Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 15 – Tuesday 23 May 2023

Virtual Hearing

Name of Registrant:	**Shaun Patrick Maher**
NMC PIN	88A2673E
Part(s) of the register:	Registered Nurse RN3- Mental Health Nursing (May 1991)
Relevant Location:	Nottinghamshire
Type of case:	Misconduct
Panel members:	John Kelly (Chair, lay member) Louise Poley (Registrant member) Chris Thornton (Lay member)
Legal Assessor:	Paul Housego
Hearings Coordinator:	Alice Byron
Nursing and Midwifery Council:	Represented by James Lloyd, Case Presenter
Mr Maher	Not present and unrepresented
No Case to Answer	Charge 15(d)
Facts proved:	Charges 1, 2, 3(a), 3(b), 4(a), 5(a), 5(b), 5(c), 6 in its entirety, 7 in its entirety, 8 in its entirety, 11, 12, 13, 14, 15(a), 15(b), 15(c), 15(e) and 15(f)
Facts not proved:	Charges 3(c), 4(b), 5(d), 9, 10
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 Maher was not in attendance and that the Notice of Hearing letter had been sent to Mr Maher's registered email address by secure email on 13 April 2023.

Mr Lloyd, on behalf of the Nursing and Midwifery Council (NMC), submitted that it 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, the time, dates of the hearing and that it was to be held virtually, including instructions on how to join. It also included information about Mr Maher'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 the information available, the panel was satisfied that Mr Maher was 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 Maher

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

Mr Lloyd referred the panel to the email from Mr Maher to the NMC on 22 March 2023, which, in response to a question about his intentions, states *"no I will not be attending"*. Mr Lloyd said that Mr Maher has voluntarily absented himself. He told the panel that there is

no useful purpose that an adjournment could serve in this matter, as there is no suggestion that Mr Maher would engage in this hearing were it to be rescheduled for a future date.

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'*.

The panel decided to proceed in the absence of Mr Maher. In reaching this decision, the panel considered the submissions of Mr Lloyd, Mr Maher's email of 22 March 2023, and the advice of the legal assessor. It 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* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- An application for an adjournment has not been made by Mr Maher;
- Mr Maher informed the NMC that he received the Notice of Hearing and stated that he would not attend;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Three witnesses are scheduled to attend to give live evidence in this matter;
- 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 2021;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Maher in proceeding in his absence. Although the evidence upon which the NMC relies has been sent to his registered email address, Mr Maher has not made any formal responses to the charges as drafted by the NMC, however the panel has before it responses from his previous representative at the Royal College of Nursing ("RCN") to the same regulatory concerns at an earlier stage in the NMC investigation. The panel noted that Mr Maher will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Maher's decision 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 to proceed in the absence of Mr Maher. The panel will not draw any adverse inference from Mr Maher's absence in its findings of fact.

Details of charge

That you a registered nurse, whilst working at the Blyth Country House Care Home ('the Home') on 10/11 October 2021;

1) Attended/worked a shift at the Home whilst unfit through alcohol. **[PROVED]**

2) Did not wear a face mask at all times during the shift. **[PROVED]**

3) At around 22:00 for Resident A's PEG Feed;

a) Informed Colleague X that you did not know how to administer PEG Feeds. **[PROVED]**
b) Did not administer Resident A's PEG Feed. **[PROVED]**
c) Inappropriately delegated/instructed Colleague X a health care assistant to conduct Resident A's PEG Feed. **[NOT PROVED]**

4) Between 00:10 and 02:30 during Resident B's seizure;
a) Did not know the difference between a resident's nurse call buzzer and a seizure alarm. **[PROVED]**
b) Did not react to Resident B's seizure in a timely manner. **[NOT PROVED]**

5) Did not take adequate steps in response to Resident B's seizure, in that you did not;
a) Call emergency services **[PROVED]**
b) Attend to Resident B **[PROVED]**
c) Conduct observations of Resident B **[PROVED]**
d) Make a decision to administer controlled drugs to Resident B. **[NOT PROVED]**

6) On one or more occasions administered morphine to Resident B without;
a) Ensuring that another member of staff acted as second checker. **[PROVED]**
b) Ensuring that another member of staff signed the controlled drug book **[PROVED]**

7) At around 05:00;
a) Instructed Colleague X to complete your nursing document. **[PROVED]**
b) Used words to the effect; *'the agency should have told you (the Home), I don't do computers.'* **[PROVED]**

8) During your handover with Colleague Y;
   a) Incorrectly informed Colleague Y that all of the Residents were fine. **[PROVED]**
   b) Had to be prompted to disclose information about Resident B's seizure. **[PROVED]**
   c) Were unable to recall what end of life drugs you had administered to Resident B. **[PROVED**
   d) Were unable to recall;
      i) The dose of medication administered to Resident B. **[PROVED]**
      ii) The frequency of medication administered to Resident B **[PROVED]**

9) Did not sign out a dose of Midazolam from the controlled drugs book. **[NOT PROVED]**

10) Did not record a retrospective entry in the controlled drugs book to declare the failure to sign out Midazolam. **[NOT PROVED]**

11) Did not sign out a dose of Morphine Sulphate from the controlled drugs book. **[PROVED]**

12) Did not record a retrospective entry in the controlled drugs book to declare the failure to sign out Morphine Sulphate. **[PROVED]**

13) Did not escalate the failure to sign out a dose of Midazolam/Morphine Sulphate to a manager. **[PROVED]**

14) Did not complete an incident report in relation to the failure to sign out Midazolam/Morphine Sulphate. **[PROVED]**

15) Did not make adequate records/entries in Resident B's daily notes, that you;

a) Did not record that Resident B suffered a seizure. **[PROVED]**
b) Did not record that paramedics attended the Home/Resident B. **[PROVED]**
c) Did not record Resident B's diet and fluid intake. **[PROVED]**
d) Did not record that Resident B's daughter had been present at the Home during the night. **[NO CASE TO ANSWER]**
e) Did not record the administration of one or more controlled drugs to Resident B. **[PROVED]**
f) Did not record the frequency/dose of the medications to Resident B. **[PROVED]**

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

Panel consideration on whether the hearing should be heard in private

At the outset of the hearing, the Legal Assessor invited the panel to consider whether parts of this hearing should be heard in private. He reminded the panel that there is an allegation contained within the charges that Mr Maher attended work whilst under the influence of alcohol, which may or may not be indicative of an underlying health condition, of which there is no evidence before the panel. The Legal Assessor invited the panel to consider whether any concerns which the panel may have about Mr Maher's health should take precedence over the public interest in the transparency of this hearing. Any decision to hear matters in private would be pursuant to Rule 19..

Mr Lloyd indicated that he was not instructed to make an application under Rule 19, however it is open to the panel to direct that whole or parts of this hearing be held in private.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel concluded that there is no evidence of any health concerns present in this matter which would require parts or the entirety of this hearing to be heard in private. The panel considered that it would be incorrect to equivalate an allegation of drinking alcohol prior to a nursing shift with a health concern in the absence of such evidence. The panel bore in mind that it is open to it hear parts or the entirety of this hearing in private at any stage of these proceedings, should it become necessary.

Decision and reasons on application to amend the charges

At the conclusion of the oral evidence the panel heard an application made by Mr Lloyd to amend the wording of charges 9, 10 and 15(d):

> That you a registered nurse, whilst working at the Blyth Country House Care Home ('the Home') on 10/11 October 2021;
>
> […]
>
> 9) ~~Did not~~ **Incorrectly** sign**ed** out ~~a~~ **two** dose**s** of Midazolam from the controlled drugs book.
>
> 10) Did not record a retrospective entry in the controlled drugs book to declare ~~the failure to sign out Midazolam~~ **error at (9) above**.
>
> […]
>
> 15) Did not make adequate records/entries in Resident B's daily notes, that you;
>
> […]

~~d) Did not record that Resident B’s daughter had been present at the Home during the night~~

In respect of charge 9, Mr Lloyd said that the proposed amendment was to clarify the regulatory concern in respect of the signing out of Midazolam from the controlled drugs book. He said that the concern is that Mr Maher didn’t properly sign out the drugs which he used, in that he signed out two doses where only one was used. Mr Lloyd said that, on reading the charge as currently drafted, it could be interpreted that Mr Maher did not sign out a single dose of Midazolam. While the panel’s questions had shown that the way the charge was framed was incorrect, he submitted that the gravamen of the charge was incorrect recording of the use of Midazolam, and the amendment set out the inaccuracy correctly. Mr Lloyd reminded the panel that the evidence was that Mr Maher signed out two doses when only one was used. It was submitted by Mr Lloyd that the proposed amendment would provide clarity, more accurately reflect the evidence and ensure that the panel decision on this charge could be understood by both Mr Maher and the public.

