Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
5 – 12 September 2022

Virtual Hearing

Name of registrant:	**Maritoni Abad**
NMC PIN:	01H1292O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 6 August 2001
Relevant Location:	Westminster
Type of case:	Misconduct
Panel members:	Richardo Childs (Chair, Lay member) Jennifer Childs (Registrant member) Christopher Reeves (Lay member)
Legal Assessor:	Richard Tyson
Hearings Coordinator:	Jumu Ahmed
Nursing and Midwifery Council:	Represented by Jasraj Sanghera, Case Presenter
Ms Abad:	Not present and not represented
Facts proved:	Charges 6i, 6ii, 6iii, 6iv, 7, 8, 9, 10, 11, 12a, 12c, 13
Facts not proved:	Charges 1, 2, 3, 4, 5, 12b, 12d
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 Ms Abad was not in attendance and that the Notice of Hearing letter had been sent to Ms Abad's registered email address on 5 August 2022.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, details of the substantive hearing which included the time, dates and the GoToMeeting link of the hearing and, amongst other things, information about Ms Abad's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Abad 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 Ms Abad

The panel next considered whether it should proceed in the absence Ms Abad. It had regard to Rule 21 and heard the submissions of Mr Sanghera who referred the panel to the case of *General Medical Council v Adeogba* [2016] EWCA Civ 162 and invited the panel to continue in the absence of Ms Abad. He submitted that Ms Abad had voluntarily absented herself.

Mr Sanghera submitted that there had been no engagement at all by Ms Abad with the NMC in relation to these proceedings. Mr Sanghera also submitted that it appeared that

Ms Abad had returned to her own country and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Ms Abad. In reaching this decision, the panel has considered the submissions of Mr Sanghera, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* 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 Ms Abad;
- Ms Abad has not engaged with the NMC and has not responded to any of the emails sent to her about this substantive hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date given her non-engagement in the proceedings today;
- 2 witnesses have attended today to give live evidence, others are due to attend. 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 2016 and 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 Ms Abad in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on

her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Abad's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Sanghera, on behalf of the NMC, to amend the wording of charge 13.

It was submitted by Mr Sanghera that the proposed amendment would provide clarity and more accurately reflect the evidence. He submitted this was merely a typographical error and it was clear which patient it related to.

Original charge:

That you, a registered nurse, whilst employed at the Imperial College Healthcare NHS Trust ("the Trust")

[…]

On 21 July 2018, following Patient X's discharge into the recovery unit;

[…]

13) Your actions in one or more of charges 10, 11 & 12 were dishonest, in that you falsified records, in an attempt to conceal that you had not taken Patient A's blood pressure reading in the recovery unit.

Amended charge:

That you, a registered nurse, whilst employed at the Imperial College Healthcare NHS Trust ("the Trust")

> […]

On 21 July 2018, following Patient X's discharge into the recovery unit;

> […]

13) Your actions in one or more of charges 10, 11 & 12 were dishonest, in that you falsified records, in an attempt to conceal that you had not taken Patient ~~A's~~ **X's** blood pressure reading in the recovery unit.

The panel accepted the advice of the legal assessor.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Ms Abad and no injustice would be caused to either party by the proposed amendment being allowed. The amendment simply corrected a typographical error. It was, therefore, appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charges (as amended)

That you, a registered nurse, whilst employed at the Imperial College Healthcare NHS Trust ("the Trust")

On 20 July 2016 following Patient A's discharge to the recovery unit;

1) Altered times in the recovery register book.

2) Tore a page out from the recovery register book.

3) Removed the torn page from the trust site and took it home.

4) Inaccurately recorded on the PACU documentation that Patient A was in the recovery unit for 45 minutes.

5) Your actions in one or more of charges 1, 2, 3 & 4 were dishonest in that you sought to conceal the accurate period of time Patient A was in the recovery unit.

On 21 July 2018, following Patient X's discharge into the recovery unit;

6) Did not undertake Post-Operative/Recovery observations of Patient X, in that you did not take Patient X's;

- i) Pulse/Heart rate
- ii) Temperature
- iii) Respiratory rate
- iv) Oxygen saturation

7) Did not take Patient X's blood pressure reading.

8) Discharged Patient X to the Day Care Unit ("DCU") without taking a blood pressure reading.

9) Did not provide Colleague B with a handover regarding Patient X.

10) At around 17:09 inaccurately recorded Patient X's blood pressure reading as 140/70 in Patient X's recovery register book.

11) At around 17:10 inaccurately recorded Patient X's blood pressure reading as 140/70 in the electronic Cerner record.

12) At around 17:54;

a) Retrospectively amended Patient X's blood pressure reading in the electronic Cerner record.

b) Did not identify that the amended entry in the electronic Cerner record was retrospective.

c) Retrospectively amended Patient X's blood pressure reading in the recovery register book.

d) Did not identify that the amended entry in the recovery register book was retrospective.

13) Your actions in one or more of charges 10, 11 & 12 were dishonest, in that you falsified records, in an attempt to conceal that you had not taken Patient X's blood pressure reading in the recovery unit.

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

Background

The NMC received a referral on 6 February 2019 from Deputy Divisional Director of Nursing at Imperial College Healthcare NHS Trust (the Trust). The charges arose whilst Ms Abad was employed as a Band 5 registered recovery nurse at the Western Eye Hospital (the Hospital).

It is alleged that on two separate occasions (first in 2016 and then again in 2018), Ms Abad failed to provide an adequate level of care on a recovery unit and was dishonest by falsifying patient records.

On 20 July 2016, following Patient A's discharge to the recovery unit, it is alleged that Ms Abad had sought to conceal the accurate period of time Patient A was in the recovery unit by altering the times in the recovery register book, tearing out a page from the recovery register book and taking it home, and inaccurately recording on the Post Anaesthetic Care Unit (PACU) documentation that Patient A was in the recovery unit for 45 minutes.

On 21 July 2018, around 17:00, Patient X was one of the Hospital's last patient of the day was transferred to the recovery room following surgery. Patient X was handed over to Ms Abad who was in charge of the recovery unit. It is alleged that Ms Abad did not undertake any post-operative observations and then had instructed the theatre support worker to transfer and discharge Patient X to the Day Care Unit (DCU).

It is alleged that around 17:10, without measuring Patient X's blood pressure, Ms Abad entered a reading of 140/70 into Patient X's notes on the Hospital's computer system

(Cerner) and recorded the same reading in the recovery register book kept in the recovery area.

