge did not take appropriate steps to mitigate the effects of a suspected overdose by administering Naloxone, providing oxygen therapy, or arranging a transfer to hospital on the night shift of 16/17 August 2015.

Accordingly, the panel found charge 1e proved.

Charge 1f)

f) Did not return to Prisoner A's cell later in the shift to conduct observations

This charge is found proved.

In reaching this decision, the panel took account of Ms 1, Ms 5, Ms 6 and Dr 7's evidence.

Mr Aldridge had initially claimed in a telephone call with Ms 5 on 25 August 2015 that he had returned to Prisoner A's cell later in the shift, around midnight, to conduct observations and that he had administered medication through a small hole in the cell door. In his police witness statement dated 18 August 2015, Mr Aldridge stated that: "*I also recorded that I observed him later…around midnight*".

The panel had regard to Ms 5's NMC witness statement, in which she stated:

> "*…Mr Aldridge said that he had been confused and he agreed that he had not returned to Prisoner A cell on a second occasion, as he had suggested on 28 August 2015…*"[sic].

The panel noted that Ms 5's evidence in this respect comes from a meeting that was held between her and Mr Aldridge on 8 September 2015.

In support of this evidence, Mr Aldridge also appears to accept that he did not return to Prisoner A's cell during the night shift of 16/17 August 2015, as he was asked during cross-examination at the Coroner's inquest "*So to be clear, after 21.22 you didn't return to the cell? That's what you say?*" and his answer to that was "*Yes that's right, sir*".

The panel reminded itself that the CCTV footage does not show Mr Aldridge return to Prisoner A's cell during the night shift of 16/17 August 2015.

In taking account of the above, the panel was satisfied that Mr Aldridge did not return to Prisoner A's cell later in the shift to conduct observations on the night shift of 16/17 August 2015.

Accordingly, the panel found charge 1f proved.

Charge 1g)

> g) Recorded in Prisoner A's medication/prescription chart that you had administered Liquid Diazepam at 21:30 on 16 August 2015 when you had not.

This charge is found proved.

In reaching this decision, the panel took account of Ms 1, Mr 2, Mr 3, Mr 4 and Ms 5's evidence, as well as Mr Aldridge's evidence at the Coroner's inquest.

The panel had sight of the Prescription and Administration Record Chart for Prisoner A and noted that there was an entry that had been signed by Mr Aldridge on 16 August 2015 at 21:30 hours. This suggested that Liquid Diazepam had been administered to Prisoner A at this time.

However, the panel noted that this contradicted other evidence of Mr Aldridge, who had told Ms 5 in a meeting on 8 September 2015 that he had not in fact given Prisoner A any medication during the night shift of 16 and 17 August 2015, as documented in her NMC witness statement. This explanation was consistent with later evidence as Mr Aldridge had been unable to administer medication to Prisoner A because he was asleep at the time he went to administer it. Mr 2, Mr 3 and Mr 4 also confirmed that Mr Aldridge had not administered any medication to Prisoner A when they were in the cell with him, and they all left Prisoner A's cell together. The CCTV footage does not show Mr Aldridge return to Prisoner A's cell subsequently during the night shift of 16/17 August 2015.

Furthermore, as recorded in the transcript at the Coroner's inquest, Mr Aldridge accepted that he had made a mistake in recording that he had administered Liquid Diazepam at 21:30 hours on 16 August 2015 in Prisoner A's Prescription and Administration Record Chart when he had not.

In taking account of the above, panel was satisfied that Mr Aldridge had recorded that he had administered prescribed medication in Prisoner A's Patient Record at 22:34 hours, when he had not.

Therefore, the panel found charge 1g proved.

Charge 1h)

h) Recorded in Prisoner A's Patient Record at 22:34 that you had administered Prisoner A's prescribed medication when you had not.

This charge is found proved.

In reaching this decision, the panel took account of Ms 1, Mr 2, Mr 3, Mr 4, Ms 5 and Ms 12's evidence.

