Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 27 March 2023 – Tuesday 4 April 2023

Virtual Hearing

Name of registrant:	**Anthony Brand**
NMC PIN:	17F2309E
Part(s) of the register:	Registered Nurse – Sub Part 1 RNLD: Learning Disabilities (October 2017)
Relevant Location:	Nottinghamshire, North Yorkshire
Type of case:	Misconduct
Panel members:	Gregory Hammond (Chair, Lay member) Kim Bezzant (Registrant member) Carolyn Tetlow (Lay member)
Legal Assessor:	John Bassett
Hearings Coordinator:	Sherica Dosunmu
Nursing and Midwifery Council:	Represented by Rebecca Butler, Case Presenter
Mr Brand:	Not present and unrepresented at the hearing
Facts proved:	Charges 1b, 3b, 4a, 4b, 5, 6, 10, 11, 13, 14, 15a, 15b, 16
Facts not proved:	Charges 1a, 2, 3a, 7a, 7b, 7c, 8a, 8b, 9, 12
Fitness to practise:	Impaired
Sanction:	**Striking-off Order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Brand was not in attendance and that the Notice of Hearing letter had been sent to Mr Brand's registered email address on 23 February 2023.

Ms Butler, 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 allegations, the time, dates and means of joining the virtual hearing and, amongst other things, information about Mr Brand's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Brand

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

Ms Butler submitted that the NMC has made numerous attempts to contact Mr Brand by email. She informed the panel that Mr Brand's last communication with the NMC was through his representative at the time, the Royal College Nursing (RCN), in July 2021. She stated that the RCN no longer represents Mr Brand, and he has not responded to any

further communication from the NMC. She submitted that the NMC has made reasonable efforts to contact Mr Brand and he is (or should be) well aware of these proceedings.

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 (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mr Brand. In reaching this decision, the panel has considered the submissions of Ms Butler, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba [2016] EWCA Civ 162* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Brand;
- Mr Brand has not engaged with the NMC since July 2021, and has not responded to any further correspondence from the NMC in relation to these proceedings;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Witnesses are due to give evidence, and may be caused inconvenience if there was a delay to this hearing; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Brand in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email address, he will not be able to challenge it and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination

and, of its own volition, can explore any inconsistencies in the evidence which it identifies. It can take into account Mr Brand's comments at the internal investigations. Furthermore, the limited disadvantage is the consequence of Mr Brand's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge (as amended)

That you, a registered nurse, whilst employed at the Priory Hospital Arnold;

1) On 20 May 2020;

    a) Inaccurately recorded that Patient Z had refused Clonazepam. **[NOT PROVED]**
    b) Did not record that Patient Z's Clonazepam had been destroyed in the Disposal of Unwanted Drugs Book. **[PROVED]**

2) On 22 May 2020 did not record that you had administered Patient Y their Clonazepam at 08:00 in the Drugs Liable for Misuse or Misappropriation (DLM) Book. **[NOT PROVED]**

3) On 26 May 2020;

    a) Incorrectly recorded that Patient X was administered Clonazepam at around 12p.m. **[NOT PROVED]**
    b) Incorrectly recorded that Patient W was administered Clonazepam. [**PROVED]**

4) Between 4 March 2019 and 3 June 2020 on one or more occasion;

   a) Pre-potted medication. **[PROVED]**
   b) Left medication in the clinic room unattended **[PROVED]**

Whilst employed at Thistle Hill Hall ('the Home');

5) On 24 September 2020 incorrectly administered Quetiapine 400mg/300mg Tablets to Resident A at 12:38 instead of at the prescribed time of 16:30. **[PROVED]**

6) On 22 October 2020 incorrectly administered Quetiapine 400mg/300mg Tablets to Resident A at 13:04 instead of at the prescribed time of 16:30 **[PROVED]**

7) Did not carry out stock checks of medication after administration on;

   a) 2 November 2020. **[NOT PROVED]**
   b) 5 November 2020. **[NOT PROVED]**
   c) 14 November 2020. **[NOT PROVED]**

8) Did not carry out nightly medication stock checks on;

   a) 19/20 November 2020. **[NOT PROVED]**
   b) 21 November 2020. **[NOT PROVED]**

9) On one or more occasion conducted an incorrect stock check/count of medication at the Home. **[NOT PROVED]**

10) On 4 November 2020 did not book in Pregabalin medication into the Home's system on arrival. **[PROVED]**

11) On 20 November 2020 inaccurately signed an unknown Patient's medical records

to indicate that you had administered medication. **[PROVED]**

12) Your actions in charge 11 above were dishonest in that you sought to misrepresent that you had administered the medication. **[NOT PROVED]**

13) Between 8 October 2020 and 28 November 2020 did not inform your employers/supervisors at the Home that you had been made subject to an interim suspension order. **[PROVED]**

14) Your actions in charge 13 above were dishonest in that you sought to conceal the restrictions on your practice from your employers. **[PROVED]**

15) Between 21 August 2020 and 30 November 2020 Did not disclose to Thistle Hill Hall Home that you had been subjected to a disciplinary investigation by Priory Hospital Arnold into allegations of;

a) Medication administration errors/outside of Trust Policy **[PROVED]**
b) Record keeping errors/outside of Trust policy **[PROVED]**

16) Your actions in charges 15 a) & b) above were dishonest in that you sought to conceal the full extent of your disciplinary investigation from Thistle Hill Hall Care Home. **[PROVED]**

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Butler to admit the following exhibits from Colleague 3 as hearsay evidence:

- An email from Colleague 7 (Exhibit 3 reference **NE/9**), a nurse at Thistle Hill Hall, dated 7 November 2020, regarding a medication stock and record keeping issue.
- An email from Colleague 9 (Exhibit 3 reference **NE/8**), a Rehabilitation Assistant at Thistle Hill Hall, dated 24 November 2020, advising of night stock check issues.

Ms Butler referred the panel to the case of *El Karout v NMC [2019] EWHC 28 (Admin),* in respect of issues of admissibility and weight of hearsay evidence. She submitted that the NMC will rely on the veracity of the facts in the above exhibits and they should be admitted as hearsay evidence.

Ms Butler acknowledged that Mr Brand did not have the opportunity to challenge the evidence provided in the exhibits at the time the concerns were raised as he had been dismissed from his employment. However, she submitted that although Mr Brand is absent from these proceedings, the evidence in this matter has been served on Mr Brand and he has been given many opportunities to challenge the allegations.

Ms Butler submitted that the evidence from these emails was admissible as there is no reason to suggest that people in such responsible positions would have reason to fabricate the evidence.

Ms Butler indicated that the emails relate to the medication stock check allegations in charges 7, 8, 9 and 10. She submitted that it would be fair for these emails to be admitted as they were not the sole and decisive evidence in support of any of the charges, as the panel will hear live evidence from Colleague 3 who may have knowledge of the issues

raised in the emails. She stated that the content of the emails can therefore be established through the live evidence of Colleague 3, whom she intends to ask open ended questions for clarification.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included Rule 31 which provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. In particular, the panel needed to consider whether the evidence sought to be admitted as hearsay was the sole or decisive evidence in support of the relevant charges and what, if any, attempts the NMC had made to secure the attendance of the witnesses.

The panel approached its decision by considering firstly the relevance of the hearsay evidence and then secondly whether it would be fair to admit it having regard to the principles identified in the case of *Thorneycroft v NMC [2014] EWHC 1565 (Admin)*.

