Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 9 May 2022 – Friday 13 May 2022

Virtual Hearing

Name of registrant:	**Mr David Mathew Smith**
NMC PIN:	93J0804E
Part(s) of the register:	Nursing – RNMH: Mental Health Nurse, Level 1 – 16 November 1996
Relevant Location:	West Sussex
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, lay member) Claire Matthews (Registrant member) Melanie Swinnerton (Lay member)
Legal Assessor:	Gareth Jones
Hearings Coordinator:	Samiz Mustak
Nursing and Midwifery Council:	Represented by Aoife Kennedy, Case Presenter
Mr Smith:	Not present or represented
Facts proved:	Charges 1, 2, 3, 4.1, 4.2 & 5
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Smith was not in attendance nor represented and that the Notice of Hearing letter had been sent to his e-mail address as recorded on the Nursing and Midwifery Council (NMC)'s register on 7 April 2022.

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

The panel accepted the advice of the legal assessor.

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

In the light of all of the information available, the panel was satisfied that Mr Smith has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Smith

The panel next considered whether it should proceed in the absence of Mr Smith. It had regard to Rule 21 and heard the submissions of Ms Kennedy who invited the panel to continue in the absence of Mr Smith.

Ms Kennedy referred the panel to the case of *General Medical Council v Adeogba* [2016] EWCA Civ 162. She reminded the panel that when considering whether to proceed in the absence of a registrant, the panel must be satisfied that *'all reasonable efforts have been made to serve the practitioner* [registrant] *with notice of the hearing.'*

Ms Kennedy submitted that there had been no engagement at all by Mr Smith with the NMC since the referral was initially made in June 2019. She referred the panel to the Proceeding in Absence bundle and submitted that numerous efforts had been made to contact Mr Smith, including a final email on 4 May 2022, to which no response had been received.

Therefore, Ms Kennedy submitted that the NMC had made all reasonable efforts to obtain Mr Smith's engagement with this hearing. She submitted that the panel could form the view that Mr Smith has voluntarily absented himself. Ms Kennedy further submitted that no application for an adjournment has been made and that there is nothing to suggest that adjourning the hearing would secure Mr Smith's attendance at some future date. Further, Ms Kennedy submitted that it is in the public interest for this case to be disposed of expeditiously. She informed the panel that six witnesses have been scheduled to give evidence and submitted that to delay matters would inconvenience them.

The panel accepted the advice of the legal assessor that included reference to the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R v Jones*.

The panel decided to proceed in the absence of Mr Smith. In reaching this decision, the panel considered the submissions of Ms Kennedy and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba and* had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Smith;

- Mr Smith has not engaged with the NMC since the referral being made in June 2019, and has not responded to any of the e-mails sent to him about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- One witness has been warned to give live evidence today, and five others are due to attend at a later stage;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Smith in proceeding in his absence and with no representative present. Although the evidence upon which the NMC relies will have been sent to his e-mail address as recorded on the NMC's register. Mr Smith has made no response to any correspondence sent to him. The panel were mindful of the duty on Mr Smith to ensure that contact details for him on the NMC register were up to date. Mr Smith will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the disadvantage is the consequence of Mr Smith's decisions to absent himself from the hearing, waive his right to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charges

That you, a Registered Nurse:

1. Between 01 January 2018 and 30 June 2018, failed to administer one or more monthly doses of Paliperidone to Patient A. **(Proved)**

2. Between 01 January 2018 and 30 June 2018 failed to make Carenote entries for Patient A. **(Proved)**

3. In respect of one or more occasions at charge 1 above, failed to discharge your duty of candour in that, you did not escalate the failure(s) to medicate. **(Proved)**

4. On or about 4 & 5 July 2018, made one or more entries on the Carenote system recording care of Patient A which were:

   4.1 Retrospective **(Proved)**

   4.2 Wholly or partly fabricated **(Proved)**

5. Your actions at 4.2 above were dishonest in that you were representing that meetings and the care recorded in them, had taken place when you knew they had not, and/or, where meetings had taken place, you were representing the records of those meetings as accurate when you knew they were not. **(Proved)**

And, in light of the above, your Fitness to Practise is impaired by reason of your misconduct.

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

Prior to hearing from Witness 1, Ms Kennedy made an application for parts of the hearing to be held in private on the basis that there may be some references to Mr Smith's health. The application was made pursuant to Rule 19.

