Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 25 – Wednesday 27 & Friday 29 July 2022
Tuesday 11 – Wednesday 12 October 2022

Virtual Hearing

Name of registrant:	**Mrs Memory Bodle**
NMC PIN:	09B2289E
Part(s) of the register:	Registered Nurse - Mental Health Nursing (February 2010)
Relevant Location:	Kent
Type of case:	Misconduct
Panel members:	Nicola Dale (Chair, lay member) Sue Davie (Lay member) Elaine Biscoe (Registrant member)
Legal Assessor:	Juliet Gibbon
Hearings Coordinator:	Isobel Clymer (25-27 & 29 July 2022) Sherica Dosunmu (11 & 12 October 2022)
Nursing and Midwifery Council:	Represented by Mary Kyriacou, Case Presenter
Mrs Bodle:	Present and represented by Mr Padley, on Monday 25 July 2022 and part of Tuesday 26 July 2022. Subsequently unrepresented.
Facts proved:	Charges 1a-d, 3, 4a-b, 5a-e, 6
Facts not considered:	2 (alternative to charge 1)
Fitness to practise:	**Impaired**
Sanction:	**Striking-Off Order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered mental health nurse working on an enhanced low secure ward:

1. Slept whilst on duty during the nightshift of:

a) 23 - 24 May 2020, for a period of approximately 4 hours and 50 minutes

b) 24 – 25 May 2020, for a period of approximately 3 hours and 40 minutes

c) 30 - 31 May 2020, for a period of approximately 4 hours and 26 minutes

d) 31 May – 1 June 2020, for a period of approximately 3 hours and 46 minutes

2. In the alternative, sat or lay down in a dark room, appearing asleep, whilst on duty during the nightshift of:

a) 23 - 24 May 2020, for a period of approximately 4 hours and 50 minutes

b) 24 – 25 May 2020, for a period of approximately 3 hours and 40 minutes

c) 30 - 31 May 2020, for a period of approximately 4 hours and 26 minutes

d) 31 May – 1 June 2020, for a period of approximately 3 hours and 46 minutes

3. Failed to conduct observations and/or failed to ensure that observations were conducted in respect of Patients A and/or B and/or C and/or D, during the periods of time specified in charge 1. a) and/or b) and/or c) and/or d)

4. Failed to ensure patient safety in that you:

a) Were unaware that Patient A had left his room and had knocked on the door of another patient at around 02.00 on or about 30 May 2020

b) Did not monitor and/or did not ensure the monitoring of the physical health of Patient A for a period of 30 minutes to an hour, following the administration of rapid tranquilisation at approximately 00.20 on 31 May 2020

5. Documented in the observation records:

a) that Patient B appeared asleep in the bedroom between 00.30 and 02.30 on 24 May 2020, at a time when you were asleep or were sitting or lying down, appearing to be asleep, in a dark room

b) that you had observed Patient B appearing to be asleep in the bedroom between 02.30 and 04.30 on 24 May 2020, at a time when you were asleep or were sitting or lying down, appearing to be asleep, in a dark room

c) that Patient B appeared to be asleep in the bedroom, between 02.30 and 04.30 on 25 May 2020, at a time when you were asleep or were sitting or lying down, appearing to be asleep, in a dark room

d) that Patient B appeared to be asleep in the bedroom, between 00.30 and 02.30 and/or 02.30 and 04.30 and/or 04.30 and 06.30 on 31 May 2020, at a time when you were asleep or were sitting or lying down, appearing to be asleep, in a dark room

e) that Patient B appeared to be asleep in the bedroom, between 00.30 and 02.30 on 1 June 2020, at a time when you were asleep or were sitting or lying down, appearing to be asleep, in a dark room

6. And your actions as specified in charge 4. a) and/or b) and/or c) and/or d) and/or e) were dishonest in that you intended to induce others to believe that you had carried out observations on Patient B when you had not done so

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Kyriacou, on behalf of the NMC, to amend the wording of charge 6.

The application was to amend the charge referred to in charge 6 from 4 to 5. It was submitted by Ms Kyriacou that the proposed amendment would provide clarity and more accurately reflect the evidence.

The panel heard submissions from Mr Padley, on your behalf, that you did not oppose the making of the proposed amendment of charge six.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment. It was therefore appropriate to allow the application to amend charge six in order to ensure clarity and accuracy.