The panel considered whether it would be relevant to admit the two emails from Mr Brand's colleagues at Thistle Hill Hall. The panel considered that both emails from Mr Brand's colleagues were created contemporaneously and raised concerns about medication stock checks as alleged in charges 7, 8, 9 and 10. The panel was of the view that the information supplied in both these emails concerned the substance of the allegations in these charges and would be relevant to the matters of this case.

The panel next considered whether it would be fair to admit this evidence. In the interest of fairness, the panel noted that it was not presented with good and cogent reasons (or indeed any reasons) for the non-attendance of the two witnesses who wrote the emails dated 7 and 24 November 2020. Further, the panel noted that no evidence has been put before it to suggest that the NMC has made any attempts to secure the attendance of these witnesses.

Additionally, the panel noted that these two emails were the sole and decisive evidence in relation to charges 7, 8 and 9.

The panel made a careful assessment of the potential consequences of admitting the evidence. The panel concluded that, in these circumstances, without any additional evidence in support of these charges, it was not satisfied that it would be fair to admit the two emails as hearsay evidence.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Butler during the course of the hearing, after the evidence of Colleague 3, to amend the wording of charge 2. The proposed amendment was to change the wording in charge 2 from '*12p.m.*' to '*08:00*'.

Ms Butler submitted that it is apparent from the evidence in this matter that the time in charge 2 is incorrect. She submitted that the proposed amendment to charge 2 would not cause prejudice or injustice as the change is within a four-hour window on the same day in relation to the same patient. Additionally, she submitted that in 2020, during the local investigations, when asked about the medication administration allegations Mr Brand did not deny these allegations but made admissions to them, and he has not denied these allegations in respect of NMC proceedings despite having the opportunity to do so. She submitted that the proposed amendment is a factual one, which does not change the substance of the allegation. On being asked, Ms Butler confirmed that this is the only amendment she sought in respect of charge 2.

<u>Original charge 2:</u>

> 2) On 22 May 2020 did not record that you had administered Patient Y their Clonazepam at 12p.m. in the Drugs Liable for Misuse or Misappropriation (DLM) Book.

Proposed charge 2:

2) On 22 May 2020 did not record that you had administered Patient Y their Clonazepam at ~~12p.m.~~ **08:00** in the Drugs Liable for Misuse or Misappropriation (DLM) Book.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that the amendment did not change the nature of the charge. The panel was therefore satisfied that there would be no prejudice to Mr Brand and no injustice would be caused to either party by the proposed amendment being allowed. The panel determined that it was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Background

The NMC received a referral from the Priory Hospital Arnold ('the Hospital'), part of Priory Healthcare ('Priory'), regarding Mr Brand's fitness to practise on 12 September 2020. Mr Brand started working at the Hospital on 4 March 2019, initially as a Registered Nurse Learning Disabilities, and then as a Senior Staff Nurse from October 2019.

At the time of the concerns raised in the referral, Mr Brand was working in the Bestwood Ward ('the Ward') in the Hospital. The Ward is an acute mixed gender ward, which admits patients who are detained under the Mental Health Act 1983, as well as informal patients (patients not detained under the Mental Health Act 1983). The Ward accommodated up to 16 patients, with male and female bed areas separated by clear corridors and observed by CCTV cameras. The CCTV cameras were operated externally by Care Protect, and one operated by the Hospital.

The referral alleges that concerns were raised that between 20 and 26 May 2020 Mr Brand made a series of errors relating to medication administration and record keeping. It is alleged that while working at the Hospital:

- On 20 May 2020, Mr Brand inaccurately signed that Patient Z refused Clonazepam, when the patient did not appear for the administration of the medication. Mr Brand also did not record that the medication had been destroyed in the Disposal of Unwanted Drugs Book.
- On 22 May 2020, Mr Brand did not record that he administered Patient Y's Clonazepam doses in the Drugs Liable for Misuse or Misappropriation (DLM) book.
- On 26 May 2020, Mr Brand incorrectly signed that he administered Patient X's 12:00 dose of Clonazepam, when according to the CCTV footage, Patient X did not appear for administration of the medication.
- On 26 May 2020, Mr Brand also incorrectly signed that he administered Patient W's 12:00 dose of Clonazepam, when according to the CCTV footage, Patient W did not appear for administration of the medication.

The alleged errors came to light on 27 May 2020. The Ward Manager (Colleague 6) was informed and they then requested a review of the CCTV footage to establish what had occurred.

Mr Brand was subsequently suspended from his duties on 3 June 2020 while the Priory commenced an internal investigation into the alleged incidents. Colleague 2, Director of Clinical Services at Priory, conducted the internal investigation. As part of this investigation, Mr Brand attended an interview on 6 July 2020. It is alleged that during this interview Mr Brand acknowledged that he may have made mistakes regarding medication administration and record keeping. Colleague 2 completed a Management Report on 24 July 2020, and the matter was referred to a disciplinary meeting.

Colleague 1, Peripatetic Director of Clinical Services at Priory, chaired the disciplinary meeting which took place on 24 August 2020. During the meeting, concerns were also

raised that Mr Brand had not been following the Medicines Management Policy in place at the Hospital, as he is alleged to have been pre-potting medication ready for administration and then leaving the medication room unattended. Mr Brand allegedly made admissions to these breaches at the meeting.

On 6 September 2020, Mr Brand resigned from his employment at the Hospital. He indicated that his resignation was due to bullying and harassment in the workplace, as well as being subject to unreasonable and unfair treatment.

On 7 September 2020, Mr Brand commenced employment with Thistle Hill Hall (the Home), after being offered a role there as a Senior Staff Nurse on 21 August 2020. As part of his role at the Home Mr Brand was responsible for administering medication to patients. It is alleged that during the employment application process, Mr Brand did not inform the Home of the disciplinary proceedings which were taking place at the Hospital.

On 24 September 2020, Mr Brand self-reported that he erroneously administered Quetiapine to Resident A at 12:30 instead of the prescribed time of 16:30. A meeting was held with Colleague 3, the Home's Assistant Manager at the time, and Mr Brand completed a reflection piece in respect of the alleged incident.

On 8 October 2020, an interim suspension order was imposed by the NMC on Mr Brand's practice, in relation to concerns raised in the referral on 12 September 2020. Despite this, Mr Brand continued to work at the Home.

It is alleged that while working at the Home, Mr Brand made the following further errors:

- On 22 October 2020, Mr Brand again administered Quetiapine to Resident A in advance of the prescribed time, reporting that he had administered it at 13:05 instead of 16:30.

- On 2, 5 and 14 November 2020, Mr Brand failed to carry out medication stock checks after medication rounds, as required by the Home, in order to ensure that there was enough medication in stock and to monitor amounts of controlled drugs.

- On 4 November 2020, Mr Brand also did not record on the Home's computer system new stocks of a controlled drug, Pregabalin, which had been delivered to the Home. The amount of Pregabalin held by the Home and what was recorded on the system therefore did not match.

- Over three consecutive nights from 19 to 21 November 2020, failed to carry out nightly medication stock checks, as required by the Home.

- On 20 November 2020 inaccurately signed an unknown patient's medical record to indicate that he had administered medication when he did not.

Towards the end of November 2020, the Home found out that Mr Brand did not have an active NMC PIN as a result of the interim suspension order which had been imposed on 8 October 2020. Mr Brand was suspended from undertaking further shifts at the Home.