The panel accepted the advice of the legal assessor and noted that Rule 19 states:

> *'(1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.*
>
> *(2) […]*
>
> *(3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied:*
>
> *(a) Having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and*
> *(b) Having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.'*

The panel accepted that the general rule is that substantive hearings are expected to be held in public unless there is a good reason for them to be held in private. Having heard that there may be some references to Mr Smith's health, the panel determined to hold such parts of the hearing in private. It was satisfied that the need to protect Mr Smith's health matters outweighed the public interest in having this hearing held entirely in public.

Decision and reasons on application to admit hearsay evidence

On Day 1 of the hearing, Ms Kennedy made an application to admit the verbal disclosures made by Patient A to Witness 1 and Witness 4 in this case under Rule 31. Providing the panel with clarity, Ms Kennedy told the panel that, whilst there is no official statement provided by or obtained from Patient A, numerous witnesses scheduled to give evidence have made references to verbal disclosures made by Patient A concerning the charges.

Ms Kennedy drew the panel's attention to the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and the guidance given by the court when considering hearsay evidence:

> *'(i) whether the statements were the sole or decisive evidence in support of the charges;*
>
> *(ii) the nature and extent of the challenge to the contents of the statements;*
>
> *(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
>
> *(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*
>
> *(v) whether there was a good reason for the non-attendance of the witnesses;*
>
> *(vi) whether the Respondent had taken reasonable steps to secure their attendance; and*
>
> *(vii) the fact that the Appellant did not have prior notice that the witness statements were to be read.'*

Ms Kennedy addressed the panel in relation to each of these factors. She submitted that the hearsay evidence adduced is not sole and decisive. She referred the panel to numerous documentary evidence which included care notes and Mr Smith's sickness absence record. Ms Kennedy further reminded the panel of the six witnesses due to give live evidence. Further, Ms Kennedy also referred the panel to an undated letter provided by Mr Smith during local investigations, which contains alleged admissions. Ms Kennedy told the panel that though charges had not been drafted or formalised by the NMC at the time the letter was written by Mr Smith, the alleged admissions made relate to the same charges before this panel.

In regard to the second factor, Ms Kennedy referred the panel again to the undated letter from Mr Smith during local investigations and submitted that alleged admissions had been made by Mr Smith and that there was limited challenge to the disclosures made by Patient A.

Addressing the panel in relation to the third factor, Ms Kennedy submitted that, based on the information and evidence before the panel, there is no suggestion that Patient A fabricated the information. She referred the panel to the witness statement of Witness 1 and submitted that information is contained within Witness 1's statement which suggests that Patient A is reliable. Ms Kennedy also referred the panel to the undated letter from Mr Smith, which was produced during local investigations, and submitted that Mr Smith allegedly appears to be in agreement as to the reliability of Patient A.

Concerning the fourth factor, Ms Kennedy submitted that the charges before the panel are serious and that if found proved, they could lead to a serious impact on Mr Smith's career as a registered nurse and to the health, safety, and well-being of patients in his care.

Regarding the fifth factor, Ms Kennedy informed the panel that Patient A is a high-risk and vulnerable patient. She referred the panel to the relevant paragraph in Witness 1's statement and submitted that the information suggests that Patient A did not wish to go on record during local investigations and that this position remained unchanged when the

NMC investigations commenced. She therefore submitted that this provides sufficient reason for Patient A's non-attendance.

Addressing the panel on the sixth factor, Ms Kennedy submitted that, due to the vulnerability of Patient A and his evidence not being sole and decisive, the NMC decided that it would not be appropriate to obtain evidence from Patient A. Ms Kennedy reminded the panel that the NMC has an obligation to consider the welfare of witnesses and submitted that it deemed this to be the appropriate course of action.

In respect of the seventh factor, Ms Kennedy submitted that prior to the hearing commencing, Mr Smith had been provided with all relevant documentation that the NMC had deemed appropriate for the panel to consider with regard to the charges in this case. She submitted that given this course of action, the panel could form the view that Mr Smith had sight of the hearsay evidence and decided not to contest it.

Ms Kennedy invited the panel to admit Patient A's hearsay evidence. She submitted that the evidence is relevant to the charges and that it is fair in all of the circumstances. She reminded the panel that should it decide to admit this evidence, there is no set indication as to what weight the panel should attach to it at a later date.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is *'fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor also referred the panel to relevant case law, namely the case of *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin) and *Thorneycroft v NMC*.

The panel was of the view that Patient A's hearsay evidence was not sole and decisive and referred itself to the numerous documentary evidence which included witness statements, care notes and Mr Smith's sickness absence record. It was mindful that it was due to hear the live evidence of six witnesses. It also considered the undated letter from

Mr Smith during local investigations and the alleged admissions that had been made by Mr Smith at the time. It was of the view that the alleged admissions related to the same allegations before the panel at this hearing.