Mr Lloyd accepted that Mr Maher is not on notice of this application to amend this charge, and has not had the opportunity to comment on whether he objects or not to such amendment. However, he said that the evidence underpinning this allegation has been available to Mr Maher throughout the NMC investigation, and that his RCN representative wrote to the NMC accepting that there had been drug handling errors on this shift in relation to this resident. Mr Lloyd said that it is not unfair to amend the charge to provide clarity, and there is no prejudice in such amendment because the gravamen of the conduct, being drug handling errors, was the same, so the nature and seriousness of the allegation was unchanged.

In respect of charge 10, Mr Lloyd submitted that this is consequential to charge 9, and should also be amended if charge 9 were amended.

In respect of charge 13(d), Mr Lloyd submitted that it is appropriate and fair to remove this sub-particular following the evidence, as the evidence the panel heard provided no basis

to support this sub-charge. He said that no prejudice can be suffered by removing this area of factual consideration, and that it would be fair to remove this sub-charge at this stage.

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

The panel decided that these amendments would not be fair or in the interests of justice. In respect of charges 9 and 10, the panel concluded that the proposed amendments go beyond a clarification of the charge and would effectively reverse the allegation, from not signing at all to signing for too many doses of Midazolam. The panel bore in mind that Mr Maher is not present and has not been notified of the proposed change to this allegation, and to therefore make any amendment which would materially alter the charge at this stage would be unfair and prejudicial. The panel bore in mind that it was open to the NMC to seek further witnesses who spoke to these charges at any stage during its investigation and did not do so. Accordingly, the panel rejected Mr Lloyd's application and will consider the evidence before it in relation to charges 9 and 10 as drafted.

In respect of charge 15(d), the panel accepted Mr Lloyd's submission that this charge is not supported by the evidence before it, however concluded that this charge would be more appropriately disposed of a by a finding of no case to answer.

Decision on no case to answer in respect of charge 15(d)

The panel, of its own volition, concluded that there is no case to answer in respect of charge 15(d).

The panel took account of the submissions made by Mr Lloyd and heard and accepted the advice of the legal assessor. It had regard to Rule 24(7).

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient

evidence had been presented, such that it could find the facts proved and whether Mr Maher had a case to answer in respect of charge 15(d).

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 15(d). proved. The evidence was that the daughter of the resident was not present at the time. It concluded that the evidence before it does not factually support this charge, and therefore it is incapable of being found proved.

Accordingly, the panel found no case to answer in respect of charge 15(d).

Background

The charges arose from events whilst Mr Maher was employed as a registered nurse during an agency night shift at Blyth Country House Care Home (“the Home”) commencing on the evening of 10 October 2021. This was the first, and only, shift he worked at the Home.

It is alleged that, on this shift, Mr Maher attended the Home smelling strongly of alcohol and unfit to work. It is also alleged that Mr Maher did not wear a face mask, which was required at the time as a result of the Covid-19 pandemic.

It is alleged that Mr Maher did not provide appropriate care in relation to Resident A’s PEG feed, in that he informed Colleague X that he did not know how to administer PEG feeds, did not administer Resident A’s PEG feed and subsequently inappropriately delegated or instructed a health care assistant to administer Resident A’s PEG feed.

It is further alleged that, in respect of Resident B, Mr Maher responded inappropriately to a seizure, as set out in the charges, including his alleged failure to record the administration of controlled drugs, make appropriate records in Resident B’s daily notes and provide an appropriate hand over to colleagues.

Decision and reasons on facts

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

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

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 X:	Health care assistant on shift at the Home at the time the charges arose;
• Colleague Y:	Staff Nurse at the Home at the time the charges arose, who came on duty the morning of 11 October 2021;
• Witness 1	Staff Nurse on the day shift at the Home who inducted Mr Maher prior to the start of his night shift at the Home.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered all the witness and documentary evidence before it.

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

Charge 1

1) Attended/worked a shift at the Home whilst unfit through alcohol.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague X, dated 20 July 2022, which states:

> *"When I arrived for my shift, I became aware that Mr Maher, an agency nurse was booked to work the shift that night. When I got to the Home Mr Maher was already there and was receiving handover from the day nurse, Witness 1. Following the handover, I had a brief interaction with Mr Maher. During this interaction, I smelled alcohol on his breath as he was not wearing a face mask.*
>
> *[…]*
>
> *The paramedics arrived quite quickly after I called them. I do not recall the exact time. A paramedic, […], went to the resident's room where Mr Maher was. She then came back and saw me and asked me if I had seen Mr Maher drinking any alcohol and I said that I had not. The paramedic said that she could smell alcohol on him and she was not very happy about it.*
>
> *[…]*
>
> *I did not think that Mr Maher was fit to work because he smelt of alcohol and appeared intoxicated throughout the shift."*

The panel had regard Colleague X's near-contemporaneous account of her concerns about Mr Maher, in which she stated:

> *"I came to work the night shift on 10th October 2021, and I noted that there was an agency nurse Sean Maher, booked to work the shift that night. When I got to work Sean was already there, and on brief interaction with him I smelled alcohol on his breath as he was not wearing a face mask.*

[…]

When the paramedics arrived they asked me if I saw him drinking any alcohol and I said I hadn't but she said that she could smell alcohol on him"

The panel found Colleague X's oral evidence to be consistent with her previous statements. She described the smell of alcohol as distinctive and said that it could not be attributable to products such as hand sanitiser or aftershave. Colleague X was clear that she recognised this smell of alcohol to emanate from Mr Maher when she was in his presence, and that she considered that Mr Maher was "*drunk*". She described how she voiced her concerns to Witness 1 and how she had telephoned Colleague Y in distress at about 2 am and told her about her concerns about Mr Maher's presentation following Resident B's seizure.

The panel also had regard to the evidence of Colleague Y, who set out in her witness statement, dated 21 July 2022:

"At the end of the telephone call with the paramedic, they mentioned that they believed Mr Maher was intoxicated.

[…]

When I arrived at the Home, I saw Colleague X who was visually upset. Colleague X said that she was not sure what drugs Mr Maher had given to Resident B. Colleague X said she believed that he was intoxicated and that the paramedics the previous night believed so too. I reassured her and told her that she had acted in the residents best interests.

After speaking to Colleague X, I put my bag in the nurses' station and then walked down the corridor. As I was walking down the corridor, I saw Mr

Maher walking up the corridor towards myself. Mr Maher was stumbling, visibly shaking and when speaking slurring his words on approach to myself.

We went into the dining room for handover. Once there Mr Maher sat himself down next to me and I could smell alcohol which alarmed me significantly. There was also three carers presents with myself for handover who looked alarmed at Shaun's presentation.

I sat down on the same side of the table as Mr Maher. I was sat to his left. We were both wearing facemasks but I could still smell alcohol on Mr Maher's breath. It was not overly powerful in the sense that I did not think he had had a drink recently but he did smell of alcohol.

During the handover, Mr Maher was slurring his speech and kept stating that he was sorry every other sentence. I was unsure as to why he was apologising. He did not provide a detailed handover and just said that everything had been fine and that all of the residents in the Home were fine. I had to ask Mr Maher for more detail about the residents.

[…]

I felt upset after the handover as I felt that Mr Maher had not given me any information about any residents at the Home. It was obvious to myself during the handover that Mr Maher was intoxicated.