On 30 November 2020, a meeting was held between Mr Brand, Colleague 3 and Colleague 8 (Clinical Lead at the Home), to discuss the non-disclosure of the disciplinary action taken by the Hospital and the non-disclosure of the interim suspension order imposed by the NMC. In this meeting Mr Brand stated that he had told the Home about the disciplinary proceedings at his previous employer and that he had only recently discovered that he was subject to an interim suspension order. Mr Brand's employment was subsequently terminated.

The interim suspension order imposed on Mr Brand's practice remains in place.

Decision and reasons on facts

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

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

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

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

- Colleague 1: Peripatetic Director of Clinical Services at Priory Healthcare;
- Colleague 2: Director of Clinical Services at Priory Healthcare, at the relevant time;
- Colleague 3: Assistant Manager at the Home, at the relevant time;
- Colleague 4: Health and Safety Administrator / PMVA Instructor at Priory Healthcare, at the relevant time;
- Colleague 5: Registered Manager, at the Home at the relevant time.

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

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

Charge 1a

1) On 20 May 2020;
    a) Inaccurately recorded that Patient Z had refused Clonazepam.

This charge is found NOT proved.

In reaching this decision, the panel had regard to the documentary evidence exhibited, which included the DLM Book, prescription chart and a written review of the Hospital's 20 May 2020 CCTV footage, in respect of Patient Z.

The panel noted that Mr Brand made an entry on 20 May 2020 in the DLM book, indicating that a dose of 1mg Clonazepam for Patient Z was dispensed and then disposed of at 09:30. The panel further noted that Mr Brand also made an entry in the prescription chart on 20 May 2020 indicating that the medication was refused, however, in this chart a time was not written but the generic 08:00 time slot had been signed. The panel was of the view that the documentary evidence was generally corroborative, and indicated that the morning dose of Clonazepam was not administered and was refused by Patient Z.

The panel also took into account the written review of the 20 May 2020 CCTV footage, in which it sets out that Patient Z did not attend the clinic for the morning dose of Clonazepam. The panel noted that the written review stated the following:

'20.05.2020 – Timeline

09:15 S/N AB enters the clinic
09:16 S/N AB exits the clinic
09:21 S/N AB enters the clinic
09:32 S/N AB exits the clinic

Between 09:32-09:45 no member of staff enters the clinic [Patient Z] *does not attend the clinic'*

The panel noted that Mr Brand is recorded to have exited the clinic at 09:16 before he re-entered at 09:21, but there is no information as to what may have occurred during that time. The panel was not satisfied that it was presented with enough information to suggest that in this circumstance the patient would have to enter the clinic within the time parameters reviewed by the Hospital in order to refuse the morning medication. It determined that the evidential value of the written review of CCTV footage was limited. The panel was satisfied as to its accuracy regarding what it did say, but was not satisfied that it could rely on the CCTV review as evidence about periods which it did not cover. It did not, for example, specifically cover the period prior to 09:15 or after 09:45, or the possibility that Mr Brand may have spoken to Patient Z elsewhere in the hospital and been told they would not take the medication. The patient could, therefore, have refused the medication without coming to the clinic.

The panel noted that in the oral evidence of Colleague 4, he stated that he reviewed the CCTV footage from around 07:45 onwards, but the evidence about how long after 08:00 (the scheduled time for the medication to be given) he had continued to review the footage was unclear and Colleague 4 could not remember when questioned. Although it was a matter for the panel to determine the weight to be given to the written review of the CCTV, it noted that Colleague 1, who had seen the CCTV recording during the disciplinary meeting, had not ruled out the possibility that the relevant events had occurred outside the time parameters of the CCTV review.

The panel could not, therefore, rely on this evidence to show that the patient had refused their medication, particularly since the DLM book and the prescription chart both showed that the medication had been refused.

The panel concluded it could not be satisfied that, on the balance of probabilities, Mr Brand inaccurately recorded that Patient Z refused the Clonazepam on 20 May 2020.

Accordingly, the panel found charge 1a not proved.

Charge 1b

1) On 20 May 2020;
    b) Did not record that Patient Z's Clonazepam had been destroyed in the Disposal of Unwanted Drugs Book.

This charge is found proved.

In reaching this decision the panel had regard to the documentary evidence exhibited, which included the Disposal of Unwanted Drugs Book, in respect of Patient Z.

The panel assessed the information recorded in the Disposal of Unwanted Drugs Book in relation to Patient Z. The panel noted that this document should be completed in the event of medication being destroyed at the Hospital. It found that there was no entry from Mr Brand in the Disposal of Unwanted Drugs Book to indicate that Patient Z's Clonazepam was destroyed on 20 May 2020.

The panel was therefore satisfied that Mr Brand did not record that Patient Z's Clonazepam had been destroyed on 20 May 2020.

Accordingly, the panel found charge 1b proved.

Charge 2 (as amended)

2) On 22 May 2020 did not record that you had administered Patient Y their Clonazepam at 08:00 in the Drugs Liable for Misuse or Misappropriation (DLM) Book.

This charge is found NOT proved.

In reaching this decision, the panel had regard to the documentary evidence exhibited, which included the DLM book in respect of Patient Y.

The panel noted that Mr Brand made an entry in the DLM book on 22 May 2020, which may indicate that a dose of 1mg Clonazepam for Patient Y was administered at 08:00. The panel considered that the handwriting of this entry was unclear and could also be read as 00:00. However, it determined that this time (midnight) did not seem likely given the entries immediately before and after.

The panel was therefore satisfied that it was more likely than not that Mr Brand did record that he had administered Patient Y their Clonazepam at 08:00 in the DLM Book.

Accordingly, the panel found charge 2 not proved.

Charge 3a

3) On 26 May 2020;
   a) Incorrectly recorded that Patient X was administered Clonazepam at around 12p.m.

This charge is found NOT proved.

In reaching this decision, the panel had regard to the documentary evidence exhibited, which included the DLM Book, prescription chart and a written review of the Hospital's 26 May 2020 CCTV footage, in respect of Patient X.

The panel noted that Mr Brand made an entry in the DLM book on 26 May 2020, indicating that a dose of 0.5mg Clonazepam for Patient X had been given at what appeared to be 11:55 but might have been later as the time of the entry appears to have been overwritten. The panel further noted that Mr Brand also made an entry in the prescription chart on 26 May 2020 indicating that the medication was given, however, in this record a time was not written but the generic 12:00 time slot had been signed. The panel was of the view that the documentary evidence was generally corroborative, and indicated that the lunchtime dose of Clonazepam was administered to Patient X.

The panel also took into account the written review of the 26 May 2020 CCTV footage, in which it sets out that Patient X did not attend the clinic for the lunchtime dose of Clonazepam. The panel noted that the written review stated the following:

> *'26.05.2020 – Timeline Patients*
>
> *12:44 S/N AB enters the clinic*
> *12:51 S/N AB exits the clinic*
>
> [Patient X/Patient W] *do not attend the clinic in the requested times.'*

The panel noted that the CCTV footage review stated that Patient X did *'not attend the clinic in the requested times'*, however no information was put before it to indicate what the *'requested times'* were. The panel was not satisfied that it was presented with enough information to show that in this circumstance the patient would have to appear at the clinic within the time parameters reviewed by the Hospital to have been administered the lunchtime medication. It determined that the written review of CCTV footage was limited as explained above in relation to charge 1a.

In view of the inadequacies of the CCTV review evidence, and taking into account the documentary evidence in the DLM book and the prescription chart, the panel could not be satisfied, on the balance of probabilities, that Mr Brand had incorrectly recorded that Patient X was administered Clonazepam at around 12:00.

Accordingly, the panel found charge 3a not proved.

