Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 21 June – Monday, 26 June 2023
Monday, 20 November – Thursday, 23 November 2023
Wednesday, 31 January – Thursday, 1 February 2024

Virtual Hearing

Name of Registrant:	Christopher Houseby
NMC PIN	02K0016A
Part(s) of the register:	RNMH: Registered Nurse - Sub Part 1 Mental Health - Level 1 - 13 September 2004
Relevant Location:	St Helens Council
Type of case:	Misconduct
Panel members:	Tracy Stephenson (Chair, Lay member) Linda Pascall (Registrant member) Alexandra Hawkins-Drew (Registrant member)
Legal Assessor:	Fiona Barnett (21 - 26 June 2023, 20 - 23 November 2023) Suzanne Palmer (31 January –- 1 February 2024)
Hearings Coordinator:	Margia Patwary
Nursing and Midwifery Council:	Represented by Nicola Kay, Case Presenter
Mr Houseby:	Present and unrepresented at the hearing (21 June – 26 June 2023) Not present and unrepresented at the hearing (20 November – 24 November 2023) Not present and unrepresented at the hearing (31 January –- 1 February 2024)
Facts proved by admission:	1c, 3, 4ci, 4cii, 6i, 6ii, 7c, and 9

Facts proved:	11a, 11b and 11c
Facts not proved:	1a, 1b, 2, 4ai, 4aii, 4bi, 4bii, 5ai, 5aii, 7a, 7b, 8, 10a, 10b, and 10c
Fitness to practise:	**Currently impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse, whilst working at the Eccleston Court Care Home:

1) On 31 May 2021, failed to:

    a) ensure that a second person/checker conducted/completed the evening controlled drugs check with you, for one or more of the residents listed in Schedule 1; **[NOT PROVED]**
    b) ensure that a second person/checker signed the controlled drugs log for the evening controlled drugs check, in your presence for one of more of the residents listed in Schedule 1; **[NOT PROVED]**
    c) physically count the controlled drugs when doing the evening controlled drugs/stock check for Resident A. **[PROVED BY ADMISSION]**

2) On, or around 31 May 2021, inaccurately recorded, or caused to be recorded, that a second person/checker had undertaken the evening controlled drugs check with you, when they had not done so, for one or more of the residents listed in Schedule 1; **[NOT PROVED]**

3) On, or around, 31 May 2021, inaccurately recorded in the evening controlled drugs check that you had physically counted the controlled drugs for Resident A when you had not done so; **[PROVED BY ADMISSION]**

4) On 01 June 2021, failed to:

    a) ensure that a second person/checker conducted/completed the controlled drugs check with you for one or more of the residents listed in Schedule 1, for;

        i) the morning check; **[NOT PROVED]**
        ii) the evening check. **[NOT PROVED]**

b) ensure that a second person/checker signed the controlled drugs log in your presence, for one or more of the residents listed in Schedule 1 for;

i) the morning controlled drugs check; **[NOT PROVED]**
ii) the evening controlled drugs check. **[NOT PROVED]**

c) physically count the controlled drugs when doing a controlled drugs/stock check for Resident A for; **[PROVED BY ADMISSION]**

i) the morning check;
ii) the evening check.

5) On, or around, 01 June 2021, inaccurately recorded, or caused to be recorded, that a second person/checker had undertaken a controlled drugs check with you, when they had not done so, for one or more of the residents listed in Schedule 1 for ;

i) the morning check; **[NOT PROVED]**
ii) the evening check. **[NOT PROVED]**

6) On, or around, 01 June 2021, inaccurately recorded that you had physically counted the controlled drugs for Resident A when you had not done so, for; **[PROVED BY ADMISSION]**

i) The morning controlled drugs check
ii) The evening controlled drugs check

7) On 02 June 2021, failed to:

a) ensure that a second person/checker conducted/completed the morning controlled drugs check with you, for one or more of the residents listed in Schedule 1; **[NOT PROVED]**

b) ensure that a second person/checker signed the controlled drugs log for the morning controlled drugs check, in your presence, for one of more of the residents listed in Schedule 1; **[NOT PROVED]**
c) physically count the controlled drugs when doing the morning controlled drugs/stock check for Resident A; **[PROVED BY ADMISSION]**

8) On, or around, 02 June 2021, inaccurately recorded, or caused to be recorded, that a second person/checker had undertaken the morning controlled drugs check with you, when they had not done so, for one or more of the residents listed in schedule 1; **[NOT PROVED]**

9) On, or around, 02 June 2021, inaccurately recorded in the morning controlled drugs check that you had physically counted the controlled drugs for Resident A, when you had not done so; **[PROVED BY ADMISSION]**