The amended charges are as follows:

'*That you, a registered nurse:*

1. Slept whilst on duty during the nightshift of:

a. 23 - 24 May 2020, for a period of approximately 4 hours and 50 minutes
b. 24 – 25 May 2020, for a period of approximately 3 hours and 40 minutes
c. 30 - 31 May 2020, for a period of approximately 4 hours and 26 minutes
d. 31 May – 1 June 2020, for a period of approximately 3 hours and 46 minutes

2. In the alternative, sat or lay down in a dark room, appearing asleep, whilst on duty during the nightshift of:

a. 23 - 24 May 2020, for a period of approximately 4 hours and 50 minutes
b. 24 – 25 May 2020, for a period of approximately 3 hours and 40 minutes
c. 30 - 31 May 2020, for a period of approximately 4 hours and 26 minutes
d. 31 May – 1 June 2020, for a period of approximately 3 hours and 46 minutes

3. Failed to conduct observations and/or failed to ensure that observations were conducted in respect of Patients A and/or B and/or C and/or D, during the periods of time specified in charge 1. a) and/or b) and/or c) and/or d),

4. Failed to ensure patient safety in that you:

a. Were unaware that Patient A had left his room and had knocked on the door of another patient at around 02.00 on or about 30 May 2020

b. Did not monitor and/or did not ensure the monitoring of the physical health of Patient A for a period of 30 minutes to an hour, following the administration of rapid tranquilisation at approximately 00.20 on 31 May 2020

5. Documented in the observation records:

a. that Patient B appeared asleep in the bedroom between 00.30 and 02.30 on 24 May 2020, at a time when you were sitting or lying down, appearing asleep, in a dark room

b. that you had observed Patient B appearing to be asleep in the bedroom between 02.30 and 04.30 on 24 May 2020, at a time when you were sitting or lying down, appearing asleep, in a dark room

c. that Patient B appeared to be asleep in the bedroom, between 02.30 and 04.30 on 25 May 2020, at a time when you were sitting or lying down, appearing asleep, in a dark room

d. that Patient B appeared to be asleep in the bedroom, between 00.30 and 02.30 and/or 02.30 and 04.30 and/or 04.30 and 06.30 on 31 May 2020, at a time when you were sitting or lying down, appearing asleep, in a dark room

e. that Patient B appeared to be asleep in the bedroom, between 00.30 and 02.30 on 1 June 2020, at a time when you were sitting or lying down, appearing asleep, in a dark room

6. And your actions as specified in charge 5. a) and/or b) and/or c) and/or d) and/or e) were dishonest in that you intended to induce others to believe that you had carried out observations on Patient B when you had not done so

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

Background

The charges arose whilst you were employed as a registered nurse by Cedar House, part of the Hundercombe Group (the Group).

The NMC received a referral from the Group on 1 July 2020. At the time of the concerns raised in the referral, you were working as an agency nurse at Cedar House Hospital (the Hospital) on the Enhanced Low Secure Ward (the Ward), part of the Group.

The Ward is a secure mental health ward with patients who were all detained in the Hospital under Section 3 or under Section 37 of the Mental Health Act 1983 (the Act). Patients admitted to the Hospital under Section 3 of the Act were detained for mental disorder(s) of a nature and/or degree that requires treatment in hospital, and necessary for their health, safety or for the protection of others. Patients admitted to the Hospital under Section 37 of the Act were sent to the Hospital by the courts instead of prison for a criminal offence, and they require treatment for serious mental health disorder(s). As a result, the Ward had high level observations in place due to the patient group.

You completed night shifts on the Ward as the sole registered nurse in charge of patient care on the following dates:

- 23 - 24 May 2020
- 24 - 25 May 2020
- 30 - 31 May 2020
- 31 May - 1 June 2020

During this period while you were on night shift duty, Patient A caused some damage to property on the Ward. The Ward Manager (Ms 1) and the Physical Intervention Trainer and Conflict Manager (Mr 2), subsequently reviewed CCTV footage to identify when the damage had been caused and whether there was any learning from the incident. The referral alleges that during the review of the CCTV footage, you were seen to go into the seclusion office, position yourself on two chairs pulled together and appeared to be asleep for a number of hours while you were on night shift duty on four separate occasions.

The referral alleges that you should have completed patient observations during the periods you were in the seclusion office but failed to do so. It is alleged that you failed to ensure patient safety while you were asleep or appearing to be asleep, and, on or about 30 May 2021, you were unaware Patient A had left his room and knocked on the door of another patient. It is also alleged that on 31 May 2020, following the administration of rapid tranquilisation, you did not ensure the monitoring of the physical health of Patient A, as you were required to do.

Further, the referral alleges that during shifts on 24, 25 and 31 May and 1 June 2020 you also falsified patient records. It is alleged that you completed the observation records for Patient B as if you had carried out observations personally at times when you were in the seclusion office.

Following the review of the CCTV footage, your shifts on the Ward were immediately cancelled while an investigation took place. At the relevant time, you were employed with DNA Care Services (the Agency), and you were suspended from the Agency as a result of the concerns raised.

Decision and reasons on facts

Prior to the hearing the panel was provided with your Case Management Form (CMF) dated December 2021 in which you admitted all of the charges.