Charge 3b

3) On 26 May 2020;
    b) Incorrectly recorded that Patient W was administered Clonazepam.

This charge is found proved.

In reaching this decision, the panel had regard to the documentary evidence exhibited, which included the DLM Book, prescription chart and a written review of the Hospital's 26 May 2020 CCTV footage, in respect of Patient W.

The panel noted that Mr Brand made an entry in the DLM book on 26 May 2020, indicating that a dose of 1mg Clonazepam for Patient W was given at 12:45. The panel noted a prescription chart which had Patient W's name on it on which Mr Brand had made an entry indicating that he had administered medication at lunchtime. However, the panel found that it could not place reliance on this chart as the complete document was not produced and neither the name of the medication nor the time of the dose were visible.

The panel also took into account the written review of the 26 May 2020 CCTV footage, in which it sets out that Patient W did not attend the clinic for the lunchtime dose of Clonazepam. The panel noted that the written review stated the following:

'26.05.2020 – Timeline Patients

12:44 S/N AB enters the clinic
12:51 S/N AB exits the clinic

[Patient X/Patient W] *do not attend the clinic in the requested times.'*

The panel noted that the time parameters reviewed by the Hospital includes the time Mr Brand recorded in the DLM to have administered Clonazepam to Patient W. The panel accepted that the CCTV review in this respect contradicted Mr Brand's 12:45 entry on the DLM as Patient W was not present at the time recorded for medication administration.

The panel also accepted the evidence of Colleague 4 that, had Mr Brand left the clinic carrying the Clonazepam to, for example, administer it in Patient W's room, that would have been apparent from the CCTV recording and he would have documented it.

In the panel's view this situation was different to that in charges 1a and 3a because the time period which the allegation concerns is covered by the CCTV review. The allegation is that Mr Brand incorrectly recorded that the patient *did* take the medication (rather than that they refused it). In the panel's view this would have to have occurred during the 7 minute window that Mr Brand was recorded as having been in the clinic, and would have required the patient to have attended the clinic, and the CCTV review shows they did not.

The panel therefore concluded that, on the balance of probabilities, Mr Brand incorrectly recorded that Clonazepam was administered to Patient W on 26 May 2020.

Accordingly, the panel found charge 3b proved.

Charges 4a and 4b

4) Between 4 March 2019 and 3 June 2020 on one or more occasion;
    a) Pre-potted medication.

b) Left medication in the clinic room unattended.

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Colleague 1. The panel also had regard to the documentary evidence exhibited, which included notes from a disciplinary meeting held on 24 August 2020.

The panel found that Colleague 1's written witness statement was consistent with her oral evidence, which it regarded as compelling and credible.

The panel noted that Colleague 1's account is supported by Mr Brand's admissions made at the disciplinary meeting, in which he conceded that he acted contrary to the Hospital's Medicines Management Policy:

> *'AB – pot it up and then when gives it and then signs it. I thought I would try that way as would have all the medication down. Would fill in half a page on DLM book for clonazepam. Then you would sign it when you have actually given it to them*
>
> [Colleague 1] – *so I am clear. It is practice in the morning when busy, to dispense medication for a number of patients*
>
> *AB – yes*
>
> [Colleague 1] – *are you saying that happens before or after the patient arrives*
>
> *AB – before. On the back counter would have multiple patient's medication in their folder. The only other nurse I haven't done meds with is […]. But all the other nurses I have done meds with do it like this.*
>
> [Colleague 1] – *can you understand why I am quite alarmed about that*

AB – yes. I think you are opening yourself up to mixing medication up or errors. And you could say you wouldn't know what is in the pot but you have potted it up so should know what is in there.'
[Colleague 1] – *would that fit with policy? AB – don't think it does, no'*

The panel also noted the following evidence from Colleague 1's written witness statement, in which she stated:

'During the hearing it became evident from the CCTV that when pre-potting medication, Anthony would walk out of the room and leave the medication unattended, so anybody could take it, give the medication to the wrong person, etc.'

The panel therefore determined that there was clear and consistent evidence that Mr Brand pre-potted medication and left medication in the clinic room unattended, between 4 March 2019 and 3 June 2020.

Accordingly, the panel found charges 4a and 4b proved.

Charge 5

5) On 24 September 2020 incorrectly administered Quetiapine 400mg/300mg Tablets to Resident A at 12:38 instead of at the prescribed time of 16:30.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 3. The panel also had regard to the documentary evidence exhibited, which included an Incident Report, dated 24 September 2020.

The panel noted the following evidence from Colleague 3's written witness statement, in which she stated:

> *'…I noted that on 24 September 2020 Anthony made a medication error, in that he administered quetiapine to patient Resident A at 12:38pm instead of the prescribed time of 4:30pm. I exhibit as **NE/11** a copy of Resident A MAR for 24 September 2020. You can see from the MAR that Anthony administered quetiapine 400mg modified release tablet and quetiapine XL 300mg tablet at 12:38pm when it was scheduled to be given at 4:30pm.'*

The panel noted that Colleague 3's account is supported by the Incident Report completed by Mr Brand, dated 24 September 2020, in which it is stated:

> *'Resident A was given her 16:30 Quetiapine at 12:30. I did not realise until after she had taken it.'*

The panel therefore concluded that, on the balance of probabilities, Mr Brand incorrectly administered Quetiapine Resident A at 12:38 instead of at the prescribed time of 16:30 on 24 September 2020.

Accordingly, the panel found charge 5 proved.

Charge 6

6) On 22 October 2020 incorrectly administered Quetiapine 400mg/300mg Tablets to Resident A at 13:04 instead of at the prescribed time of 16:30.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 3. The panel also had regard to the documentary evidence exhibited, which included an Incident Report, dated 22 October 2020.

The panel noted the following evidence from Colleague 3's written witness statement, in which she stated:

> *'Following the first medication error on 24 September 2020 ….four weeks later on 22 October 2020 he made the exact same error again with the same patient.*
> *[…]*
>
> *Also at paragraph 5 of my previous statement, I refer to an error Anthony made on 22 October 2020 with the same patient. I exhibit as* ***NE/12*** *a copy of Resident A MAR for 22 October 2020.* ***NE/12*** *show Anthony gives Resident A sondate XL 300mg modified release tablet and sondate XL 400mg modified release tablet at 1:04pm instead of 4:30pm as scheduled.'*

The panel noted that Colleague 3's account is supported by the Incident Report completed by Mr Brand, dated 22 October 2020, in which it is stated:

> *'Sondate 700mg given at 13:05 instead of 16:30. Items scanned and did not realise until* [Resident A] *had taken them at it then advised it was too early.'*

The panel noted that in her oral evidence Colleague 3 explained that Sondate is a brand name for the Quetiapine medication used to treat mental health disorders.

The panel therefore concluded that, on the balance of probabilities, Mr Brand incorrectly administered Quetiapine Resident A at 13:04 instead of at the prescribed time of 16:30 on 22 October 2020.

Accordingly, the panel found charge 6 proved.

Charges 7a, 7b and 7c

7) Did not carry out stock checks of medication after administration on;
   a) 2 November 2020.
   b) 5 November 2020.
   c) 14 November 2020.

These charges are found NOT proved.

When considering charge 7 and its sub sections, the panel bore in mind that the only direct evidence in relation to this matter comes from an email dated 24 November 2020, from Colleague 9. The panel reminded itself that this email was excluded from evidence as inadmissible hearsay.