The panel had sight of Prisoner A's records of care and noted that there was an entry that had been made by Mr Aldridge on SystmOne dated 16 August 2015, timed at 22:34 hours. This entry stated:

> "*History: Oral diazepam (x01BA)*
> *Examination: precribed medicatiom given*"

However, the panel noted that this contradicted other evidence of Mr Aldridge, who had later stated on multiple occasions that he had been unable to administer the medication to Prisoner A because he was asleep at the time he went to administer it. Mr 2, Mr 3 and Mr 4 also confirmed that Mr Aldridge had not administered any medication to Prisoner A when they were in the cell with him, and they all left Prisoner A's cell together. The CCTV footage does not show Mr Aldridge return to Prisoner A's cell subsequently during the night shift of 16/17 August 2015.

In taking account of the above, panel was satisfied that Mr Aldridge had recorded that he had administered prescribed medication in Prisoner A's Patient Record at 22:34 hours, when he had not.

Therefore, the panel found charge 1h proved.

Charge 1i)

i) Your conduct at Charge 1g) and/or 1h) above was dishonest in that you knew you had not administered the medication to Prisoner A.

This charge is found NOT proved.

In reaching this decision, the panel took account of Ms 1, Ms 5 and Ms 12's evidence.

It had regard to the case of *Ivey v Genting Casinos Ltd t/a Crockfords [2017] UKSC 67* in determining whether Mr Aldridge had been dishonest in his actions, as outlined in charges 1g and 1h. In particular, the panel noted in paragraph 74:

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

The panel had identified that Mr Aldridge had clearly made two incorrect entries relating to medication administered to Prisoner A on the night shift of 16/17 August 2015. It was of the view that in recording that he had administered Liquid Diazepam to Prisoner A when he had not, Mr Aldridge could have given a misleading impression that nursing care had been delivered to Prisoner A when it had not been.

However, whilst the panel considered there to be evidence of poor nursing practice in making two incorrect entries for Prisoner A, it determined that there was a lack of evidence to find that Mr Aldridge had been dishonest at the time of making those recordings. The panel noted that Dr 14, the Lead Substance Misuse Doctor for HMP Winchester stated in his oral evidence at the Coroner's inquest that:

> "*If the observation was done in a…cell or in a corridor, it's either kept in memory, come back and put in the computer system, or short notes taken to paper and transcribed into the computer system…*

Night-time is a specific challenge for us…you pretty much do outreach work at night-time, going around dispensing medications. So in that case, even if I was in that position I would rely on memory or my handwritten notes to come back and transfer the information onto the computer".

The above suggested that it was common practice for members of the Integrate Substance Misuse Service ("ISMS") to make handwritten notes or attempt to recollect which prisoners had received which medication before an entry was recorded into SystmOne at the end of the drug round. SystmOne was not actively available for members of ISMS to update when inside of a prisoner's cell. Mr Aldridge would have completed the drug round for all prisoners before entering all of the information on to SystmOne. The shortcomings with this approach were identified by the multiple investigations into Prisoner A's death. A number of recommendations were made at the Coroner's inquest and these were subsequently implemented at HMP Winchester.

Therefore, the panel concluded that Mr Aldridge may have made two honest mistakes at the point of recording these entries for Prisoner A. It was of the view that it was entirely possible that Mr Aldridge could have made an error when completing all the entries as a batch following his medication round.

In taking account of the above, the panel determined that the NMC had not been able to discharge its burden of proof in respect of this charge. It decided that ordinary and decent people would not have regarded Mr Aldridge's actions as being dishonest in the circumstances outlined in charges 1g and 1h.

Accordingly, the panel found charge 1i not proved.

Charge 2a)

2. On 18 August 2015:

a) Made a statement to the police in which you said and it was recorded that:

i. "*I ensured that [Prisoner A] took the diazepam, he swallowed it in front of me*" when this did not happen.

ii. "*I also recorded that I had observed him later, I am not sure when I observed him but it would have been about midnight*" when you had not returned to Prisoner A's cell.

These charges are found proved.

In reaching this decision, the panel took account of Ms 1, Mr 9 and Ms 10's evidence.

In considering these charges, the panel had sight of Mr Aldridge's witness statement for Hampshire Constabulary dated 18 August 2015, which states:

> "*I ensured that [Prisoner A] took the Diazepam, he swallowed it in front of me…*"
>
> "*I also recorded that I had observed him later, I am not sure when I observed him but it would of been about midnight…*"[sic].