Further, the panel noted that Mr Smith did have an opportunity to challenge the nature and extent of the evidence produced by the NMC prior to this hearing and had not done. It also deemed the charges to be serious and considered that, if found proved, they could lead to a serious impact on Mr Smith's career as a registered nurse and to the health, safety, and well-being of patients in his care.

The panel considered that Patient A is high-risk and a vulnerable patient, and whilst it was of the view that the NMC could have made attempts to secure a statement from Patient A, it reminded itself of the NMC's obligation to keep the welfare of such vulnerable witnesses in consideration and deemed that appropriate decisions had been made around this. It also considered witness statements around Patient A's reliability and deemed that there is enough information before it to support the view that there was no reason for Patient A to fabricate the disclosures which he made to medical professionals responsible for his care. The panel was mindful that it must also be fair to Mr Smith and decided that it would further explore the reliability of Patient A's disclosures when receiving live evidence from the witnesses to whom he made these disclosures.

In these circumstances, the panel determined it would be fair and relevant to accept into evidence Patient A's hearsay evidence but would give it such weight it deems appropriate once the panel had heard and evaluated all the evidence.

Decision and reasons on facts

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

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

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

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

- Witness 1: Service manager at the Trust at the time of the allegations;
- Colleague A: Team Leader at the Trust at the time of the allegations;
- Witness 2: Community Psychiatric Nurse at the Trust at the time of the allegations;
- Witness 3: Clinical Nurse Specialist at the Trust;
- Witness 4: Team Leader at the Trust;
- Witness 5: Consultant Psychiatrist at the Trust.

Background

The charges arose whilst Mr Smith was employed as a Community Psychiatric Nurse ("CPN") at Sussex Partnership NHS Foundation Trust ("the Trust"). Between January 2018 and July 2018, Mr Smith was based at the Bedale Centre ("the Centre") which assesses and treats people with specialist mental health needs.

Excerpts from the Trust's job description outlined the following about what the CPN role entailed:

> *'The role of Community Nurse is to work in partnership with service users in the designated care group with complex health presentations, developing their care plans and recovery plans to enable them to lead fulfilling lives. They will demonstrate an understanding of clinical interventions relevant the care group to include education, care plans and discharge planning, working closely with carers, families and partner agencies to facilitate this. The post holder will work at all times to promote the safety and the well being of service users and their families/carers. The post holder will assess, plan and implement care, and provide specialist nursing advice and carry out specialist nursing procedures. They will provide clinical supervision to staff and students.'*

Patient A had been an inpatient at the Centre in December 2017 and was discharged in January 2018. Upon their discharge, Patient A was given a Community Treatment Order ("CTO") and Mr Smith was allocated to be his CPN – this required Mr Smith to visit Patient A to administer monthly Paliperidone Depot injections.

Concerns first arose when Patient A was due to have a hearing to review the continuation of his CTO. Witness 4, a Team Leader at the Centre, had prepared for the review hearing to take place in May 2018 and had asked Mr Smith to prepare a Social Circumstances Report. However, Mr Smith failed to do this before he left the Centre to commence a new role.

In preparation for preparing the report, Witness 4 visited Patient A on 3 July 2018. During this visit, disclosures were made by Patient A that he had not received his Paliperidone Depot injections since being discharged from the Centre in January 2018 and had not seen Mr Smith since March 2018.

Concerned by these disclosures, Witness 4 checked Patient A's Carenotes and further concerns were raised that Mr Smith had completed Patient A's Carenotes retrospectively.

A local investigation was conducted by the Trust which resulted in a disciplinary hearing on 4 June 2019. Mr Smith attended this hearing, presented a statement, and set out that he had missed seeing Patient A for one injection due to problems managing his caseload and was late for the proceeding one. He further provided that when he went to give Patients A their injection, Patient A had said that they did not want to receive it and would not agree to restarting the Paliperidone Depot injections.

Mr Smith further provided that he had panicked due to his error in missing the injection and had not known what to do. He further told the Trust that he had agreed with Patient A not to tell anyone. This information only came to light at the very end of the investigative process. Until that point, Mr Smith had maintained during formal interviews that he had both visited Patient A and administered the Paliperidone Depot injections.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1

1. Between 01 January 2018 and 30 June 2018, failed to administer one or more monthly doses of Paliperidone to Patient A.

This charge is found proved.

In reaching its decision, the panel took into account the witness evidence, Patient A's hearsay evidence, the Carenote entries made by Mr Smith and Patient A's blood test results dated 25 July 2018.