At 17:23, Ms Abad and another registered nurse (Witness 2), measured Patient X's blood pressure whilst Patient X was in the DCU and this reading was entered into the Patient's Cerner records and on the recovery register book.

It is also alleged that subsequently Ms Abad logged into Patient X's Cerner records and altered the entry she made at 17:10. Also it is alleged that she subsequently altered she had made in the recovery register book at 17:10.

Ms Abad was dismissed for gross misconduct on 5 December 2018.

Proceedings in the course of the evidence

The panel heard live evidence on day 1 from the following witnesses called on behalf of the NMC:

- Witness 1: Matron at the Trust;
- Witness 2: Band 5 Nurse at the Trust;

Decision and reasons on application to admit Witness 4's written statement and supplementary witness statement as hearsay evidence

The panel heard an application made by Mr Sanghera on day 2 under Rule 31 to allow the written statement dated 10 September 2020, and the supplementary witness statement dated 5 August 2021, of Witness 4 into evidence. Witness 4 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unwilling to attend the hearing due to her disengaging with the NMC proceedings. Mr Sanghera informed the panel that Witness 4 had retired and moved back

to her home country. He submitted that Ms Abad was informed of Witness 4’s disengagement and was given an opportunity to engage and make representations, which she had chosen not to.

Mr Sanghera referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). He submitted that Witness 4’s evidence is highly relevant because she was the only direct witness to any of the July 2016 allegations. He submitted that in relation to the July 2018 allegations, Witness 4’s evidence is not the sole and decisive evidence as the panel had heard from two live witnesses on this and had the opportunity to cross examine the evidence. He also submitted that Witness 3 is due to attend and give evidence, so therefore the panel will have the opportunity to hear Witness 3’s evidence which relate to the 2016 and 2018 allegations, and therefore it will be in a position to form a well-informed view on the reliability of Witness 4’s evidence.

Mr Sanghera submitted that if Witness 4’s evidence is admitted, then any unfairness to Ms Abad can be mitigated by the panel exercising its discretion to attach the weight that it considers appropriate. However, if the panel was to exclude Witness 4’s evidence altogether, the prejudice and unfairness to the NMC could not be mitigated at all. He, therefore, submitted that it would be fair to admit Witness 4’s evidence and to attach the appropriate weight that the panel sees fit, rather than to exclude the entire evidence altogether.

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

In making its decision, the panel noted that Witness 4’s witness statement and supplementary witness statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *‘This statement is true to the best of my knowledge and belief. I can confirm that I am willing to attend a hearing and give evidence before a Committee of the NMC if required to do so’* and signed by her on 10 September 2020 and 5 August 2022.

The panel considered whether Ms Abad would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 4 to allowing hearsay testimony into evidence. The panel noted that Ms Abad was notified of Witness 4's disengagement on 15 August 2022. The panel also noted that Ms Abad was given the opportunity to make representations on this, which she did not.

The panel next considered whether it would be relevant and fair to admit Witness 4's witness statement and supplementary witness statement as hearsay evidence. In relation to the 2016 allegations, the panel was of the view that Witness 4's evidence was relevant as she was the only direct witness. Furthermore, Witness 4's evidence was not the sole and decisive evidence and the panel is due to hear another witness on this.

In relation to the 2018 allegations, the panel determined that Witness 4's evidence was not the sole and decisive evidence on these allegations because it had already heard from two witnesses in relation to these matters, and is due to hear from one more witness.

The panel also noted that Ms Abad had been provided with a copy of Witness 4's evidence and, as the panel had already determined that Ms Abad had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case.

The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 4 and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to admit Witness 4's witness statement, the supplementary witness statement and the documents she exhibited as hearsay evidence, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to adjourn under Rule 32

Mr Sanghera made an application on the afternoon of day 2 to adjourn and to proceed the next morning on day 3 to allow the NMC to make further contact with Witness 3 and to secure her attendance at the hearing. Mr Sanghera informed the panel that Witness 3 had engaged with the NMC throughout the proceedings and had indicated that she is willing to attend and to give evidence. Mr Sanghera also informed the panel that Witness 3 had informed the NMC that she will be on holiday when the hearing takes place, however that she would still attend virtually to give evidence.

Mr Sanghera referred the panel to the case officer's communication bundle with Witness 3. He submitted that on 28 August 2022, on the Bank Holiday weekend, Witness 3 had successfully run a GoToMeeting (GTM) test with the case officer.

In the Case Officer's telephone attendance note dated 28 August 2022, she stated:

> *'I carried out a GTM test with* [Witness 3] *which was successful.* [Witness 3] *told me that although she was going to be in* [PRIVATE] *she can give evidence from there. I asked her to let me know if she cannot give evidence on Tuesday morning at the earliest opportunity, she said that she would. I said we would do our best to work around her and to please keep me abreast of anything that would affect her giving evidence, I explained the importance of witnesses to proceedings and that it was important that the hearing doesn't go part-heard. She said that she understood and was able to access her papers and would be able to access her work emails whilst abroad. I thanked her and said that we were really grateful that she would be assisting with the hearing whilst on holiday, I apologised for the inconvenience.'*

Mr Sanghera submitted that efforts are being made to get Witness 3 to attend the hearing. He informed the panel that the Hearings Coordinator and the Case Officer are emailing and attempted to call Witness 3. He submitted that, as Witness 3 is not in the country, and

as she was willing to give evidence from [PRIVATE], it would be fair and proper to allow the NMC sufficient time to attempt to get in contact with Witness 3 by adjourning in the afternoon.

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

The panel took into account the submissions made by Mr Sanghera and decided to adjourn for the afternoon. In reaching this decision it had regard to the factors set out in Rule 32. The panel took into account the seriousness of the charges and the importance of Witness 3 attending. It considered that it would be unfair to the NMC to hear the case without the live evidence of Witness 3, particularly where she had indicated that as she has engaged and was willing to give evidence, albeit from another country.

The panel was of the view that an adjournment would give the NMC the opportunity to get in contact with Witness 3 and for her to attend the hearing.

Taking into account fairness to both parties, and the public interest in the expeditious disposal of this case, as well as the interests of justice, the panel determined to adjourn today's hearing for the afternoon.

Decision and reasons on application to admit Witness 3's written statement as hearsay evidence

Mr Sanghera made an application on day 3 under Rule 31 to allow the written statement of Witness 3 into evidence. He submitted that Witness 3 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she had not responded to them at all. Mr Sanghera informed the panel that the reason for Witness 3's non-attendance is unknown, however that she had indicated throughout the NMC proceedings that she is willing to attend the hearing and give evidence from [PRIVATE]. He submitted that the NMC had made efforts before the hearing and on day 1 of the hearing to ensure that she attends the hearing.