Therefore, the panel was satisfied that Mr Aldridge had made a statement to the police which included words to the effect of what was alleged in the charge. The panel noted that the author of the handwritten witness statement for Hampshire Constabulary had mistakenly used the word '*of*' instead of '*have*' in the latter quote, but it did not consider this to have altered the substance of the charge against Mr Aldridge.

The panel reminded itself that the CCTV footage does not show Mr Aldridge returning to Prisoner A's cell subsequently during the night shift of 16/17 August 2015.

Accordingly, the panel found charges 2a(i) and 2a(ii) proved.

Charge 2b

b) Signed a Statement of Truth confirming the accuracy of the statement you had given to the police which you knew to be untrue.

This charge is found proved.

In reaching this decision, the panel took account of Ms 1, Mr 9 and Ms 10's evidence.

The panel had regard to Mr 9's NMC witness statement, in which he stated:

> "*I drafted a statement for Mr Aldridge whilst he gave me a verbal account of the events of 16 August 2015. Usually, when I take a statement from a witness, I then ask them to read the Statement of Truth, which is contained at the top of the first page of a statement. I therefore think there is very likely that I would have asked Mr Aldridge to read the Statement of Truth contained on page one of the statement once he finished his verbal account but I cannot remember whether I did so or not in this instance. To the best of my memory, Mr Aldridge did not raise any difficulty with the statement of truth.*
>
> *I then witnessed Mr Aldridge sign the statement of truth, the section at the bottom of page one of the statement, and the line immediately below the final sentence on page two of the statement*".

In considering this charge, the panel noted that Mr Aldridge had been given advanced notice that the police were going to contact him regarding the death of Prisoner A. Mr Aldridge had also been given Prisoner A's name by this point, so it was of the view that he would have had the opportunity to reflect on the incident before giving his account to Mr 9. Mr 9 attended Mr Aldridge's home address to take his statement on 18 August 2018, only a day or so after the incident, so the panel considered this to be a contemporaneous account provided by Mr Aldridge.

The panel also noted that in his statement to the police, Mr Aldridge had been clear about a number of issues that he said he did not recollect as well those issues where he appeared to have a clear recollection.

Despite this, the panel noted that Mr Aldridge still provided incorrect information to Mr 9, which was recorded in the Statement of Truth by Mr 9. Had there been any confusion on the part of Mr Aldridge at this point, he should have raised this with Mr 9 in the recording of this Statement of Truth. However, there is no evidence that he did so. Instead, Mr Aldridge signed the Statement of Truth in three places to confirm the contents of it was correct.

Therefore, the panel was satisfied that Mr Aldridge had signed a Statement of Truth to confirm the accuracy of the statement he had given to the police, which he knew to be untrue.

Accordingly, the panel found charge 2b proved.

Charge 3)

3. Your conduct at Charge 2 a)i and b was dishonest in that you knew you had not administered the medication to Prisoner A.

This charge is found proved.

In reaching this decision, the panel took account of Ms 1, Mr 2 and Ms 5's evidence.

In considering this charge, the panel applied the case of ***Ivey*** and took account of its findings in charges 2a(i) and 2b. The panel had found Mr Aldridge to have stated in his Statement of Truth that "*I ensured that [Prisoner A] took the diazepam, he swallowed it in front of me*" and it had also found Mr Aldridge to have signed a Statement of Truth to confirm the accuracy of a statement he had given to the police, which he knew to be untrue.

The panel was satisfied that through his actions, Mr Aldridge had fabricated several alternative versions of events in order to conceal what really happened on the night shift of 16/17 August 2015. It noted that Mr Aldridge had been given Prisoner A's name by this point, and that he should have had time to reflect on the events that led up to Prisoner A's death. The panel was of the view that Mr Aldridge had concocted and embellished an

elaborate story to coincide with his initial statement given to HMP Winchester, rather than him confessing to any clinical shortcomings.

The panel determined that Mr Aldridge did not make an honest mistake and it determined that ordinary and decent people would consider Mr Aldridge's actions to have been dishonest in the circumstances.

Therefore, the panel found charge 3 proved on the balance of probabilities.

Charge 4)

4. Your conduct at Charge 2 a)ii and b was dishonest in that you knew you had not returned to Prisoner A's cell.

This charge is found proved.