The panel had no reason to doubt the credibility and reliability of Witness 4's evidence regarding her dealings with Patient A, in particular, his disclosure to her that he had not received his Paliperidone Depot injection since his discharge from the Centre in January 2018 and had not seen Mr Smith since March 2018. It noted that Witness 4's reliance on Patient A's version of events/level of honesty is based on her dealings with Patient A since these allegations arose, and examination of his previous medical notes. There was no information before the panel to suggest any previous concerns with Patient A's reliability and credibility.

The panel had regard to the blood test results dated 25 July 2018 which indicated that there was no Paliperidone in Patient A's bloodstream. It noted that Witness 4 stated that Paliperidone is present in a patient's bloodstream for '29 – 40 days' after it is administered.

The panel noted the Carenote entry dated 19 June 2018 made by Mr Smith that states that he administered a Paliperidone injection to Patient A. It noted that this was 30 days before Patient A's blood test results and considered that it could not rely on this Carenote entry as Patient A's blood test shows that there was no Paliperidone in his bloodstream.

The panel also noted that no depot card for Patient A could be located during the local investigation. The panel heard evidence that a depot card would evidence accurately when the Paliperidone Depot injections had been administered and that this would have been the responsibility of Mr Smith to complete.

The panel had regard to the local investigation notes in which Mr Smith stated he had administered the Paliperidone Depot injections; however, at the final local investigation meeting, he admitted that he did not. The panel considered that this called into question Mr Smith's credibility.

The panel also had regard to entries made on the Carenotes system and noted that these were not made contemporaneously by Mr Smith, rather they were made some months later.

Having identified that Mr Smith did not administer the Paliperidone Depot injection when he claimed to have done so on 19 June 2018 based on the blood test results of Patient A and the absence of any credible evidence to confirm that he had indeed administered any of the prescribed injections whatsoever, the panel considered it more likely than not that he failed to administer any of the Paliperidone Depot injections, in line with the disclosures made by Patient A to Witness 4.

In view of the above, the panel considered it more likely than not that Mr Smith failed to administer one or more monthly doses of Paliperidone to Patient A.

The panel therefore found this charge proved.

Charge 2

2. Between 01 January 2018 and 30 June 2018 failed to make Carenote entries for Patient A.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence in this case. The panel noted the Health Records Policy ("the Policy") before it. The panel was satisfied that this was the Policy in place at the time the charges occurred.

The panel had regard to the following extract from the Policy:

> *"Records should be accurate and up to date (entries completed no later than the end of the following working day). Filing must be up to date."*

The panel noted the Carenote entry records before it. It noted that entries relating to visits to Patient A between February and June 2018 were created my Mr Smith on the 4 and 5 July 2018. As a consequence, the panel found that Mr Smith had failed to comply with the Policy that such entries should be completed no later than at the end of the following day.

The panel also had regard to Mr Smith's responses during his local investigation meeting with Witness 1 on 20 August 2018. The panel noted Mr Smith's admission to Witness 1 that he did not adhere to the NMC Code of Conduct, which states that that nurses must keep clear and accurate records written up closely after the event in respect of Patient A. The panel found Witness 1's oral evidence as to this matter to be consistent with her witness statement and the documentary evidence provided. The panel therefore determined that, on the balance of probabilities between 1 January 2018 and 30 June 2018 Mr Smith failed to make Carenote entries for Patient A.

The panel therefore found this charge proved.

Charge 3

3. In respect of one or more occasions at charge 1 above, failed to discharge your duty of candour in that, you did not escalate the failure(s) to medicate.

This charge is found proved.

In reaching its decision, the panel took into account the witness evidence and the documentary evidence.

The panel noted that Mr Smith was Clinical Lead at the time of the incidents and considered that due to his senior position, he should have been fully aware of the need to escalate when Patient A's medication had not been administered. The panel had regard to Witness 3 and Witness 4's evidence and noted that both witnesses confirmed that the

correct procedure would have been for Mr Smith to inform his team leader, line manager, supervisor, or a consultant who would then call a multidisciplinary meeting to consider whether to continue with the Patient's treatment or to discontinue it. The panel had no evidence before it of Mr Smith following this procedure.