[…]

After Mr Maher left the Home, I rang his agency straight away and reported that he was intoxicated and that I would be safeguarding him."

The panel had regard to the incident form completed by Colleague Y, dated 11 October 2021, in which she states:

> *"On arrival on to shift i found night nurse agency intoxicated and i [sic] immediately reported this to his agency"*

The panel found Colleague Ys oral evidence to be consistent with her previous statement and incident report. She described for the panel the smell of alcohol as distinctive and not the same smell as hand sanitiser. Colleague Y also described how Mr Maher's speech was slurred and that he was shaking when speaking to her after the paramedics had left. She also described how Mr Maher had not been able to exit the building by entering a simple door code. She stated that Colleague X was distressed and upset when explaining to her on the telephone that Mr Maher had attended the Home intoxicated.

The panel noted that this account was supported by the referral from the East Midlands Ambulance Service ("EMAS"), dated 11 October 2021, which states:

> *"sean smelt strongly of alcohol […] concerns raised due to level of care provided by nurse sea [sic] and smelling strongly of alcohol with tremors"*

The panel heard from Witness 1 that soon after Mr Maher had arrived at the Home Colleague X had raised her concerns about Mr Maher's potential intoxication to her, and that she observed him for a period of approximately 90 minutes from a distance and did not share the same concerns.

The panel noted that Mr Maher has not provided any responses to this charge as drafted. However, in a written statement to his former agency, Mr Maher said:

> *"I DID NOT have any alcohol whatsoever either prior to my shift or whilst on it so fully deny that I smelt of alcohol. If smelling of alcohol was a genuine concern then surely the agency would be contacted immediately for a nurse*

to replace myself or management of the home? Why would I be allowed to continue to do a full shift? I have a clause in the contract I have with Orb that states random drug and alcohol testing can be requested at any point, which I would be happy to do so on that shift or any shift undertaken. […] I was nervous with being so closely watched and therefore may have a slight shake, I would like to reiterate this would be due to being nervous not alcohol related as insinuated.”

Further, Mr Maher's former representative at the RCN, on 19 November 2021 stated in a letter to the NMC that:

“The Registrant denies that he consumed alcohol prior to his shift and attended work under the influence of alcohol.

[…]

The Registrant denies that he was shaking while administering the syringe to the patient due to being under the influence of alcohol […] [PRIVATE]. This is in addition to the lack of training in using the syringe driver. He was also nervous as this was his first time working at the home and he was being watched closely by the paramedic. The culmination of these factors meant the Registrant regrettably left this impression on his colleagues that he was unable to perform this task.”

The panel bore in mind that there is a material conflict between the evidence of Colleagues X and Y, and that of Witness 1, which supports Mr Maher's denials. The panel assessed all of the evidence before it at this stage. It noted that both Colleague X and Y spent a more significant period in Mr Maher's presence, and their evidence is supported by contemporaneous concerns documented by the EMAS referral. They noted that Colleague Y stated that she had not observed Mr Maher other than from a distance.

The panel found Colleagues X and Ys evidence to be clear and consistent in that Colleague X was sure that Mr Maher was "*drunk*", and Colleague Y was clear that Mr Maher was *"physically shaking, very slurry when he was talking, wasn't walking straight and stumbling"*. The panel considered that it is unlikely that all such actions would be attributable to Mr Maher's nerves. The panel also found the action which Colleague Y took following Mr Maher leaving the Home, including making an immediate referral to his agency and requesting a different agency nurse for subsequent shifts, to be reliable in supporting her assertion that Mr Maher attended the Home whilst unfit through alcohol.

The panel accepted the hearsay evidence about the paramedics forming the same opinion because they had raised a safeguarding concern about Mr Maher being unfit for duty by reason of alcohol and that report was provided to the panel.

Accordingly, the panel preferred the evidence of Colleagues X and Y, and found that, on the balance of probabilities, Mr Maher attended/ worked a shift at the Home whilst unfit through alcohol.

The panel therefore found this charge proved.

Charge 2

2) Did not wear a face mask at all times during the shift.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague X, dated 20 July 2022, which states:

“Following the handover, I had a brief interaction with Mr Maher. During this interaction, I smelled alcohol on his breath as he was not wearing a face mask.”

The panel had regard Colleague X’s near-contemporaneous account of her concerns about Mr Maher, in which she stated:

“I came to work the night shift on 10th October 2021, and I noted that there was an agency nurse Sean Maher, booked to work the shift that night. When I got to work Sean was already there, and on brief interaction with him I smelled alcohol on his breath as he was not wearing a face mask.”

The panel found Colleague X’s oral evidence to be consistent with her previous statements.

The panel noted that this account was supported by the referral from EMAS dated 11 October 2021, which states:

“sean was not wearing ppe, when asked he did put on a mask.”

The panel also bore in mind that, in their oral evidence, both Colleague Y and Witness 1 said that at times during the shift, they observed Mr Maher not wearing a face mask.

The panel noted that Mr Maher has not provided any responses to this charge.

The panel concluded that there is clear, cogent and independently verified contemporaneous evidence before it to support this charge. It noted that the witnesses who gave evidence all provided a similar account of Mr Maher’s failure to wear a face mask, which was supported by the contemporaneous records of Colleague X and EMAS. The panel bore in mind that neither the witnesses or paramedics who attended the Home

had previously met or interacted with Mr Maher, therefore the potential for fabrication of this concern was low.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021, Mr Maher did not wear a face mask at all times during the shift.

The panel therefore found this charge proved.

Charges 3(a) and 3(b)

3) At around 22:00 for Resident A's PEG Feed;
    a) Informed Colleague X that you did not know how to administer PEG Feeds.
    b) Did not administer Resident A's PEG Feed.

These charges are found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague X, dated 20 July 2022, which states:

> *"Around 22:00, I told Mr Maher that it was time for Resident A's PEG feed. Mr Maher said he did not know how to do it. Witness 1 and Ms 2 had left the Home by this point and were not at the Home to assist.*
>
> *I told Mr Maher that I was not supposed to do this and that he was the nurse. However, he told me that he did not know how to do PEG feeds and asked me whether I could do it. As a carer, it is not part of my role to do residents' PEG feeds.*

A few weeks prior to this shift, I had been shown how to do PEG feeds because I was going to undertake further training to become a nurse. As Mr Maher was not going to do the PEG feed, I did it myself because if I did not do it, then the resident would not have had her feed or any fluids and I was worried about this.”

The panel had regard Colleague X’s near-contemporaneous account of her concerns about Mr Maher, in which she stated:

“After they had gone home Sean asked me to do a PEG feed which have been due at 10:00 PM. I told him that I was not supposed to do this and he was the nurse however he told me that he didn't know how to do peg feeds could I therefore do it. As I have been shown how to do peg feeds but it really is not my job I did the pig [sic] feed because if I didn't the lady would not have had her feed or any fluids, And I was worried about this.”

The panel found Colleague X’s oral evidence to be consistent with her previous statements.

The panel noted that Mr Maher has not provided any responses to this charge.

The panel concluded that there is clear and cogent evidence before it to support this charge. It noted that Colleague X gave clear oral evidence which was consistent with her contemporaneous statement given to the Home, and her NMC witness statement. The panel bore in mind that Colleague X had not previously met or interacted with Mr Maher, therefore the potential for fabrication of this concern was low.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021, Mr Maher informed Colleague X that he did not know how to administer PEG feeds, and did not administer Resident A’s PEG feed.

The panel therefore found these charges proved.

Charge 3(c)

3) At around 22:00 for Resident A’s PEG Feed;

    […]

    c) Inappropriately delegated/instructed Colleague X a health care assistant to conduct Resident A’s PEG Feed.