In reaching this decision, the panel took account of Ms 1, Mr 2 and Ms 5's evidence.

In considering this charge, the panel applied the case of ***Ivey*** and took account of its findings in charges 2a(ii) and 2b. The panel had found Mr Aldridge to have stated in his Statement of Truth that "*I also recorded that I had observed him later, I am not sure when I observed him but it would of been about midnight…*"[sic] and it had also found Mr Aldridge to have signed a Statement of Truth to confirm the accuracy of a statement he had given to the police, which he knew to be untrue.

The panel was satisfied that through his actions, Mr Aldridge had fabricated several alternative versions of events in order to conceal what really happened on the night shift of 16/17 August 2015. It noted that Mr Aldridge had been given Prisoner A's name by this point, and that he would have had time to think about the events that led up to Prisoner A's death. The panel was of the view that Mr Aldridge had concocted and embellished an

elaborate story to coincide with his initial statement given to HMP Winchester, rather than him confessing to any clinical shortcomings.

The panel determined that Mr Aldridge did not make an honest mistake and it determined that ordinary and decent people would consider Mr Aldridge's actions to have been dishonest in the circumstances.

Therefore, the panel found charge 4 proved on the balance of probabilities.

Charge 5)

5. Your conduct at 2b was dishonest in that you sought to mislead a criminal investigation into Prisoner A's death.

This charge is found proved.

In reaching this decision, the panel took account of Ms 1, and Mr 9's evidence, as well as Mr Aldridge's evidence at the Coroner's inquest.

The panel was aware that Mr 9 had initially drafted the Statement of Truth based on what Mr Aldridge had said to him. Whilst Mr Aldridge had initially said that he was confused as to which prisoner had died, Mr Aldridge had been informed who Prisoner A was by this point. Mr Aldridge does not raise any concerns in respect of being confused at the point of providing the Statement of Truth.

Anyone reading the Statement of Truth would have been under the impression that Mr Aldridge had administered medication to Prisoner A as it is recorded "*I entered Prisoner A cell with two prison officers, I can't recall who they were. I can't recall if he was lying down, however I am sure that he took his prescribed Diazepam…I ensured that Prisoner A took the Diazepam, he swallowed it in front of me. Prisoner A appeared to be fine, he didn't*

complain or anything…"[sic]. However, this statement contradicts all the other evidence received on this point, as Prisoner A was not awake when Mr Aldridge and the prison officers attended his cell.

In providing this inaccurate information, the panel was of the view that Mr Aldridge's conduct had the potential to mislead the criminal investigation into Prisoner A's death. It considered him to have changed his account to give the impression that Prisoner A had been in receipt of his medication. Mr Aldridge denied deliberately giving false information to the police at the Coroner's inquest, but the panel formed the view that he did so knowingly.

The panel determined that Mr Aldridge had sought to create a misleading impression in signing a Statement of Truth to confirm the accuracy of the statement he had given to the police, which he knew to be untrue.

Therefore, the panel found charge 5 proved.

Charge 6

6. On 28 August 2015 informed the Head of Healthcare at HMP Winchester that you did not administer medication at approximately 22:00/23:00 but had returned approximately 1 hour later and administered the medication through the inundation point when you had not.

This charge is found proved.

In reaching this decision, the panel took account of Ms 1 and Ms 5's evidence.

The panel had regard to Ms 5's NMC witness statement, in which she stated:

> "*I spoke to Mr Aldridge over the telephone on 28 August 2015. During the course of this conversation, Mr Aldridge said that he had been confused when he had completed his police witness statement on 18 August 2015. He stated that, when he*

had attended the cell of Prisoner A with the three prison officers, which he stated was around 2200/2300, he had not administer medication because Prisoner A was indeed asleep and snoring loudly.

Mr Aldridge went on to say that he then returned on his own to Prisoner A prison cell approximately one hour later (at around 0000) and then administer medication to Prisoner A via the small hole in his cell door. He remembered that, at the point that he had done so, Prisoner A had complained that he had not received medication earlier that evening. Therefore, Mr Aldridge gave a further version of events to me during a telephone call of 28 August 2015, which not only differed from that of the prison officer, but also from the statement he had made to the police on 18 August 2015…"[sic].