The panel noted the live evidence of Witness 3 and took into account that Mr Smith would regularly have clinical supervision meetings with Witness 3. The panel considered these meetings offered Mr Smith opportunities to raise the issues. It further noted the live evidence of Witness 5 and noted Mr Smith having 'a good working relationship' and considered that Mr Smith could have disclosed the issue to Witness 5 but chose not to. Whilst the panel heard some evidence regarding Mr Smith having a poor relationship with his line manager, it also heard evidence of other individuals, both peers and supervisors, to whom Mr Smith could have escalated his failure to administer the Paliperidone Depot injections to Patient A.

The panel also had regard to its findings at charge 1 that Mr Smith failed to administer Paliperidone Depot injections to Patient A, therefore it follows that, as Patient A's CPN, Mr Smith had breached his duty of candour by not escalating his failure to medicate Patient A.

In view of the above, the panel found that Mr Smith had breached his duty of candour and the panel found this charge proved.

Charge 4

4. On or about 4 & 5 July 2018, made one or more entries on the Carenote system recording care of Patient A which were:

4.1 Retrospective

4.2 Wholly or partly fabricated

This charge is found proved in its entirety.

4.1

For the same reasons given in relation to charge 2 above, the panel was satisfied on the balance of probabilities that this charge is proved.

4.2

In reaching its decision, the panel took into account the witness evidence and the documentary evidence.

Having found charge 1 proved and concluding that entries made on the Centre's Carenotes system were not made contemporaneously by Mr Smith, the panel considered it more likely than not that Mr Smith made one or more entries on the Carenote system which were wholly or partly fabricated in order to conceal the fact that he had not administered the Paliperidone Depot injections to Patient A.

The panel therefore found this charge proved.

Charge 5

5. Your actions at 4.2 above were dishonest in that you were representing that meetings and the care recorded in them, had taken place when you knew they had not, and/or, where meetings had taken place, you were representing the records of those meetings as accurate when you knew they were not.

This charge is found proved.

In reaching its decision, the panel took into account the witness evidence and the documentary evidence.

It had regard to the case of *Ivey v Genting Casinos Ltd t/a Crockfords [2017] UKSC 67* in determining whether Mr Smith had been dishonest in his actions. 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 noted that as Clinical Lead, Mr Smith was in a senior position, and he should have been fully aware of the need to either give Patient A his Depot injections as per his prescription and his CTO or to report that Patient A was refusing them. During the local investigation meetings, Mr Smith maintained that he had administered the Paliperidone Depot injections, but later admitted at the final local investigation meetings that he had missed one and was late to give another. The panel had sight of the undated letter submitted by Mr Smith in which he admitted:

> *'In brief, I had missed administering a Paliperidone injection and was late for the proceeding one.*

I saw the client, who refused to consider restarting it and I panicked. Unbelievably and stupidly, I tried to cover up my error as I thought my job and career would be finished.'

The panel determined that Mr Smith would have been aware that the Carenote entries made by him were retrospective and wholly or partly fabricated as he had not administered any Paliperidone Depot injections to Patient A since his discharge from the Centre in January 2018, nor had he seen Patient A since March 2018.

The panel was satisfied that Mr Smith was dishonest when he had made Carenote entries indicating that he had carried out meetings with Patient A during which he had administered Paliperidone Depot injections in an effort to conceal his failings.

Therefore, the panel was not satisfied that Mr Smith had made an honest mistake nor were there any other valid reasons for making inaccurate and fabricated entries in Patient A's Carenotes, and it determined that ordinary and decent people would consider his actions to be dishonest.

The panel therefore found this charge 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 Smith'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 Smith's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

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

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

Ms Kennedy identified the specific, relevant standards where Mr Smith's actions amounted to misconduct and submitted that Codes 8.1, 8.2, 8.3, 8.5, 8.6, 9.3, 10.1, 10.2, 10.3, 13.1, 13.2, 14 in its entirety, 16, 16.1, 16.3, 17, 17.1, 17.2, 17.3, 18.2, 20.1 and 20.2 had all been engaged.

Addressing the panel first on misconduct in particular to charges 1 and 2, Ms Kennedy submitted that the failure to administer medication and keep accurate records is serious. She reminded the panel of the live witness evidence heard in this case and that at the time of the incidents, there was a high caseload and staff shortages at the Centre, which put Mr Smith under extreme pressure.

Addressing the panel next on charges 3, 4.1, 4.2 and 5, Ms Kennedy submitted that these are more serious charges and referred the panel again to the live witness evidence. Ms Kennedy told the panel that the risk of not administering the Paliperidone Depot injections after consecutive doses had been missed includes a risk of relapse and risk of being hospitalised. Ms Kennedy referred the panel to the Witness evidence of Witness 4 who informed the panel that Patient A did relapse shortly after these incidents occurred and was admitted into hospital in September 2018.