At the outset of the hearing, the panel heard from Mr Padley who informed the panel that you made full admissions to charges 2a-d, 4a-b, 5a-e and 6, and a partial admission to charge 3. You denied charge 1.

However, during your oral evidence the position on your admissions became very unclear and you set out denials to some of the charges previously admitted.

After you had given evidence and before the panel had heard submissions on the facts, Mr Padley told the panel that he, and your solicitor at the Royal College of Nursing, were unable to continue representing you because they were professionally embarrassed. You then informed the panel that you would be representing yourself.

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

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, under affirmation, from the following witnesses called on behalf of the NMC:

- Ms 1: Ms 1 was a ward manager at Cedar House at the time of the incidents, and watched CCTV footage for the time of the incidents alleged in the charges.

- Mr 2: Mr 2 was a physical intervention trainer and conflict manager at Cedar House at the time of the incidents, and watched CCTV footage for the time of the incidents alleged in the charges.

The panel also heard evidence from you under affirmation and was provided with a copy of your reflective piece, dated 15 July 2022.

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

The panel noted that, on your NMC CMF, submitted in December 2021, you had admitted all the charges. At the start of the hearing, Mr Padley, on your behalf, stated that you admitted all of the charges except Charge 1 and part of Charge 3 (the part relating to ensuring observations were done). During your evidence, you appeared to resile from some of your earlier admissions. However, in your reflection, dated 15 July 2022, you had admitted some of the charges.

In light of the above, the panel determined that it could not rely entirely on your admissions on the CMF or at the start of the hearing, and it therefore determined that it should consider each of the charges on the evidence before it in order to reach its findings on facts.

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

Charges 1a, 1b, 1c, 1d

> '1. *Slept whilst on duty during the nightshift of:*
> *a. 23 - 24 May 2020, for a period of approximately 4 hours and 50 minutes*
> *b. 24 – 25 May 2020, for a period of approximately 3 hours and 40 minutes*
> *c. 30 - 31 May 2020, for a period of approximately 4 hours and 26 minutes*
> *d. 31 May – 1 June 2020, for a period of approximately 3 hours and 46 minutes*'

This charge is found proved.

On your CMF you admitted this charge, however you denied it at the outset of the hearing.

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

The panel considered the evidence of Witnesses Ms 1 and Mr 2, who viewed the CCTV footage showing you curled up or laying on two chairs pushed together in the seclusion office with your eyes closed and facing upwards on the dates and times set out in Charge 1.

The panel noted your written reflection, dated 15 July 2022, in which you wrote '*… I had never slept on any shift before this time. I should have known my limits and not worked excessive hours. I should never have slept or appeared asleep on duty. I am sorry*'.

The panel acknowledged that when questioned under affirmation you initially denied being asleep, but did admit to being seated on a chair with your legs elevated, with a cover over your body and your eyes closed alone in the darkened seclusion office. The panel also took into account that when questioned regarding your reflective piece, you said, '*when you fall asleep you don't know if you are sleeping or not*' and accepted that it was possible that you were asleep. You said that you had been working 16-18 hour shifts on occasion during the pandemic.

The panel noted the evidence of Ms 1, who had spent three days reviewing the CCTV footage of the night shifts in question. Ms 1 said that your eyes were closed and that you did not move from your position curled up on the two chairs for the duration of the times set out in Charge 1a-d, save for one of the shifts when you were seen eating an apple and leaving the seclusion office to go to the bathroom.

The panel accepted the evidence of Ms 1, who they found to be a credible witness with no motive to lie about what she'd seen on the CCTV footage. Further, her evidence about what was depicted on the CCTV footage was corroborated by the evidence of Mr 2, who

had also viewed it. Both witnesses also included the times and dates in email/internal statements to hospital management in early June 2020.

On the basis of the evidence before it, including your previous admissions, the panel determined, on the balance of probabilities that it was more likely than not that you were asleep on duty during each of the times and dates set out in the Charge 1 a-d.

Charge 2

'2. In the alternative, sat or lay down in a dark room, appearing asleep, whilst on duty during the nightshift of:
a. 23 - 24 May 2020, for a period of approximately 4 hours and 50 minutes

b. 24 – 25 May 2020, for a period of approximately 3 hours and 40 minutes

c. 30 - 31 May 2020, for a period of approximately 4 hours and 26 minutes

d. 31 May – 1 June 2020, for a period of approximately 3 hours and 46 minutes'

Charge 2 is charged in the alternative to Charge 1 and so the Panel did not consider it, having found Charge 1 proved.

Charge 3

'Failed to conduct observations and/or failed to ensure that observations were conducted in respect of Patients A and/or B and/or C and/or D, during the periods of time specified in charge 1. a) and/or b) and/or c) and/or d).'

This charge is found proved.