Mr Sanghera referred the panel to the Case Officer's communication bundle with Witness 3. He submitted that the NMC's efforts to secure Witness 3 began in March 2022 and continued through to August 2022. He also referred the panel to Witness 3's email to the case officer on 25 August 2022, which stated:

> *'For what ever reason I cannot open your previous email that I assume has the hearing date. I can do a video link tmrw but after that im out of the country on holiday.'*

Mr Sanghera also referred the panel to the Case Officer's telephone attendance note dated 27 August 2022, which stated:

> *'I called* [Witness 3] *as I had not had a reply to my email, I spoke with her and apologised for having to rearrange our GTM appointment this morning.* [Witness 3] *said that it wasn't a problem, we agreed that we could do it at 11:00 tomorrow instead. I thanked her for her cooperation and understanding.'*

He also referred to the Case Officer's telephone attendance note dated 28 August 2022 as set out above.

Mr Sanghera submitted that the NMC was aware that Witness 3 would be abroad and believed that she would be giving evidence from her holiday.

Mr Sanghera referred panel to *Thorneycroft v Nursing and Midwifery Council*. He submitted that the evidence of Witness 3 is highly relevant as she speaks to both the 2016 and 2018 allegations and produces relevant exhibits. He submitted that her evidence is inherently reliable. He informed the panel that Witness 3 had been an employee in the Trust since 1991 and had been the Matron since 1999.

In relation to the 2018 allegations, he submitted that Witness 3's evidence is not the sole and decisive evidence as there is evidence from three other witnesses before the panel. He also submitted that Witness 3's evidence for the 2018 allegations provides a second hand evidence in her role in the local investigation and through the collation of documentation. Mr Sanghera submitted that, by the panel admitting this evidence, it would help to provide important contextual evidence which can be cross referenced to other evidence before it.

In relation to the 2016 allegations, Mr Sanghera accepted that Witness 3's evidence is the sole and decisive evidence. He submitted that Witness 3 does not provide direct evidence as she was not present when the alleged incident took place but she carried out the investigation upon it. However, he submitted that in admitting this evidence, it will benefit the panel as it can provide direct evidence to a purported admission by Ms Abad in which Ms Abad did not resile from. He submitted that for the 2016 allegations, it may be the sole and decisive evidence, but that it is important in allowing the panel to properly determine whether the charges occurred from a factual perspective.

Mr Sanghera referred the panel to the case of *El Karout v NMC* [2019] EWHC 28 (Admin) and submitted that this case emphasises the importance of assessing whether or not hearsay evidence is admissible in the first instance and whether it is fair. He submitted that the panel must conduct a balancing exercise for the fairness of the registrant and to the NMC. He further submitted that Ms Abad had chosen voluntarily to absent herself from these proceedings, so therefore, she would not be in a position to cross-examine this witness in any case, and therefore any issue of fairness is limited by Ms Abad's non-engagement.

Mr Sanghera submitted that if Witness 3's evidence is admitted, then any unfairness to Ms Abad can be mitigated by the panel exercising its discretion to attach the weight that it considers appropriate. However, if the panel was to exclude Witness 3's evidence altogether, the prejudice and unfairness to the NMC could not be mitigated at all. He, therefore, submitted that it would be fair to admit Witness 3's evidence and to attach the

appropriate weight that the panel sees fit, rather than to exclude the entire evidence altogether.

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

In reaching its decision, the panel noted that the witness statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement is true to the best of my knowledge and belief. I can confirm that I am willing to attend a hearing and give evidence before a Committee of the NMC if required to do so'* and signed by her on 21 September 2020. The panel noted that the NMC had taken reasonable steps to get Witness 3 to attend the hearing and to give evidence.

The panel considered whether Ms Abad would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 3 to allowing hearsay testimony into evidence. The panel determined that Ms Abad would be at a disadvantage because Witness 3's evidence would not be tested.

The panel next considered whether it would be relevant and fair to admit Witness 3's witness statement as hearsay evidence. As the panel had already determined that Ms Abad had chosen voluntarily to absent herself from these proceedings, it noted that she would not be in a position to cross-examine this witness in any case.

In relation to the 2016 allegations, the panel determined that Witness 3's evidence is the sole and decisive evidence for charges 1 and 4, there being no evidence before the panel that it could ascertain for charges 2 and 3. The panel noted that Witness 3 is a senior nurse and the investigating nurse, so was of the view that she would not have a reason to fabricate the evidence. However, as this evidence was the sole and decisive evidence for these charges, it would not be fair on Ms Abad to admit this evidence. Therefore, Witness 3's witness statement in relation to the 2016 allegations were not admitted.

In relation to the 2018 allegations, the panel determined that as Witness 3's evidence was not the sole and decisive evidence and, therefore, it could be compared to the other evidence before it. The panel also noted that Ms Abad had been provided with a copy of Witness 3's evidence and, as the panel had already determined that Ms Abad had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case.

The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 3 and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to admit Witness 3's witness statement in relation to the 2018 allegations only as hearsay evidence, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to reopen the NMC's case and to adjourn the hearing

On day 5 of the proceedings, having closed his case and the panel having decided upon the facts but before it handed down its determination on them, Mr Sanghera made an application for the panel to reopen the NMC's case to allow Witness 3 to attend the hearing to give oral evidence.

Mr Sanghera submitted that Witness 3 was due to give evidence on day 2 of the hearing but that it was not possible to establish a contact with her on that day. He informed the panel that Witness 3 responded to the Case Officer at the end of day 4 and referred to the email on 8 September 2022:

> *'I'm just back from* [PRIVATE]*. My sincere apologies my phone was lost out there so I had no access to contacts or anything to let you know.*
>
> *Again my apologies but there was nothing I could do.'*

Mr Sanghera also informed the panel that Witness 3 had confirmed that she does want to give evidence but that she is only available from 19 September 2022 onwards. He submitted that the panel excluded Witness 3's evidence in relation to the 2016 allegations, which concerned charges 1, 2, 3, 4 and 5. He submitted that the panel should reopen the NMC's case in the public interest and should hear from Witness 3 as her live evidence would add to the significance and seriousness of this case. He informed the panel that in 2018 Ms Abad was on a final warning by the Trust in relation to the matters which were the subject of the 2016 allegations, and if charges 1, 2, 3, 4 and 5 were proved it would point to Ms Abad's propensity to act in a certain way. He submitted that, in relation to the 2018 allegations, the 2016 evidence would play an important part in the panel's determination when determining, if required, on misconduct, impairment and sanction. He referred the panel to the case of *the Professional Standards Authority For Health And Social Care v The Nursing And Midwifery Council & Jozi* [2015] EWHC 764 (Admin) and submitted that the NMC has a positive duty to consider all possible lines of evidence and proactively consider this matter for reasons of public protection and for the wider public interest. He submitted that if the panel were to grant his application to reopen the NMC's case, it would allow the panel to hear evidence on these important, significant and serious 2016 charges.