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague X, dated 20 July 2022, which states:

> *“Around 22:00, I told Mr Maher that it was time for Resident A’s PEG feed. Mr Maher said he did not know how to do it. Witness 1 and Ms 2 had left the Home by this point and were not at the Home to assist.*
>
> *I told Mr Maher that I was not supposed to do this and that he was the nurse. However, he told me that he did not know how to do PEG feeds and asked me whether I could do it. As a carer, it is not part of my role to do residents' PEG feeds.*
>
> *A few weeks prior to this shift, I had been shown how to do PEG feeds because I was going to undertake further training to become a nurse. As Mr Maher was not going to do the PEG feed, I did it myself because if I did not do it, then the resident would not have had her feed or any fluids and I was worried about this.”*

The panel had regard Colleague X’s near-contemporaneous account of her concerns about Mr Maher, in which she stated:

> *“After they had gone home Sean asked me to do a PEG feed which have been due at 10:00 PM. I told him that I was not supposed to do this and he was the nurse however he told me that he didn't know how to do peg feeds could I therefore do it. As I have been shown how to do peg feeds but it really is not my job I did the pig [sic] feed because if I didn't the lady would not have had her feed or any fluids, And I was worried about this.”*

The panel had regard to Colleague X’s oral evidence in which she outlined that Mr Maher had not at any point asked her to conduct Resident A’s PEG feed, but instead she had assumed this responsibility herself as she considered that, if she had not done so, Resident A would not have received feed or fluids

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN, on 19 November 2021 stated in a letter to the NMC that: *“the Registrant denies that he delegated the administration of a peg feed to a care assistant and will say that he did not give her instructions to do this.”*

The panel had regard to all of the evidence before it. It bore in mind that there is evidence before it that administering residents’ PEG feeds at the Home was the responsibility of nursing staff. However, given the evidence of Colleague X, that she assumed the responsibility for Resident B’s PEG feed, the panel was not satisfied that there was sufficient evidence before it that Mr Maher delegated or instructed Colleague X to do so.

The panel therefore found this charge not proved.

Charge 4a)

> 4) Between 00:10 and 02:30 during Resident B’s seizure;

a) Did not know the difference between a resident’s nurse call buzzer and a seizure alarm.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague X, dated 20 July 2022, which states:

> *“I realised that it was not the resident's nurse call buzzer but that it was Resident B's seizure alarm that was sounding. The seizure alarm sounds completely different to the nurse call buzzer. I thought that Mr Maher would know the difference between the alarms as he was an agency nurse and had worked at different homes.”*

The panel bore in mind that Colleague X gave significant oral evidence on this charge, including a description of how each buzzer sounded, and that seizure mat alarms were not capable of being reset from central panels. It found this evidence to be clear. However, it bore in mind that she said that the alarm systems were quite old and were fixed soon after Mr Maher worked at the Home.

The panel also had regard to the oral evidence of Colleague Y, who said that an explanation of the different alarms should always form part of the nurse handover to a member of staff who has not worked at the unit before. However, Witness 1, who handed over to Mr Maher accepted that she did not provide a description or demonstration of the alarms during her handover to Mr Maher.

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN on 19 November 2021 stated in a letter to the NMC that: *“He also denies that he failed to take appropriate action when a patient had a seizure as he had no knowledge this was the case.”*

On the basis of the evidence before it, the panel were satisfied that, on the balance of probabilities, Mr Maher did not know the difference between a resident's nurse call buzzer and a seizure alarm. The panel bore in mind that, given the evidence that Witness 1 had not informed him of the difference between these alarms, the criticism which may be levelled at him for his lack of knowledge in this regard is a matter which should be properly considered at the misconduct stage.

The panel therefore found this charge proved.

Charge 4b)

4) Between 00:10 and 02:30 during Resident B's seizure;
   […]
   b) Did not react to Resident B's seizure in a timely manner.

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague X, dated 20 July 2022, which states:

> *"Later in the shift, Mr Maher was upstairs when a resident's alarm sounded. I do not recall the exact time but the whole incident between 00:10 and 02:30. The resident involved was Resident B. Mr Maher came down approximately five minutes after the alarm had started. Mr Maher said that he could not find the buzzer to turn it off.*
>
> *I told Mr Maher that I would show him where the buzzer is. As I got to the bottom of the stairs, I realised that it was not the resident's nurse call buzzer but that it was Resident B's seizure alarm that was sounding."*

The panel had regard Colleague X's near-contemporaneous account of her concerns about Mr Maher, in which she stated:

> *"Sean was upstairs when Resident B's alarm sounded and he came down about 5 minutes later to say he could not find the buzzer to turn it off. So I told him I would show him and I got to the bottom of the stairs and I realised that it was not her nurse call but her seizure alarm that was sounding. So I ran upstairs and Resident B was having seizures. she was having these seizures for 7 minutes under the nurse had not acted upon this, Resident B was really hot and I was holding her hand and as the nurse had not acted he was just standing there looking clueless , I rang 999, as I could not trust him to do anything or act upon what was in front of him.."*

The panel noted that, while Colleague X had given differing accounts about where in the building Mr Maher was when the alarm sounded, she had always said that he reacted immediately to it.

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN on 19 November 2021 stated in a letter to the NMC that: *"He also denies that he failed to take appropriate action when a patient had a seizure as he had no knowledge this was the case."*

The panel had regard to the wording of this charge. The panel read this charge to relate to Mr Maher's actions upon hearing the alarm, and not his reaction to the seizure, which is the mischief alleged within charge 5. In light of this, the panel concluded that the NMC had not adduced sufficient evidence that Mr Maher failed to react to Resident B's seizure in a timely manner, given Colleague X's evidence that he responded immediately to Resident B's seizure mat buzzer.

Accordingly, the panel found this charge not proved.

Charges 5(a), 5(b) and 5(c)

5) Did not take adequate steps in response to Resident B's seizure, in that you did not;
    a) Call emergency services
    b) Attend to Resident B
    c) Conduct observations of Resident B

These charges are found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague X, dated 20 July 2022, which states:

> *"I ran upstairs to Resident B's bedroom and saw the resident having a seizure. By this point, it was approximately seven minutes after the alarm had first sounded. It had been five minutes when mr Maher [sic] came to see me and took me two minutes to get to Resident B's room. I estimated that Resident B had been having a seizure for approximately seven minutes and that Mr Maher had not acted during this time. Resident B was really hot and I was holding her hand.*
>
> *Mr Maher did not act and just stood there looking clueless and was expecting me to do something. I called 999, as I could not trust him to do anything or act upon what was in front of him.."*

The panel had regard Colleague X's near-contemporaneous account of her concerns about Mr Maher, in which she stated:

"Resident B was really hot and I was holding her hand and as the nurse had not acted he was just standing there looking clueless , I rang 999, as I could not trust him to do anything or act upon what was in front of him."

The panel found Colleague X's oral evidence in respect of these charges to be consistent with her previous statements. It bore in mind that both Colleague X and Colleague Y clearly recounted that Colleague X called the emergency services to attend to Resident B, after Colleague X had called Colleague Y.

The panel noted that Colleague X's account was supported by the referral from EMAS, dated 11 October 2021, which states:

"sean said he was an agency nurse and was unaware of pt medication /condition. 999 was called by caere [sic] as she was unsure what to do and stated the nurse on scene was unsure how to manage pt"

It also bore in mind that there is no documentary evidence before it, such as contemporaneous patient notes, which would suggest that Mr Maher called the emergency services, attended to Resident B and/or conducted observations of Resident B.

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN on 19 November 2021 stated in a letter to the NMC that: *"He also denies that he failed to take appropriate action when a patient had a seizure as he had no knowledge this was the case."*

The panel concluded that there is clear and cogent evidence before it to support these charges. It noted that Colleague X gave clear oral evidence which was consistent with her contemporaneous statement given to the Home, and her NMC witness statement. The panel bore in mind that Colleague X had not previously met or interacted with Mr Maher, therefore the potential for fabrication of this concern was low. The panel also accepted

and took account of Colleague Y's evidence that Colleague X was highly distressed when she called Colleague Y.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021, Mr Maher did not take adequate steps in response to Resident B's seizure, in that he did not call emergency services, attend to Resident B and/or conduct observations of Resident B.

The panel therefore found this charge proved.

Charge 5(d)

5) Did not take adequate steps in response to Resident B's seizure, in that you did not;

    […]

    d) Make a decision to administer controlled drugs to Resident B.