At the outset of the hearing your representative, Mr Padley, informed the panel that you admitted the charge in part. You admitted that you had not conducted observations on the patients, but your case was that you had ensured that the observations were conducted by others. The panel also had sight of the CMF in which you admitted the charge in full.

In reaching this decision, the panel took into account the evidence of Ms 1, who informed the panel that you were in the seclusion office alone when observations should have been carried out. She informed the panel that four of the five patients on the ward were under Level 3 observations, which requires at least two members of staff to keep the patient in their line of sight at all times. She told the panel that at the times you were seen to be asleep you should have been awake and either conducting observations or ensuring that the support workers were doing so.

In her statement Ms 1 stated that '*the Nurse's responsibilities during the night shift included carrying out observation of the five patients on the Ward and providing guidance to the care workers who also conduct observations*.'

The panel noted the observation policy in place at the time which states ' *the nurse in charge assumes overall responsibility for the duties delegated over the course of the shift* …'.

When questioned, you admitted that you had failed to personally conduct the patient observations, and had relied on the support workers, whom you trusted, who had informed you that the observations had been carried out. You accepted that you should not have signed to indicate that the observations had been carried out and you also accepted that, as the entries had not been signed, that they may not have actually been carried out.

The panel noted that in Ms 1's statement she stated that at the time of these events, hospital management had identified several issues in relation to staff not conducting patient observations and that these issues persisted on both day and night shifts. She described it as '*a culture*' on the ward of staff not doing the relevant patients' observations.

You told the panel that you now know that a patient's observations should only be written up by the person who carried them out.

The panel found the charge proved on the balance of probabilities. The evidence before the panel was that you were alone in the seclusion office for continuous periods of between three hours forty minutes and four hours fifty minutes. It, therefore, found that you could not have carried out the observations that you recorded during those times. It also found it inconceivable that you would have been able to supervise and ensure that the observations were being properly carried out during those times. The panel further considered that as the ward was short staffed and four of the patients were on Level 3 observation, there was a greater responsibility on you to assist your colleagues to carry out the patients' observations.

The panel also noted Ms 1's statement where she confirms that, due to short staffing, at some point during the time you were in the seclusion office, you would have been personally required to conduct patient observations.

The panel determined that you were the nurse in charge, the Ward was short staffed, and you had a duty to conduct and/or oversee your colleagues to carry out observations on Patients A, B, C & D during the night shift. The panel found you had deliberately taken yourself out of action by going into the seclusion office and sleeping for a number of hours during the relevant period. It found that you had taken no positive action to ensure that the patient observations had been carried out according to their care plans.

It, therefore found, on the balance of probabilities, that you had both failed to conduct the patients' observations and failed to ensure that the observations had been carried out.

Charge 4 a)

'4. Failed to ensure patient safety in that you:

a. *Were unaware that Patient A had left his room and had knocked on the door of another patient at around 02.00 on or about 30 May 2020.'*

This charge is found proved.

You admitted this charge on the CMF and also at the outset of the hearing. During your evidence you denied the charge.

In reaching this decision the panel took into account all of the evidence before it, including the statement of Ms 1 and the email that she had sent to the Hospital's management on 3 June 2020 about the incident which was very soon after viewing the CCTV for the second time.

Ms 1 in her statement, stated that she had viewed the CCTV in slow time and seen Patient A leave his room and knock on Patient C's door on a couple of occasions. The panel noted that Ms 1 had sent an email to the Hospital's management on 3 June 2020 stating that she had seen Patient A knocking on Patient C's door, while you were alone in the seclusion office, and that neither you or a support worker had intervened.

When questioned, you informed the panel that you thought that it was impossible that Patient A had left his room, because you did not hear them do so, the support workers had not reported it and you had not been asked to complete a Datix report relating to it.

The panel preferred the evidence of Ms 1 who was very clear about what she had viewed on CCTV and reported her findings to hospital management soon after the events. It found, on the balance of probabilities, that Patient A had left his room and knocked on the door of another patient during the time that you were in the seclusion office asleep. You had, therefore, failed to ensure patient safety because neither you or any of your colleagues were aware of Patient A's movements.

Charge 4 b)

'b. Did not monitor and/or did not ensure the monitoring of the physical health of Patient A for a period of 30 minutes to an hour, following the administration of rapid tranquilisation at approximately 00.20 on 31 May 2020.'

This charge is found proved.

You admitted this charge on the CMF and also at the outset of the hearing but during your evidence you denied the charge.

In reaching its decision, the panel took into account the evidence of Ms 1 and Mr 2 that you entered the seclusion office 20 minutes after you had administered the rapid tranquilisation injection to Patient A at 00:20 on 31 May 2020 and remained there for more than four hours. The panel also found that you did not attempt to delegate the observations to a support worker.

You told the panel that Patient A was being verbally abusive and refusing all attempts for you to carry out observations. The panel also noted that you accepted that you had retrospectively written '*refused*' in Patient A's records to indicate that he had refused to have the necessary observations carried out.