Mr Sanghera also made an application to adjourn the hearing to allow Witness 3 to attend the hearing as she was not available to attend before 19 September 2022.

The panel heard and accepted the advice of the legal assessor, which included reference to the cases of In *Re L and Anor (Children) (Preliminary Finding: Power to Review)* [2013] UKSC and *TZ v General Medical Council* [2015] EWHC 1001 (Admin).

The panel did not receive any reason as to why Witness 3 was not able to make other arrangements to attend the hearing on day 2. The panel was aware of Ms Abad's original 2016 Trust investigation and of the Trust's two year final warning as a result. Witness 3 had carried out the Trust's 2016 investigation. It noted that, when deciding on Mr Sanghera's hearsay application for Witness 3, the panel determined that Witness 3's evidence was the sole and decisive evidence for charges 1 and 4, and that there was no evidence before the panel, that it could ascertain, for charges 2 and 3. While there was some evidence in Witness 3's investigation report relating to charges 1 and 4 the panel was of the view that such evidence was not sufficiently strong for it to feel confident that it could fairly make a finding on dishonesty in relation charge 5. The panel also took into account that, if it were to reach the stage when it had to make a determination on sanction, it would be in a position take into account Ms Abad's 2016 investigation and the two year final warning she received as a result.

Taking into account fairness to both parties, and the public interest in the expeditious disposal of this case, as well as the interests of justice, the panel determined not to reopen the NMC's case or grant the related adjournment application.

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.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Sanghera.

The panel has drawn no adverse inference from the non-attendance of Ms Abad.

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 considered each of the disputed charges and made the following findings.

Charge 1

That you, a registered nurse, whilst employed at the Imperial College Healthcare NHS Trust (“the Trust”)

On 20 July 2016 following Patient A’s discharge to the recovery unit;

1) Altered times in the recovery register book.

This charge is found NOT proved.

In reaching this decision, the panel took into account Mr Sanghera’s submissions that, in light of the panel’s decision to exclude Witness 3’s evidence in relation to the 2016 incident, which was the sole and decisive evidence for this charge, there is no other evidence that the panel can rely on.

The panel determined that there was no evidence submitted by the NMC to support this charge. Therefore, this charge is found not proved.

Charge 2)

2) Tore a page out from the recovery register book.

This charge is found NOT proved.

In reaching this decision, the panel took into account Mr Sanghera's submissions that, in light of the panel's decision to exclude Witness 3's evidence in relation to the 2016 incident, which was the sole and decisive evidence for this charge, there is no other evidence that the panel can rely on.

The panel determined that there was no evidence submitted by the NMC to support this charge. Therefore, this charge is found not proved.

Charge 3)

3) Removed the torn page from the trust site and took it home.

This charge is found NOT proved.

In reaching this decision, the panel took into account Mr Sanghera's submissions that, in light of the panel's decision to exclude Witness 3's evidence in relation to the 2016 incident, which was the sole and decisive evidence for this charge, there is no other evidence that the panel can rely on.

The panel determined that there was no evidence submitted by the NMC to support this charge. Therefore, this charge is found not proved.

Charge 4)

4) Inaccurately recorded on the PACU documentation that Patient A was in the recovery unit for 45 minutes.

This charge is found NOT proved.

In reaching this decision, the panel took into account Mr Sanghera's submissions that, in light of the panel's decision to exclude Witness 3's evidence in relation to the 2016

incident, which was the sole and decisive evidence for this charge, there is no other evidence that the panel can rely on.

The panel determined that there was no evidence submitted by the NMC to support this charge. Therefore, this charge is found not proved.

Charge 5)

5) Your actions in one or more of charges 1, 2, 3 & 4 were dishonest in that you sought to conceal the accurate period of time Patient A was in the recovery unit.

This charge is found NOT proved.

As the panel did not find any of the charges 1, 2, 3 or 4 proved, this charge cannot be found proved.

Charge 6)

On 21 July 2018, following Patient X's discharge into the recovery unit;

6) Did not undertake Post-Operative/Recovery observations of Patient X, in that you did not take Patient X's;

- i) Pulse/Heart rate
- ii) Temperature
- iii) Respiratory rate
- iv) Oxygen saturation

This charge is found proved.

In reaching this decision, the panel took into account the evidence of witnesses 2, 3 and 4 and their exhibits.

In Witness 2’s written statement, she stated:

> *‘[…] in order to ascertain whether they had been taken and to resolve the confusion, I decided to ask the patient as this would overcome the confusion.* Witness 4 *and I went to the patient and I asked if her blood pressure was checked in recovery and she responded no.’*

In Witness 2’s exhibit statement, she also stated:

> *‘… one of the theatre nurses came to me at the nurses desk to ask what the patient blood pressure was in recovery, I said i don’t know but I will check on cerner as I wasn’t told verbally by the recovery nurse.*
>
> *There was a blood pressure reading on cerner however the theatre nurse said its not been checked. So I decided to ask the patient was your Blood pressure checked in the recovery area and the patient stated no.’*

It also took into account Witness 3’s witness statement:

> *‘Maritoni admits in the meeting that she did not take the patients observation and apologised to the patient and took the observations in the presence of* [Witness 2] ...’

The panel also noted from Witness 3’s witness statement:

> *‘[…] This confirms that the registrant received the patient at 17:10. It then states ’17:12 patient returned in the DSU pls see obs and assessment surgical note*

order.' The patient was in Marinoni's care for approximately 2 minutes before being discharged to the DSU.'

From the Trust's investigation Report which was held by Witness 3, the panel noted that all of the staff working in the Hospital did not see Ms Abad take Patient X's observations.

The panel further noted from Witness 4's supplementary statement that she stated:

'In that [my first] statement I say that Maritoni did not take observations for the patient. I have been asked to clarify what I mean by observations. When I say observations I mean blood pressure, pulse rate, temperature, respiratory rate and SPO2% oxygen saturation in the blood. These are the standard observations done after surgery for all patients. We have to record all of these. We call it vital signs'

The panel also noted from Witness 2's evidence that Patient X was in the recovery room for such a short amount of time that it would be unlikely that observations had taken place.

