Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 17 July 2023 – Friday, 21 July 2023
Monday, 24 July 2023 – Tuesday, 25 July 2023
Monday, 4 September 2023 – Wednesday, 6 September 2023

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Sherryann Gracelyn Nevins**
NMC PIN	97D0461E
Part(s) of the register:	RNMH: Registered Nurse – (sub part 1) Mental Health – Level 1 – 3 April 2000
Relevant Location:	Cambridgeshire
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, Lay member) Kathryn Smith (Registrant member) Pauline Esson (Registrant member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Max Buadi
Nursing and Midwifery Council:	Represented by Molly Dyas, Case Presenter
Mrs Nevins:	Present and represented by Mr Hussain-Dupré, (instructed by Sequentus) Not present but represented by Mr Hussain-Dupré (6 September 2023)
Facts proved by admission:	Charges 1c, 1e, 1f, 5a, 5b, 7a, 7b, 9a, 9b, 11a, 11b, 11c, 11d and 11e
Facts proved:	Charges 1a(i), 1a(iii), 1b, 1d, 4, 12a, 12b and 12c.

Facts not proved:	Charges 1a(ii), 1a(iv), 2, 3, 6, 8 and 10.
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim Suspension Order (18 months)

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

[PRIVATE]

Details of charge

That you, a registered nurse:

1. On 2 January 2018:

(a) Administered
- (i) an unknown substance to Resident A and/or
- (ii) unprescribed medication to Resident A, namely quetiapine and/or
- (iii) medication at a time when no medication was prescribed for Resident A to have.
- (iv) Unprescribed risperidone to Resident A.

(b) Failed to administer prescribed doses of Quetiapine to Resident B at 14.00 hours and 18.00 hours.

(c) incorrectly recorded the administration of Quetiapine on Resident B's MAR chart for 14.00 hours and 18.00 hours.

(d) Failed to administer a prescribed dose of Risperidone to Resident C at 18.00 hours.

(e) Incorrectly recorded the administration of Risperidone on Resident C's MAR chart for 18.00 hours.

(f) Removed a quantity of Lormetazepam tablets from Bramley Court Care Home without permission or clinical reason.

2. Your conduct at charge 1) c) above was dishonest in that you intentionally sought thereby to represent that you had administered the Quetiapine to Resident B when you knew that you had not.

3. Your conduct at charge 1) e) above was dishonest in that you intentionally sought thereby to represent that you had administered Risperidone to Resident C when you knew that you had not.

4. Your conduct at charge 1) f) above was dishonest in that you knew Lormetazepam tablets did not belong to you and had not been prescribed to you.

5. On 17 March 2017:

   (a) Failed to administer prescribed doses of Co-Amoxiclav to Resident D at 14.00 hours and 18.00 hours ;
   (b) Incorrectly recorded the administration of Co-Amoxiclav on Resident D's MAR chart for 14.00 and 18.00 hours ;

6. Your conduct at charge 5) b) above was dishonest in that you intentionally sought thereby to represent that you had administered Co-Amoxiclav to Resident D when you knew that you had not.

7. On 19 March 2017;

   (a) Failed to administer prescribed doses of Co-Amoxiclav to Resident D at 09.00 hours and 18.00 hours.

   (b) Incorrectly recorded the administration of Co-Amoxiclav on Resident D's MAR chart for 09.00 hours and 18.00 hours.

8. Your conduct at charge 7) b) above was dishonest in that you intentionally sought thereby to represent that you had administered Co-Amoxiclav to Resident D when you knew that you had not.

9. On 21 March 2017;

   (a) Failed to administer prescribed doses of Co-Amoxiclav to Resident D at 14.00 hours and 18.00 hours
   (b) Incorrectly recorded the administration of Co-Amoxiclav on Resident D's MAR chart for 14.00 hours and 18.00 hours

10. Your conduct at charge 9) b) above was dishonest in that you intentionally sought thereby to represent that you had administered Co-Amoxiclav to Resident D when you knew that you had not.

11. Removed a quantity of medication from Bramley Court Care Home without permission or a clinical reason, namely

   (a) After the 13th June 2015, a phosphate enema prescribed to Resident F
   (b) After the 6th June 2016, 300 ml docusate prescribed to Resident G.
   (c) After the 2nd March 2017, fusidic acid cream prescribed to Resident H.
   (d) After the 26th September 2017, seven lansoprazole tablets prescribed to Resident I
   (e) After the 27th November 2017, paracetamol tablets prescribed to Resident J

12. Your removal of the medication from Bramley Court Care Home identified in Charge 11 was dishonest in that you knew

   (a) The medication did not belong to you and/or
   (b) The medication was not prescribed for you and/or
   (c) You were not authorised to take it.

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

After the charges were read, the panel heard from Mr Hussain-Dupré, who informed the panel that you made full admissions to charges 1c, 1e, 1f, 5a, 5b, 7a, 7b, 9a, 9b, 11a, 11b, 11c, 11d and 11e.

The panel therefore finds charges 1c, 1e, 1f, 5a, 5b, 7a, 7b, 9a, 9b, 11a, 11b, 11c, 11d and 11e proved in their entirety, by way of your admissions.

Background

The charges arose whilst you were employed as a registered nurse at Bramley Court Care Home ("the Home"). You had been working there since 2014. The Home is for elderly people with dementia and physical illnesses.

The Mayfield unit within the Home had 15 residents at the time and these residents had dementia.

The first charge came to light on 3 January 2018 when Ms 1, who at the time was a Care Home Associate Practitioner, found it difficult to arouse Resident A. Ms 1 informed Ms 2, the Home Manager, of her concerns. Enquiries were made and it was alleged that you had administered an unknown substance/medication to Resident A at 18:00 the day before. CCTV appeared to corroborate this. Resident A was not prescribed anything at that time.

The NMC state that CCTV footage will show you remove a quantity of Lormetazepam tablets from the Home. The CCTV footage was reviewed by Ms 2 and an external company called The Care Project.

It is alleged that an empty box was found which should have contained 28 tablets. During a local investigation you produced a pack which Ms 2 saw had three tablets missing.

Your explanation was that you took the pack Home with the intention of researching them on google with the intention of returning them. However there has been no explanation as to why three tablets were missing.

On 5 January 2018, Ms 2 sent you a letter of suspension with immediate effect. You were invited to an investigatory meeting. At this meeting, you stated that you believed Resident A's medication was wrong and you decided to split the Quetiapine between breakfast and teatime. You also disputed the CCTV footage and stated that you had not given Resident A another resident's medication and you had only administered Quetiapine.

As a result of this incident Ms 1 conducted a drug check and found that Risperidone for Resident C was missing. It is alleged that Resident C was not administered the prescribed dose of Risperidone. Ms 2 asked you about this and stated that you accepted had not administered the mediation nor had you signed the MAR chart due to a mistake.

Charges 5 to 12 relate to failing to administer medication and incorrectly recording that that medication had in fact been administered. The NMC's position is that those actions were dishonest.

Resident D had been prescribed a course of antibiotics on discharge from the hospital on the 16 March 2017. The GP informed Ms 2 on the 21 March 2017 Resident D had not been administered two doses of that antibiotic which had been prescribed three times per day. Ms 2 contacted the agency staff working on 18 and 20 March 2017 who provided statements. The CCTV footage was again reviewed by Care Protect, and they confirmed that the agency staff had not administered medication on 17, 19 and 21 April, but that you can be seen signing to say that it had been given.

With regards to Charge 11, it is accepted that various medications were found at your home address by the police during the police investigation. The NMC's case, in respect of the medications found at your home address is that taking them home, is dishonest for one of the reasons set out in 12(a), (b) or (c), or multiple of those reasons.

Decision and reasons on application to admit the transcript of the cross examination of Ms 5 as hearsay

Before hearing the submissions, the panel had sight of an extract of a transcript of the cross examination of a Ms 5 (a witness for the prosecution) at a crown court hearing, where you stood trial, dated 16 October 2019. The panel also had sight of a signed police witness statement from Ms 5, dated 7 October 2019.

The panel heard an application made by Mr Hussain-Dupré under Rule 31 to allow the transcript of the cross examination of Ms 5 as hearsay evidence. Mr Hussain-Dupré informed the panel that this is a transcript of a criminal trial and Ms 5 was the Deputy Home Manager of the Home at the material time.

The transcript shows that Ms 5 accepts that a member of staff of the Home was allowed to take a laxative from the disposal box for her personal use with her permission.

Mr Hussain-Dupré submitted that the admission of the transcript is opposed by the NMC on the basis that you do not have the entirety of the transcript of the criminal trial.

Mr Hussain-Dupré submitted that you had made a previous application for the entire transcript of the criminal trial to be obtained but the NMC refused this. He submitted that you point to an inequality of arms argument in respect of this.

Mr Hussain-Dupré submitted that Ms 5 was the Deputy Home Manager and can support your defence of charge 12.

Mr Hussain-Dupré informed the panel that the NMC only added charges 11 and 12 in April or May 2023. He submitted that you found it difficult to recall what happened during the criminal proceedings. He also submitted that retrieving the transcripts come at a financial cost, especially when you do not know what you are looking for. He submitted that you applied to get the cross examination of Ms 5 but there was a severe delay with this.

Mr Hussain-Dupré submitted that if the panel are not minded to admit the transcript as hearsay then it should summon Ms 5 as a witness.

In relation to the transcript, Ms Dyas opposed the application. She submitted that the transcript is a very limited portion of the evidence from the criminal proceedings and a limited portion of Ms 5’s witness evidence.

Ms Dyas submitted that it was not fair to admit the transcript as it provides a very limited picture. Ms Dyas submitted that she can understand why you want to adduce the point made in the transcript as it speaks to charge 12. She submitted, however, that it would not be fair to admit the transcript because the panel will be provided a limited view on Ms 5's views on taking medication home.

Ms Dyas submitted that it could be that the witness is saying that there is a narrow exception as the member of staff had a particular need for the laxative and so let her take it on ethical grounds.

Ms Dyas submitted that this is an issue that can only be resolved by the witness explaining in a wider sense what the position was.

In regards to the application to summon Ms 5 to give evidence, Ms Dyas then referred the panel to Rule 22 (5) which stated:

> *22. (5) The Committee may of its own motion require a person to attend the hearing to give evidence, or to produce relevant documents.*

Ms Dyas submitted that the NMC are neutral regarding this. She submitted that the NMC accepts that there are clearly parts of this issue which Ms 5 can assist the panel with.

Regarding the evidence itself, Ms Dyas submitted that it is a matter which needs to be explored regarding exactly the position on medications being removed from the Home. She submitted that the NMC does not agree that there was a permissive attitude with removing medication nor does it accept that this was the reason why you took the medication. She submitted that the laxative, an "over-the-counter" medication, appears to have been permitted on a limited occasion. She submitted that this is different to the medication taken by you.

Ms Dyas informed the panel that the NMC wrote to Ms 5 in April 2023. She submitted that the NMC contacted her on 5 July 2023 via email and it was explained to Ms 5 that the defence wanted to speak to her regarding her evidence. She submitted that Ms 5 refused to contact your representative and that is as far as the NMC got with Ms 5.

Ms Dyas addressed the panel on why it may be preferable for you to have made this application to summon Ms 5 rather than the NMC. Ms Dyas submitted that the NMC's position is although it has attempted to assist you as much as possible, it does not have an open duty to gather witnesses particularly where registrants are represented.