The panel found that you were in the seclusion office between 00:40 and 05:06 and you could not, therefore, have monitored Patient A as required by the Hospital's rapid tranquilisation policy. The panel did not accept your evidence that Patient A had refused the observations because you were not in a position after 00.40 to carry them out or to attempt to, as you were in the seclusion office. The panel noted that you accepted that you had retrospectively completed the observation form. The panel determined that you had done so because you had not carried out the necessary observations. The panel therefore

found, on the balance of probabilities, that you did not ensure the monitoring of the physical health of Patient A and therefore failed to ensure patient safety.

Charge 5

'5. Documented in the observation records:

a. that Patient B appeared asleep in the bedroom between 00.30 and 02.30 on 24 May 2020, at a time when you were sitting or lying down, appearing asleep, in a dark room

b. that you had observed Patient B appearing to be asleep in the bedroom between 02.30 and 04.30 on 24 May 2020, at a time when you were sitting or lying down, appearing asleep, in a dark room

c. that Patient B appeared to be asleep in the bedroom, between 02.30 and 04.30 on 25 May 2020, at a time when you were sitting or lying down, appearing asleep, in a dark room

d. that Patient B appeared to be asleep in the bedroom, between 00.30 and 02.30 and/or 02.30 and 04.30 and/or 04.30 and 06.30 on 31 May 2020, at a time when you were sitting or lying down, appearing asleep, in a dark room

e. that Patient B appeared to be asleep in the bedroom, between 00.30 and 02.30 on 1 June 2020, at a time when you were sitting or lying down, appearing asleep, in a dark room.'

This charge is found proved.

You admitted this charge on the CMF and at the outset of the hearing.

In reaching its decision on this charge, the panel took into account your admission in oral evidence that you had retrospectively signed Patient B's observation record later in the shift when you found blank entries. You told the panel that you had asked the support workers if they had carried out the relevant observations and they said they had. You said that you had trusted them. You also, however, told the panel that you felt guilty that you may have signed for something that had not been observed but you had relied on your support workers. You accepted that the patient observation records should be completed at the time the patient observations are carried out and signed by the person doing them.

The panel determined that, as an experienced nurse, you would have known that observation records should only be signed by the person completing the observations. Despite this, you had signed Patient B's observation records indicating that the observations had been carried out by you.

The panel, therefore, found Charge 5 a-e proved.

Charge 6

> '*6. And your actions as specified in charge 5. a) and/or b) and/or c) and/or d) and/or e) were dishonest in that you intended to induce others to believe that you had carried out observations on Patient B when you had not done so.'*

This charge is found proved.

You admitted this charge on the CMF and also at the outset of the hearing. During your evidence you both admitted and denied it.

In reaching this decision, the panel took into account the evidence of Ms 1 and Mr 2, together with the observation records of Patient B.

It noted that you had admitted dishonesty in the CMF, and at the start of the hearing. It also noted that you admitted in cross-examination that you had acted dishonestly in signing that you had carried out Patient B's observations at a time when you were in the seclusion office and not in a position to do so. In particular, the panel noted that you stated in cross-examination in respect of your reflective piece: '*I accept I was dishonest'.*

As an experienced nurse, you would have known that anyone looking at the patient's observation records would think that you had carried out the observation as you had signed that you had done so. If the observation had been carried out by a support worker, then you should have asked that person to sign the observation record or, at the very least, documented who had carried out the observation. The panel noted that you had stated in your reflective piece that you were aware that other nurses left the record blank if it had not been signed during the shift.

The panel found that you were an experienced nurse, who knew that the purpose of carrying out the observations was to inform the condition of the patient and to inform anyone reading the record who had carried out the observation. You were not in the position to know the condition of the patient. You had not completed the observations on the patient as you had been in the seclusion office at the time. The panel determined that, in putting your signature on the observation record, you were aware that anyone looking at the record would think that you had carried out the patient's observations, as recorded, and that is what you intended them to believe.

You admitted the dishonesty in your CMF on 7 December 2021. You also admitted dishonesty at the start of the hearing; in cross examination and in your reflective piece. The panel noted that you had denied dishonesty at times during your evidence. It was satisfied, however, that your conduct, in signing the observation record, was to induce others to believe that you had carried out the observations when you had not.

The panel found that you could have left the missed observations blank because you stated in your reflective piece of 15 July 2022 that other nurses did so. You could also

have asked the relevant colleague to sign the record. Alternatively, you could have written down the name of the person who, you said, had carried out the observations, if in fact they had been done. The panel found, on the balance of probabilities, that you had acted dishonestly when you signed Patient B's observation form in that you intended to induce others to believe that you had carried out the patient's observations personally when you had not.