The panel was therefore of the view, that on the balance of probabilities, it is more likely than not that Ms Abad did not undertake the post-operative/recovery observations of Patient X. The panel, therefore, found charge 6 proved.

Charge 7)

7) Did not take Patient X's blood pressure reading.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of witnesses 2, 3 and 4 and their exhibits.

In Witness 2's written statement, which she confirmed in her oral evidence, she said:

'[…] in order to ascertain whether they had been taken and to resolve the confusion, I decided to ask the patient as this would overcome the confusion. Witness 4 *and I went to the patient and I asked if her blood pressure was checked in recovery and she responded no.'*

[…]

'… one of the theatre nurses came to me at the nurses desk to ask what the patient blood pressure was in recovery, I said i don't know but I will check on cerner as I wasn't told verbally by the recovery nurse.

There was a blood pressure reading on cerner however the theatre nurse said its not been checked. So I decided to ask the patient was your Blood pressure checked in the recovery area and the patient stated no.'

[…]

'I returned to my desk and was finishing off what I was doing and was going to get the patient's observations. Maritoni entered the ward, however, she was not in her uniform and looked really worried. She told me she had forgotten to take the patient's blood pressure'

From the Trust's investigation Report which was held by Witness 3, the panel noted that all of the staff working in the Hospital did not see Ms Abad take Patient X's blood pressure in the recovery unit.

Further, Ms Abad in the Trust's investigation Report had made an admission to not taking a blood pressure reading:

'MA – I did not do B/P in Recovery as had to go to the toilet.'

The panel accepted Witness 2’s and Witness 3’s evidence that a blood pressure reading had not taken place and that Witness 2 was the person who subsequently took it. The panel noted that when Patient X was asked as to whether a blood pressure reading had taken place by Ms Abad, the Patient X responded saying no.

The panel was therefore of the view, that on the balance of probabilities, it is more likely than not that Ms Abad failed to take Patient X’s blood pressure reading. The panel, therefore, finds this charge proved.

Charge 8)

8) Discharged Patient X to the Day Care Unit (“DCU”) without taking a blood pressure reading.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of witnesses 2, 3 and 4 and their exhibits.

As the panel had determined that Ms Abad had not taken Patient X’s blood pressure reading and that Patient X was in the recovery room for approximately two minutes, it was therefore of the view, that on the balance of probabilities, it is more likely than not that Ms Abad discharged Patient X to the DCU without taking a blood pressure reading. The panel, therefore, finds this charge proved.

Charge 9)

9) Did not provide Colleague B with a handover regarding Patient X.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 (Colleague B) and her exhibits.

Witness 2 in her witness statement, stated:

> *'Maritoni walked over to the desk next to me and placed her notes in the tray and returned to the recovery unit. The normal procedure that should have been followed by Maritoni is when the patient is taken into the waiting room in day care she should have provided me with a handover by informing me of the surgery that had taken place, the blood pressure observations recorded and the medication that should be given to the patient on discharge. Maritoni did not follow the normal procedure on this occasion.'*

In Witness 2's live evidence, she was consistent as she told the panel that Ms Abad had placed the notes in the tray and had returned to the recovery unit.

The panel also noted that Ms Abad had done this before to Witness 2:

> *'I have worked with Maritoni on many occasions and a lot of the time she would left the notes in the tray without providing me with a proper handover.'*

The panel was therefore of the view, that on the balance of probabilities, it is more likely than not that Ms Abad did not provide Colleague B with a handover regarding Patient X.

Charge 10)

10) At around 17:09 inaccurately recorded Patient X's blood pressure reading as 140/70 in Patient X's recovery register book.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of witnesses 3 and 4 and their exhibits.

The panel took into account Witness 4's written statement, which stated:

> *'I looked at the recovery book which is a paper book stored at our unit and noticed that the patient's observations were recorded as 140/70. I was confused and could not understand why Maritoni had recorded the observations as she had not taken the observations.'*
>
> […]
>
> *'I know that Maritoni did not take the patient's observations as she did not move the blood pressure machine and the patient was only in recovery for a very short period before she transferred her to day care.'*
>
> *'The initial observations have been crossed out and are unreadable and have been replaced by the reading 130/82. This shows that Maritoni changed the log entry from the made up observation to the copied ones.'*

The panel also took into account of the Trust's Investigation Report:

> '[Witness 3] – *where did you get 140/70 from*
> *MA – I don't know it just came out of my head'*

The panel had sight of Patient X's entry in the recovery register book. It noted that there was an entry crossed out which was then rewritten. Taking all this into account and the panel's prior finding that Ms Abad did not take the blood pressure reading for Patient X, the panel was of the view that Ms Abad inaccurately recorded Patient X's blood pressure reading as 140/70 in the recovery register book. It, therefore, finds this charge proved.

Charge 11)

11) At around 17:10 inaccurately recorded Patient X's blood pressure reading as 140/70 in the electronic Cerner record.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of witnesses 2, 3 and 4 and their exhibits.

In Witness 2's witness statement, it stated:

> *'I returned to my desk and was finishing off what I was doing and was going to get the patient's observations. Maritoni entered the ward, however, she was not in her uniform and looked really worried. She told me she had "forgotten to take the patient's blood pressure". I informed Maritoni that there was a reading on the computer. I asked her who took the reading. I informed Maritoni that I had checked the reading and it stated that the action had been inputted and it contained her name next to the entry. Maritoni said something along the lines of I forgot, I don't remember doing it.'*

In Witness 4's written statement, she stated:

> '[Witness 2] *logged into the patient record on the computer and looked at the recovery notes.* [Witness 2] *told me that Maritoni did take the observations as they were recorded on the computer as being taken at 17:10 and the observations were 140/ 70.'*
>
> *[…]*

‘I know that Maritoni did not take the patient’s observations as she did not move the blood pressure machine and the patient was only in recovery for a very short period before she transferred her to day care.’

The panel also noted from Witness 3’s Investigation Report that when Ms Abad was questioned about where the recording of 140/70 came from, Ms Abad responded:

> ‘[Witness 3] – *17.10 PACU document 140/70 was inaccurate*
> *MA – yes this was not when I was well. This is recorded in DSU.*
> ‘[Witness 3] – *17.23 was the actual reading. Was this documented on CERNER – did you put a note to say that it had changed.*
> *MA – no I was distracted at the time.*
>
> […]
>
> [Witness 3] – *where did you get 140/70 from*
> *MA - ‘I don’t know it just came out of my head.’*

In taking all of this into account and the panel’s prior finding that Ms Abad did not take the blood pressure reading for Patient X, the panel was of the view that Ms Abad inaccurately recorded Patient X’s blood pressure reading as 140/70 in the electronic Cerner record. It, therefore, finds this charge proved.