The panel noted that Colleague 3's account of stock checks on 2, 5 and 14 November 2020 was wholly reliant on issues identified in the email from Colleague 9. The panel took into account that, when questioned in her oral evidence, Colleague 3 stated that she did not independently check the alleged issues and did not have personal knowledge of them.

In the absence of any further evidence, the panel found charges 7a, 7b and 7c not proved.

Charges 8a and 8b

8) Did not carry out stock checks of medication after administration on;
   a) 19/20 November 2020.
   b) 21 November 2020.

These charges are found NOT proved.

When considering charge 8 and its sub sections, the panel bore in mind that the only direct evidence in relation to this matter comes from an email dated 24 November 2020, from Colleague 9. The panel reminded itself that this email was excluded from evidence as inadmissible hearsay.

The panel noted that Colleague 3's account of stock checks on 19 - 21 November 2020 was wholly reliant on issues identified in the email from Colleague 9. The panel took into account that, when questioned in her oral evidence, Colleague 3 stated that she did not independently check the alleged issues and did not have personal knowledge of them.

In the absence of any further evidence, the panel found charges 8a and 8b not proved.

Charge 9

9) On one or more occasion conducted an incorrect stock check/count of medication at the Home.

This charge is found NOT proved.

When considering charge 9, the panel bore in mind that the only direct evidence in relation to this matter comes from an email dated 7 November 2020, from Colleague 7, and an email dated 24 November 2020, from Colleague 9. The panel reminded itself that both emails were excluded from evidence as inadmissible hearsay.

The panel had regard to its reasoning for charges 7 and 8 in respect of Colleague 3's account of stock checks.

In the absence of any further evidence, the panel found charge 9 not proved.

Charge 10

10) On 4 November 2020 did not book in Pregabalin medication into the Home's system on arrival.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 3.

The panel noted the following evidence from Colleague 3's written witness statement, in which she stated:

> *'On the 4 November 2020 he didn't book in Pregabalin medication that had arrived. On this occasion, another nurse* [Colleague 7]*, recorded the medication in the Controlled Drug book and Anthony was supposed to record it on the system but he didn't. This meant the amount of medication on the system and the amount of medication held didn't match.'*

The panel found that Colleague 3's written witness statement was consistent with her oral evidence, in which she further explained the two-person process for recording on the Home's system. Colleague 3 also indicated in her oral evidence that she checked the medication herself and identified the inconsistency. The panel regarded Colleague 3's account as compelling and credible.

The panel found that Mr Brand had a duty as one of the two nurses involved in the checking-in of the drug, and the fact that the other nurse had admitted an error in not recording it did not absolve Mr Brand of his responsibility.

The panel accepted Colleague 3's evidence and determined that, on the balance of probabilities, Mr Brand, in conjunction with Colleague 7, was required to book Pregabalin medication into the Home's system on arrival on 4 November 2020, but did not do so.

Accordingly, the panel found charge 10 proved.

Charge 11

11) On 20 November 2020 inaccurately signed an unknown Patient's medical records to indicate that you had administered medication.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 3.

The panel noted the following evidence from Colleague 3's written witness statement, in which she stated:

> *'On the 20 November 20 Anthony signed for medication that he didn't administer. The home has residents who are medicated in their bedrooms, so we carry a laptop around to record when the medication has been administered. However, staff need to make sure the laptop syncs with the PC they have on the clinic. On this occasion, another nurse went into the service users room and administered the medication, signed for it on the online system with the laptop. It seems Anthony then went into the PC in the clinic and signed for that medication as well, despite the fact that he had not been the person administering it. This meant that when the laptop and the PC synchronised, it looked in the system (MAR sheet) like the resident had received the medication twice. I do not have a copy of the MAR chart to produce as an exhibit.*'

The panel found that Colleague 3's written witness statement was consistent with her oral evidence, which it regarded as compelling and credible. The panel was satisfied that Colleague 3 personally viewed the duplicate entries.

The panel accepted Colleague 3's evidence and determined that, on the balance of probabilities, as a matter of fact Mr Brand inaccurately signed an unknown Patient's medical records to indicate that he had administered medication on 20 November 2020.

Accordingly, the panel found charge 11 proved.

Charge 12

12) Your actions in charge 11 above were dishonest in that you sought to misrepresent that you had administered the medication.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague 3.

The panel applied the legal test for dishonesty and referred to the case of *Ivey v Genting Casinos* [2017] UKSC 67. The panel was satisfied that, as Mr Brand did not in fact administer the medication himself, he would have known he had made an inaccurate entry in the medical records. The panel then considered whether his actions had been dishonest.

The panel took into account that, in her oral evidence, Colleague 3 indicated that she was unsure why Mr Brand also signed for administration of medication to the patient when it had already been done by Colleague 7. In her oral evidence Colleague 3 said that it is possible that Mr Brand was trying to make the records match to show that medication had been administered by another nurse, which it had, but it did not show on the system at that time because the two computers had not yet been synchronized. The panel determined that, in the light of Colleague 3's account, it could not be satisfied that there was a dishonest motive for Mr Brand's actions.

The panel therefore concluded that it could not be satisfied that, by the standards of ordinary and decent people, Mr Brand's actions in this regard were dishonest.

Accordingly, the panel finds charge 12 not proved.

Charge 13

13) Between 8 October 2020 and 28 November 2020 did not inform your employers/supervisors at the Home that you had been made subject to an interim suspension order.

This charge is found proved.

At the outset of the hearing, the panel had noted that there was no evidence before it of the interim suspension order decision or that it had been served on Mr Brand. Consequently, Ms Butler provided the panel with a copy of the letter sent to Mr Brand informing him of the interim suspension order and a copy of an email, dated 9 October 2020, by which that letter had been sent to him. The panel requested that copies of these documents be sent to Mr Brand and, prior to retiring for consideration of its findings, was informed by Ms Butler that they had been sent to Mr Brand's registered email address in accordance with Rule 34(3)(b).

In reaching its decision, the panel took into account the evidence of Colleague 3 and Colleague 5, and the documentary evidence exhibited.

The panel found that it was a matter of fact that an interim suspension order was imposed on Mr Brand's practice at an Interim Order hearing on 8 October 2020. The panel noted that although Mr Brand had not been in attendance, effective notice of that hearing was served on Mr Brand on 30 September 2020.

The panel found that Colleague 3 and Colleague 5's evidence corroborate one another's account that Mr Brand did not inform the Home that he had been made subject to an interim suspension order. It also noted from the minutes of the meeting that took place on 30 November 2020 that Mr Brand did not assert that he had informed the Home of the interim suspension order before 28 November 2020.

The panel therefore determined that there was clear and consistent evidence that Mr Brand did not inform the Home that he had been made subject to an interim suspension order, between 8 October 2020 and 28 November 2020.

Accordingly, the panel found charge 13 proved.

Before making its determination on charge 14 the panel considered it appropriate to first consider charges 15 and 16 because its findings on those charges are relevant to the issue of dishonesty in charge 14.

Charges 15a and 15b

15) Between 21 August 2020 and 30 November 2020 Did not disclose to Thistle Hill Hall Home that you had been subjected to a disciplinary investigation by Priory Hospital Arnold into allegations of;
    a) Medication administration errors/outside of Trust Policy
    b) Record keeping errors/outside of Trust policy

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Colleague 3 and Colleague 5. The panel also had regard to the documentary evidence exhibited, which included Mr Brand's completed application to the Home, dated 21 August 2020.