The panel reminded itself that the CCTV footage does not show Mr Aldridge returning to Prisoner A's cell subsequently during the night shift of 16/17 August 2015. Mr Aldridge attended once, alongside three prison officers, at 21:22 hours. Therefore, Mr Aldridge could not have administered medication through the inundation point to Prisoner A, as he never returned to his cell at a later point.

Therefore, the panel found charge 6 proved.

Charge 7)

7. Your conduct at Charge 6 was dishonest in that you sought to mislead the Central and North West London NHS Foundation Trust's investigation into events on 16-17 August 2015.

This charge is found proved.

In reaching this decision, the panel took account of Ms 1 and Ms 5's evidence.

The panel noted that Mr Aldridge had given multiple inconsistent accounts to Ms 5, as part of the Central and North West London NHS Foundation Trust's investigation. Mr Aldridge

had given at least two different answers as to how he came to administer medication to Prisoner A:

- Mr Aldridge had said that he had watched Prisoner A swallow the Diazepam in front of him when he attended Prisoner A's cell in accompaniment of the prison officers.
- Mr Aldridge claimed to have returned to Prisoner A's cell at approximately 00:00 hours, where he administered the medication through the inundation point of Prisoner A's cell.

The panel concluded that none of the above were true. It considered Mr Aldridge to have fabricated several versions of events in order to give the impression that he had administered medication to Prisoner A, when he was fully aware that he had not done so. The panel was of the view that Mr Aldridge had tried to mislead the Central and North West London NHS Foundation Trust into thinking that he had acted appropriately.

Therefore, the panel found charge 7 proved.

Charge 8)

8. Your conduct at Charge 2 and/or Charge 6 demonstrates a lack of candour in that you gave false or misleading accounts when asked about your interactions with Prisoner A on 16-17 August 2015.

This charge is found proved.

In reaching this decision, the panel took account of Ms 1, Ms 5, Mr 9 and Ms 10's evidence.

The panel also had regard to the NMC's guidance on the professional duty of candour, which states:

"*Every health and care professional must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.*

This means that health and care professionals must:

- *tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong*
- *apologise to the person (or, where appropriate, their advocate, carer or family)*
- *offer an appropriate remedy or support to put matters right (if possible)*
- *explain fully to the person (or, where appropriate, their advocate, carer or family) the short and long term effects of what has happened.*

Health and care professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns".

As the panel had found Mr Aldridge to have been dishonest in charges 2 and 6, the panel also considered him to have breached his duty of candour. As the investigation into Prisoner A's death developed, the panel noted that Mr Aldridge continued to provide false and misleading accounts regarding his interactions with Prisoner A on 16/17 August 2015. If Mr Aldridge had been confused as to which prisoner had died, the panel considered that he would have raised this at an earlier point, and he would have taken the opportunity to check contemporaneous notes of Prisoner A for 16/17 August 2015.

The panel was of the view that Mr Aldridge had many opportunities to exercise his professional duty of candour, but did not do so. It had found him to have provided false or misleading accounts when asked about his interactions with Prisoner A on 16-17 August 2015.

Therefore, the panel found charge 8 proved.

Charge 9)

9. Your acts and/or omissions set out at any or all of charge 1 contributed to the loss of chance to avert the death of Prisoner A.

This charge is found proved.

In reaching this decision, the panel took account of Ms 6, Dr 7 and Dr 11's evidence.

The panel had sight of Dr 7's expert witness report, which states:

> "*8.3…if the observation on 16/8/15 of an increased PR, which in itself is of unknown significance, had been followed up and there may have been opportunities to note signs and symptoms of methadone toxicity and reduce the chances of the death happening*
>
> *8.4 If Mr Aldridge had carried out further observations (or indeed come back to the cell to give the diazepam) when Prisoner A was found snoring and unrousable in the cell on 16/8/15 then it is also possible that the death could have been averted…*".

This was also supported by Ms 6's expert witness report, which stated:

> "*It is my opinion that the standard of care fell far below that expected of a reasonably competent registered nurse. Nurse Aldridge failed to act in accordance with the NMC Code, as set out in subsection 5.1. He failed to adhere to Standards 2 and 8 of the 'Medicines Management' guideline (NMC 2017). He also failed to deliver care to the standards outlined by the Department of Health for substance misuse services, and failed to identify the risks associated with methadone use. Nurse Aldridge further failed to document or communicate his findings accurately…*".