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 your 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

The panel also 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 Kyriacou invited the panel to take the view that the facts found proved amount to misconduct. She identified the specific, relevant standards where your actions fell short of the Code and amounted to misconduct.

Ms Kyriacou submitted that your actions found proved fell significantly short of the standards expected of a registered nurse. She submitted that you acted dishonestly in falsifying records and recording that you had carried out observations when you had not, which calls into question your trustworthiness as a registered nurse. She stated that as an experienced nurse with many years of practice, you would have known that the observation records should be completed by the person carrying out the observations and would have to be competed honestly and accurately. She submitted that, by failing to do so, you have breached your duty of candour by attempting to cover up the fact that you had not completed the observations that you were required to. She stated that this was the premise to you falsifying the records. Further, she submitted that your actions demonstrate deep seated attitudinal problems.

Ms Kyriacou submitted that further to your attempts to cover up your own failings to complete observations, you placed Patient A at significant risk of harm through documenting that you completed observations after administering rapid tranquilisation when you had not. She submitted that, at the time you were working on a ward with some volatile and unwell patients and, by not observing these patients or ensuring they were observed, she submitted that you placed all patients and colleagues at risk of harm.

Ms Kyriacou submitted that there are some contextual issues to take into account. She submitted that this includes the indication that there was a culture on the Ward of not completing observations, a culture of '*bedding down'*, and your completion of longer shifts at the request of your manager which were sometimes in excess of 16 hours. She submitted that these may have been contributing factors to your actions.

You submitted that your actions occurred during the height of the COVID-19 pandemic, when the Ward was short staffed, everyone was doing long hours, and there was increased worrying during that time. You stated that management would continue to call you regarding additional shifts, and you thought you were helping Cedar House by taking on additional shifts.

You stated that, at the relevant time, [PRIVATE], so you went to the seclusion office at the Ward to put your legs up only.

You stated that you have still not seen the CCTV footage, and you will not accept that there was no one observing the patients at the time as observations were being completed by Support Workers.

Submissions on impairment

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

Ms Kyriacou invited the panel to find your fitness to practise impaired on both public protection and public interest grounds. She submitted that your actions found proved had breached fundamental tenets of the nursing profession to act with honesty, integrity and candour, which is more difficult to remediate.

Ms Kyriacou submitted that your actions included sleeping on shifts, not ensuring observations were carried out and not assisting with observations at a time when the Ward was understaffed. She reminded the panel that, while you were asleep, Patient A knocked

on another patient's door, which could have resulted in harm for that patient. She submitted that your actions placed patients at risk of harm, and had you not been asleep on shifts such risk of harm could have been avoided. She indicated that you were responsible for volatile patients with complex mental health needs and as an experienced nurse, you ought to have realised the risks of your actions. She submitted that there would be a risk to the public if a finding of impairment were not made in this case.

Additionally, Ms Kyriacou submitted that the public would be shocked to hear of a nurse sleeping on duty, on such a ward. She submitted that public confidence in the profession would be undermined if a finding of impairment were not made in this case.

Ms Kyriacou submitted that on the basis of your misconduct, you have breached all four limbs of the test in *Grant*. She submitted that the panel is also required to take into account the factors set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin). She submitted that in this respect, your conduct is not easily remediable, has not been remediated, and is likely to be repeated, given that you did repeat the misconduct throughout the week long period that was observed on CCTV.

Ms Kyriacou submitted that you have demonstrated no insight. She stated that this is evident in the convoluted account that you have provided with varying degrees of acceptance of your own behaviour. She submitted that perhaps you want to accept some of your actions, but you have offered no insight or adequate detailed reflection into your behaviour over the week long period. She submitted that whilst there had initially been an admission of dishonesty and to a degree an understanding that you had a responsibility to the patients and your colleagues to assist with conducting observations, you have in equal measure denied this and continue to do so. She submitted that this lack of insight is extremely problematic and it follows that the risk of repetition is high.

Ms Kyriacou submitted that you have not demonstrated that you have learnt from your actions, but rather appear to contend that you have not done anything wrong. She submitted that what you have said to the panel throughout this hearing is contrary to the

testimonials presented, which largely comment on reflection and insight that you have undertaken.

You submitted that everyone makes mistakes and stated that if you were to ever return to work as a nurse again you would not make the same mistakes again. You stated that you thought observations were done by Support Workers, but if you were to return to nursing this is something you would never accept.

You submitted that you helped Cedar House with the work you did during that period. You stated that Cedar House is now closing down and all the patients except for Patient A have now left that part of the Group. You indicated that although you know the hard work you have completed whilst employed at Cedar House, you will accept the decision of the NMC.

You stated that [PRIVATE], and you have had to start work as a Support Worker since your referral. You stated that the Agency has continued to call you to ask for help throughout the two years of the NMC proceedings, but you have had to decline due to this case.