Further, Ms Kennedy referred the panel to the live witness evidence of Colleague A who informed the panel that if doses are missed, the Paliperidone depot injections would have to be titrated, otherwise there would be a risk of overdosing the patient, a risk of oversedation and severe illness with potentially fatal risks. Ms Kennedy submitted that Patient A was exposed to these risks as he was not in the hospital at the time so could not be monitored.

Ms Kennedy submitted that is it the role of nurses to protect and care for vulnerable patients under their care, and to be open and candid when mistakes are made. She submitted that Mr Smith clearly failed those duties and that his conduct proved to have fallen far short of what is expected of a registered nurse.

Addressing the panel next on impairment, Ms Kennedy referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and the four-limb “test”. Ms Kennedy submitted that all four limbs of *Grant* are engaged.

Ms Kennedy addressed the panel in relation to all four limbs.

In respect of limb one, Ms Kennedy submitted that Mr Smith’s failure to document and escalate that Patient A had not received the Paliperidone Depot injections put Patient A at risk of harm. However, Ms Kennedy submitted that the most significant risk posed by Mr Smith was by his dishonesty in that he fabricated the Carenote records to indicate that the

Paliperidone Depot injections had been administered to Patient A, thereby putting him at risk of receiving further injections when he had missed consecutive doses.

Ms Kennedy submitted that the nursing profession *'demands'* that nurses are open and candid when mistakes are made, and that they act with honesty and integrity. She told the panel that patient wellbeing is expected to be prioritised to monitor and minimise the risks to their safety and submitted that Mr Smith's misconduct put Patient A at serious and unwarranted risk of harm.

Addressing the panel on the second limb, Ms Kennedy told the panel that the public has the right to expect nurses to provide effective care, refer to colleagues, escalate matters where appropriate and act with honesty and integrity. She submitted that Mr Smith's conduct in fabricating records to conceal his mistakes and his sustained dishonesty throughout the local level investigations undermined public confidence in the nursing profession and has brought the profession into disrepute.

Concerning limb three and four, Ms Kennedy submitted that Mr Smith's conduct breached the fundamental tenets of the profession and that his actions were dishonest.

Addressing the panel next on remediation, insight, and risk of repetition, Ms Kennedy submitted that a finding of impairment is required on the grounds of public protection and is also in the wider public interest.

In respect of charges 1 and 2, Ms Kennedy referred the panel to the evidence it had heard concerning high caseloads and staffing shortages. She submitted that in regard to the misconduct relating to charges 1 and 2, the actions of Mr Smith are remediable through training and some form of supervision. In relation to charges 3, 4.1, 4.2 and 5, Ms Kennedy submitted that these charges are more serious and due to their nature, more difficult to remediate. Ms Kennedy referred the panel to the relevant guidance and submitted that the most serious kind of breach is that of a nurse deliberately breaching his or her duty of candour.

Further, Ms Kennedy submitted that Mr Smith has not engaged with the NMC since the referral and has yet to formally respond to the charges. She drew the panel's attention to the undated statement provided by Mr Smith at local level investigations and submitted that whilst this demonstrates some level of insight, there is no indication of remorse or remediation and how his actions could have impacted on the health, safety, and well-being of Patient A. Therefore, Ms Kennedy submitted that due to the lack of insight into remediation, there is a risk of repetition and consequently a real risk of harm. She submitted that members of the public would find such behaviour deplorable and that a finding of impairment is required to maintain confidence in the professions and the NMC as a regulator.

The panel accepted the advice of the legal assessor which included references to the cases of *Roylance* and *Grant.*

Decision and reasons on misconduct

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

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

> *'8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate…*
>
> *8.2 maintain effective communication with colleagues…*
>
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff…*

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…

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required…

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

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers…

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly…

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices…

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can…

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

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information…

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people…

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment…'

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 Mr Smith was in a senior role as a Clinical Lead and was responsible for the care of a vulnerable patient with mental health issues. Whilst the panel noted that Mr Smith had a poor working relationship with his team

leader and there was a high caseload with staffing issues, the panel reminded itself that support had been put in place at the Centre to aid Mr Smith, especially with his paperwork.

The panel determined that failing to administer consecutive Paliperidone Depot injection doses put Patient A at a risk of serious harm. Further, the panel considered that fabricating records also put Patient A at a risk of significant harm as, from the live evidence heard in this matter and all other evidence considered, no one had been aware of the missed doses. The panel considered that Patient A's dosage of Paliperidone would have had to be titrated otherwise there could have been a potential risk of overdose, oversedation and severe illness with potentially fatal risks. The panel also determined that failing to inform and escalate the incidents and maintaining dishonesty throughout the local level investigations is deplorable and amounts to serious misconduct.