In Dr 11's Clinical Review, he also stated:

"*There is concern over the level of observation maintained by nursing staff in the substance misuse team from Saturday lunchtime until he was found dead late on the Monday morning, and also a failure to follow up on a potentially significantly abnormal observation on Sunday afternoon. It is not known for definite that the outcome would have been altered had his care been different, although it is the opinion of the clinical reviewer that there is a significant chance Prisoner A would not have died if earlier medical intervention had occurred. It is important that key learning points are drawn from this case about the crucial role of regular observations in the safe management of prisoners undergoing detoxification from drugs and alcohol, and the need to assess and act on abnormal/deteriorating observations in an appropriate way. The observation of a fairly acute rise in the pulse rate observed in the afternoon of 16.8.15 was not apparently interpreted by the nursing team involved with the degree of potential clinical significance that I would have attached to it, and I suspect this may have been influenced by the apparent wellness of Prisoner A otherwise. This would seem a training issue. The circumstances related to the evening visit by nurse Aldridge as related to me are clearly of potentially significant concern and I understand are the subject of further separate investigation. I should emphasise again that I have not been able to interview Mr Aldridge for the purposes of compiling this report to ascertain either the facts or interpretation of events from his perspective…*".

In taking account of the various clinical opinions, the panel was satisfied that Mr Aldridge's acts and/or omissions, set out at any or all of charge 1, contributed to the loss of chance to avert the death of Prisoner A.

The panel noted that Mr Aldridge was the clinical professional that attended to Prisoner A on the night shift of 16/17 August 2015. Prisoner A was unconscious, and the opportunity to identify signs and symptoms of an overdose was lost in failing to conduct observations on him.

The panel was of the view that Mr Aldridge should have taken the opportunity to conduct observations, taking account of the contextual background of Prisoner A. Mr Aldridge should have known that Prisoner A was a drug addict who had been prescribed

methadone, and was within ‘the danger period’ for a patient on a gradually rising dose of methadone on day 4 or day 5 of the treatment plan. Had observations been taken on the night shift of 16/17 August 2015, there may have been an opportunity to avert the death of Prisoner A.

Therefore, the panel found charge 9 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 Aldridge’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 Aldridge’s fitness to practise is currently impaired as a result of that misconduct.

Decision and reasons on misconduct

The panel heard and accepted the advice of the legal assessor, which included reference to a number of judgments, including: *Roylance* v *General Medical Council (No 2) [2000] 1 A.C. 311*. It also had regard to the NMC's statement of case.

When determining whether 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").

The panel was of the view that Mr Aldridge's actions did fall significantly short of the standards expected of a registered nurse, and breached the following provisions of the Code:

"***1 Treat people as individuals and uphold their dignity***
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns
To achieve this, you must:
2.1 work in partnership with people to make sure you deliver care effectively

6 Always practise in line with the best available evidence
To achieve this, you must:
6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work co-operatively
To achieve this, you must:
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:
10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 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

Preserve Safety
You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

15 Always offer help if an emergency arises in your practice setting or anywhere else
To achieve this, you must:
15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
To achieve this, you must:
17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

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".

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that in these particular circumstances, Mr Aldridge's actions were sufficiently serious so as to justify a finding of misconduct.

The panel noted that Mr Aldridge's actions were not a single instance of misconduct, although they all relate to the same incident on a single night shift.

The panel considered the charges to be very serious, in particular, Mr Aldridge's dishonesty and lack of duty of candour. Mr Aldridge had provided false information to a number of parties involved in investigating Prisoner A's death, including the police, which could have had serious ramifications. Mr Aldridge was seeking to provide a misleading impression of the care delivered to Prisoner A during the night shift of 16/17 August 2015. The panel considered Mr Aldridge to have embarked on a course of conduct whereby he provided false information to exonerate himself from any wrongdoing.