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague X, dated 20 July 2022, which states:

> *"Mr Maher did not act and just stood there looking clueless and was expecting me to do something. I called 999, as I could not trust him to do anything or act upon what was in front of him.."*

The panel noted that Colleague X's account was supported by the referral from EMAS, dated 11 October 2021.

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN on 19 November 2021 stated in a letter to the NMC that: *"He also denies that he failed to take appropriate action when a patient had a seizure as he had no knowledge this was the case."*

The panel had regard to the documentary evidence before it in respect of this charge. It noted that it had before it the controlled drug book in respect of Resident B, and that Mr Maher had signed against the administration of Midazolam, for two doses. In the light of this record, the panel found that there was evidence before it that Mr Maher had made a decision to administer controlled drugs to Resident B, in response to their seizure.

Accordingly, the panel found this charge not proved.

Charge 6

6) On one or more occasions administered morphine to Resident B without;
   a) Ensuring that another member of staff acted as second checker.
   b) Ensuring that another member of staff signed the controlled drug book

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague X, dated 20 July 2022, which states:

> *"After the paramedics had gone, I witnessed Mr Maher giving a dose of morphine to Resident B in her right arm.*
>
> *The normal practice when a nurse administers a controlled drug, is that I go to the medication cupboard with the nurse who then shows me how much medication they are giving out, and they record this in the controlled drug*

> *book and how much medication is left. I then act as a second check and then sign the controlled drug book.*
>
> *I was in the cupboard witnessing him doing the administration but Mr Maher did not ask me to sign as a witness in the Controlled Drug book. I was really busy at this point because I was answering buzzers."*

The panel had regard Colleague X's near-contemporaneous account of her concerns about Mr Maher, in which she stated:

> *"I then went about my jobs and the paramedic went and an out of hours nurse came and sat with me and the nurse told us it was okay to give more morphine 2 1/2 hours later to keep Resident B relaxed and not in pain. I witnessed the nurse giving more morphine but he did not asked me to sign as a witness in the CD book. he gave it in her right arm..."*

The panel found Colleague X's oral evidence to be consistent with her previous statements, in that she said that she witnessed Mr Maher in the drug cupboard preparing and then subsequently administering morphine to Resident B, however she was not asked at any stage to act as second checker.

The panel also had regard to the documentary evidence before it. It noted that the controlled drug book for morphine in respect of Resident B does not record that morphine was taken out, signed or checked by Mr Maher or any other member of staff on the night of 10 to 11 October 2021. However, it demonstrates that an ampoule of morphine was missing and not accounted for at some stage following this shift.

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN on 19 November 2021 stated in a letter to the NMC that: "*he however accepts that he did not record the second medication administration. The Registrant had started work at 7.30pm and gave the first injections at*

1am and the second one six hours later, shortly before he was due to handover. The injections were morphine sulphate and midazolam. This was an unfortunate oversight by him and he states if he was notified during the shift of his mistake, he would have returned to record this correctly. We submit that this error was a one-off incident which will not be repeated by him."

The panel concluded that there is clear and cogent evidence before it to support these charges. It noted that Colleague X gave clear oral evidence which was consistent with her contemporaneous statement given to the Home, and her NMC witness statement. The panel bore in mind that Colleague X had not previously met or interacted with Mr Maher, therefore the potential for fabrication of this concern was low. Further, the panel noted that Mr Maher seemingly accepted these concerns, via a letter from the RCN on 19 November 2021 which specifically refers to morphine sulphate.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021, Mr Maher, on one or more occasions administered morphine sulphate to Resident B without ensuring that another member of staff acted as second checker and ensuring that another member of staff signed the controlled drug book.

The panel therefore found this charge proved.

Charge 7

7) At around 05:00;
    a) Instructed Colleague X to complete your nursing document.
    b) Used words to the effect; *'the agency should have told you (the Home), I don't do computers.'*

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague X, dated 20 July 2022, which states:

> *"At approximately 05:00, Mr Maher asked me to write his nursing documentation such as blood sugar readings. The nursing documentation is completed on the Home's computer. I told him no and that I had my own paperwork to do and that it was his responsibility. Mr Maher said that the agency should have told us at the Home that he does not do computers."*

The panel found Colleague X's oral evidence to be consistent with her previous statements, in that she could clearly recall the conversation which she had with Mr Maher in which he instructed her to complete his nursing document and told her that he does *"not do computers"*. It noted that Colleague X, Colleague Y and Witness 1 gave clear and consistent evidence as to how agency staff logged into the patient record system at the Home.

The panel also had regard to the documentary evidence before it. It bore in mind that Resident B's daily notes from 10 and 11 October 2021 do not demonstrate that any update was provided from Mr Maher in respect of this shift.

The panel noted that Mr Maher has not responded to this charge.

The panel concluded that there is clear and cogent evidence before it to support these charges. It noted that Colleague X gave clear oral evidence which was consistent with her NMC witness statement. The panel bore in mind that Colleague X had not previously met or interacted with Mr Maher, therefore the potential for fabrication of this concern was low.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021, Mr Maher, instructed Colleague X to complete his nursing

document and used words to the effect; *'the agency should have told you (the Home), I don't do computers.'*

The panel therefore found this charge proved.

Charge 8

8) During your handover with Colleague Y;
   a) Incorrectly informed Colleague Y that all of the Residents were fine.
   b) Had to be prompted to disclose information about Resident B's seizure.
   c) Were unable to recall what end of life drugs you had administered to Resident B.
   d) Were unable to recall;
      i) The dose of medication administered to Resident B.
      ii) The frequency of medication administered to Resident B

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague Y, dated 21 July 2022, which stated:

> *" […] He did not provide a detailed handover and just said that everything had been fine and that all of the residents in the Home were fine. I had to ask Mr Maher for more detail about the residents.*
>
> *I knew from my telephone call with Colleague Y and the paramedic that Resident B had had a seizure during the night shift. However, Mr Maher did not give me any information during the handover about Resident B and her seizure. I had to ask him about Resident B. Mr Maher said that the paramedics told him that she had a seizure and he said that the paramedics*

instructed him to give controlled drugs. Mr Maher said that he gave end of life medication to Resident B but he was unable to say what medication he administered and how many times it was administered. Mr Maher did not give a lot of detail about Resident B considering that she had suffered a seizure during the night.

I felt upset after the handover as I felt that Mr Maher had not given me any information about any residents at the Home."

The panel found Colleague Y's oral evidence to be consistent with her statement. It found that she clearly outlined what information would have expected to have been provided in a handover, and that she asked Mr Maher about each resident in turn. In respect of Resident B, Colleague Y told the panel that she had to inform Mr Maher that she was aware that the paramedics had been called to prompt him to disclose this information. She said that, when asked what medication he administered to Resident B. Mr Maher responded with "*end of life medications*", but was unable to recall which specific medication and the dose and the frequency of such medication administered to Resident B.

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN on 19 November 2021 stated in a letter to the NMC that: *"He also denies that he failed to take appropriate action when a patient had a seizure as he had no knowledge this was the case."*

The panel concluded that there is clear and cogent evidence before it to support these charges. The panel accepted the evidence that Resident B had suffered a seizure. It noted that Colleague Y gave clear oral evidence, which was consistent with her NMC witness statement.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021 and during his handover with Colleague Y, Mr Maher

incorrectly informed Colleague Y that all of the residents were fine, had to be prompted to disclose information about Resident B’s seizure, was unable to recall what end of life drugs were administered to Resident B and was unable to recall the dose and frequency of medication administered to Resident B.

The panel therefore found this charge proved.

Charge 9

9) Did not sign out a dose of Midazolam from the controlled drugs book.

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to Resident B’s controlled drug book.

The panel had regard to the witness statement of Colleague Y, dated 21 July 2022, which states:

> *“When the Community Matron arrived, we counted Resident B's controlled drugs which is the normal practice before administering any controlled drug. Upon counting the controlled drugs, we noticed that the count was wrong and that there was one dose of midazolam missing which really alarmed me. I do not know where the missing dose of midazolam went and it was never found.”*

However, the panel noted that, during her oral evidence, Colleague Y accepted that the controlled drug book, which is before the panel, suggests that Mr Maher signed out two doses of Midazolam for Resident B.