Ms Dyas submitted that the NMC are neutral because it would be preferable for this issue to be explored with Ms 5 rather than for it to be admitted through the narrow viewpoint of the transcripts.

Ms Dyas submitted that if the panel are minded to admit the transcript and not summon Ms 5, she asked that the police witness statement of Ms 5 be admitted as hearsay with the transcript. She submitted that it is relevant and fair as it provides a thorough picture and follows from the transcript as it is questioning that which arises from the police witness statement.

Ms Dyas responded to the panel's question in regard to the NMC's position on requesting the entire criminal proceedings transcript. Ms Dyas submitted that the NMC would be making the same application. She submitted that the witness statement relates to specific point whereby a member of staff was able to take medication home. She submitted that it is the NMC's view that you are trying to extrapolate from this transcript that it was ok for you to take medication. She submitted that the NMC would prefer Ms 5 to be present to so that this can be explored.

Mr Hussain-Dupré submitted that he was led to believe that enquiries regarding Ms 5 could not come directly from you and are surprised to learn of the contact made on 5 July

2023. Mr Hussain-Dupré submitted that you have not made a formal approach to Ms 5 but now know that any attempts would have been rebuffed.

Ms Dyas submitted that the NMC served a notice on 7 July 2023 to Ms 2 asking permission to ask further questions of Ms 2. She submitted that at a pre-hearing in March 2023 an application was made to attain the full transcript of the criminal proceedings and it was refused. She submitted that transcript of the cross examination of Ms 5 was served by you on 6 July 2023 and you wanted it admitted as hearsay. Ms Dyas submitted that the NMC did not agree to this.

Ms Dyas submitted that it is noted that Ms 5, in the police witness statement, makes it clear that the medication she allowed the member of staff to take was a "homely medication" which can be bought "over the counter". Ms Dyas submitted that Ms 5 makes a clear distinction between "homely medication" and other medication.

Ms Dyas submitted that the aforementioned notice served on 7 July 2023 that the transcript was clearly a key point for you. She submitted that the NMC were under a duty to serve all the evidence in relation to charge 11 and 12 by 6 March 2023. She submitted that the NMC provided you with an approach that could allow Ms 5 to be summoned however the NMC could not provide the personal contact details of Ms 5.

Ms Dyas submitted that the notice also stated that it was not desirable for the issue to be determined on basis of the transcript and the police witness statement alone. She submitted that this is why the NMC is still opposing this application now.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He also referred the panel to the NMC guidance titled "Evidence" (reference DMA-6) and the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin).*

Transcript of the cross examination of Ms 5

The panel bore in mind that both Mr Hussain-Dupré and Ms Dyas accept that the transcript is relevant as it speaks to charge 11 and 12. The panel also agreed with this.

The panel considered *Thorneycroft* and determined the following:

> *(1) whether the statement was the sole or decisive evidence in support of the charge;*

The transcript was not the sole and decisive evidence in support of the charges. There will be other witnesses, who are members of staff at the Home, who will speak to this.

> *(2) the nature and extent of the challenges to the contents of the statement;*

The NMC cannot challenge this transcript if it was admitted into evidence as hearsay.

> *(3) whether there was any suggestion that the witness had reason to fabricate their allegations;*

There is no evidence that the transcript had been fabricated. There is a signed police witness statement that supports the transcript.

> *(4) the seriousness of the allegations, taking into account the impact that adverse findings might have on the Registrant's career;*

The allegations are very serious, includes dishonesty, and could have an adverse impact on your nursing career.

> *(5) whether there was a good reason for the non-attendance of the witness;*

The panel, at this stage, do not know of any good reason for the non-attendance of Ms 5. It does know that Ms 5 has not been formally asked to attend these proceedings at this stage.

(6) whether the NMC had taken reasonable steps to secure the attendance;

The NMC provided the contact details of your representative to Ms 5 and asked her to make contact. Ms 5 refused. The panel do not consider this to be reasonable steps to secure the attendance of Ms 5.

(7) the fact that the registrant did not have prior notice that the witness statement was to be read.

You had prior notice that Ms 5 provided a witness statement for the criminal proceedings.

The panel decided that, at this stage, it would refuse the application to admit the transcript and the police witness statement as it was unfair to the NMC. Whilst it has not exhausted opportunities to seek the attendance of Ms 5 in person. However, it took account of your second application to require Ms 5 to attend the hearing.

The panel bore in mind that Ms 5 has never actually been asked to appear at these proceedings. It noted that Ms 5 is a registered nurse and has a duty to engage with her regulator. It also reminded itself that the allegations are serious and include charges of dishonesty which could have an adverse impact on your nursing career. In light of this, the panel determined to use its discretion to require Ms 5 to attend the hearing to assist the panel and provide clarification on the discreet issue pertaining to the policy and/or practice relating to staff taking medication home.

The panel was content for the police statement of Ms 5 to be adopted as her evidence in chief and as a result be open to cross examination.

The panel also noted that charges 11 and 12, which this application refers to, were only added in March 2023. It was of the view that every effort should be made for the best evidence to be produced in respect of these charges. The panel determined that the best evidence pertaining to these charges come from Ms 5 giving evidence at these proceedings.

The panel would consider reviewing its decision to refuse the application to admit the transcript and police witness statement subject to any difficulties that occur in summoning Ms 5.

Ms 5 was contacted on behalf of the panel. She agreed to attend and gave evidence at this hearing.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Dyas, on behalf of the NMC, to amend the wording of charge 1a(iii).

The proposed amendment was to add the "and/or" to the end of the charge. It was submitted by Ms Dyas that this was omitted from the charges due to a typographical error and the proposed amendment would present all the charges within charge 1a as alternatives.

Proposed Amendment

That you, a registered nurse:

1. On 2 January 2018:

(a) Administered

(iii) medication at a time when no medication was prescribed for Resident A to have **and/or**

Mr Hussain-Dupré had no objections to the application.

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

The panel bore in mind that Mr Hussain-Dupré had no objections to the amendment. It was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered nurse:

1. On 2 January 2018:

(a) Administered
- (i) an unknown substance to Resident A and/or
- (ii) unprescribed medication to Resident A, namely quetiapine and/or
- (iii) medication at a time when no medication was prescribed for Resident A to have and/or
- (iv) Unprescribed risperidone to Resident A.

(b) Failed to administer prescribed doses of Quetiapine to Resident B at 14.00 hours and 18.00 hours.

(c) incorrectly recorded the administration of Quetiapine on Resident B's MAR chart for 14.00 hours and 18.00 hours.

(d) Failed to administer a prescribed dose of Risperidone to Resident C at 18.00 hours.
(e) Incorrectly recorded the administration of Risperidone on Resident C's MAR chart for 18.00 hours.
(f) Removed a quantity of Lormetazepam tablets from Bramley Court Care Home without permission or clinical reason.

2. Your conduct at charge 1) c) above was dishonest in that you intentionally sought thereby to represent that you had administered the Quetiapine to Resident B when you knew that you had not.

3. Your conduct at charge 1) e) above was dishonest in that you intentionally sought thereby to represent that you had administered Risperidone to Resident C when you knew that you had not.

4. Your conduct at charge 1) f) above was dishonest in that you knew Lormetazepam tablets did not belong to you and had not been prescribed to you.

5. On 17 March 2017:

   (a) Failed to administer prescribed doses of Co-Amoxiclav to Resident D at 14.00 hours and 18.00 hours ;
   (b) Incorrectly recorded the administration of Co-Amoxiclav on Resident D's MAR chart for 14.00 and 18.00 hours ;

6. Your conduct at charge 5) b) above was dishonest in that you intentionally sought thereby to represent that you had administered Co-Amoxiclav to Resident D when you knew that you had not.

7. On 19 March 2017;

(a) Failed to administer prescribed doses of Co-Amoxiclav to Resident D at 09.00 hours and 18.00 hours.

(b) Incorrectly recorded the administration of Co-Amoxiclav on Resident D's MAR chart for 09.00 hours and 18.00 hours.

8. Your conduct at charge 7) b) above was dishonest in that you intentionally sought thereby to represent that you had administered Co-Amoxiclav to Resident D when you knew that you had not.

9. On 21 March 2017;

(a) Failed to administer prescribed doses of Co-Amoxiclav to Resident D at 14.00 hours and 18.00 hours

(b) Incorrectly recorded the administration of Co-Amoxiclav on Resident D's MAR chart for 14.00 hours and 18.00 hours

10. Your conduct at charge 9) b) above was dishonest in that you intentionally sought thereby to represent that you had administered Co-Amoxiclav to Resident D when you knew that you had not.

11. Removed a quantity of medication from Bramley Court Care Home without permission or a clinical reason, namely

(a) After the 13th June 2015, a phosphate enema prescribed to Resident F

(b) After the 6th June 2016, 300 ml docusate prescribed to Resident G.

(c) After the 2nd March 2017, fusidic acid cream prescribed to Resident H.

(d) After the 26th September 2017, seven lansoprazole tablets prescribed to Resident I

(e) After the 27th November 2017, paracetamol tablets prescribed to Resident J

12. Your removal of the medication from Bramley Court Care Home identified in Charge 11 was dishonest in that you knew

    (a) The medication did not belong to you and/or
    (b) The medication was not prescribed for you and/or
    (c) You were not authorised to take it.

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

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Dyas on behalf of the NMC and by Mr Hussain-Dupré on your behalf.

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:

- Ms 1: A Care Home Associate Practitioner at the relevant time;
- Ms 2: Manager at the Home.
- Ms 3: Night nurse at the Home;

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

- Ms 5: Deputy Manager at the Home;

The panel also heard evidence from you under oath/affirmation.

The panel had sight of witness statements from the following:

- Ms 4: A registered mental health nurse;
- Ms 6: A reviewer of CCTV footage at Care Project;
- DC 7: Police officer;
- Ms 8: A reviewer of CCTV footage at Care Project;
- DC 9: Police officer;

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

In its consideration for the charges in 1a, the panel noted that your evidence is that Resident A was previously prescribed 50mg of Quetiapine in the morning, 100mg of Quetiapine at 6pm and 100mg of Quetiapine at 10pm. You stated that there appeared to be an error with Resident A's MAR chart because this was not the dosage shown on there at the time of the allegation. The MAR chart only showed 50mg in the morning. You stated that you had made a note in the team diary to point out the potential error and asked staff to follow up "as a matter of urgency". While you knew it was wrong, you stated that you had no authority to make the change.

The panel noted that while you were of the belief that Resident A's prescribed dosage should be changed, you did not consult with Ms 2, any other nurses, an on call doctor or the pharmacy.

Charge 1a(i)

1. On 2 January 2018:

(a) Administered
    (i) an unknown substance to Resident A and/or

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 2 and your evidence.