Charge 12a)

12) At around 17:54;

a) Retrospectively amended Patient X’s blood pressure reading in the electronic Cerner record.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of witnesses 1, 2 and 4 and their exhibits.

In Witness 1's witness statement, she stated:

> *'I only understood the true extent of what had happened once* [Witness 4] *and* [Witness 2] *explained exactly what happened and I looked through the document via the audit trail on the CERNER system and realised that Maritoni had changed the observation on the computer in my presence'*
>
> *[…]*
>
> *I opened the system to verify this and saw that Maritoni modified her CERNER entry at 17:54, BP 130/82 from her original entry recorded at 17:11. I was sat in front of Maritoni when she recorded the entry at 17:54.*
>
> [Witness 4] *and* [Witness 2] *then showed me a photocopy of Maritoni's original entry on CERNER recorded at 17:11 and a photocopy of her vital signs recording on a book which was later changed.*
>
> *Maritoni's BP record at 17:54 did not correspond to her previous documentation at 17:11 and the handwritten record on the book.*
>
> *[…]*
>
> *Maritoni has not only changed the observation on the computer but has gone to the effort to change the observation on the record book.'*

In her oral evidence, Witness 1 was clear in that she was able to see that the record had been amended by Ms Abad when she conducted an audit of Patient X's record at the time, but was unable to see what the original entry was.

In Witness 2's witness statement, she stated:

> *'I remember Maritoni started typing on the computer as I was explaining to* [Witness 1] *what had happened. I noticed that my smartcard was still inserted in the computer. I looked over and noticed that Maritoni was copying the blood pressure readings I had taken when she was with me. I removed my smartcard from the computer as I was not letting Maritoni record anything under my name. Maritoni placed her card in the computer and opened the patient's record and amended her initial blood pressure reading and copied my reading.'*

In Witness 4's witness statement, she stated:

> *'I can confirm that Maritoni changed the observations from 140/70, her original observations, to 130/82 which are the exact same observations* [Witness 2] *took.'*

The panel noted that Ms Abad was seen to do this by a number of witnesses. In Witness 1's Trust statement, the panel noted:

> '[Witness 2] *then looked at me and said "Oh my God* [Witness 1]*, she just did it in front of you!"*

The panel was, therefore, of the view that Ms Abad had retrospectively amended Patient X's blood pressure reading in the electronic Cerner record. This charge, is therefore, found proved.

Charge 12b)

12) At around 17:54

b) Did not identify that the amended entry in the electronic Cerner record was retrospective.

This charge is found NOT proved.

In reaching this decision, the panel did not have evidence as to how Ms Abad did not identify the amended entry in the electronic Cerner record as retrospective. The panel also did not have any evidence that Ms Abad had a responsibility or a duty to do what it is alleged she should have done.

The panel did not have any other evidence on this, therefore on the balance of probabilities, the panel did not find this charge proved.

Charge 12c)

12) At around 17:54;

c) Retrospectively amended Patient X's blood pressure reading in the recovery register book.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1, 3 and 4's evidence and exhibits.

In Witness 1's witness statement, she stated:

‘[Witness 2] and [Witness 4] *showed me the photocopy of the record book. The record book had an observation which was crossed out and a new observation had been recorded.’*

In Witness 4’s witness statement, she stated:

‘While passing recovery, I noticed that the recovery register book had been moved from the trolley and placed at the end of the bed. I looked at the register book and saw that the blood pressure had been crossed out and another set of observations had been written, namely 130/ 82.’

The panel also had sight of the recovery register book which had a crossing of an entry which was then rewritten.

The panel, therefore, was of the view that Ms Abad had retrospectively amended Patient X’s blood pressure reading in the recovery register book at around 17:54.

Charge 12d)

12) At around 17:54;

d) Did not identify that the amended entry in the recovery register book was retrospective.

This charge is found NOT proved.

For the same reasons as charge 12b, the panel did not have any other evidence on this, therefore on the balance of probabilities, the panel did not find this charge proved.

Charge 13)

13) Your actions in one or more of charges 10, 11 & 12 were dishonest, in that you falsified records, in an attempt to conceal that you had not taken Patient X's blood pressure reading in the recovery unit.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1, 2, 3 and 4's evidence and their exhibits.

In considering whether Ms Abad's actions were dishonest, the panel had regard to the test as set out in the case of *Ivey v Genting Casinos* [2017] UKSC 67:

- *What was the defendant's actual state of knowledge or belief as to the facts; and*
- *Was his conduct dishonest by the standards of ordinary decent people?*

The panel also took into account the NMC Guidance document 'Making decisions on dishonesty charges.'

In considering whether Ms Abad's conduct would be regarded as dishonest by the standards of 'ordinary decent people', the panel bore in mind her state of mind at the time of this incident. The panel considered that the starting point in its deliberations was that Ms Abad would have known that she did not undertake observations as required for Patient X. When Ms Abad was asked where she got the blood pressure reading of 140/70 she informed Witness 3 that *'it just came out of* [her] *head.'* Therefore, the panel was of the view that when Ms Abad initially completed the two entries she knew she was being dishonest, and further when she subsequently sought to change those entries, she also knew that she was being dishonest as she had never completed any observations at all.

Having established Ms Abad's actual state of knowledge, the panel moved on to the objective limb of *Ivey*. The panel was of the view that to make false entries in the patient's

records, and then to amend those entries in an attempt to conceal the fact that she had not taken the blood pressure reading for Patient X in the recovery unit, would be regarded as dishonest by the standards of ordinary decent people. The panel, therefore, found Ms Abad's actions in relation to charges 10, 11, 12a and 12c to be dishonest. This charge is, therefore, found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Abad'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, Ms Abad's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Sanghera invited the panel to take the view that the facts found proved amount to misconduct. Mr Sanghera referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code).

Mr Sanghera identified the specific, relevant standards where he submitted that Ms Abad's actions amounted to misconduct. In relation to charge 6, 7 and 8, he submitted that it is clear that it would be considered proper if Ms Abad was to undertake Patient X's post-operative/recovery observations, check the patients vital signs and then to discharge the patient into the DCU. By Ms Abad not doing this, she breached paragraphs 1.2 and 1.4 of the Code.