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

Decision and reasons on misconduct

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

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

*‘**1 Treat people as individuals and uphold their dignity***

1.2 make sure you deliver the fundamentals of care effectively

8 Work co-operatively

8.2 maintain effective communication with colleagues

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

10 Keep clear and accurate records relevant to your practice

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

10.3 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 Be accountable for your decisions to delegate tasks and duties to other people

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

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

13 Recognise and work within the limits of your competence

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

18 …administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

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

20 Uphold the reputation of your profession at all times

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered the charges individually and collectively, as well as the circumstances of the case as a whole. It took account of all the evidence before it, including your bundle of documents.

The panel had regard to the facts found proved and determined that your actions demonstrated failings in basic fundamental elements of nursing. The panel considered that as an experienced nurse and the only registered nurse on duty, you ought to have been aware of the risk of harm you caused by removing yourself from your duties and responsibilities for very significant proportions of your shifts. The panel was of the view that this demonstrated an unacceptably low standard of professional practice.

The panel considered that you deliberately sought to falsify records to represent that you had undertaken observations when you had not done so. The panel was of the view that the dishonesty related directly to your clinical practice, which presents an ongoing risk to patients in your care. The panel determined that your dishonesty was sufficiently serious to amount to serious misconduct.

The panel took into account that you were responsible for volatile patients with complex mental health needs. It noted that while you were asleep on shift, Patient A managed to leave his room and knock on another patient's door, without your knowledge. The panel found that your actions exposed vulnerable patients to serious risk of harm and also

impacted on the safety and work of your colleagues. However, you continue to maintain that Patient A could not have left his room because you were not informed that he had done so.

The panel also had regard to context, and it considered that your actions found proved happened at a time when you completed longer shifts at the request of your manager, which you indicated was at a time when the Ward was short staffed. However, the panel also noted, that in such a busy period, you were able to find time to sleep on duty for four to five hours at a time.

The panel was in no doubt that your actions found proved amounted to serious misconduct. The panel was of the view that sleeping on duty and failing to undertake observations while seeking to represent that you have done so, demonstrates a complete disregard for patient safety and untrustworthiness as a nurse. The panel determined that your actions would be considered unacceptable by both the public and fellow practitioners, thereby damaging the trust that the public places in the profession.

The panel therefore concluded that your actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your 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 determined that all four limbs in the above test were engaged in this case.

Taking into account all of the evidence adduced in this case, the panel found that patients were put at risk of serious harm as a result of your misconduct. The panel was of the view that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty, which put patients at risk, extremely serious.

The panel next went on to consider the matter of insight. It took into account your reflective account written in July 2022. The panel found that your reflection demonstrated emerging insight, however, it also found that your reflection was not consistent with your oral evidence and submissions given at the hearing, which were also at times contradictory and fluctuating. As a result, the panel determined to attach little weight to your reflective account. The panel was of the view that your accounts given at the hearing had not consistently demonstrated any understanding of how your actions put patients at a risk of serious harm or how this impacted negatively on your fellow team members and the reputation of the nursing profession. The panel found that you have demonstrated a significant lack of insight and remorse, particularly in the context of your inconsistent responses to the charges.

The panel determined that elements of the misconduct in this case is capable of remediation, although it noted that dishonesty is more difficult to remediate. The panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. However, the panel has not received any information to suggest that you have taken steps to address the specific concerns raised in this case about your practice, especially as you do not consistently acknowledge those concerns.

The panel was of the view that there is a high risk of repetition based on the lack of consistent evidence of insight, remorse, and evidence that you have strengthened your practice. The panel considered that your actions set out in the charges found proved

demonstrate behaviour that fails to acknowledge professional and clinical protocols, which inevitably led to unsafe practice. On the basis of all the information before it, including your inconsistent views on the charges throughout this case, the panel decided that there would be a risk to the public if you were allowed to practise without restriction. The panel therefore determined that a finding of current impairment on public protection grounds is necessary.

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 concluded that public confidence in the profession would also be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the NMC Register. The effect of this order is that the NMC Register will show that you have been struck-off the NMC Register.

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Kyriacou informed the panel that in the Notice of Hearing, dated 21 June 2022, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired.

Ms Kyriacou submitted that the NMC guidance states that before imposing a striking-off sanction, key considerations the panel should take into account include:

- Do the regulatory concerns about the nurse raise fundamental questions about their professionalism?
- Can public confidence in nurses be maintained if the nurse 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?

Ms Kyriacou submitted that your actions were inappropriate and call in to question your professionalism and that public confidence would not be maintained if you were not removed from the register, and the striking-off order is the only appropriate sanction to protect the public.