Ms 2 in her witness statement stated:

> *"On 3 January 2018, I was informed by [Ms 1] (the nurse in charge of the day shift that day) that she was concerned that Resident A had been administered medication that he wasn't prescribed the previous evening. [Ms 1] informed me that Resident A was very drowsy which was unusual for him and one of other the nurses, [Ms 10] (who had worked the day shift previously) had told [Ms 1] she had seen Sherry give Resident A medication in a cup the previous evening (2 January 2018)…. On receipt of this information I looked at Resident A's MAR Chart... This shows that Resident A's morning (9am) medication was made up of Quetiapine, Tamsulosin, Citalopram and Donepezil. He was then prescribed Docusate Sodium twice a day; morning (9am) and bedtime (10pm). It clearly shows Resident A was not prescribed any medication at lunchtime (2pm) or Tea time (6pm). It also shows that there is no signature to indicate that anything had been given at teatime on 2 January 2018…After this incident I sent the CCTV Footage to a company called*

Care Protect to complete a CCTV investigation. I am aware this report has been exhibited by [Ms 6]. The CCTV Footage which I have provided to the NMC shows Sherry mixing a cocktail of medication into a yellow cup."

Ms 2 reiterated this in her oral evidence.

The panel took account of the evidence you have given regarding this incident since 2018. In the minutes of the Investigation meeting with Ms 2, which took place on 12 January 2018, you stated:

> *[Ms 2] Resident A is not prescribed any medication at 6pm. Can you explain why and what medication was given at 6pm on 2/1/18*
> *[Mrs Nevins] explains that Resident A medication was wrong – his monthly medication was not correct she noticed this and put a note on 2/1/18 to be investigated and corrected the following. She explained that he prescribed Quetiapine 25rmgs two tablets at 8am so she decided to share this and give 25mgs at 9am and 25mgs at 6pm, as he can be agitated at this time.*

In your witness statement dated 3 August 2021, you stated:

> *"On 2nd January 2018, I administered the prescribed medication to Resident A, but had administered it at a time later than what was indicated on the MAR Chart."*

In the aforementioned investigation meeting, when this incident is first brought to your attention, you stated that you had given Resident A 25mgs of Quetiapine at 9am and 6pm. However, in your witness statement, you stated that you had administered the prescribed medication to Resident A at a later time that what was indicated on the MAR chart. There is no indication that you had administered it in the morning.

The panel noted that later in the same witness statement you stated:

“I administered Resident A’s medication dosage at the relevant time in the evening consistent with the original intentions of the prescribing doctor.”

The panel took account of Resident A’s Care file and noted that the doctors record did show that he was to be prescribed 50mg in the morning, 100mg in the evening and 100mg at night. However, this was not reflected on the MAR chart, which was the documents registered nurses are required to follow.

In response to a question from the panel, you stated that you did not administer Resident A any medication in the morning. You stated that you administered what was intended for Resident A in the morning, namely two 25mg of Quetiapine, in the evening.

The panel noted that there are inconsistencies between your account at the investigation meeting, your witness statement, and your oral evidence at this hearing.

The panel also took account of the CCTV footage. The panel found the CCTV footage reliable as it had an unobstructed view of the medication room. It also bore mind that it the footage was of good quality and was not contested. The panel can see you put things into a yellow pot. You stated that it was Resident A’s morning dose of Quetiapine. You also accepted that you administered this to Resident A. However, upon watching the CCTV footage, it noted that there are no identifying marks to assist the panel in ascertaining exactly what is being added to the yellow pot. The panel had sight of Resident A’s MAR chart and there is no entry made by you regarding what the medication is that Resident A received. As a result, the substance you stated you administered to Resident A is unknown.

The panel therefore concluded that on the balance of probabilities you administered an unknown substance to Resident A on 2 January 2018.

The panel therefore finds this charge proved.

Charge 1a(ii)

1. On 2 January 2018:

(a) Administered
(ii) unprescribed medication to Resident A, namely quetiapine and/or

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms 2 and your evidence.

The panel bore in mind Ms 2's witness statement referenced in charge 1a(i). It also noted she stated:

> *"I looked at Resident A's MAR Chart... This shows that Resident A's morning (9am) medication was made up of Quetiapine, Tamsulosin, Citalopram and Donepezil. He was then prescribed Docusate Sodium twice a day; morning (9am) and bedtime (10pm). It clearly shows Resident A was not prescribed any medication at lunchtime (2pm) or Tea time (6pm). It also shows that there is no signature to indicate that anything had been given at teatime on 2 January 2018…After this incident I sent the CCTV Footage to a company called Care Protect to complete a CCTV investigation. I am aware this report has been exhibited by [Ms 6]. The CCTV Footage which I have provided to the NMC shows Sherry mixing a cocktail of medication into a yellow cup…I believe the first substance to be Resident B's Quetiapine ... I believe this to be the case…Resident B's medication had been omitted…but yet all of the other medication was present."*

The panel took account of Resident A's MAR Chart, which starts from 1 January 2018, which stated that two 25mg of Quetiapine are to be administered in the morning.

The panel reminded itself of the inconsistencies between your account at the investigation meeting, your witness statement, and your oral evidence at this hearing. In the aforementioned investigation meeting, on 12 January 2018, you stated that you did not administer Resident A's morning dose of Quetiapine and instead administered one 25mg dose in the morning and another in the evening. In your witness statement, dated 2021, you stated that you administered Resident A's prescribed evening dose of Quetiapine in the evening. In oral evidence to the panel, you stated that you administered Resident A's intended morning dose of Quetiapine in the evening.

The panel bore in mind that this incident of you administering unprescribed medication to Resident A is said to have occurred at around 6pm. The panel accepts that the CCTV footage in relation to this charge does show that you administered unprescribed medication to Resident A at 6pm. It also noted that you accept that the scene in CCTV footage would have occurred at 6pm and you stated that you administered Resident A's prescribed Quetiapine at this time.

However, the panel reminded itself that it is for the NMC to prove the charge. It took account of the evidence from the NMC but noted that Resident A's MAR chart, does not indicate that Quetiapine was administered at this time. The panel noted that there is no way of knowing that the medication you administered to Resident A was Quetiapine other than you saying it was.

The panel further noted that Ms 2 stated that you had administered Quetiapine, prescribed to Resident B, to Resident A. While the panel does not believe Ms 2 was trying to mislead that panel, the NMC had not provided the panel with any evidence that supports this. This charge is not supported by the CCTV footage or any other documentation before the panel.

The panel also bore in mind that it had already found that you had administered an unknown substance to Resident A. It was of the view that it could not come to that conclusion and then subsequently conclude that you had administered Quetiapine.

The panel therefore finds this charge not proved.

Charge 1a(iii)

1. On 2 January 2018:

(a) Administered

(iii) medication at a time when no medication was prescribed for Resident A to have and/or

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 2 and your evidence.

The panel took account of Resident A's MAR Chart, which starts from 1 January 2018, which stated that two 25mg of Quetiapine are to be administered in the morning. It does not indicate that Resident A should have been administered medication at 6pm.

However, the panel bore in mind that you accepted that you had administered Resident A's prescribed Quetiapine at around 6pm and also accepted that the scene in CCTV footage demonstrated this.

The panel also took account of the Record of Interview by DC 9 dated 7 February 2018 where you stated:

"NEVINS is asked what times she gave the medication, she says she gave [Resident A] all his medication in the evening as he was asleep in the morning."

The panel therefore concluded that you had administered medication to Resident A at a time when medication was not prescribed to him.

The panel therefore finds this charge proved.

Charge 1a(iv)

1. On 2 January 2018:

(a) Administered
    (iv) Unprescribed risperidone to Resident A.

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 2 and your evidence.

Ms 2 in her witness statement stated:

"I looked at Resident A's MAR Chart... This shows that Resident A's morning (9am) medication was made up of Quetiapine, Tamsulosin, Citalopram and Donepezil. He was then prescribed Docusate Sodium twice a day; morning (9am) and bedtime (10pm). It clearly shows Resident A was not prescribed any medication at lunchtime (2pm) or Tea time (6pm). It also shows that there is no signature to indicate that anything had been given at teatime on 2 January 2018…After this incident I sent the CCTV Footage to a company called Care Protect to complete a CCTV investigation. I am aware this report has been exhibited by [Ms 6]. The CCTV Footage which I have provided to the NMC shows Sherry mixing a cocktail of

medication into a yellow cup… I assume the unknown substance being put in the yellow cup was 3 x 0.5ml doses of Liquid Risperidone belonging to another resident, Resident C. I believe this to be the case as there was 1.5ml missing the following day…but yet all of the other medication was present."

Ms 2 reiterated this in her oral evidence. Upon viewing the CCTV footage, she explained that she believed you administered Resident C's risperidone to Resident A.

Ms 1 in her witness statement stated:

Resident C was prescribed 0.25ml twice a day (0.5ml in total per day). So Resident C should have had 1.5ml in 3 days meaning there should have been 13.5ml remaining in the 15ml bottle. The bottle only had 9ml. Risperidone was prescribed to Resident C to prevent agitation and to stop her becoming aggressive.

Ms 1 in oral evidence stated that she conducted two audits on 3 January 2018. The panel took account of Resident C's record of risperidone liquid which demonstrated Ms 1's findings. Next to the date 2 January 2018, under the heading "Amount tablets sachets or liquid medication taken over At start of shift [sic]", "14.75mls" is recorded. Under the heading "Amount tablets sachets or liquid medication administered" "0.5mls" is recorded and under "Amount of tablets sachets or liquid medication left at the end of the shift", "14.0mls" is recorded. You have signed your name next to this.

However there appears to be figures that have been crossed out due to an error in calculation and a correction pertaining to 1 January 2018. The panel further noted that next to the date 3 January 2018 something has been crossed out and the following has been recorded *"checked and amount incorrect actual 9mls in bottle".*

The panel noted that there is no audit trail which shows the exact volume of risperidone on 1 January 2018 and then on 3 January 2018. It noted that what appears to have been recorded are estimates with some values crossed out. The panel also noted that there is

no signature next to these corrections to confirm them. The panel was of the view that this document was not reliable.

The panel bore in mind that it had evidence that Risperidone is in a liquid form and needs to be syringed. It also bore in mind that the CCTV footage of this incident did not demonstrate you using a syringe. It had already accepted that you appeared to place something in a yellow pot which you subsequently administered to Resident A. You stated that this was Quetiapine.

The panel reminded itself that it is for the NMC to prove the charge and noted that the NMC has referenced Resident C's record of risperidone to support its case. However, the panel was not able to establish a direct correlation between the alleged missing 4 ½ mls of missing risperidone and the unknown medication you prepared in the CCTV footage. The panel also could not conclude that just because 4 ½ ml of Risperdone is missing, it meant that you administered it to Resident A. As a result, the panel did not place much weight on this document.

The panel therefore finds this charge not proved.

Charge 1b

1. On 2 January 2018:
   (b) Failed to administer prescribed doses of Quetiapine to Resident B at 14.00 hours and 18.00 hours.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 2 and your evidence.

The panel noted that the charge stated you “Failed”. It bore in mind that this implies that there is an obligation of a duty for you to undertake the task described in the charge. The panel reminded itself that you had accepted that you were on duty on 2 January 2018. Further, you accepted that as a senior nurse, it would have been your responsibility to ensure that the prescribed doses of medication was administered, even if that responsibility was delegated. Therefore, the panel established that you had a duty.

The panel took account of Resident B’s MAR chart which showed that Quetiapine was to be administered at 2pm and 6pm. You accepted that your signatures are on the MAR chart for those times on 2 January 2018 indicating that you had administered the Quetiapine medication.