The panel therefore found that Mr Smith's actions did fall short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

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

The panel found that all of the limbs were engaged in this case.

The panel found that Mr Smith had placed Patient A at a risk of significant harm by not administering the monthly doses of Paliperidone Depot injections and by failing to inform and escalate matters. The panel heard insufficient explanations for Mr Smith's actions and nothing as to why he had failed to inform or escalate the matter and was of the view that Mr Smith's actions were to conceal his errors.

The panel found that Mr Smith did not adhere to the standards expected of a nurse and that his behaviours brought the profession into disrepute. It considered that Mr Smith's fellow practitioners would find his behaviour and dishonesty deplorable.

The panel also found that maintaining dishonesty throughout local investigations breached fundamental tenets of the profession.

In relation to the charges found proved regarding dishonesty, the panel noted that Mr Smith was under clinical supervision by Witness 3 and met with her regularly to discuss any concerns/issues. The panel further noted that Mr Smith had *'a good working relationship'* with Witness 5. Considering both, the panel concluded that Mr Smith had ample opportunities to inform and escalate his failures but knowingly decided not to do so and only disclosed his failure to administer one of the Paliperidone Depot injection at the final local level investigation meeting. The panel determined that there is no information before it to account for Mr Smith's dishonest actions, demonstrate remorse or show sufficient insight into how his actions may have impacted Patient A and his colleagues. It therefore considered that there is a risk that Mr Smith may act dishonestly again.

The panel next considered whether Mr Smith's practice can be strengthened in relation to the serious and repeated misconduct identified.

Considering charges 1 and 2, the panel was of the view that, although these are serious charges, they can be remediated through training and some form of supervision. However, considering charges 3, 4.1, 4.2 and 4.3, the panel was of the view that the concerns raised in these charges would be more difficult to remediate. The panel noted that Mr Smith has

not engaged with the NMC since the referral from the Trust was received and that it has no information before it today to suggest if Mr Smith has in some way addressed the concerns identified or developed insight into how his actions put Patient A and colleagues at risk of harm.

The panel noted the undated statement provided by Mr Smith at the local level investigations and was of the view that though there was some insight concerning his actions, this was not enough to show that the likelihood of the dishonesty and failures are reduced. The panel reminded itself of the live evidence of Witness 5, who made admissions that the concerns were *'out of character'* and that Mr Smith had a *'good clinical understanding'*; however, the panel was not satisfied, on the evidence before it, that Mr Smith has sufficient insight into his actions and considered that he has not demonstrated any strengthening of his practice.

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

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

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

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

Sanction

The panel has considered this case carefully and had decided to make a striking-off order. It directs the registrar to strike Mr Smith off the register. The effect of this order is that the NMC register will show that Mr Smith has been struck-off the register.

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

Submissions on sanction

Ms Kennedy invited the panel to make a striking-off order. She reminded the panel that the most serious kind of dishonesty is when a nurse deliberately breaches the professional duty of candour to be open and honest when mistakes are made; however, that cases of dishonesty will always be serious.

Ms Kennedy informed the panel that when making its decision, the panel must consider firstly, the aggravating factors, and secondly, it must consider the mitigating factors.

Addressing the panel first on the aggravating factors, Ms Kennedy submitted that Mr Smith's lack of insight into his failing, a pattern of sustained and repeated dishonesty throughout local investigations and his conduct of putting Patient A at a risk of suffering serious harm are all factors the panel must consider.

Addressing the panel next on the mitigating factors, Ms Kennedy submitted that at the time of the incidents, Mr Smith was under pressure due to high caseloads and that the Centre had staffing shortages. Ms Kennedy invited the panel to consider these factors in its decision making.

Ms Kennedy reminded the panel that when considering the appropriate sanction to impose, the panel must start by looking at the least restrictive sanction. She addressed the panel on each sanction.

In respect of no further action and a caution order, Ms Kennedy submitted that these would not be the appropriate sanctions. She submitted that given the seriousness of the conduct and the identified risk of repetition, taking no further action or a caution order would be insufficient in protecting the public and the wider public interest.