The panel noted that in the application form to the Home, dated 21 August 2020, when asked '*Have you ever any disciplinary action or procedure against you?*', Mr Brand circled *'yes'* and stated the following:

> *'allegations of theft of which RCN is helping me refute'.*

The panel also considered that the notes of Mr Brand's interview at the Home did not mention the previous disciplinary investigation.

The panel accepted the evidence that Mr Brand did not declare the disciplinary investigation into medication administration and record keeping errors during the application process to the Home.

The panel noted the following evidence from Colleague 3's written witness statement, in which she stated:

> *'…I along with the clinical lead* [Colleague 8*], met with him on the 30 November 2020, but this was to discuss the NMC referral and why he hadn't informed us of the medication errors in his previous employment. In preparation of this meeting I read the NMC documentation, including the medication issues which occurred during his time of employment at Priory Group and discussed these with him. The meeting was very strange, Anthony said he thought he had told us about these issues, however, there was nothing on his application or interview recorded about this.'*

The panel noted the following evidence from Colleague 5's written witness statement, in which she stated:

> '*Mr Brand did not once disclose any medication errors or medication administration concerns at interview.*

In her oral evidence, Colleague 5, who was present at the interview, confirmed that Mr Brand had not mentioned, when interviewed for employment with the Home, the disciplinary action taken by the Hospital in respect of medication administration and record keeping errors. Colleague 5 further stated that, had he done so, they would not have taken '*the risk'* of employing him because '*medication is something we are really hot on'*. The panel considered that when asked in interview about his comment in the application form about the allegations of theft Colleague 5 said that Mr Brand had explained that this concerned a patient who '*was known to make accusations'*. Colleague 5 stated that Mr Brand had not mentioned anything about medication administration or record keeping. The panel accepted this evidence.

The panel found that Colleague 3 and Colleague 5's evidence corroborate one another's account that Mr Brand did not inform the Home that he had been subject to disciplinary action in relation to medication administration and record keeping errors prior to a meeting on 30 November 2020. The panel regarded this evidence as compelling and credible.

Accordingly, the panel found charges 15a and 15b proved.

Charge 16

> 16) Your actions in charges 15 a) & b) above were dishonest in that you sought to conceal the full extent of your disciplinary investigation from Thistle Hill Hall Care Home.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 3 and Colleague 5. The panel also had regard to the documentary evidence exhibited, which included notes from a meeting with Mr Brand, dated 30 November 2020.

The panel applied the legal test for dishonesty (*Ivey v Genting Casinos)*. The panel considered whether Mr Brand sought to conceal the full extent of the disciplinary investigation from the Home; and whether he was dishonest when he did not disclose this information.

The panel took into account Mr Brand's response when asked about the non-disclosure in a meeting dated 30 November 2020, the record for which states:

> *'[*Colleague 3] *discussed that the hearing letter stated that he had attended a disciplinary meeting prior to starting at Thistle Hill Hall and that the main focus of this had been around medication management. As a result of this meeting, they had stated that Anthony needed to be supervised during all administration of medication until further training had been completed.* [Colleague 3] *asked why Anthony had not mentioned this in either his application form or during his interview. Anthony stated that he had been open and honest about this and states he had told Thistle Hill Hall about his disciplinary*. [Colleague 3] *informed Anthony that the only thing he had mentioned in his application form was about an allegation of theft which was not upheld – there had been no mention of medication being an issue. Anthony stated that he had discussed this during his interview however* [Colleague 8] *(who was present in his interview) stated that she did not recall this being mentioned and this had not been documented in his interview notes.'*

The panel has found as a fact that, contrary to his assertion at the meeting on 30 November 2020, Mr Brand did not disclose either in his application form or during his employment interview that he had been the subject of a disciplinary investigation and had attended a disciplinary meeting in respect of medication administration and record keeping while employed at the Hospital. It follows, therefore, that he had not been '*open*' in the course of the employment interview. Mr Brand was clearly aware of the disciplinary process that had occurred at the Hospital as he had fully participated in it. He applied for a post at the Home while that process was still ongoing.

The panel considered that the only plausible explanation for Mr Brand's not disclosing in his application and in his employment interview that he was the subject of a disciplinary process at the Hospital was that he believed that it would jeopardise his chances of securing employment with the Home.

The panel concluded that, by the standards of ordinary and decent people, Mr Brand's actions were dishonest.

Accordingly, the panel found charge 16 proved.

The panel then returned to consider charge 14.

Charge 14

14) Your actions in charge 13 above were dishonest in that you sought to conceal the restrictions on your practice from your employers.

This charge is found proved.

In considering this charge, the panel recognised that it must be satisfied, on the balance of probabilities, that Mr Brand actually knew by 28 November 2020 that he had been made the subject of the interim suspension order. It noted that he had not attended the Interim Order hearing, nor had he been represented at it. The fact that he would have been deemed to have been served with notice of the hearing and with notice of the outcome, did not necessarily mean that he knew of the interim suspension order before 28 November 2020.

In reaching its decision, the panel took into account the evidence of Colleague 3 and Colleague 5.

The panel considered that Colleague 3's evidence was that Mr Brand was due to meet Colleague 8 on 28 or 29 November 2020 for the purposes of his revalidation. It noted that Mr Brand's entry on the NMC's WISER system confirms that his registration was due to expire on 30 November 2020. Colleague 3's evidence was that she thought that Mr Brand had contacted Colleague 5 prior to his meeting with Colleague 8 to tell her '*there might be a problem with his PIN'*. While Colleague 5 stated that she was not the person whom Mr Brand contacted, the panel was satisfied that Mr Brand had made contact with someone at the Home and, as a consequence Colleague 3, Colleague 5 and Colleague 8 had all searched the NMC's Register that weekend and discovered that Mr Brand was the subject of the interim suspension order and therefore no longer had a valid PIN.

The panel is satisfied that the only reasonable and plausible explanation for Mr Brand making this contact with someone at the Home was because he knew he was the subject of the interim suspension order and this would be discovered by the Home when he went through his revalidation with Colleague 8.

The panel was satisfied that this also explains his apparent lack of concern about the situation at the meeting on 30 November 2020. At that meeting, he accepted that he had in fact received the email from the NMC informing him of the interim suspension order but said he had not read it because *'this was not something he had seen at the time… he gets lots of junk emails come through and just didn't see it'*. The panel also considered that explanation to be implausible, particularly because Mr Brand would have been receiving emails from the NMC connected with his revalidation, which he appears to have received.

The panel has already found that Mr Brand's failure to disclose the Hospital's disciplinary process to be dishonest. It found that Mr Brand's failure to disclose the interim suspension order is consistent with a pattern of conduct in failing to disclose information that would affect his employment.

The panel concluded that, by the standards of ordinary and decent people, Mr Brand's actions were dishonest.

Accordingly, the panel found charge 14 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mr Brand's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Mr Brand's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Butler invited the panel to have regard to the cases of *R. (Remedy UK Ltd) v GMC* [2010] EWHC 1245 and *Nandi v GMC* [2004] EWHC 1245 (referring to the House of Lords sitting as Privy Council in the case of *Roylance v GMC* (No. 2) [2000] 1 AC 311). *Roylance v General Medical Council* defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Butler provided written submissions. In the written submissions, she outlined the facts found proved in the Hospital and the Home between 20 May and 30 November 2020. She submitted that it has been established that Mr Brand has committed numerous drug irregularities related to Clonazepam (a Drug Liable to Misuse), Quetiapine (a drug of abuse and dependence) and Gabapentin (a Class C Controlled Drug). She submitted that these were not one-off occurrences and it is not suggested that human error is involved in these actions. Further, she submitted that Mr Brand repeated this conduct at the Home within weeks of the disciplinary proceedings at the Hospital and, by virtue of the facts found and the repetitive nature of the conduct, he is liable in the future to do the same.