Ms 2 in her witness statement stated:

> *“As a result of my CCTV Review other concerns were brought to my attention. On 2 January 2018, Resident B was in her bedroom (G18 Mayfield Unit). She was unwell with a cold and was in bed. Resident B was prescribed Quetiapine at teatime (6pm) but I could see from the CCTV that this was not administered to her. Resident B’s MAR Chart however indicated that this had been administered by Sherry at 6pm who had signed it.*
>
> *At the investigation meeting…I asked Sherry if she administered the Quetiapine at 2pm and 6pm and Sherry said she did. I explained that we can see from the CCTV that Resident B was in her bedroom all day and Sherry did not enter the room all afternoon. Sherry said she gave both doses at 2pm as she can be agitated in the evening. I asked Sherry once again why she didn’t make any record of this change or consult the GP first and she just said she hadn’t. I stated how unacceptable it was to change resident’s medication without consulting a GP. There was no actual patient harm but the risk of harm frim being administered two doses is that she may have become sedated.” [sic]*

Ms 2 reiterated in her oral evidence that you did not administer the medication to Resident B as you had not entered Resident B's room all day according to CCTV footage.

The panel took account of the minutes of the investigation meeting, dated 12 January 2018, which stated:

> *[Ms2] Did you administer medication to Resident B*
> *[Mrs Nevins] Yes*
> *[Ms2] Did you administer her Quetiapine at 2pm and 6pm?*
> *[Mrs Nevins] Yes*
> *[Ms 2] from CCTV monitoring Resident B was in her bedroom all day and you never entered her room all afternoon. You never when to see her.*
> *[Mrs Nevins] I gave her both doses at once.*
> *[Ms 2] Why did you do this? Her medication is twice a day.*
> *[Mrs Nevins] Resident B can be agitated in the evening and I though it better to give her it all at once.*
> *[Ms 2] Once again you did not make any record of this change or consult with the GP.*
> *[Mrs Nevins] No.*

The panel noted that you initially stated you had administered Resident B both doses of Quetiapine at 2pm and 6pm. However, when confronted with the CCTV footage, you then said that you had administered both doses at once.

However, in your witness statement, dated August 2021, you stated:

> *"The medications I prepared and administered to Resident B was that of Quetiapine as prescribed and the shelve where it was kept, I had moved higher up for easy access.*
>
> *I prepared Resident B's medications and asked the Healthcare assistant to*

assist Resident B to consume the medications.

Resident B didn't trust staff the Resident was not familiar with for giving her medication.

The Healthcare Assistant confirmed to me that Resident B had consumed her medication and I signed for the medication afterwards."

The panel also noted that in your oral evidence to the panel, you also stated that you were not familiar with this unit and was only there due to staff shortages. You stated that you chose the carers based on their rapport with each resident and that you delegated the administration of Resident B's medication to a senior carer. You stated that the reason for this was because Resident B was more friendly with that particular carer and would have accepted the medication from her.

You stated that the senior carer confirmed to you that the medications had been administered to Resident B. However, you also accepted that you should have indicated this with an 'o' or a 'c' on Resident B's MAR chart, indicating the medication had been on administered by a carer, instead of adding your own initials.

You also accepted that the minutes of the investigatory meeting were at odds with your present case. You stated that the atmosphere in the meeting was oppressive and the minutes recorded were not verbatim. You also stated that you felt like Ms 2 had already made up her mind about what happened and you stopped defending yourself because you did not see the point.

Under cross examination, you stated that parts of the conversation were missing. However, you later appeared to concede this point when Ms Dyas took your through the minutes of the investigation meeting to establish where the gaps were. You then appeared to accept that you had said what was recorded.

The panel accepted the minutes of the investigation meeting as a contemporaneous record of happened at the material time. While the minutes are not signed, Ms 2 was present at the hearing and Mr Hussain-Dupré never challenged the accuracy or the inappropriateness of the minutes recorded.

The panel do not accept that you stopped defending yourself during the meeting. This is because that meeting would have been your first opportunity to give the Home manager, Ms 2, an account of what happened. The panel noted that it did not have evidence before it of you ever challenging Ms 2 concerning the accuracy of the investigation meeting minutes since it occurred. It appears to the panel that you have only done this during these proceedings. At this hearing you appeared to concede under cross examination that the conversation recorded in the investigation meeting was accurate.

The panel bore in mind that it did not have sight of the CCTV footage that Ms 2 viewed. However, it considered the fact that there were inconsistencies with your explanation when asked at the investigation meeting in 2018. You initially stated that you had administered Resident B's medication at 2pm and 6pm, however when confronted with the CCTV footage, you then said you had administered both doses at once. You then changed your account in your witness statement in 2021 and in your oral evidence today to say that you delegated the responsibility to a carer.

While the panel recognise that you do not have to disprove the charge, it was not assisted with the accounts you provided which showed inconsistencies. The panel was of the view that your account has taken a drastic change from 2018 to now and it therefore preferred the more contemporaneous evidence of the minutes of the investigation meeting.

The panel also bore in mind that the carer had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no evidence before the panel to support your account that you had delegated the responsibility of administering Quetiapine to Resident B.

The panel therefore concluded that, on the balance of probabilities, you failed to administer prescribed doses of Quetiapine to Resident B at 14:00 hours and 18:00 hours on 2 January 2018:

The panel therefore finds this charge proved.

Charge 1d

1. On 2 January 2018:
   (d) Failed to administer a prescribed dose of Risperidone to Resident C at 18.00 hours.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 2 and your evidence.

As with charge 1b, the panel established that you had a responsibility, as senior nurse, to ensure that the prescribed doses of medication was administered, even if that responsibility was delegated

The panel took account of Resident C's MAR chart which showed that Risperidone was to be administered at 9am and 6pm. The panel also bore in mind that you had admitted charge 1e, that on 2 January 2018, you incorrectly recorded the administration of Risperidone on Resident C's MAR chart for 18.00 hours. You also accepted that your signatures are on the MAR chart for 9am on 2 January 2018 indicating that you had administered the Risperidone medication.

Ms 2 in her witness statement stated:

“From viewing the CCTV it was also discovered that Resident C was not actually given her 6pm dose of Risperidone on 2 January 2018. The MAR shows that Sherry had signed to say that it had been administered. I asked Sherry about this during her investigation meeting…and she said that Resident C was very sleepy that evening so she decided not to give her the medication. I have been asked by the NMC if this is the right thing to do; if someone is sleepy and we feel it is due to the sedation we will withhold medication if it is a regular omission and we will then discuss this with the doctor. I asked Sherry why she had signed the MAR to say it had been administered when it hadn’t and she said it must have been a mistake.”

Ms 2 reiterated this in her oral evidence.

The panel took account of the minutes of the investigation meeting, dated 12 January 2018. It stated:

[Ms2] Can we move into Resident C. She is prescribed Risperidone liquid 0.25mgs in 0.25,ls twice a day. Resident C was not given her evening dose of Risperidone on 2/1/18. Her daughter visited until 5pm then it was evening meal at not time did you give Resident C any medication.
[Mrs Nevins] Resident C was very sleepy so I didn’t give her any medication.
[Ms2] If that is the case why did you sign the MAR chart to say you had administered the medication?
[Mrs Nevins] it must have been a mistake.

In your reflective statement, dated August 2021, you stated:

“I administered Resident C’s medication as prescribed and signed for it afterwards.”

The panel noted that in the investigation meeting, you stated that Resident C was sleepy which is why you did not administer the medication. You also stated that signing the MAR

chart indicating that you had must have been a mistake. However, the panel noted that there is no entry made by you on Resident C's MAR chart to indicate that you did not administer the Risperidone. Additionally, there is no mention of the action you took as a result of not administering the Risperidone in Resident C's daily notes.

The panel noted that in your reflective statement you stated that you did administer Risperidone to Resident C and signed the MAR chart indicating that you had. However, in your oral evidence to the panel, you said that you had delegated this responsibility to a carer. The panel noted that there are inconsistencies between your account at the investigation meeting, your witness statement, and your oral evidence at this hearing. The panel was of the view that your account has taken a drastic change from 2018 to now and it therefore preferred the more contemporaneous evidence of the minutes of the investigation meeting.

The panel also bore in mind that the carer had not attended to give evidence at this hearing or provided a formal witness statement. As a result, there was no evidence before the panel to support your account that you had delegated the responsibility of administering Risperidone to Resident C.

The panel therefore finds this charge proved.

Charge 2

2. Your conduct at charge 1) c) above was dishonest in that you intentionally sought thereby to represent that you had administered the Quetiapine to Resident B when you knew that you had not.

This charge is found not proved.

In reaching this decision, the panel bore in mind the test for dishonesty in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67*. It had to now determine what your

actual state of mind was as to the facts and decide whether your conduct with that state of mind would be considered dishonest by the standards of ordinary honest and decent people.

The panel bore in mind that you accepted charge 1c, in that you incorrectly recorded the administration of Quetiapine on Resident B's MAR chart for 14:00 and 18:00 hours.

The panel also took account of your response in the contemporaneous minutes of the Investigation meeting where you initially stated you had administered Resident B both doses of Quetiapine at 2pm and 6pm. However, when you were confronted with the CCTV footage, you then said that you had administered both doses at once.

The panel also bore in mind that you have subsequently changed your account in your witness statement in 2021 and your oral evidence to the panel when you stated you had delegated the responsibility to administer Resident B's medication to a carer. While you accept that you pre-signed the MAR chart to indicate that you had administered the medication you stated that you should not have done this.

The panel was of the view that your evidence in relation to this charge was inconsistent. However, it took account of the circumstances at the time and your state of mind.

In assessing what your state of mind was at the time, the panel took account of your oral evidence where you spoke about the circumstances of the Home at the material time. You explained that the Home is divided into two units. You stated that, at the material time, you were working within the unit you did not normally work in. You said that you were providing cover for that unit administering the medication because they were short staffed. Resident B was in this unit.

The panel took account of the Record of Interview by DC 9 dated 7 February 2018, where you stated:

"I don't know if I did it on that day, but I know I didn't sign for his medication, or did I sign for his medication on that day, I don't know. I don't know if I did do exactly that, but I know on that day there was so much things to be chased up that I made some errors."

While the panel recognise that this is not in reference to Resident B, it is a reflection of the type of day you were having on 2 January 2018. The panel was of the view that it supports your account of how busy the unit was due it being understaffed.

[PRIVATE].

The panel took account of the case of *Penny Ann Lavis v Nursing & Midwifery Council (2014) EWHC 4083 (Admin)* which stated:

"While dishonesty was plainly one of the possible explanations, it was not the only one: it would have been appropriate, and in my judgment proper, for the Panel to have explicitly considered in respect of each of the entries whether the Appellant had acted in an unthinking way, out of habit, in a 'slapdash' manner or while 'distracted'".

Whilst the panel have a number of explanations which are inconsistent and show you to be lacking in credibility, it took account of your state of mind and the circumstances you found yourself in on 2 January. As a result, the panel considered that there is an alternative explanation in respect of the mistakes you made. It was satisfied that the pre signing of medication could have been a genuine mistake due to your state of mind and the circumstances at the Home. Further, it was of the view that your action in this charge could have been poor practice rather than an intentionally dishonest act.

Given the circumstances and the state of mind you were in, the panel was satisfied that an ordinary decent member of the public would not consider your actions to be dishonest.

The panel therefore finds this charge not proved.