In relation to charge 9, Mr Sanghera submitted that as Ms Abad did not provide Witness 2 with a handover, she had breached paragraphs 2.1, 8.2, 8.3, 8,5 and 8.6 of the Code.

Mr Sanghera submitted that, in relation to charge 10 and 11 which was the first instance of dishonest conduct, Ms Abad breached paragraph 10.1 of the Code.

In relation to charge 12a and 12c, Mr Sanghera submitted that Ms Abad breached paragraphs 10.1, 10.3, 14.2 and 14.3 when she retrospectively amended Patient X's blood pressure reading in the electronic Cerner record and in the recovery register book.

Mr Sanghera submitted that in relation to dishonesty, charge 13, Ms Abad breached paragraph 20.2 of the Code by falsifying records.

In respect of all of the charges found proved, Mr Sanghera submitted that Ms Abad breached paragraph 20.1.

Mr Sanghera submitted that each of Ms Abad's breaches of the Code are serious in nature and constitute misconduct on each occasion because of their individual gravity and because she was dishonest.

Submissions on impairment

Mr Sanghera moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the

need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Sanghera submitted that all four limbs of the *Grant test* were engaged in respect of past and future conduct.

Mr Sanghera submitted that current impairment can be found either on the basis that there is a continuing risk or that the public confidence in the nursing profession and the NMC as regulator would be undermined if such a finding were not made. He further submitted that Ms Abad's conduct and dishonesty brought the medical professional into disrepute and breached the fundamental tenets of the nursing profession.

Mr Sanghera submitted that Ms Abad's fitness to practise must be gauged by looking at her past conduct and how she is likely to behave in the future. When considering whether Ms Abad's misconduct impairs her practice, it is necessary to determine whether any impairment present at the time of the incident is still present today. In this regard, Mr Sanghera submitted that Ms Abad had not engaged with the NMC process nor with this substantive hearing. He submitted that the panel heard no evidence concerning Ms Abad's insight or remorse, and did not have the benefit of having a reflective statement. He submitted that the panel did not have any evidence of any remediation with regard to the regulatory concerns. Further, there is no evidence from Ms Abad to confirm that the concerns have been remedied and that the conduct will not be repeated.

In light of the above, Mr Sanghera invited the panel to find Ms Abad's fitness to practise as a registered nurse as currently impaired.

The panel accepted the advice of the legal assessor.

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 Ms Abad's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Abad's actions amounted to breaches of the Code. Specifically:

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

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

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 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

To achieve this, you must:

14.2 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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 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, it determined that Ms Abad's failings and dishonesty amounted to misconduct.

The panel determined that Ms Abad's actions in each of the individual charges found proved fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct. It was of the view that Ms Abad had discharged Patient X to the DCU without undertaking post-operative/recovery observations which demonstrated significant departures from the standards expected of a registered nurse.

The panel considered that nurses may make errors, but it is their duty to report that error, in order to protect the patient. The panel was of the view that Ms Abad was a registered nurse who would have known that she needed to be transparent about not undertaking the post-operative/recovery observations with her colleagues in order to protect patients and service users, which inadvertently placed the patient at a potential risk of significant harm. The panel determined that Ms Abad's conduct failed to prioritise people and the safety of patients, which is a requirement of her as a registered nurse. The panel also found that Ms Abad had misled her colleagues when she put Patient X's blood pressure reading as 140/70 when she had not, in fact, taken a reading. There is no evidence that harm was caused to Patient X, but had there been, this would have misled the medical professional in treating Patient X properly which could have caused actual harm. It also considered that in Ms Abad not providing her colleague with a handover, put Patient X at real risk of harm,

especially in light of the records having been completed incorrectly. The panel considered that Ms Abad, in deleting an entry on the Cerner system and the recovery register book, was attempting to correct an inaccurate and invented entry.

The panel determined that Ms Abad's dishonesty breached fundamental tenets of the Code. The panel was also of the view that Ms Abad's conduct was very serious and would be considered as '*deplorable*' by fellow practitioners.

On the basis of the above, the panel was of the view that Ms Abad's conduct and dishonest behaviour fell significantly short of the standards expected of a registered nurse and is sufficiently serious to amount to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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 of the Grant test were engaged in this case both in the past and in the future.

Whilst there is no evidence to suggest that Ms Abad's actions caused actual harm to Patient X, her actions in deliberately making entries that were invented and incorrect was dishonest and her failure to notify her colleagues of not undertaking the post operative/recovery observations put Patient X at risk of significant harm. Furthermore, having breached multiple provisions of the Code, the panel determined that Ms Abad's

misconduct had breached fundamental tenets of the nursing profession, namely that a nurse should act with honesty, and therefore brought its reputation into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find Ms Abad's fitness to practise to be impaired and the charges relating to dishonesty as extremely serious.

In assessing how Ms Abad would act in the future, the panel looked at the evidence before it. The panel did not have any evidence before it addressing Ms Abad's insight on the impact her actions could have had on her patients, colleagues, the nursing profession and the wider public as a whole. Therefore, the panel was of the view that Ms Abad had not demonstrated any insight into the misconduct. The panel could not be satisfied, in the absence of any evidence, that Ms Abad understands and appreciates the seriousness of her failure to act appropriately and her dishonesty.

In considering whether Ms Abad had remediated her nursing practice, the panel noted that it did not have any relevant information before it. It bore in mind that dishonesty is often more difficult to remediate than clinical concerns.

The panel noted that Ms Abad had acted similarly in 2016, for which she received a two year final warning. The panel also noted that in Ms Abad's internal Trust statement, she stated:

> *'I apologised quickly to the patient in DSU waiting area and said to me it's alright'*

The panel also noted during the Trust's disciplinary hearing on 3 December 2018 that Ms Abad stated:

> *'I am human so I am not perfect'*
>
> […]

‘I’m just a human being like the others I’m not perfect.’

The panel was of the view that Ms Abad had showed, at best, limited remorse into her actions.

Therefore, in having regard to the above, the panel considered there to be no evidence to demonstrate that Ms Abad had remediated her misconduct. The panel was of the view that Ms Abad has not demonstrated that she has a level of insight into the concerns identified. The panel also did not have any evidence to allay its concerns that Ms Abad may currently pose a risk to patient safety. In the absence of any evidence to the contrary and taking into account the previous two year final warning Ms Abad received in 2016, it considered there to be a risk of repetition of Ms Abad’s dishonesty and a risk of unwarranted harm to patients in her care, should adequate safeguards not be imposed on her nursing practice. Therefore, the panel determined that for the above reasons Ms Abad would also be liable to act contrary to the four limbs identified in the future.