Ms Butler submitted that nurses must act with honesty and integrity. She outlined the facts found proved in relation to dishonesty at the Home, between August and November 2020. As part of her written submissions, Ms Butler submitted that among other things Mr Brand had breached his professional duty of candour to be open and honest when things go wrong in the following respects:

- His job application form 21 August 2020;
- His interview at Thistle Hill Hall 21 August 2020; and
- Failing to disclose the interim suspension order imposed on 8 October 2020 by the NMC.

Ms Butler invited the panel to take the view that the facts found proved amount to misconduct. She drew that panel's attention to 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and submitted that there have been breaches and that Mr Brand's actions amounted to misconduct.

Submissions on impairment

Ms Butler moved on to the issue of impairment and provided the panel with written submissions 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. It also included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Butler submitted all four limbs of the test set out by Dame Janet Smith in the fifth Shipman report and adopted in *Grant* were engaged in this case, in that Mr Brand:

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 profession into disrepute;*
c) *Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession;*
d) *Has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

Ms Butler submitted that the poor clinical actions of Mr Brand in the past have put patients at unwarranted risk of harm.

Ms Butler submitted that Mr Brand has brought the reputation of the profession into disrepute. She submitted that the drugs that are the subject of the facts found proved are regularly administered in Psychiatric Therapeutic areas and a Registered Nurse, who is a specialist in this area of clinical practice who cannot be trusted to safely administer and dispense these drugs causes serious questions to be asked of their practice. Further she submitted that the future risk of Mr Brand repeating this conduct is high.

Ms Butler submitted that fundamental tenets of the profession have been breached in this case. She submitted that medication administration must be safe and the established procedures of '*Practising Effectively'* must be followed in order that '*Prioritising People'* is preserved. She submitted that a nurse found to have failed in the past to administer drugs correctly and accurately (given the status of the drugs) neither '*Preserves Safety* or *Promotes Professionalism and Trust'*.

Ms Butler highlighted that Mr Brand has been found to have acted dishonestly. She submitted that when considering impairment, the panel should consider the context of dishonesty, and specifically areas of context directly linked to the reasons why the proven events occurred. She submitted that there are personal factors to take into account, …[PRIVATE]. Additionally, she submitted that Mr Brand's working environment and culture should also be taken into account, including that there has been some evidence that *'potting-up'* was common practice at the Hospital. However, she submitted that this does not excuse an individual nurse of breaching policies and the tenets of safe practice to '*follow the herd'* and not call-out poor practice on the part of others in his clinical setting.

Ms Butler submitted that there is no evidence of further relevant training or supervision undertaken by Mr Brand. She submitted that the panel had heard from the witnesses that Mr Brand has showed poor insight and understanding of the issues raised in the facts found proved. Further, she submitted that no steps have been taken by Mr Brand to address the concerns raised by management at the Hospital and, in fact, Mr Brand's response to the disciplinary action was to apply for the post at the Home. She submitted that there is no evidence about Mr Brand's current skills and fitness to practise.

Ms Butler invited the panel to find Mr Brand's fitness to practise impaired on both public protection and public interest grounds. She submitted that the concerns raised in this case are so serious that a finding of impairment is required to uphold proper professional standards and conduct, and to maintain public confidence in the profession.

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 determined that Mr Brand's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Brand's actions amounted to a number of breaches of the Code, specifically the following:

> *'**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*
> *10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.4 take all steps to keep medicines stored securely

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

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public

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…

23 Cooperate with all investigations and audits

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.'

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 cumulatively, as well as the circumstances of the case as a whole. It took account of all the evidence before it.

The panel considered charge 1b and charge 3b separately. In respect of these charges the panel found that Mr Brand did not record Clonazepam as destroyed, and incorrectly recorded that he had administered the medication, on separate occasions. The panel bore in mind that Clonazepam is not a controlled drug, but a drug which is liable to misuse. The panel was therefore of the view that creating an accurate audit trail for this medication is particularly important for the safety of patients and the follow up care patients receive from other professionals. The panel determined that in respect of these charges Mr Brand demonstrated failings in fundamental aspects of nursing which amounted to misconduct.

The panel considered that in charge 4a and 4b Mr Brand is found to have pre-potted medication and left medication unattended on more than one occasion. The panel was of the view that as an experienced nurse Mr Brand ought to have known the risks associated with pre-potting, such as increasing the likelihood of the wrong medication being administered. Additionally, the panel noted that the risks created by Mr Brand's actions in charge 4a were compounded by charge 4b, in which it was found that he also left medication unattended. It determined that Mr Brand demonstrated an unacceptably low standard of professional practice in this area and his actions in each charge amounted to misconduct.

The panel next considered charge 5. The panel found that Mr Brand incorrectly administered Quetiapine to a patient earlier than its prescribed time. The panel decided that such an error in the first instance constitutes a mistake rather than misconduct.

The panel considered that in charge 6 Mr Brand made the same error with Quetiapine with the same patient less than a month after the first occasion. The panel took into account evidence which indicated that, after the error was made on the first occasion there was significant intervention from management in respect of the error and Mr Brand completed

a reflective piece. The panel determined that the repetition of the error, despite the steps taken to avoid future risks, amounted to misconduct.

The panel found that in charge 10 Mr Brand did not book in Pregabalin medication onto the Home's system upon its arrival. The panel had regard to the evidence of Colleague 3, which indicated that although another nurse was involved in this error Mr Brand had equal responsibility, and it was found that he failed his duty in this regard to rectify the error. The panel bore in mind that Pregabalin is a drug which is liable to misuse. Similar to Mr Brand's failures in charge 1b and charge 3b, the panel was of the view that creating an accurate audit trail for this type of medication is particularly important for the safety of patients. The panel determined that Mr Brand demonstrated failings in fundamental aspects of nursing in this charge, which amounted to misconduct.

The panel next considered charge 11. The panel found that in this charge Mr Brand inaccurately signed for a patient's medication. The panel considered this charge in conjunction with its findings for charge 12, in which it was found, contrary to what Ms Butler appeared to submit, that there was no evidence of a dishonest motive for Mr Brand's actions in this regard. It took into account the oral evidence of Colleague 3, where she explained that it is possible Mr Brand was trying to make the records match to show that medication had been administered by another nurse, which it had been, but it did not show on the system at that time because the two computers had not yet been synchronized. The panel determined that, given this potential explanation, Mr Brand's actions in this charge demonstrated poor practice, not misconduct.

The panel considered charges 13, 14, 15a, 15b and 16 separately. The panel found that these charges all involved the non-disclosure of important information about Mr Brand's practice with serious implications for patient safety. Mr Brand failed to disclose information about disciplinary action from the Hospital in respect of medication administration and record keeping errors, and also failed to disclose information about the interim suspension order imposed on his practice. In charges 14 and 16 the panel has found dishonesty proved in respect of these disclosure failures. The panel was of the view that honesty and

integrity are fundamental to the nursing profession and to deliberately fail to disclose that there were concerns about his practice would create the potential for harm to patients. The panel determined that Mr Brand's actions in each charge, and in particular in relation to dishonesty, would be considered deplorable by fellow practitioners, thereby damaging the trust that the public places in the profession. It therefore found these charges amounted to misconduct.