Charge 3

3. Your conduct at charge 1) e) above was dishonest in that you intentionally sought thereby to represent that you had administered Risperidone to Resident C when you knew that you had not.

This charge is found not proved.

In reaching this decision, the panel bore in mind the test for dishonesty in Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67 as stated in charge 2.

The panel bore in mind that you accepted charge 1e, in that you incorrectly recorded the administration of Risperidone on Resident C's MAR chart for 18.00 hours.

The panel also took account of your response in the contemporaneous minutes of the Investigation meeting where you stated that you did not administer Risperidone to Resident C because she was sleepy. When Ms 2 asked you why you signed the MAR chart to indicate that you had administered the Risperidone, you said that it must have been a mistake.

The panel also bore in mind that you have subsequently changed your account in your witness statement in 2021 where you stated that you administered Resident C's medication and signed for it afterwards. Then in your oral evidence to the panel when you stated you had delegated the responsibility to administer Resident C's medication to a carer. While you accept that you pre-signed the MAR chart to indicate that you had administered the medication you stated that you should not have done this.

Whilst the panel have a number of explanations which are inconsistent and show you to be lacking in credibility, as it did with charge 2 above, the panel bore in mind your state of mind and the circumstances you found yourself in on 2 January 2018.

The panel considered the explanation you gave initially, namely that this was a genuine mistake to pre-sign Resident C's MAR chart, and bore in mind that this explanation subsequently changed to say that a carer administered the medication.

The noted that while you have a number of explanations which are inconsistent and show you to be lacking in credibility, it was of the view that an alternative explanation could be that your conduct, as described in charge 1e was a genuine mistake.

Given the circumstances and the state of mind you were in, the panel was satisfied that an ordinary decent member of the public would not consider your actions to be dishonest.

The panel therefore finds this charge not proved.

Charge 4

4. Your conduct at charge 1) f) above was dishonest in that you knew Lormetazepam tablets did not belong to you and had not been prescribed to you.

This charge is found proved.

In reaching this decision, the panel bore in mind the test for dishonesty in Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67 as stated in charge 2 and 3 above.

The panel bore in mind that you accepted charge 1f, namely that you removed a quantity of Lormetazepam tablets from Bramley Court Care Home without permission or clinical reason.

The panel heard evidence from Ms 1 and Ms 5 stating that they did not give you permission to take the medication home.

In your oral evidence, you stated that you removed the Lormetazepam tablets because you wanted to google them at the nurse's station. You said that you wanted to do this because it was new medication to you. You also stated that due to an emergency situation at the Home you had to deal with, you put them in your pocket and only discovered that you still had them when you went home. When you got home you said you put them medication in an envelope, added a note to stated that you had taken them home by mistake, and returned them at the earliest opportunity. This was at the investigation meeting on 12 January 2018. You also said that it was a genuine mistake.

The panel was of the view that your explanation was not plausible. The panel bore in mind that Resident E had already been on Lormetazepam for at least the previous month, therefore it would not have been a new medication to you. It noted that Ms 2 had taken a photograph of the box of Lormetazepam which has a date of 27 November 2017. Further, the panel noted that Resident E was in the hospital at the material time so would not have required Lormetazepam.

The panel also took account of the Record of Interview by DC 9 on 7 February 2018 where you stated:

> *"The reason why I didn't take the box as I said to [Ms 2] is that my logical thinking at that time was there is cameras inside of here, inside of the treatment room, if I took the whole box of medication out with me they will think I am stealing the meds."*

The panel noted that rather than take the whole box of Lormetazepam you had removed the tablets and left the box. The aforementioned photograph taken by Ms 2 shows there is one tablet remaining. It considered that there would be no reason for you to remove the tablets from the box if all you had wanted to do was to "google it". It was of the view that it

would be more plausible that you would have taken the whole box instead with the name of the medication on it which you would need to research on google.

In assessing what your state of mind was at the time, the panel took account of your oral evidence where to spoke about the circumstances of the Home at the material time and your personal circumstances, as stated in Charge 2.

While the panel accept the Home was busy, it did not accept that you would take time to google medication for a resident that was not present at the Home. It was of the view that considering you knew Resident E was in the hospital and would not require Lormetazepam, removing the medication from the trolley was a deliberate act.

In light of the above the panel was satisfied that an ordinary decent member of the public would consider your actions in removing Lormetazepam tablets, which did not belong to you and had not been prescribed to you, to be dishonest.

The panel was mindful that it had considered your state of mind, as 2 January 2018, in charges 2 and 3 and determined that there was a possibility of an alternative explanation and accordingly found these allegations not proved. The panel is satisfied, in respect of charge 4, that in all the circumstances there is compelling evidence which rules out the possibility of an alternative explanation.

The panel therefore finds this charge proved.

Charge 6, 8 and 10

6. Your conduct at charge 5) b) above was dishonest in that you intentionally sought thereby to represent that you had administered Co-Amoxiclav to Resident D when you knew that you had not.

8. Your conduct at charge 7) b) above was dishonest in that you intentionally sought thereby to represent that you had administered Co-Amoxiclav to Resident D when you knew that you had not.
10. Your conduct at charge 9) b) above was dishonest in that you intentionally sought thereby to represent that you had administered Co-Amoxiclav to Resident D when you knew that you had not.

These charges are found not proved.

The panel considered each of these charges separately but as the evidence in relation to each is similar it has dealt by them under one heading. In reaching this decision, the panel bore in mind the test for dishonesty in Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67 as stated in charge 2.

The panel bore in mind that you accepted charges 5b, 7b and 9b. It also noted that you accepted this during the local investigation, and it was dealt with by the Home. It noted that in a letter dated 12 April 2017, you were invited to a disciplinary meeting for 19 April 2017.

In assessing what your state of mind was at the time, the panel took account of your oral evidence where you spoke about the circumstances of the Home at the material time and your personal circumstances, as stated in Charge 2. It also noted that in your contemporaneous reflective statement, following the disciplinary meeting, you accepted the errors you had made and also stated:

> *"On the week of the 16th March I was mildly unwell with flu like symptoms…"*

In your contemporaneous reflective statement, you also go on to provide what the panel considered to be a reasonable explanation for the errors, when you stated:

"I got involved in the other activities which caused me to lose focus on my initial tasks.

…

I underestimated the effect and impact of my physical un-wellness and the effect could have on my working ability [sic]"

The panel noted that dishonesty, in relation to these errors, was never put to you at the time during the local investigation. It appears to the panel that your explanation was accepted at the material time by the Home and you subsequently undertook re-training in respect of the errors. The panel noted that Ms 2 in her witness statement, appears to acknowledge this when she stated:

"We acknowledge that Sherry had said she felt unable to function effectively due to illness at the time and had provided a lot of remorse and reflection."

In the panel's judgement, the errors described in charges 5b, 7b and 9b were dealt with locally by the Home and dishonesty did not appear to be an issue at the material time. Given these circumstances and the state of mind you were in, the panel was satisfied that an ordinary decent member of the public would not consider your actions to be dishonest.

The panel therefore finds these charges not proved.

Charge 12a, 12b and 12c

12. Your removal of the medication from Bramley Court Care Home identified in Charge 11 was dishonest in that you knew
    (a) The medication did not belong to you and/or
    (b) The medication was not prescribed for you and/or
    (c) You were not authorised to take it.

These charges are found proved.

The panel considered each of these charges separately but as the evidence in relation to each is similar it has dealt by them under one heading. In reaching its decision, the panel bore in mind the test for dishonesty in Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67 as stated in charge 2.

The panel bore in mind that the medication referred to in this charge was a phosphate enema, docusate, fusidic acid cream, lansoprazole and paracetamol.

The panel bore in mind that you accepted charge 11. In your oral evidence, you accepted that the medication did not belong to you, nor was it prescribed to you. However, you did not accept that you were not authorised to take it.

Under cross examination, you stated that Ms 5 gave you permission to take the paracetamol, the docusate and the lansoprazole. You also stated that taking the fusidic acid cream and the phosphate enema was a mistake.

However, Ms 5 in her oral evidence made it clear that she did not give you permission to take these medications. She also stated that all the aforementioned medications had been prescribed for someone and did not expect nurses to be taking them home. Ms 2 also made it clear that medication should not be removed from the Home.

The panel also took account of the Home's Medication Policy pertaining to the disposal of medication. It noted that nothing within that policy indicated that staff members were authorised to take medication.

The panel took account of the Police Report by DC 9 dated 7 February 2018. It noted that this is the only contemporaneous response it has to these matters. It also bore in mind the police had searched your home where they found the aforementioned medication. Within this report you stated that you had taken the lansoprazole and the paracetamol for

personal use. You also stated that you would have asked to take the Phosphate enema and you could not say who used the Anti-fungal cream.

The panel was of the view that there is an inconsistency from what you told the police and what you have told the panel pertaining how you came to have the medication in your home.

The panel particularly noted that you had stated the phosphate enema was already used and placed back into its box. In such circumstances, the panel was of the view that if anybody had a used enema in their possession it was highly likely that they would dispose of it straightaway.

The panel also noted that the fusidic acid cream, used for to treat bacterial infections, was prescribed for somebody else's feet. It bore in mind that Ms 2 was confused as to why anybody would want used fusidic acid cream.

The panel also bore in mind that you stored the medications in your kitchen for a number of years. You also stated that your children must have placed them inside of your cupboard as you had left next to your cupboard.

The panel considered your explanation as to how you came into possession of these medications to be wholly unrealistic.

In assessing what your state of mind was at the time, the panel took account of your oral evidence where to spoke about the circumstances of the Home at the material time and your personal circumstances, as stated in Charge 2. It bore in mind that the events in these charges took place over a two-year period.

The panel was of the view that there could be a plausible explanation for taking the medication home by mistake. However, the fact that they were stored in your kitchen

cupboard for a number of years and only discovered by the police indicated to the panel the this was a dishonest act.

In the panel's view that you would have had to have known that the medication should not have been in your possession. You would have had plenty of opportunity to dispose of them at your home if you had taken them by mistake or return them to the Home during the two-year period and failed to do so.

As a result, the panel determined that the first part of the test in *Ivey* has been satisfied.

The panel was also satisfied that an ordinary decent member of the public would consider your actions in respect of charges 12a, 12b and 12c to be dishonest.

The panel therefore finds these charges 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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

Ms Dyas submissions on misconduct and impairment

Ms Dyas referred the panel to the case of *Roylance v GMC (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.'* She also referred the panel to the cases of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Ms Dyas invited the panel to take the view that the facts found proved amount to misconduct as your actions fell below the standards expected of a registered nurse. She directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified where, in the NMC's view, your actions amounted to misconduct.

With regards to charge 1, Ms Dyas submitted that nurses without the authority to prescribe medication should follow MAR charts and perform the role of administering medication described in those charts rather than take matters into their own hands by trying to work out what they think the prescription should be.

With regards to charges 1, 5, 7 and 9, Ms Dyas submitted that there are several instances of incorrect recordings of medication or failure to record medication. She submitted the charges relating to Co-Amoxiclav all occurred in March 2017. She reminded that you had undertaken retraining and yet the errors continued in January 2018.

Ms Dyas submitted that charges 1f and 11 dealt with the dishonest removal of medication from the Home. With regards to charge 11, Ms Dyas reminded the panel that it had found that this had occurred over the span of a two-year period. She submitted that the dishonest removal of medication prescribed for elderly patients at a care home would be seen as deplorable by fellow nurses and constitutes misconduct.