In light of this, the panel found that there was evidence before it which directly contradicted this charge. It concluded that there was clearly an error in counting Resident B's Midazolam, however it could not be satisfied that such error was attributable to Mr Maher. This was because the error was not discovered for some days.

Accordingly, the panel found this charge not proved.

Charge 10

10) Did not record a retrospective entry in the controlled drugs book to declare the failure to sign out Midazolam.

This charge is found NOT proved.

The panel bore in mind that this charge is reliant upon charge 9. Having found no failure in respect of charge 9, the panel was found that this charge is not capable of being found proved.

Accordingly, the panel found this charge not proved.

Charge 11

11) Did not sign out a dose of Morphine Sulphate from the controlled drugs book.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague Y, dated 21 July 2022, which states:

“[…] I recorded in the incident form that after setting up the syringe driver for Resident B we found the amount of medications for Resident B's midazolam and morphine did not add up right so we both recounted. Ms 3 double counted so that we could identify what had gone wrong, however on doing so we established one Midazolam missing after the recount.

We carried out a further investigation to determine the cause for the missing medication. A dose was allegedly not signed out of the controlled drug book by Mr Maher. However, at the time of finding there was also an omission to declare the error in the controlled drug book and transparency was not followed through.”

The panel found Colleague Y’s oral evidence to be consistent with her statement. It found that she clearly outlined the steps she took to identify the error, and how the stock check identified the absence of a record in respect of one missing dose of Morphine Sulphate. The panel noted that this concern is supported by contemporaneous incident reports completed by both Colleague Y on 11 October 2021 and Mr 4 on 13 October 2021.

The panel also had regard to Resident B’s controlled drug book for October 2021. It noted that there is no entry to indicate that a dose of Morphine Sulphate was signed out of the controlled drugs book by Mr Maher on 10 or 11 October 2021.

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN on 19 November 2021 stated in a letter to the NMC that: “*he however accepts that he did not record the second medication administration. The Registrant had started work at 7.30pm and gave the first injections at 1am and the second one six hours later, shortly before he was due to handover. The injections were morphine sulphate and midazolam. This was an unfortunate oversight by him and he states if he was notified during the shift of his mistake, he would have returned to record this correctly. We submit that this error was a one-off incident which will not be repeated by him.”*

The panel concluded that there is clear and cogent evidence before it to support these charges. It noted that Colleague Y gave clear oral evidence, which was consistent with her NMC witness statement, and was supported by contemporaneous incident reports. Further, the panel noted that Mr Maher seemingly accepted these concerns, via a letter from the RCN on 19 November 2021.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021, Mr Maher, did not sign out a dose of Morphine Sulphate from the controlled drugs book.

The panel therefore found this charge proved.

Charge 12

> 12) Did not record a retrospective entry in the controlled drugs book to declare the failure to sign out Morphine Sulphate.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the witness statement of Colleague Y, dated 21 July 2022, which states:

> *"[…] I recorded in the incident form that after setting up the syringe driver for Resident B we found the amount of medications for Resident B's midazolam and morphine did not add up right so we both recounted. Ms 3 double counted so that we could identify what had gone wrong, however on doing so we established one Midazolam missing after the recount.*

We carried out a further investigation to determine the cause for the missing medication. A dose was allegedly not signed out of the controlled drug book by Mr Maher. However, at the time of finding there was also an omission to declare the error in the controlled drug book and transparency was not followed through.”

The panel found Colleague Y’s oral evidence to be consistent with her statement. It found that she clearly outlined the steps she took to identify the error, and how the stock check identified the absence of a record in respect of one missing dose of Morphine Sulphate. The panel noted that this concern is supported by contemporaneous incident reports completed by both Colleague Y on 11 October 2021 and Mr 4 on 13 October 2021.

The panel also had regard to Resident B’s controlled drug book for October 2021. It noted that there is no retrospective entry to indicate a previous failure to declare that a dose of morphine sulphate was signed out of the controlled drugs book by Mr Maher on 10 or 11 October 2021.

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN on 19 November 2021 stated in a letter to the NMC that: “*he however accepts that he did not record the second medication administration. The Registrant had started work at 7.30pm and gave the first injections at 1am and the second one six hours later, shortly before he was due to handover. The injections were morphine sulphate and midazolam. This was an unfortunate oversight by him and he states if he was notified during the shift of his mistake, he would have returned to record this correctly. We submit that this error was a one-off incident which will not be repeated by him.”*

The panel concluded that there is clear and cogent evidence before it to support these charges. It noted that Colleague Y gave clear oral evidence, which was consistent with her NMC witness statement, and was supported by contemporaneous incident reports.

Further, the panel noted that Mr Maher seemingly accepted these concerns, via a letter from the RCN on 19 November 2021.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021, Mr Maher, did not record a retrospective entry in the controlled drugs book to declare the failure to sign out Morphine Sulphate.

The panel therefore found this charge proved.

Charge 13

13) Did not escalate the failure to sign out a dose of Midazolam/Morphine Sulphate to a manager.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had regard to its findings in respect of charges 9 and 10, and therefore interpreted this charge in relation to Mr Maher's failure to sign out a dose of morphine sulphate only. It had particular regard to the witness statement of Colleague Y, dated 21 July 2022, which states:

> *"[…] I recorded in the incident form that after setting up the syringe driver for Resident B we found the amount of medications for Resident B's midazolam and morphine did not add up right so we both recounted. Ms 3 double counted so that we could identify what had gone wrong, however on doing so we established one Midazolam missing after the recount.*
>
> *We carried out a further investigation to determine the cause for the missing medication. A dose was allegedly not signed out of the controlled drug book by Mr Maher. However, at the time of finding there was also an omission to*

declare the error in the controlled drug book and transparency was not followed through."

The panel found Colleague Y's oral evidence to be consistent with her statement. It found that she clearly outlined the steps she took to identify the error, and how the stock check identified the absence of a record in respect of one missing dose of morphine sulphate and that neither she nor a manager at the Home were aware of Mr Maher's failure to sign out a dose of morphine sulphate until after he left the Home. The panel noted that this concern is supported by contemporaneous incident reports completed by both Colleague Y on 11 October 2021 and Mr 4 on 13 October 2021.

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN on 19 November 2021 stated in a letter to the NMC that: "*he however accepts that he did not record the second medication administration. The Registrant had started work at 7.30pm and gave the first injections at 1am and the second one six hours later, shortly before he was due to handover. The injections were morphine sulphate and midazolam. This was an unfortunate oversight by him and he states if he was notified during the shift of his mistake, he would have returned to record this correctly. We submit that this error was a one-off incident which will not be repeated by him."*

The panel concluded that there is clear and cogent evidence before it to support these charges. It noted that Colleague Y gave clear oral evidence, which was consistent with her NMC witness statement, and was supported by contemporaneous incident reports. Further, the panel noted that Mr Maher seemingly accepted these concerns, via a letter from the RCN on 19 November 2021.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021, Mr Maher, did not escalate the failure to sign out a dose of Morphine Sulphate to a manager.

The panel therefore found this charge proved.

Charge 14

14) Did not complete an incident report in relation to the failure to sign out Midazolam/Morphine Sulphate.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had regard to its findings in respect of charges 9 and 10, and therefore interpreted this charge in relation to Mr Maher's failure to sign out a dose of morphine sulphate only. It had particular regard to the witness statement of Colleague Y, dated 21 July 2022, which states:

> *"[…] I recorded in the incident form that after setting up the syringe driver for Resident B we found the amount of medications for Resident B's midazolam and morphine did not add up right so we both recounted. Ms 3 double counted so that we could identify what had gone wrong, however on doing so we established one Midazolam missing after the recount.*
>
> *We carried out a further investigation to determine the cause for the missing medication. A dose was allegedly not signed out of the controlled drug book by Mr Maher. However, at the time of finding there was also an omission to declare the error in the controlled drug book and transparency was not followed through."*

The panel found Colleague Y's oral evidence to be consistent with her statement. It found that she clearly outlined the steps she took to identify the error, and how the stock check identified the absence of a record in respect of one missing dose of morphine sulphate.