Ms Kyriacou submitted that, generally, the forms of dishonesty which are most likely to call into question whether a nurse should be allowed to remain on the NMC Register will involve vulnerable victims, direct risk to patients and premeditated, systematic or longstanding deception. She submitted that your actions did involve vulnerable victims, did present a direct risk to patients, was premeditated, since you made a clear decision to go into the room to sleep for a number of hours at a time, and was systematic as it was on four occasions.

Ms Kyriacou referred to the case of *Parkinson v NMC* [2010] EWHC 1898 (Admin), and submitted that this case makes it clear that a nurse who has acted dishonestly will always be at risk of being removed from the NMC Register.

Ms Kyriacou submitted that you have not provided an in-depth reflective explanation for your actions over the week long period, nor the reasons for your dishonesty. She submitted that you have not demonstrated any understanding of the impact of your behaviour on patients and colleagues and therefore these attitudinal concerns are difficult to put right. She stated that you have placed patients and colleagues potentially at serious risk of harm as a senior nurse in charge of the Ward.

Ms Kyriacou submitted that with no demonstrated insight, your continuation on the NMC Register would continue to place patients at risk of harm as there is a high risk of repetition. She submitted that the only appropriate sanction to protect the public, to maintain professional standards and to maintain confidence in the profession would be a striking-off order.

In your submissions, you stated that you were shocked about the panel's decision, which concluded that you pose a risk of harm to patients.

You submitted that you liked your job and liked your profession. You submitted that you would like another chance to work under supervision in order to prove yourself. You stated that your expectation is that you would be monitored in practice.

You stated that if a striking-off sanction were imposed, you would think that you have not been treated fairly.

You submitted that your previous representative, the RCN, initially misled you and told you to say yes to everything. You submitted that after you had reflected, you moved away from that position.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Conduct which put particularly vulnerable patients as well as colleagues at risk of harm;
- Repeated misconduct;
- Lack of insight into failings;
- Repeatedly taking yourself away from your duties for significant amounts of time, despite accepting additional responsibilities and being short staffed; and
- Misconduct including dishonesty, which is indicative of deep-seated attitudinal problems.

The panel also took into account the following mitigating features:

- Apparent lack of support in the workplace;
- Misconduct occurred during the height of COVID-19 pandemic when you were asked to do additional hours; and
- Positive testimonials about your clinical practice from colleagues including other registered nurses.

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 not protect the public or satisfy 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 your 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 your 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 your registration would be a sufficient and appropriate response. The panel noted that the concerns in this matter related to you demonstrating repeated failure to follow professional and clinical protocols and dishonesty, which, in the panel's view is indicative of deep-seated attitudinal problems. The panel also noted that you showed a lack of evidence of insight and remorse. The panel was therefore of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately protect the public and meet the public interest, nor would it mark the gravity of the multiple failings in this case.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel considered that the concerns in this case do not relate to an isolated incident and found that the misconduct was repeated on three further shifts over a week long period. The panel was of the view that the repeated misconduct including dishonesty in this case reflected deep-seated attitudinal problems. It also found a lack of insight or remorse, and a consequent significant 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 your actions is fundamentally incompatible with you remaining on the NMC 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 NMC Register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that the findings in this particular case demonstrate that your actions were serious and, to allow you to continue practising, would put patients at risk of serious harm and undermine public confidence in the profession and in the NMC as a regulatory body.

The panel noted the positive testimonials that you have provided together with your training certificates and reflective account.

The panel determined that honesty and integrity is at the heart of the nursing profession. It considered that you were entrusted with the care of vulnerable patients yet deliberately took yourself away from that position of trust in order to sleep for a significant proportion of each shift leaving these patients without a registered nurse to oversee patient care. It determined that you then sought to cover up your absence by signing observation logs as if you yourself had undertaken them during the shift.

The panel found that you have demonstrated a lack of insight and remorse into your misconduct. Further, the panel noted your evidence throughout the hearing which was contradictory both whilst represented and when representing yourself. The panel considered that you have not demonstrated that you can be trusted as a registered nurse, to act with care and keep patients and colleagues safe from unwarranted risk of harm. In addition, the panel has had no information to indicate that you have done anything to strengthen your practice in relation to the specific concerns of this case. The panel was of the view that members of the public would be concerned if a registered nurse who breached professional and clinical protocols, and was dishonest, as in the circumstances of this case, was allowed to remain on the NMC Register. Taking account of the SG, the panel could not be satisfied that anything less than a striking-off order would maintain professional standards, keep the public protected and address the public interest in your case.

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

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

This will be confirmed to you in writing.

Submissions on interim order

The panel took account of the submissions made by Ms Kyriacou. She submitted that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest. She invited the panel to impose an interim suspension order for a period of 18 months for the reasons stated in the panel's findings.

You submitted that it was already the case that you have not been working as a nurse for two years now.

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 your own interests until the strike-off sanction takes effect.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the

facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to allow for any possible appeal.

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

That concludes this determination.