Ms Dyas invited the panel to find misconduct in this case.

Ms Dyas moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin, *Nicholas-Pillai v GMC [2009] EWHC 1048* and *Sayer v General Osteopathic Council [2021] EWHC 370 (Admin)*.

Ms Dyas submitted that your actions brought risk of harm to patients. She submitted that in relation to medication, using Co-Amoxiclav as an example, Resident D was not getting antibiotics as prescribed which would have placed him at risk.

Ms Dyas submitted that there is always a risk in not recording medication properly in MAR charts. She submitted that if nurses are not aware of medication that has been administered the patients could have an overdose if they are administered the same medication again. She reminded the panel of its decision with regards to charge 1a in that it was unable to determine what medication Resident A was administered.

Ms Dyas submitted that your actions had in the past brought and/or is liable in the future to bring the medical profession into disrepute. She submitted that this is engaged due to the dishonest removal of medication from the Home and then being stored in your own home.

Ms Dyas submitted that your actions had in the past breached one of the fundamental tenets of the medical profession. She reminded the panel of her submissions where she directed it to specific aspects of the Code and how your actions were in breach of this. She submitted that you have not acted with integrity and have not been open and honest which are fundamental tenets of nursing.

Ms Dyas submitted that you have acted dishonestly. She reminded the panel that it had found dishonesty in charge 4 and charge 12.

With regards to insight, pertaining to the recording of medication, Ms Dyas submitted that you have limited insight based on the reflective statement of 2021. She submitted that this is further limited because in certain aspects of your oral evidence, you stepped away from what was written in your reflective statement.

With regards to remediation, pertaining to recording of medication, Ms Dyas reminded the panel that you had completed a medication course after the March 2017 incident, however further incidents occurred in January 2018. Ms Dyas also submitted that the panel may consider that you have demonstrated a “lax attitude” both in the administrating of medication and handling of medication that ended up in your possession.

Ms Dyas submitted that the dishonesty in this case is difficult but not impossible to remediate. She submitted that there is no insight in relation to the dishonesty in this case. She also submitted that there is nothing to suggest that you have reflected on the issue of dishonesty specifically. She submitted that this is not a single incident which occurred on a single day and reminded the panel that the removal of medication took place over a significant period of time.

Ms Dyas submitted that there is a lack of insight and remediation in relation to dishonesty in this case. She submitted that even though dishonesty is difficult to remediate the lack of insight and remediation in relation to the dishonesty in this case gave rise to a concern of attitudinal issues. She submitted that there is a risk of repetition.

Ms Dyas invited the panel to find your fitness to practice is currently impaired.

Mr Hussain-Dupré's submissions on impairment

Mr Hussain-Dupré provided the panel with your interim conditions of practice order (ICOPO) which were varied from 2020 to 2021. He submitted that you were initially had an interim suspension order (ISO) imposed on your practice. This was replaced with an ICOP on 4 January 2020 and included direct supervision. However, the ICOP imposed at this time now include indirect supervision.

Mr Hussain-Dupré made no submissions on misconduct and indicated to the panel that he was focusing on the issue of present impairment. He submitted that you are aware that you have made mistakes and that the charges found proved are of a serious nature. He submitted that you have been through a criminal investigation and a fitness to practice process so you have an appreciation of the consequences of your actions.

Mr Hussain-Dupré submitted that you explained to the panel that there were decisions you made at the Home which, with the benefit of hindsight, you clearly see were wrong. He submitted that even if you thought at the time that there may have been an element of flexibility in the rules or in everyday practice, you stated in your evidence that you had to take responsibility for your own professional standards.

Mr Hussain-Dupré submitted that you have explained you have taken steps to remediate your practice in order to comply with the ICOP. He submitted that following the imposition of the ISO you were employed by Valley Court Care Home from February 2021 until December 2022. He submitted that towards the end of your tenure, the ICOP with indirect supervision was put into place.

With regards to your time at Valley Court Care Home, Mr Hussain-Dupré reminded the panel that in your evidence, due to your heightened awareness of some of the mistakes you had made, it was you pointing out the mistakes of other registrants in their record keeping.

Mr Hussain-Dupré drew the panel's attention to the training certificates within the bundle attained during your time at Valley Court Care Home. This included a medication administration certificate and medication training for home staff.

Mr Hussain-Dupré also drew the panel's attention to the positive testimonials from managers and colleagues at Valley Court Care Home.

With regards to your personal circumstances, Mr Hussain-Dupré submitted that you had explained that this was a discreet moment in time and not circumstances that were in place at this particular juncture.

Mr Hussain-Dupré submitted that you had recently taken a step back from nursing while you dealt with the stress of the latter stages of these fitness to practice procedures. He submitted that you did this so there would be no possible impact on your work or patient safety.

Mr Hussain-Dupré submitted that as you are not currently working as a nurse, and if you are permitted to return to work as a nurse you would have to complete training and competency assessments which you are willing to do.

Mr Hussain-Dupré asked the panel to consider how your ICOP has eased over the years and submitted that over five years since the 2018 incident, you have had no further complaint or incident in relation to your practice.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included *Professional Standards Authority v Health and Care Professions Council and Ghaffar [2014] EWHC 2723 (Admin)* and *Professional Standards Authority For Health and Social Care v. General Medical Council and Uppal [2015] EWHC 1204 (Admin)*

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Decision and reasons on misconduct

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

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

Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
>
> *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*
>
> ***4 Act in the best interests of people at all times***
>
> *To achieve this, you must:*
>
> *4.2 make sure that you get properly informed consent and document it before carrying out any action*

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

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

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity…'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel bore in mind that Mr Hussain-Dupré did not make representations addressing your misconduct.

The panel bore in mind that in relation to your actions in the facts found proved under charge 1, you were acting outside of your scope of practice as a nurse. You were administering medication at the incorrect times and not recording you had done so. It was of the view that each of these actions had the potential to cause harm to patients. The panel also bore in mind that these charges occurred after you had already undertaken retraining in this area.

With regards to charge 1ai), it found that you had administered an unknown substance to Resident A, and you had not recorded anything on their MAR chart to indicate what had been administered. It also considered that if Resident A would have had a reaction to the unknown substance, nobody would know what had been administered. This would put Resident A at risk of harm. The panel bore in mind that you are not a prescriber and therefore you were acting outside of your scope of practice. It considered your actions did

fall short of the conduct and standards expected of a nurse and were serious departures from the standards, amounting to misconduct.

With regards to charge 1aiii, the panel found that you had administered medication to Resident A at a time when medication was not prescribed to him. It bore in mind that you are not prescriber and concluded that you had, again, acted outside your scope of practice. It also bore in mind that even if the medication had not been prescribed, there is no record that you had discussed this action with anyone, nor did you record that you had administered the medication on Resident A's MAR chart. You therefore put Resident A at risk of harm. It considered your actions did fall short of the conduct and standards expected of a nurse and were serious departures from the standards, amounting to misconduct.

With regards to charge 1b, 1c, 1d and 1e, the panel found that you had failed to administer and failed to record the administration of Quetiapine and Risperidone to Resident B and Resident C respectively. It was of the view that you were acting outside of your scope of practice by not administering the respective medication. Further, you had recorded that you had administered the respective medication when you did not. It was of the view that any nurse looking at the MAR chart would be unaware that the residents had not been administered their prescribed medication which could place them at a risk of harm. It considered your actions did fall short of the conduct and standards expected of a nurse and were serious departures from the standards, amounting to misconduct.

With regards to 1f, the panel considered that your actions in relation to this charge were deplorable and reprehensible. It was of the view that you cannot remove medication from the Home, let alone medication that has been prescribed for residents. The panel noted that your actions could have had an adverse impact on those residents who may have needed the medications. It bore in mind that nurses are in a position of trust and to remove medication without permission, clinical reason and contrary to the policy of the Home would, in the panel's view, be considered deplorable by fellow practitioners. It

concluded that your actions fell short of the standards expected of a nurse and amounted to serious misconduct.

With regards to charge 4, the panel concluded that you would have known the medication belonged to the residents and had not been prescribed to you. You took the medication home, which was a breach of the Home's policy, and only returned them during a disciplinary meeting. The panel was of the view nurses are in a position of trust and the public must have confidence in nurses. Additionally, fellow nurses must have confidence in their colleagues. It was of the view that your actions would be considered deplorable by fellow practitioners and amounted to serious misconduct.

With regards to charge 5a the panel considered that failing to administer medication one time could be seen as an isolated one off incident. It was of the view that mistakes happen and that this would not automatically amount to misconduct. With regards to charge 5b, panel considered that incorrectly recording that you had administered the medication could be seen as misconduct. This is because nurses looking at the MAR chart would think medication had been administered when it had not therefore placing patients at risk of harm due to them not receiving their prescribed medication.

The panel also bore in mind that charges 7a, 7b, 9a and 9b similarly relate to the failure of administering medication and incorrectly recording that you had done so.

However, the panel took account of your personal circumstances at the time. It also bore in mind that the Home had dealt with these incidents internally and noted that the Home did not take any disciplinary action and had you undertake competency training in relation to this. In light of this, the panel determined that it would be unfair to make a finding of misconduct in relation to charges 5, 7 and 9.

With regards to charge 11 and 12, the panel found its reasoning to be similar to charge 1f and charge 4. It was of the view that the removal of prescribed medication from the Home, contrary to policy, would be considered deplorable by fellow practitioners. It considered

your actions in relation to these charges and the dishonesty associated with it did fall short of the conduct and standards expected of a nurse and were serious departures from the standards, amounting to misconduct.

In light of the above the panel determined that the charges admitted and found proved individually and collectively amounted to a serious departure from appropriate standards expected and amounted to misconduct.

Decision and reasons on impairment

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

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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

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

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

For reasons already set out above in relation to misconduct, the panel determined that limbs a, b, c and d were engaged by your misconduct.

The panel finds that where you had administered unknown substances not prescribed, not administered medication prescribed and your record keeping in relation to medication all placed patients at a potential risk of significant harm. It also considered that the theft of medication, and thereby depriving residents of their medication, could have had an adverse impact.

The panel determined that your misconduct had breached fundamental tenets of the nursing profession, particularly relating to promoting professionalism and trust and therefore brought its reputation into disrepute. It also bore in mind that you been dishonest about the removal of medication from the Home on two occasions and was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel recognised that it must make an assessment of your fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether you would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether you have provided evidence of insight and remorse.

Regarding insight, the panel bore in mind that you had produced a reflective piece and a witness statement which addressed your administration of medication and your record keeping. However, it noted that during your oral evidence, you appeared to abandon what you stated within these statements. While the panel noted that there were inconsistencies between your account at the Home investigation meeting, your witness statement, and your oral evidence, it considered that you had demonstrated some understanding, within your oral evidence, of the mistakes you had made regarding your administration of medication and your record keeping. It concluded that your insight in relation to this was very limited.

The panel was satisfied that the misconduct in this case pertaining to the administration of medication and record keeping were capable of being addressed. It bore in mind that misconduct involving dishonesty is often said to be less easily remediable than other kinds of misconduct. However, in the panel's judgment, evidence of insight, remorse and reflection together with evidence of subsequent and previous integrity are all relevant in considering the risk of repetition, as is the nature and duration of the dishonesty itself.