She clearly explained how an incident report should have been, but was not, completed when controlled drugs such as morphine sulphate should have been, but were not, signed out. The panel noted that this concern is supported by contemporaneous incident reports completed by both Colleague Y on 11 October 2021 and Mr 4 on 13 October 2021. The panel noted that there is no contemporaneous incident report completed by Mr Maher before the panel.

The panel noted that Mr Maher has not provided any responses to this charge as drafted, however, his former representative at the RCN on 19 November 2021 stated in a letter to the NMC that: "*he however accepts that he did not record the second medication administration. The Registrant had started work at 7.30pm and gave the first injections at 1am and the second one six hours later, shortly before he was due to handover. The injections were morphine sulphate and midazolam. This was an unfortunate oversight by him and he states if he was notified during the shift of his mistake, he would have returned to record this correctly. We submit that this error was a one-off incident which will not be repeated by him.*"

The panel concluded that there is clear and cogent evidence before it to support these charges. It noted that Colleague Y gave clear oral evidence, which was consistent with her NMC witness statement, and was supported by contemporaneous incident reports, and the absence of an incident report completed by Mr Maher. Further, the panel noted that Mr Maher seemingly accepted these concerns, via a letter from the RCN on 19 November 2021.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021, Mr Maher, did not complete an incident report in relation to the failure to sign out morphine sulphate.

The panel therefore found this charge proved.

Charge 15

15) Did not make adequate records/entries in Resident B’s daily notes, that you;

a) Did not record that Resident B suffered a seizure.
b) Did not record that paramedics attended the Home/Resident B.
c) Did not record Resident B’s diet and fluid intake.
d) […]
e) Did not record the administration of one or more controlled drugs to Resident B.
f) Did not record the frequency/dose of the medications to Resident B.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence before it. It had particular regard to the witness statement of Colleague Y, dated 21 July 2022, which states:

> *“Mr Maher did not record any entries in the resident's notes during the night shift despite the resident having a seizure and the paramedic being called to the Home.*
>
> *If I have been working during the night shift, I would have recorded a detailed entry in the resident's notes which I expected Mr Maher as a registered nurse to have done as well. The entry should have included the number of seizures that the resident had during the shift and that the paramedics had attended. The entry should also include the resident's diet and fluid intake, and that her daughter had been present at the Home during the night. It should be a detailed entry because it was an urgent and serious event that happened.*
>
> *The administration of medication is recorded on resident's medication charts.*

However, I also expected Mr Maher to record in the resident's daily notes, as a backup, what medication was administered and how often this is given.
35. Mr Maher's failure to record an entry in the resident's notes can have an impact on the care provided. I was only aware from the night carer that the resident had a seizure and had been administered controlled drugs. If I had relied on the resident's daily notes I would have been unaware of this. If the resident had another seizure during the day, I would not have been able to provide accurate information to paramedics or doctors who would need to know how many seizures the resident has had over the last 24 hours and when the seizures were."

The panel found Colleague Y's oral evidence to be consistent with her previous statement. It found that she clearly outlined what information should be in Resident B's daily notes to ensure continuity of care and to avoid inadvertent overdose. In her oral evidence, Colleague Y was clear that such detail was not contained within Resident B's daily notes.

The panel also had regard to Resident B's daily notes, which were before it. It noted that there were no contemporaneous records or entries from 10/ 11 October 2021 input by Mr Maher or any other member of staff which related to Resident B's seizure, the paramedics attending the Home, Resident B's diet and fluid intake, the administration of controlled drugs to Resident B, and the frequency of the administration of such controlled drugs.

The panel noted that Mr Maher has not responded to this charge.

The panel concluded that there is clear and cogent evidence before it to support these charges. It noted that Colleague Y gave clear oral evidence, which was consistent with her NMC witness statement, and was supported by the absence of detail withing Resident B's daily notes.

Accordingly, the panel found that, on the balance of probabilities, whilst working at the Home on 10/11 October 2021, Mr Maher, did not make adequate records/entries in

Resident B's daily notes in that he did not record that Resident B suffered a seizure, did not record that paramedics attended the Home/ Resident B, did not record Resident B's diet and fluid intake, did not record the administration of one or more controlled drugs to Resident B and did not record the frequency/ dose of medications to Resident B.

The panel therefore found this charge proved.

Fitness to practise

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

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* The panel had regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) in making its decision.

Submissions on misconduct

Mr Lloyd invited the panel to take the view that the facts found proved amount to misconduct.

Mr Lloyd identified 18 specific standards where he submitted that Mr Maher's actions amounted to misconduct.

Mr Lloyd submitted that the facts found proved individually and collectively fall below the standards expected of a registered nurse, which he said include and encompass breaches of policies in place at the Home at the time, and the NMC Code. Mr Lloyd submitted that Mr Maher's actions involve serious misconduct which breaches the fundamental tenets of nursing and would be regarded as deplorable by other registered nurses. He said that such misconduct involved a failure to provide care promptly, work in co-operation with other healthcare professionals, keep proper patient records and ensure patient safety. He submitted that poor communication could impact on the ability of other healthcare professionals to provide continuity of care and give rise to a serious risk of harm to patient safety, including the potential for controlled drugs to be wrongly administered.

In light of this, Mr Lloyd submitted that this is a matter in which misconduct is plainly established.

Submissions on impairment

Mr Lloyd 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 Lloyd invited the panel to have regard to the NMC guidance on impairment, he said that this is a forward-thinking exercise which requires the panel to consider whether Mr Maher's misconduct is capable of remediation, whether Mr Maher has taken remedial action, and whether his misconduct is likely to be repeated.

In respect of whether Mr Maher's misconduct is capable of remediation, Mr Lloyd submitted that there is no evidence of a deep-seated attitudinal concern, therefore Mr Maher's failings are capable of being remediated, for example, through proper training, thorough insight and acknowledgement of his previous misconduct.

However, Mr Lloyd submitted that there is no evidence before the panel that Mr Maher has taken any remedial action in this matter. He said that Mr Maher has not worked as a nurse since he was referred to the NMC and he has chosen not to provide evidence from which the panel can consider his insight, save for some acceptance on his part in respect of controlled drug administration and recording errors. Mr Lloyd said that Mr Maher has not provided evidence of continued professional development, insight or a reflective piece to demonstrate insight into his failings. Therefore, there is no evidence of insight of remediation.

In respect of the likelihood of repetition, Mr Lloyd submitted that Mr Maher's failings are significant, for which he has not offered an explanation, targeted insight or reflection. In light of this, Mr Lloyd submitted that, in the absence of any explanation from Mr Maher, the panel might be concerned that this was not a one-off incident nor caused by a particular set of events. Mr Lloyd submitted that there is a risk of repetition, and that a finding of impairment is necessary on the grounds of public protection and also in the wider public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cheatle v GMC* [2009] EWHC 645 (Admin), *Cohen v GMC* [2008] EWHC 581 (Admin), *Nandi v General Medical Council* [2004] EWHC 2317

(Admin), *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, and *Spencer v General Osteopathic Council* [2012] EWHC 3147 (Admin).

Decision and reasons on misconduct

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

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

13 Recognise and work within the limits of your competence

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

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

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

19 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

To achieve this, you must:

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

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

To achieve this, you must:

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel decided that all of the charges individually and collectively would be regarded as deplorable by Mr Maher's nursing colleagues, and fall seriously short of the standards expected of a registered nurse to be sufficiently serious to amount to misconduct, save for charges 3a, 4a, 7, 12, 13 and 14.

In respect of charge 3a, the panel concluded that, although Mr Maher had a responsibility as a registered nurse to only agree to undertake work for which he was suitably trained to carry out competently. Informing Colleague X of the limitations of his clinical competencies and experience was not sufficiently serious to amount to misconduct.