Mr Aldridge had also demonstrated poor clinical judgment, and the panel had found his acts and/or omissions to have contributed to the loss of chance to avert the death of Prisoner A. as he had incorrectly recorded that he had administered medication to Prisoner A on the night shift of 16/17 August 2015 when he had in fact not. The panel agreed with the NMC's submission that keeping accurate records of patient care is a basic and fundamental nursing skill. The panel considered his record keeping to have fallen far below the standards expected of a registered nurse. By incorrectly recording that medication had been administered to Prisoner A on the night shift of 16/17 August 2015, this also had the potential to mislead others into believing that Prisoner A was provided with treatment when he was not.

The panel was of the view that other registered nurses would consider Mr Aldridge's actions to be deplorable in the particular circumstances of this case.

In taking account of all the above, the panel determined that both individually and collectively, Mr Aldridge's behaviour fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

Registered 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 registered nurses with their lives and the lives of their loved ones. To justify that trust, registered 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 *Grant* in reaching its decision. In paragraph 74, she said:

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

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

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

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

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

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

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

The panel considered all of the above limbs to be engaged in this case.

The panel determined that Mr Aldridge had exposed a patient in his care to a risk of harm, had acted in a way that would have brought the nursing profession into disrepute, and had breached fundamental tenets of the nursing profession in being dishonest and breaching his duty of candour.

In assessing Mr Aldridge's level of insight, the panel had no evidence before it to suggest that he had reflected upon the severity of his conduct. There was nothing before the panel demonstrating any understanding by Mr Aldridge about how his actions had negatively impacted the public's perception of registered nurses, what lessons he had learned, or how he would better uphold the reputation of the nursing profession in future. The panel noted that Mr Aldridge had disengaged from proceedings in 2018 when his representative withdrew from the case stating that Mr Aldridge had retired. Because of the lack of engagement, there was nothing to suggest that Mr Aldridge has developed his understanding of what he did wrong. In circumstances where a registrant has not demonstrated insight, there remains a significant risk of repetition of the misconduct. In absence of evidence to the contrary, the panel was clear that Mr Aldridge had a lack of appreciation for the consequences of his actions, which clearly had the potential to adversely impact upon public perception of registered nurses.

In considering whether Mr Aldridge has remediated his nursing practice, the panel had regard to the factors set out in *Cohen*. Whilst the panel was satisfied that Mr Aldridge's clinical errors could be addressed through retraining, it was of the view that dishonesty is often more difficult to remediate, in principle, as it could be suggestive of a deep-seated attitudinal concern. In any event, Mr Aldridge has not provided the panel with any evidence of remediation, insight or remorse since he has disengaged. From the evidence before the panel in the paperwork, Mr Aldridge had denied misleading investigations into Patient A's death, and the panel had no reason to believe that Mr Aldridge had changed his view on this.

Therefore, the panel was satisfied that there was no evidence of remediation, and it considered there to be a high risk of repetition of the misconduct identified.

In light of the above, the panel had no evidence before it to allay its concerns that Mr Aldridge may currently pose a risk to patient safety. It considered there to be a continuing risk of unwarranted harm to patients in Mr Aldridge's care, should he be permitted to practise as a registered nurse. The panel concluded that Mr Aldridge is not a safe and effective nursing practitioner at the current time. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered there to be a high public interest in the consideration of this case. It was of the view that a fully informed member of the public would be extremely concerned by Mr Aldridge's misconduct and current impairment. Mr Aldridge had attempted to mislead a number of investigations into Prisoner A's death, including the police investigation. It concluded that public confidence in the nursing profession would be seriously undermined if a finding of impairment were not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mr Aldridge's fitness to practise as a registered nurse is currently impaired on both public protection and 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 Mr Aldridge's name off the NMC register. The effect of this order is that the NMC register will show that Mr Aldridge has been struck-off.

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 heard and accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr Aldridge'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 considered the following aggravating factors to be involved in this case:

- Prisoner A suffered actual harm, and the panel had found Mr Aldridge's acts and/or omissions contributed to the loss of chance to avert his death.
- Mr Aldridge's dishonest conduct was repeated and lasted for a significant period of time.

- Mr Aldridge has not demonstrated any insight, remorse or remediation, having disengaged from the NMC process since 2018.

The panel considered the following mitigating factors to be involved in this case:

- Mr Aldridge was working within a challenging prison environment where some of the systems in place were not up to an adequate standard. A number of recommendations were made and implemented as a result if the investigations into Prisoner A's death.