Regarding the theft of medication and the dishonesty associated with it was serious because it was taken while you were in a position of trust and bore in mind that this was a breach of the Home's policy. This was not an isolated incident and the panel found that you had removed medication after 13 June 2015, 6 June 2016, 2 March 2017, 26 September 2017, 27 November 2017 and 2 January 2018. It bore in mind that the medication removed was both over the counter medication and those that had been prescribed to residents. You also stated you had justification to remove the medication

from Ms 5, which she denied. The panel was of the view that there was no recognition of the impact your actions had on patients, colleagues and the nursing profession. The panel particularly noted that this dishonesty occurred within the health and care environment. It concluded that that you had shown no insight in relation to this.

The panel carefully considered the evidence before it in determining whether or not you had taken steps to strengthen your practice. In relation to the administration of medication and record keeping, the panel bore in mind that you had undertaken training as required by your ICOPO. It had sight of certificates of training undertaken while you were at Valley Court Care Home including the medication administration certificate and medication training for home staff. It also had sight of the staff competency assessment competed on 2021 which included record keeping.

The panel also took account of the positive testimonials from management and colleagues from Valley Court Care Home. It appears to the panel that you have been able to strengthen your practice with your ICOPO under direct supervision and subsequently under indirect supervision.

The panel was of the view that there was evidence of progress made at Valley Court Care Home in relation to medication administration and record keeping and the risk of repetition in relation to either was low.

However, the panel noted that you had not presented any evidence of strengthened practice in relation to the dishonesty. It concluded that you had no insight regarding this and the theft of medication and it considered that your lack of remediation means there remains a high risk of repetition. The panel therefore determined 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.

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

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

The panel was satisfied that, having regard to the nature of the misconduct in this case, "the need to uphold proper professional standards and public confidence in the profession would be undermined" if a finding of current impairment were not made. It was of the view that a reasonable, informed member of the public would be very concerned if your fitness to practise were not found to be impaired.

For all the above reasons the panel determined that a finding of impairment on public interest grounds is required.

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

Sanction

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

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

Submissions on sanction

Ms Dyas submitted that a striking off order is the most appropriate sanction. She submitted that the dishonesty in this case is not a single instance as it occurred over a significant period of time. She submitted that the dishonesty related to different types of medication removed from the Home.

Ms Dyas submitted that the dishonesty raises concerns about Ms Nevins' professionalism and suitability to remain on the NMC register. She submitted that a striking off order is the only sanction that will protect the public and satisfy the public interest in this case.

Ms Dyas took the panel through the aggravating and mitigating factors she considered to be engaged in this case. She also drew the panel's attention to the NMC Guidance entitled "Considering sanctions for serious cases".

Ms Dyas submitted that a rejected defence of honesty is likely to be regarded as an aggravating factor if it is based on a disagreement between the panel and the registrant about the facts raised regarding the registrant's subjective state of mind.

Ms Dyas submitted that this is the case here as Ms Nevins' defence appears to be that she took the medication home by accident and the panel has rejected this by finding that it was done dishonestly.

Ms Dyas submitted that a sanction of no further action would not be appropriate. She submitted that a caution order only applies to cases at the lower end of the spectrum of impaired fitness to practice. She submitted that this case is towards the upper end.

Ms Dyas submitted that a conditions of practice order cannot address the attitudinal concerns. She further submitted that Ms Nevins' lack of insight and reflection does not make a conditions of practice appropriate.

Ms Dyas reminded the panel that a suspension order is only for a specific period of time. She submitted that the attitudinal concerns have not been remediated and therefore a suspension order would not be appropriate.

Ms Dyas submitted that due to the attitudinal concerns raised and the dishonesty, the appropriate sanction is a striking off order.

Mr Hussain-Dupré provided the panel with written submissions which the panel have read:

> *1. In considering sanction there are no universal or inflexible rules (Atkinson v General Medical Council [2009] EWHC 3636 (Admin), Blake J at para 13) and the individual circumstances of the case must be a factor. The exercise is a balancing act between the prospect of the individual registrant returning to practice and the reputation of the profession being disproportionately damaged if they were so permitted.*
>
> *2. The panel is already aware that the Registrant has been under various ICOPOs since her original suspension order in 2018, the most recent ICOPO allowing her to work with indirect supervision. Throughout this time she has worked without incident or any complaint against her.*
>
> *3. Evidence of the Registrant's performance during this time is provided in the bundle (Exhibits p.198 to p.237) through her certificates of training, the competency assessment to allow her to work at Valley Court, supervision record and testimonials from managers and colleagues in that setting.*

4. The panel's attention has been drawn specifically to the records and comments in relation to the handling, storing and administration of medication. The consistent theme is that the Registrant possesses the knowledge and competence to be entrusted with the safe execution of these tasks and that she shows professionalism, knowledge and compassion in her daily practice. The clinical lead at Valley Court, Donna Foley, concludes that there are no concerns with regards to the Registrant's ability to lead the care team (Exhibits p.211). It is clear that Ms Nevins still has a lot to offer the profession.

5. The Registrant's own reflections on her performance are also in evidence (Exhibits p.198, p.208) demonstrating her awareness of the need to adhere to NMC guidelines as well as focussing on the safety and care of her patients.

6. The Registrant left Valley Court in December 2022. This was a conscious decision as she was beginning to feel overwhelmed by the continuing FTP process. Reflecting on her past performance, she did not want her own worries to become a distraction, or to compromise her standard of care in any way.

7. The panel concluded in its finding on impairment that the risk of repetition in relation to the charges associated with the administration and recording of administration of medication to be low.

Dishonesty

8. In its finding on impairment, at p.61 para 2, the panel references the 'theft' of medication, with a second reference the same on p.62 at para 1.

9. At p.61, para 2, the panel concluded that there was 'no recognition of the impact your actions had on patients, colleagues and the nursing profession'.

10. At p.62, para 1, the panel concluded that the Registrant had 'no insight' regarding dishonesty and 'the theft of medication' and accordingly considered that the 'lack of remediation means there remains a high risk of repetition'.

11. The Registrant takes issue with the reference to the term 'theft' in respect of both Charge 4 and Charge 12.

12. Whilst the issue of the criminal proceedings have not been explicitly explored before this panel, there was a tacit understanding between the parties that those proceedings and the outcome were not immediately relevant to the instant proceedings. However, the Registrant's witness statement, which has been previously referenced in these proceedings, states clearly (Exhibits, p.196, para 38) that she had in fact been acquitted in relation to charges of the theft of medication.

13. The charges on which the Registrant was acquitted by a jury at Birmingham Crown Court in October 2019 translate broadly into Charge 1(f), Charge 4 and the entirety of Charges 11 and 12 in the instant proceedings.

14. It is accepted that the outcome of the previous criminal proceedings is not determinative of these fitness to practise proceedings, nor is the panel obliged to attach any weight to the outcome, on the basis that it operates to the civil rather than the criminal standard of proof.

15. However, none of the charges in the instant proceedings is deals with theft - and its constituent parts - as a criminal offence.

16. As the panel is aware from the defence's earlier hearsay application, Ms 5 gave evidence at the Crown Court trial. Ms 2 also gave evidence.

17. The issue at hand plays into case law on 'rejected defence' upon which the panel has already received advice from the Legal Assessor.

18. It is the Registrant's case that it would be impossible for her to show wide-ranging insight into dishonesty when availing herself of the same defence by which she had already been acquitted, on similar criminal charges, which themselves turned on dishonesty.

19. A reflective and witness statement were submitted by the Registrant to the NMC (Exhibits, p.191 and p.194 respectively). The date of sending is not presently known, but it is the Registrant's case that it was sent after the conclusion of the Crown Court proceedings and most likely with the witness statement (Exhibits, p.194) which is dated 3 August 2021.

20. There has been previous discussion of the reflective, on the basis that elements were submitted by the Registrant's previous representative and did not precisely reflect the extent of her instructions. The Registrant gave some explanation in live evidence. Submissions were made on this point at the impairment stage both by the NMC and then by the defence, on the basis that the panel could draw its own inferences from the contents.

21. Nevertheless, the reflective states:

I feel very ashamed of what had happened and I am genuinely sorry for the concerns my conduct had caused for the safety of patients, my colleagues and the reputation of the NMC.

(Exhibits, p.191, para 2)

Medications prescribed for a patient is the property of that patient and should not be used for any other patient and neither should it be taken by any member of staff for any reason.

(Exhibits, p.192, para 4)

In hindsight of the medication I had unintentionally taken home, I could have checked all my pockets before leaving my shift to ensure all items belonging to the Home and that of patients are not taken with me when I finish my shifts. Also, I could have called the home the same evening of my discovery of the medication in my uniform pocket so as to register my finding at the same time.

(Exhibits, p.192, para 6)

I continue to be vigilant to ensure that I do not repeat any of my past conduct.

(Exhibits, p.193, para 3)

22. As has already been set out, there is no burden of proof at this stage in the proceedings and the panel must exercise its judgment. However, it is submitted that the panel must take into account relevant matters and the circumstances of each case (Atkinson).

23. The NMC has already cited Sawati v GMC [2022] EWCH 283, which distills the earlier authorities and sets out a four-part consideration of dishonesty in relation to a rejected defence and its bearing on sanction:

[104] First: the primary allegations against the doctor. The proper place of dishonesty (or other states of mind such as 'deliberate' and 'knowing') in the scheme of the allegations matters. A rejected defence of honesty may be more fairly relevant to an overall assessment of conduct where dishonesty (the noun) is the primary allegation - deceit, fraud, forgery or similar – than where 'dishonestly' (the adverb) is a secondary allegation, aggravating a primary allegation of other misconduct which may or may not be done honestly – or not a formal allegation at all. As Lord Hoffmann emphasised, particular alertness is needed to the 'charging

trap': adding 'dishonestly' to a primary allegation to aggravate it disproportionately, colour any denial of the primary allegation with dishonesty, or characterise denial of the dishonesty as itself dishonest or lacking insight. But even short of oppressive charging, the fair relevance to sanction of a doctor's rejected honesty defence depends on its relationship to what they were primarily defending.

[105] Second: what if anything the doctor is positively denying. There is a difference between denying 'primary facts' – what happened and what the doctor did or did not do – and denying 'secondary facts' – the evaluation of the primary facts through the lens of what the doctor knew or thought and the choices available to them. Resistance to the objectively verifiable is potentially more problematic behaviour (and more relevant to sanction) than insistence on an honest subjective perspective. This is not of course an exclusive binary classification: what a doctor thinks or knows will often have to be deduced evidentially from objective circumstances. A secondary fact such as dishonesty may be inferred in some defended cases from an overwhelming accumulation of primary facts. If a doctor denies their alleged state of mind with a defence at the unreal, unreasonable or 'frankly ludicrous' end of the spectrum, that may be more fairly relevant to sanction than one where the only thing being denied is that dishonesty rather than honest mistake gives the better account of things.