Addressing the panel next on the sanction of imposing a conditions of practice order, Ms Kennedy submitted that although the panel found the concerns in charges 1 and 2 to be remediable through training and some of supervision, the concerns in charges 3, 4.1. 4.2 and 5 relating to dishonesty are more serious and difficult to remedy. She submitted that the dishonesty concerns indicate serious attitudinal issues which, although relating to Mr Smith's clinical practice, are not easily monitored or assessed by training and some form of supervision. Ms Kennedy reminded the panel that since the referral was made to the NMC, Mr Smith has not engaged and therefore, there is nothing to suggest that conditions of practice would be adhered to or would be appropriate, workable, or measurable in the circumstances.

Concerning the sanction of imposing a suspension order, Ms Kennedy submitted that charges of dishonesty, by nature, will always be serious. She submitted that on the evidence before the panel, the dishonesty in this case is of the most serious kind and referred the panel's attention to the NMC guidance on 'Considering Sanctions for Serious Cases'.

Taking the panel through the relevant points, Ms Kennedy submitted that Mr Smith's actions deliberately breached the professional duty of candour in that he tried to conceal his errors and that this had potential to cause Patient A serious and fatal harm. She reminded the panel that Patient A was a vulnerable patient and that though Mr Smith's actions were not premeditated or systematic, they were longstanding.

Ms Kennedy submitted that Mr Smith's dishonesty was sustained over a period of time and suggests a disregard for the health, safety, and well-being of Patient A. She reminded the panel that it has found that Mr Smith's actions were serious and fell short of the standard expected of a registered nurse and that on this basis and the above, a suspension order would not be appropriate as it would not mark the seriousness of Mr Smith's misconduct.

Addressing the panel on reasons why a striking-off order is the appropriate sanction, Ms Kennedy reminded the panel that the guidance makes clear that a nurse who has behaved dishonestly will always be at risk of being removed from the register. She outlined the following extract in particular:

> *'Nurses, midwives and nursing associates who behaved dishonestly can engage with the Fitness to Practise Committee to show that they feel remorse, that they realise they acted in a dishonest way, and tell the panel that it will not happen again. They can do this in person, through anyone representing them, or by sending information they want the Committee to consider. If they do this, they may be able to reduce the risk that they will be removed from the register.'*

Ms Kennedy submitted that in light of the serious nature of the concerns and the complete lack of engagement with the NMC from Mr Smith, together with the lack of insight and remorse in this case, public confidence in nurses will not be maintained if Mr Smith were not removed from the register. She submitted that a striking-off order is the only sanction to sufficiently protect patients, the wider public and to maintain professional standards.

Decision and reasons on sanction

Having found Mr Smith'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 Sanction Guidance. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- A lack of insight and remorse into failings;
- Conduct which put Patient A at a risk of suffering serious and potential fatal harm;
- Sustained and repeated dishonesty throughout local level investigations.

The panel also took into account that at the time of the incidents, there had been a high caseload and staffing shortages and deemed these as mitigating features.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Smith's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Smith's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Smith's registration would be a sufficient and appropriate response. The panel is of the view that though charges 1 and 2 could be remediated by training and some form of supervision,

charges 3, 4.1, 4.2 and 5, which relate to dishonesty, are not so easily remediable and that conditions would be difficult to formulate to address this. Further, the panel noted that Mr Smith has not engaged with the NMC since the referral from the Trust was received and that the panel has no information before it to suggest that a conditions of practice order would be complied with by Mr Smith. Therefore, the panel concluded that the placing of conditions on Mr Smith's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel determined that this was not a single instance because this was repeated conduct sustained over a long period of time. The panel found that the sustained nature of the dishonesty, that only ended at the final local level investigation meeting, suggested deep seated attitudinal issues. The panel found, as seen above, that there was insufficient evidence of insight, and a real risk of repetition.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Smith's actions is fundamentally incompatible with Mr Smith remaining on the register.

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

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

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

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

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

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

The panel took into account that this sanction will prevent Mr Smith from practising as a nurse but decided that the need to protect the public and uphold the public interest outweighed his interest in this regard.

This will be confirmed to Mr Smith in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Kennedy who submitted that a corresponding interim order is necessary and that the NMC apply for an interim suspension order for a duration of 18 months. Ms Kennedy submitted that an interim suspension order is necessary to protect the public and is otherwise in the wider public interest. Ms Kennedy submitted that 18 months would allow for an appeal process, if relevant, to conclude.

Decision and reasons on interim order

In reaching its decision, the panel had regard to the facts found proved relating to serious misconduct and reasons set out in its decision for the substantive order.

The panel concluded that an interim suspension order would be necessary to protect the public and is otherwise in the public interest, due to the reasons already identified in the

panel’s determination for imposing the substantive order. The panel therefore impose 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 Smith is served with the decision of this hearing in writing.

That concludes this determination.