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 action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel was of the view that Mr Aldridge's behaviour was not at the lower end of the spectrum of fitness to practise and it determined that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing a conditions of practice order on Mr Aldridge's nursing registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the misconduct in this case. Whilst the panel had determined that the clinical deficiencies were capable of remediation, it was not satisfied that a conditions of practice order was sufficient to address Mr Aldridge's dishonest conduct and his breach of duty of candour, having regard to the public protection and public interest elements of this case. As Mr Aldridge has not engaged with the NMC since 2018, the panel had no recent evidence of insight, remorse or remediation. There is no

evidence before it to suggest that Mr Aldridge appreciates the serious ramifications of his acts and/or omissions. The panel considered there to be an underlying attitudinal issue present in this case, which may prevent Mr Aldridge from reflecting upon the extent of his actions and how it had impacted on Prisoner A's family, colleagues, the nursing profession and the wider public.

In taking account of the above, the panel determined that placing a conditions of practice order on Mr Aldridge's nursing registration would not be practicable, nor would it adequately address the seriousness of this case, nor would it satisfy the public interest considerations.

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

The panel noted that Mr Aldridge had engaged in multiple instances of misconduct. It had found him to have breached multiple provisions of the Code, as well as fundamental tenets of the nursing profession. It had found Mr Aldridge's acts and/or omissions contributed to the loss of chance to avert the death of Prisoner A, and it had found him to compound matters by providing false and misleading information which he knew to be untrue.

Mr Aldridge has offered no evidence by way of insight, remorse or remediation into his misconduct; despite having a substantial amount of time to reflect. The panel could not be satisfied that Mr Aldridge would attempt to alleviate the outstanding concerns at some point in the future, due to him having allegedly retired, and it found him to be likely to repeat his misconduct. Therefore, there remains a significant risk of harm to the public, should Mr Aldridge be permitted to practise as a registered nurse at some point in the future.

Mr Aldridge's misconduct was of the utmost seriousness and was not a one-off incident. In the panel's view, he had embarked upon a calculated course of conduct, intending to mislead investigations into Prisoner A's death.

Taking account of the above, the panel determined that Mr Aldridge's misconduct was not merely a serious departure from the standards expected of a registered nurse and a

serious breach of professional standards, it was fundamentally incompatible with him remaining on the NMC register. In the panel's judgment, to allow someone who had behaved in this way to maintain his NMC registration would undoubtedly undermine public confidence in the nursing profession and in the NMC as a regulatory body.

In reaching its decision, the panel bore in mind that its decision could have an adverse effect on Mr Aldridge, both professionally and personally. However, the panel was satisfied that the need to protect the public and address the public interest elements of this case outweighs the impact on Mr Aldridge in this respect.

In balancing all of the factors, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Aldridge's misconduct 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 a striking-off order would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the nursing profession. It determined that a striking-off order would send a clear message to the public and the nursing profession that behaviour of this kind will not be tolerated. Mr Aldridge's actions were completely contrary to the standards expected of a registered nurse.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case.

It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest, or is in Mr Aldridge's own interest, until the substantive order takes effect.

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

Determination on Interim Order

The panel accepted the advice of the legal assessor.

The panel noted that the NMC had invited it to impose an interim suspension order on the grounds of public protection and public interest.

The panel considered the imposition of an interim order and determined that an interim order is necessary for the protection of the public and it is otherwise in the public interest. In deciding this, it had regard to the seriousness of the facts found proved, and the reasons set out in its determination for imposing a striking-off 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. Owing to the seriousness of the misconduct in this case and the risk of repetition identified, it determined that Mr Aldridge's conduct was sufficiently serious to justify the imposition of an interim suspension order, until the striking-off order takes effect. In the panel's judgment, public confidence in the regulatory process would be damaged if Mr Aldridge were to be permitted to practise as a registered nurse, prior to the substantive order coming into effect.

The panel decided to impose an interim suspension order in the particular circumstances of this case. To conclude otherwise would be incompatible with its earlier findings.

The panel therefore imposed an interim suspension order for a period of 18 months.

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

This will be confirmed to Mr Aldridge in writing.

That concludes this determination.