[106] Third: whether there is evidence of lack of insight other than the rejected defence. Before a rejected defence is held to be relevant evidence of 'lack of insight', it is necessary to consider what other evidence of insight or lack of insight is present. There are cases, including some of the sexual impropriety cases, where being 'in denial' up to and including sanction proceedings is a richly evidenced course of conduct, in which a range of supportive and restrictive interventions have demonstrably failed to bring a doctor to a proper, fair and reasonable acknowledgment of the reality of their established problems and failings. At the other end of the spectrum, there are cases in which the only evidence of failure of insight seems to be robust defence at the fact-finding stage. Damascene

conversions aside, a rejected defence which on a fair analysis adds to an evidenced history of faulty understanding is more likely to be relevant fairly to sanction than one said to constitute such faulty understanding in and of itself.

[108] Fourth: the nature and quality of the rejected defence. 'Not telling the truth to the Tribunal', when not freshly charged in separate proceedings as akin to perjury, has to amount to something more than a failure to admit to an allegation (especially a secondary allegation of dishonesty) or a putting to proof, before it can properly count against a doctor. It is likely to have to amount to more than offering an 'honest' alternative explanation of events alleged to be explicable as dishonesty, or it is hard to see how a dishonesty charge is to be effectively defended. It is going to require some thought to be given to the nature of the rejected defence. Was it a blatant and manufactured lie, a genuine act of dishonesty, deceit or misconduct in its own right? Did it wrongly implicate and blame others, or brand witnesses giving a different account as deluded or liars? Or was it just a failed attempt to tell the story in a better light than eventually proved warranted?

24. On the first limb, it is submitted that the primary facts, of taking the Lormetzepam off the premises, related to Charge 1(f), were admitted. The Registrant gave evidence that she should not have taken the medication of the premises and knows this to be the case.

However, the Registrant denied that she had done so dishonestly, as in Charge 4 and secondary to Charge 1(f).

25. In relation to the second limb, the Registrant did not deny the primary facts, but her explanation of the secondary facts required evaluation by the panel based on her evidence. In her evidence, the Registrant did not resist the 'objectively verifiable' and when it was put to her by the panel that Resident E may have been taking Lormetazepam as early as 27 November 2017, she explained quite openly that the handwritten date on the box '4/12/17' would have been an indication of the

actual date on which the medication was first administered. The Registrant pointed out that she considered the medication to be 'new' as Resident E had not been taking it for a full month. She had earlier explained that her concerns arose because of the decline in Resident E's condition and she questioned whether the Lormetazepam being introduced had had a negative effect. The Registrant also dealt candidly with the CCTV evidence and detailed her actions, even though it was her case that none of the four clips showed her actually taking the medication.

26. In order for the second limb to be made out, the Registrant's evidence as to dishonesty would have had to be at the 'unreal, unreasonable or 'frankly ludicrous' end of the spectrum' in order to for it to be fairly relevant to sanction. For reasons outlined in relation to the other limbs, it is submitted that the Registrant's evidence does not fall into this category.

27. As to the third limb, it is submitted that there is no other evidence of a lack of insight other than the rejected defence. In relation to Charge 4, there is no 'richly evidenced course of conduct, in which a range of supportive and restrictive interventions have demonstrably failed to bring a doctor [nurse] to a proper, fair and reasonable acknowledgment of the reality of their established problems and failings.' Although in its findings of fact the panel determined that the Registrant's explanation for the Lormetazepam being taken off the premises was not plausible, this was evaluative and not as a result of the Registrant being confronted with evidence that her explanation was patently untrue and then continuing to maintain the same defence regardless.

28. There is no persistent lack of insight (R (Farah) v GMC [2008] EWHC 731 (Admin)) and therefore mitigating factors are relevant and a strike order should not be inevitable.

29. Further, as outlined above, there is positive evidence that the Registrant has demonstrated insight, couched for example in the general terms of it not being

acceptable to take a resident's medication (Exhibits, p.192, para 4), albeit without admitting compromising her defence to the dishonesty in the charges.

30. On the fourth limb, it is submitted that the Registrant did not come with freshly concocted and deliberate lie to defend against these proceedings, but a defence to dishonesty which was consistent with her defence in her criminal trial and which was largely consistent with her police station interview. Whilst the panel may have received additional evidence compared the jury in the Crown Court, the Registrant was entitled to put the NMC to proof on this.

31. The panel has already been directed on the passage of time and reliability of witness testimony.

32. In relation to Charge 12, even though the panel did not accept the Registrant's evidence as to dishonesty, the Registrant was clear in her evidence that in future, even if something seemed permissible, but was potentially in breach of policy she would definitely act in accordance with the policy. It is submitted that this is allied to insight into dishonesty.

Conclusions

33. On the basis of the above, the panel is invited to consider whether the dishonesty found proven in Charges 4 and 12 is in fact remediable. It is argued that a lack of insight does not necessarily flow from the rejected defence(s) and that the Registrant has shown that she has reflected and does have the necessary level of insight to these charges such that her previous course of conduct is remediable.

34. Further or alternatively, the submissions in respect of Charge 4, diminish the cumulative effect of findings of dishonesty on both charges.

35. The panel having already determined the risk of repetition on the administration and recording charge to be low, and there being a strong potential that the dishonesty can be remediated, the panel is invited to impose a conditions of practice order as the final sanction in this matter.

36. The Registrant has already demonstrated that conditions of practice are workable and that she is able to find employment with either direct or indirect supervision requirements. The Registrant would be obliged to notify any future employer of such conditions of practice and be supervised accordingly. The panel is invited to consider this as relevant when determining the proportionality of sanctions.

37. The panel is further invited to take into account the Registrant's unblemished career prior to the complained of incidents.

The panel addressed Mr Hussain-Dupré regarding his written submissions relating to the use of the term "theft" in its determination. The panel was of the view that its' use of the word "theft" is a reference to the layman term, namely removal without permission, and not the criminal term.

The panel heard and accepted the advice of the legal assessor. During the panel's deliberations he provided further legal advice which cited the case of *Abbas v General Medical Council | [2017] EWHC 51 (Admin).* This stated:

'erasure is not necessarily inevitable and necessary in every case where dishonest conduct by a medical practitioner has been substantiated. There are cases where the panel, or indeed the court on appeal, have concluded in the light of the particular elements that a lesser sanction may suffice and it is the appropriate sanction bearing in mind the important balance of the interests of the profession and the interests of the individual. It is likely that for such a course to be taken, a panel would normally require compelling evidence of insight and a number of other

factors upon which it could rely that the dishonesty in question appeared to be out of character or somewhat isolated in its duration or range, and accordingly there was the prospect of the individual returning to practice without the reputation of the profession being disproportionately damaged for those reasons.'

Ms Dyas and Mr Hussain-Dupré were invited to make any further submissions.

Ms Dyas made no further submissions.

Mr Hussain-Dupré referred the panel to his written submissions regarding Ms Nevins's insight. He submitted that it is possible to demonstrate insight while defending dishonesty.

Decision and reasons on sanction

Having found Ms Nevins' 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 carefully considered the submissions of Ms Dyas and Mr Hussain-Dupré relating to rejected defence. It acknowledged that Ms Nevins had undergone previous criminal proceedings where she adopted a defence. At this hearing, Ms Nevins adopted a similar defence. However, the panel found inconsistencies between aspects of her written evidence presented to the panel and her oral evidence.

In relation to fairness to all parties, the panel did not consider Ms Nevins' rejected defence to be an aggravating feature in this case. However, it does find the following to be aggravating features:

- Abuse of a position of trust given that Ms Nevins a senior nurse who had unsupervised access to medication contained within a locked cupboard;
- Lack of insight in respect of the dishonesty;
- A pattern of misconduct over a period of time in respect of the removal of medication
- Conduct which potentially put patients at risk of suffering harm due to the removal of medicines and the mis-management of medication and administration.

The panel also took into account the following mitigating features:

- Some insight into the clinical concerns;
- Some admissions;
- Undertaken retraining in regard to the clinical concerns relating medications management;
- Positive testimonials;
- Personal mitigation.

The panel also took account of the NMC Guidance “Considering sanctions for serious cases” which stated:

> *‘Cases involving dishonesty*
>
> *The most serious kind of dishonesty is when a nurse, midwife or nursing associate deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone’s care.*
>
> *However, because of the importance of honesty to a nurse, midwife or nursing associate’s practice, dishonesty will always be serious.*
>
> *In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. Not all dishonesty is equally serious. Generally, the forms of*

dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:

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

The panel was not of the view that the first bullet point of the guidance applies. It bore in mind that Ms Nevins returned some of the medication, albeit, during a disciplinary meeting. It also did not consider there to be a misuse of power.

However, the panel noted that Ms Nevins' dishonest act adversely affected vulnerable patients at the Home. It was satisfied that there could have been some gain as the medication may have been for personal use. There was no direct risk to patients as a result of her dishonesty but the panel was satisfied that there was a long-standing deception.

The panel again referred to the NMC Guidance "Considering sanctions for serious cases" which also stated:

'Dishonest conduct will generally be less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *incidents in private life of nurse, midwife or nursing associate'*

The panel was satisfied that this was not a one-off incident as the dishonesty spanned a significant period of time. It was of the view that it was not opportunistic or spontaneous, however there was potential personal gain. The panel also bore in mind that the act of dishonesty occurred while Ms Nevins was at the Home employed as a registered nurse.

The panel considered the seriousness of the dishonesty in this case. It bore in mind that Ms Nevins did not admit she was dishonest in this case and it accepts that that she is entitled to do so.

The panel acknowledged that while Ms Nevins' dishonesty is not at the upper end of the scale of seriousness, it is not at the lower end because it relates to the removal of medication over a significant period of time from a nursing home where vulnerable patients were at a potential risk of harm. There is a breach of trust and Ms Nevins is in a position where she had access to medication, some of which were prescribed.

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

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

The panel next considered whether placing conditions of practice on Ms Nevins' registration would be a sufficient and appropriate response. The panel acknowledged that

Ms Nevins had been placed on an ICOPO to address the clinical concerns relating to medication management. It bore in mind that this has been reduced through time and she has been complying with the ICOPO up until 2022.

However, the panel considered that this case involves dishonesty and found that Ms Nevins had little or no insight or evidence of remediation in this regard. It was of the view that there are no practical or workable conditions that could be formulated, given the nature of the dishonesty. Additionally, the panel was of the view that the dishonesty identified in this case was not something that can be addressed through retraining. The panel concluded that placing conditions on Ms Nevins' registration would not adequately address the seriousness of this case, would not protect the public nor meet the public interest.

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

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

The aggravating factors that the panel took into account were that the dishonesty found proved was not an isolated incident. It occurred multiple times ranging from 2015 until 2018 and related to the removal of a range of medication including over the counter medication and prescribed medication from the Home which was contrary to the Home's policy. The panel found that there is some evidence of deep seated attitudinal problems which was displayed though numerous inconsistencies in Ms Nevins' accounts.

While the panel did not have any evidence of repetition of the behaviour since the incident, it did find that due to there being no insight into the dishonesty, there is a high risk of repetition.

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

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

Finally, in looking at a striking-off order, the panel bore in mind the advice of the legal assessor and the aforementioned case of *Abbas v General Medical Council | [2017] EWHC 51 (Admin)*. It also 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?*

Ms Nevins' actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Nevins' actions were serious and to allow her 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 Ms Nevins' actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself and the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Ms Nevins in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Nevins' 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 Ms Dyas. Given the panel's findings in relation to sanction she submitted that only an interim suspension order for a period of 18 months will be appropriate. She also submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

Mr Hussain-Dupré did not oppose the application.

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 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.

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

That concludes this determination.