Accordingly, in taking into account the above, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel considered there to be a public interest in the circumstances of this case. The panel found that the charges found proved are serious and include dishonesty. It was of the view that a fully informed member of the public would be concerned by its findings on facts and misconduct. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Ms Abad’s fitness to practise as a registered nurse is currently impaired on the grounds of public protection and public interest.

Sanction

The panel has decided to make a striking-off order. It directs the registrar to strike Ms Abad off the register. The effect of this order is that the NMC register will show that Ms Abad has been struck-off the register.

Submissions on sanction

In the Notice of Hearing, dated 5 August 2022, the NMC had advised Ms Abad that it would seek the imposition of a striking-off order if Ms Abad's fitness to practise was found to be currently impaired.

Mr Sanghera informed the panel that it must take into account the principle of proportionality; the aggravating and mitigating features; and the seriousness of the case. In respect of the principle of proportionality, Mr Sanghera submitted that the panel is required to strike a fair balance between the interests of Ms Abad and the NMC's overarching principles of public protection.

Mr Sanghera submitted that the aggravating features include previous disciplinary findings in 2016; Ms Abad's lack of insight in relation to the 2016 and 2018 failings; dishonesty; a pattern of misconduct and dishonesty; and misconduct which had the potential to put patients at serious risk of harm.

[PRIVATE]. However, he submitted that this was not expanded upon because Ms Abad had not attended or engaged with the hearing. In respect of insight, remorse, remediation or steps taken to strengthen Ms Abad's practice or to keep her practice up to date, he submitted that there was limited evidence.

Mr Sanghera referred the panel to the NMC's guidance on *'Considering sanctions for serious cases'* (SAN-2). He submitted that in considering seriousness, a nurse who deliberately breaches the professional duty of candour to be open and honest commits the

most serious kind of dishonesty, especially when something goes wrong. He submitted that a nurse who acted dishonestly will always be at the risk of being removed from the register.

Mr Sanghera submitted that Ms Abad had the right to attend in person, be represented and/or to send information/evidence for the Fitness to Practise Committee to consider when the panel considers a removal from the register. He submitted that Ms Abad had not done any of this.

In respect of misconduct, Mr Sanghera submitted that the panel had found Ms Abad's misconduct fell seriously short of the conduct expected of a registered nurse and therefore she is impaired. He submitted that, therefore, taking no action or making a caution order would not be the proportionate nor the appropriate order as it would not sufficiently protect the public or the wider public interest. In respect of a conditions of practice order, Mr Sanghera submitted that it would not be possible to formulate proportionate, workable, appropriate or measurable conditions given Ms Abad's dishonesty and her non-engagement with the substantive hearing. In respect of a suspension order, Mr Sanghera submitted that this order falls short of the order that should be made. He referred the panel to the case of *Parkinson v NMC* [2010] EWHC 1898 (Admin) and submitted that Ms Abad had forfeited the chance of persuading the panel to adopt an outcome that is not a striking off order as she failed to demonstrate remorse, an understanding that her conduct was dishonest or to show that there is no real risk of repetition, especially as there are two similar incidents.

Mr Sanghera invited the panel to impose a striking off order. He submitted that this order would be the appropriate and proportionate order as no other order can meet the need and provide a deterrence to others, and maintain confidence in the nursing profession.

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.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Previous disciplinary findings
- A pattern of misconduct and dishonesty in 2016 and 2018
- Fabricated post-operative/recovery observations which put patients at risk of significant harm
- Fabricated post-operative/recovery observations on the Cerner system and the recovery register book which demonstrated that it was not a spur of the moment decision but a deliberate conduct
- Dishonesty in a workplace setting which is directly linked to patient care
- No evidence of insight or remediation
- No evidence of steps taken by Ms Abad to remedy the concerns identified

In terms of mitigating factors, the panel noted that Ms Abad had stated, in the later stage of the Trust's investigation, [PRIVATE]. However, the panel had no further evidence or information on this. [PRIVATE], it does not justify the dishonest conduct of fabricating the records on the Cerner system and in the recovery register book or subsequently amending those entries. The panel noted that Ms Abad had said in the Trust's investigation that she apologised to the patient but was the limited extent of any apology. Therefore, the panel concluded that the aggravating features of this case far outweigh the mitigating features.

The panel had regard to the NMC guidance on *'Considering sanctions for serious cases'* (SAN-2) and considered that Ms Abad's dishonesty was towards the higher end of the spectrum. In reaching this decision, the panel considered that Ms Abad's dishonesty was significantly serious as she did not undertake the post-operative/recovery observations, but invented them, which inadvertently placed Patient X at a potential risk of significant harm. Ms Abad misled her colleagues when she put Patient X's fabricated blood pressure reading on the Cerner system and the recovery register book as 140/70 when she had not, in fact, taken a reading. Ms Abad had also failed to provide her colleague with a handover, and had attempted to correct an inaccurate and invented entry. Whilst there is no evidence of patient harm, there was a direct risk which could have potentially caused significant harm to patients.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Abad'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 Ms Abad'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 Ms Abad's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct and dishonesty identified in this case was not something that can be addressed through retraining, particularly where Ms Abad had not

demonstrated any insight or remorse into her failings. The panel, therefore, concluded that the placing of conditions on Ms Abad'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 panel had regard to the SG which outlines the circumstances where a suspension order may be appropriate. This case concerns a pattern of misconduct with similar incidents in 2016 and 2018. Ms Abad has not demonstrated any insight, shown very limited remorse, or taken steps to strengthen her practice regarding her failings.

The panel was of the view that Ms Abad's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. It noted that the serious breach of a fundamental tenet of the profession evidenced by Ms Abad's actions is fundamentally incompatible with her remaining on the register and as such, determined that a suspension order would not be a sufficient, appropriate or proportionate sanction in that it would not protect patients or maintain confidence in the nursing profession. The panel also noted that Ms Abad did not engage with the NMC during the proceedings, did not attend the substantive hearing and had not provided the panel with any undertaking to ensure that this type of behaviour would not be repeated. The panel, therefore, determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel determined that Ms Abad's actions and her dishonesty were a significant departure from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Abad's misconduct was serious, placed patients at risk of harm, and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. The panel recognised the adverse effect that a striking off order may have on Ms Abad but was mindful of case law and of the NMC's own guidance that the reputation of the nursing profession is more important than the fortunes of an individual nurse.

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 Ms Abad's 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 Ms Abad 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 Ms Abad'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 Mr Sanghera. He submitted that an interim suspension order is necessary to protect the public and is otherwise in the public interest.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.