The panel therefore concluded that Mr Brand's actions found proved in charges 1b, 3b, 4a, 4b, 6, 10, 13, 14, 15a, 15b and 16 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, Mr Brand'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.'

The panel referred to the limbs of the test quoted by Ms Butler from *Grant* and determined that all four were engaged in this case.

Taking into account all of the evidence adduced in this matter, the panel found that patients were in the past put at unwarranted risk of harm as a result of Mr Brand's misconduct. The panel determined that Mr Brand's misconduct had breached the fundamental tenets of the nursing profession and has in the past 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 extremely serious.

The panel next went on to consider the matter of insight. It noted that it had not received any evidence to suggest that Mr Brand has demonstrated an understanding of how his actions had put patients at a risk of harm or how this impacted negatively on the reputation of the nursing profession. The panel took into account that it had received evidence to the contrary in the oral evidence of both Colleague 2 and Colleague 5. They both stated that at the time of the matters being investigated at the Hospital and the Home Mr Brand had demonstrated poor insight and did not appear to understand the seriousness of the matters raised or the risks to patient safety. The panel considered that it was not presented with any information regarding Mr Brand's current level of insight. The panel therefore determined that Mr Brand demonstrated a significant lack of insight. Nor did the panel receive any evidence of remorse from Mr Brand.

The panel considered that the pattern of dishonesty in this case would be difficult to remediate in comparison to the medication and recording failures. The panel carefully considered the evidence before it and concluded that it has not received any information to suggest that Mr Brand has taken any steps to address the specific concerns raised about his practice, such as relevant training or reflection on the consequences of his dishonesty.

The panel was of the view that due to the lack of insight, remorse and evidence of strengthened practice, there remains a high risk of repetition of the misconduct. The panel considered that Mr Brand's actions set out in the charges found proved demonstrated a pattern of medication administration and record keeping failures. Additionally, it noted that Mr Brand's actions also included repeated dishonesty, in that he failed to disclose information about disciplinary action and the imposition of an interim suspension order to his new employers and then continued to make medication and recording errors which were similar to those he had been making at the Hospital. The panel noted that Mr Brand's actions could have placed multiple patients at a significant risk of harm. On the basis of all the information before it, the panel decided that there is a risk to the public if Mr Brand was 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 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 be undermined if a finding of impairment were not made in this case. The public would be shocked if no finding of impairment was made. The panel therefore also finds Mr Brand's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Brand's 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 Mr Brand off the register. The effect of this order is that the NMC register will show that Mr Brand has been struck-off the 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 Butler informed the panel that the NMC was seeking the imposition of a striking-off order.

Ms Butler referred the panel to the SG and invited the panel to consider whether the sanction with the least impact would be enough to achieve public protection, and if it was not, the panel should then consider escalation until it arrives at a sanction with the most appropriate outcome.

Ms Butler submitted that making no order or imposing a caution order would not be sufficient in this case.

Ms Butler submitted that a conditions of practice order would not be appropriate given the seriousness of the concerns in this case. She submitted that Mr Brand has not been in practice for 28 months and therefore this sanction would have no meaning.

Ms Butler submitted that Mr Brand has been subject to an interim suspension order since 8 October 2020 and in that period there has been no reflection, training, expressions of

remorse or even engagement with the NMC. She submitted that this is not a case where there is a single instance of misconduct, and there appears to be evidence of harmful deep-seated personality and attitudinal problems. She submitted that a suspension order could not adequately address the dishonesty factor in this case, neither would it adequately address public protection or the public interest.

Ms Butler submitted that Mr Brand has demonstrated limited remediation, remorse or insight and therefore the risk of repetition remains high. She submitted that a striking-off order is the only sanction capable of protecting the public, maintaining public confidence in the profession and the NMC whilst simultaneously declaring and upholding proper standards of conduct and performance.

Ms Butler outlined the aggravating and mitigating factors she identified in this case.

Ms Butler referred the panel to the case of *Huang v Secretary of State for the Home Department* [2007] UKHL 11. She submitted that although Mr Brand does not have a fitness to practise history, the absence of previous history in this case is not relevant when considering the most proportionate sanction.

Decision and reasons on sanction

Having found Mr Brand'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, it 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:

- Lack of insight and remorse;

- A pattern of misconduct involving medication administration and record keeping failures of a similar nature, which continued after Mr Brand moved to a different employer;
- Repeated dishonesty of a similar nature;
- Deep-seated attitudinal problems; and
- Conduct which put patients at risk of harm.

By way of mitigation, the panel noted that it had received indirect evidence from the disciplinary meeting, dated 24 August 2020, in which it was [PTIVATE]. The panel also considered that it was not presented with any direct evidence of Mr Brand's personal circumstances during these proceedings, such as [PRIVATE]. The panel therefore decided that it was unable to place weight on Mr Brand's [PRIVATE] as a personal mitigation in this case.

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

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

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

considered that the concerns in this case did not only relate to Mr Brand's clinical practice, but also to Mr Brand's behaving dishonestly and disregarding the interim suspension order imposed on his practice. In this respect the panel considered that the misconduct in this case reflected deep-seated attitudinal problems. In these circumstances, the panel determined that there are no practicable or workable conditions that could be formulated, nor could it be satisfied that Mr Brand would comply with them given that he had ignored the interim suspension order imposed upon him. The panel therefore concluded that a conditions of practice order would not adequately protect the public nor meet the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a 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 none of these factors applied in this case. The concerns in this case do not relate to an isolated incident and there was a pattern of misconduct across two separate employers. It noted that the misconduct in this case included repeated dishonesty, which is indicative of deep-seated attitudinal problems. The panel also took into account that it was not presented with any evidence of insight or remorse, and therefore found a consequent high risk of repetition.

The panel also had regard to the NMC's guidance on '*seriousness*' and '*cases involving dishonesty*'. The panel accepted that not all dishonesty is equally serious. However, in

respect of the guidance on dishonest conduct that is at the upper end of the spectrum of seriousness, the panel was of the view that the following were applicable to this case:

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
- *personal financial gain from a breach of trust*
- *direct risk to patients*
- *premeditated systematic or longstanding deception.*

The panel found that Mr Brand secured alternative employment whilst a disciplinary process related to medicines administration and record keeping failures was underway at the Hospital. In doing so, he did not inform his new employer of the fact of or the reasons for the disciplinary matters. The panel considered that he made a deliberate and premeditated attempt to hide these issues from his new employer.

Having regard to the above, the panel found that Mr Brand's dishonesty was serious. It determined that the misconduct found proved was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Brand's actions is fundamentally incompatible with Mr Brand's 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 register?*

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel found that Mr Brand has demonstrated a lack of insight or remorse regarding his misconduct. Further, the panel noted that it had no evidence that Mr Brand has strengthened his current practice in respect of all the specific concerns in this matter. The panel considered that honesty and integrity are at the heart of the nursing profession, and repeated dishonesty is fundamentally incompatible with nursing. The panel found that Mr Brand has not demonstrated that he can be trusted as a registered nurse to keep patients safe from unwarranted risk of harm, which raises fundamental questions about his professionalism. The panel determined that members of the public would be shocked if a registered nurse who demonstrated and failed to remediate a pattern of medication administration and record keeping failures, and was repeatedly 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 Mr Brand's case.

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

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the 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 Mr Brand in writing.

Submissions on interim order

The panel took account of the submissions made by Ms Butler. 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.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Brand's own interest until the suspension 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 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 Mr Brand is sent the decision of this hearing in writing.

That concludes this determination.