In respect of charge 4a, the panel had regard to the evidence that this was Mr Maher's first shift at the Home. During his induction he was not told about the difference between by the sound made by a resident's nursing call alert and a seizure alarm. The panel was told by Colleague Y that this should have formed part of his induction. It also noted the evidence of Colleague X, that there were faults in the alarm systems at the Home. In the circumstances where such deficiencies in the induction and alarm system were present, the panel concluded that Mr Maher not knowing the difference between a resident's nurse call buzzer and a seizure alarm was not misconduct.

In respect of charge 7, the panel had regard to the mischief alleged and concluded that a registered nurse asking a health care assistant to input his clinical notes on a computerised system, and telling Colleague X that *"the agency should have told you, I don't do computers"* was not sufficiently serious to amount to misconduct.

In respect of charges 12 – 14, the panel had regard to Mr Maher's previous responses to this regulatory concern, in which he accepts that he made a medication error, albeit he was not aware of his error at the time. The panel also had regard to the evidence of Colleague Y that the error was not discovered until Mr Maher had left the Home. In light of this, the panel concluded that it would be unreasonable to expect Mr Maher to have taken remedial action, as set out in charges 12 - 14 in respect of an error which he did not know he had made. In these circumstances, the panel concluded that Mr Maher's failings in respect of charges 12 – 14 were not sufficiently serious to amount to misconduct.

Notwithstanding its findings above, the panel found that Mr Maher's actions 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 Maher'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. 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;

d) […].'

The panel found that the first three limbs of the above test are engaged in this case. Mr Maher put all residents at the home at risk by attending his shift whilst unfit to work and because of his poor handling of controlled drugs. He put Resident B at risk through his failure to respond effectively to the seizure. Additionally, his actions overall put the reputation of the nursing profession into disrepute; members of the public would be appalled to learn about Mr Maher's misconduct, including that he attended a shift as the sole registered nurse to care for vulnerable people whilst unfit to do so. His actions breached fundamental tenets of the nursing profession relating to minimising harm associated with his practice and promoting professionalism.

Regarding insight, the panel noted that although Mr Maher was initially represented and engaged with the NMC following his referral, the most recent correspondence about his current circumstances is dated 27 July 2022, in which Mr Maher stated: *"nothing has changed or needs updating from last time. I no longer work as a nurse or haven't done so since all this began."*. The panel concluded that, although Mr Maher made some early concessions to medication errors, there is no recent evidence before it which demonstrates insight.

The panel was satisfied that the misconduct in this case is capable of being addressed. The panel carefully considered whether or not Mr Maher has taken steps to strengthen his practice. The panel noted that there is no evidence of strengthened practice such as training, professional development or a thorough reflective piece in relation to the areas of concern.

The panel noted that the charges related to a single agency shift, however, in the absence of any evidence of Mr Maher's insight or remediation, it is of the view that there is a risk of repetition. Consequently, the first three limbs of the *Grant* test are also made out in relation to future risk. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

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

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

Sanction

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

Mr Lloyd invited the panel to have regard to the NMC guidance on sanctions alongside the NMC guidance on serious offences. He said that the panel must impose a proportionate sanction, being the least restrictive which provides the necessary level of public protection and declares, maintains and upholds the proper standards of conduct for a registered nurse. He reminded the panel that the purpose of this exercise is not to punish Mr Maher, however, submitted that the appropriate sanction on this matter is a striking-off order.

Mr Lloyd addressed the panel on the aggravating features of this matter, which he identified as:

- The nature of the concerns in this matter are serious and varied;
- Mr Maher's attendance at the Home whilst intoxicated;
- Mr Maher's lack of engagement, remediation, remorse or insight;
- Mr Maher's position of responsibility as the only registered nurse at the Home on the shift; and

- Misconduct which posed significant risk of harm to residents in his care.

Mr Lloyd addressed the panel on the mitigating features of this matter, which he identified as:

- Mr Maher has no fitness to practise history before his regulator;
- Mr Maher has previously engaged with the NMC to a limited extent.

Mr Lloyd submitted that the panel must consider the appropriate sanction to address Mr Maher's impairment. He invited the panel to have regard to the NMC guidance on suspension orders and said that part of the checklist contained within that guidance may appear to have some relevance in this case. He said, for example, that there is no suggestion of repetition of the type of conduct found proved, and the possibility that the charges should be considered to be a single instance of misconduct. However, Mr Lloyd said that, although Mr Maher's failings took place on a single shift, it could not be classed as a single instance of misconduct within it. Further, he said that Mr Maher has not demonstrated sufficient remediation to make a suspension order appropriate.

Mr Lloyd invited the panel to have regard to the NMC guidance on striking off orders. He said that this is a sanction of last resort, and there must be serious concerns present for such an order to be warranted. Mr Lloyd submitted that, in this case, a striking off order is appropriate and necessary. This is because the regulatory concerns are associated with fundamental questions about Mr Maher's professionalism, fitness to provide appropriate care, and cooperation with colleagues.

Further, Mr Lloyd submitted that, were Mr Maher permitted to practise as a nurse in any manner, even under restrictions, public confidence in the nursing profession and the NMC as a regulator would be undermined. He said that a member of the public fully aware of these facts would expect nothing short of a striking off order.

Decision and reasons on sanction

Having found Mr Maher’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:

- Absence of insight into his failings;
- Mr Maher’s behaviour comprised a series of serious failings within a single shift;
- Failings in a position of responsibility as the sole registered nurse on the shift;
- Working as a registered nurse whilst intoxicated; and
- Mr Maher’s conduct put residents at risk of suffering harm.

The panel also took into account the following mitigating feature:

- Some early limited acknowledgements of failings in respect of the medication errors.

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 had regard to Mr Lloyd’s submissions and the NMC guidance FTP-3 *“how we determine seriousness”* and determined that this matter is serious and falls into the category of *“serious concerns based on the need to promote public confidence in nurses, midwives and nursing associates”*. The panel determined that it was particularly serious that Mr Maher attended for work at the Home whilst unfit through alcohol consumption. It bore in mind that he was the only registered nurse on that shift and was directly responsible for the welfare of the numerous residents in his care. The panel had regard to its findings on impairment and

noted that Mr Maher exposed residents to a risk of harm as a result of his misconduct. Accordingly, 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 and public interest issues identified, an order that does not restrict Mr Maher's practice would not be appropriate in the circumstances. 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 Maher'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 Maher's registration would be a sufficient and appropriate response. The panel found that it could not formulate a workable, proportionate and measurable conditions of practice order which would address the concerns in this matter. It noted that, although Mr Maher's clinical failings may be addressed through retraining, he has not engaged with the NMC since 2022, the panel has received evidence that Mr Maher is no longer working as a nurse, and he has not demonstrated evidence of remediation or insight. Therefore the panel could not be satisfied that Mr Maher would engage with a conditions of practice order. Furthermore, the panel concluded that placing conditions on Mr Maher's registration would not adequately address the seriousness of this case, would not protect the public or satisfy the public interest.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*

- *No evidence of repetition of behaviour since the incident;*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel considered that Mr Maher's breach of fundamental tenets of the profession is fundamentally incompatible with him remaining on the register. The panel considered that the clinical failings on this shift were exacerbated by the fact that Mr Maher had attended for work unfit through alcohol. The panel noted that, although there does not appear to have been a repetition of his behaviour since the incidents, Mr Maher has not been working as a nurse. For these reasons, and given his failure to remediate and in the absence of insight and expression of remorse, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

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

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a

striking-off order. Having regard to the effect of Mr Maher's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurses conduct themselves, 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 Mr Maher in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Maher's own interests 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 Lloyd. He submitted that the public protection and public interest concerns found by the panel which led to a striking off order arise immediately, therefore an interim suspension order for a period of 18 months should be imposed. He said that such order is necessary to protect the public and declare uphold proper standards of conduct for the same reasons as the substantive striking off order, until such time until the substantive striking off order can take effect, and to cover the period of any potential appeal.

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 ensure public protection and uphold the public interest throughout the period in which any appeal of this order may be made.

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

That concludes this determination.