10) Your conduct at any and/or all of charges 2 and/or 5 and/or 8 above was dishonest in that you: **[NOT PROVED]**

a) Knew that a second person/checker had not undertaken a controlled drugs check with you;
b) Intended to create the misleading impression that a second person/checker had undertaken a controlled drugs check with you when they had not done so;
c) Intended to create the misleading impression that you had followed the controlled drug procedures when you knew that you had not done so;

11) Your conduct at any and/or all of charges 3 and/or 6 and/or 9 was dishonest in that you: **[FOUND PROVED]**

a) Knew that you had not physically counted the controlled drugs;
b) Intended to create the misleading impression that you had physically counted the controlled drugs when you had not done so;

c) Intended to create the misleading impression that you had followed the controlled drug procedures when you knew that you had not done so.

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

Schedule 1

Resident A

Resident B

Resident C

Resident D

Resident E

Unknown Resident F

Unknown Resident G

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Kay, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charges 1 and 2. She submitted that the amendments are an extension to the current charges which will cover two further dates and an additional word in relation to the allegations. She further submitted that you were only given notice of this application yesterday afternoon.

Ms Kay proposed that the amendments would provide clarity and more accurately reflect the evidence. The proposed amendments is as follows:

"That you, a registered nurse, whilst working at the Eccleston Court Care Home:

1) On **27 May and/or 28 May and/or** 31 May 2021, failed to:

    a. ensure that a second person/checker conducted/completed the **morning/** evening controlled drugs check with you, for one or more of the residents listed in Schedule 1;

    b. ensure that a second person/checker signed the controlled drugs log for the **morning/**evening controlled drugs check, in your presence for one of more of the residents listed in Schedule 1;

2) On, or around, **27 May and/or 28 May and/or** 31 May 2021, inaccurately recorded, or caused to be recorded, that a second person/checker had undertaken the **morning/**evening controlled drugs check with you, when they had not done so, for one or more of the residents listed in Schedule 1;"

You did not oppose the proposed amendments.

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 determined that by accepting the proposed amendments there could be unfairness to you. To do so would extend the scope of your misconduct. The panel also noted that you were only notified yesterday afternoon of this matter and that you were not given a reasonable amount of time to consider the proposed amendments and prepare accordingly.

The panel therefore refused the application to amend charges 1 and 2.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Kay under Rule 31 to allow the written statement of Witness 3 into evidence. She explained that Witness 3 was not present at this hearing and, whilst the NMC had made a number of attempts to ensure that this witness was present, she informed the NMC that she does not wish to assist with the NMC with its investigation.

Ms Kay summarised the correspondences between the NMC and Witness 3 and stated that despite attempts made by the NMC, Witness 3 has decided to disengage and as she is not a registered nurse, there is no formal obligation for her to assist the NMC.

Ms Kay provided written submissions which included the following:

"Background

In summary, the Registrant was working as a registered nurse at the Home. The charges relate to failures to follow the correct procedures in respect of checks of controlled drug medication and inaccurate record keeping in respect of those controlled drugs checks.

These allegations came to light after a controlled drug check by an NMC witness [Witness 4] who found a discrepancy between the controlled drug records and the physical number of controlled drugs for one particular resident, Resident A.

During a local investigation, the controlled drugs records revealed that [Witness 3], an Advanced Carer countersigned these records for the morning controlled drugs checks on 31st May and 1st June 2021. A local witness statement was provided by [Witness 3]. Signed and dated 18 June 2021, in which [Witness 3] detailed that Mr Houseby had approached them to say that he had already counted and signed the controlled drugs and requested that when [Witness 3] had a minute, could they countersign them.

…

It is the local witness statement of [Witness 3] that the NMC wish to rely upon as hearsay.

…

[Witness 3] was contacted by the NMC external investigators and indicated they did not wish to assist the NMC. There has been no further response from [Witness 3] despite follow up emails and telephone calls [hearsay bundle]."

Ms Kay referred the panel to Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (the Rules) which states:

'31.—(1) Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in the appropriate Court in that part of the United Kingdom in which the hearing takes place).'

She also referred the panel to case law which included *El-Karout v NMC [2019] EWHC 28*

and *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565.

Ms Kay submitted that Witness 3's statement is clearly relevant to the issues before the Tribunal. In terms of fairness, Ms Kay submitted that it would be fair to admit the statement of Witness 3 for the following reasons:

a) It is a signed and dated witness statement provided for an internal investigation.
b) [Witness 5], who spoke to [Witness 3] to double check their statement and the veracity of the contents, can be cross-examined.
c) The evidential value is significant, because:
    i. It contain details of the specific allegations against the Registrant.
    ii. It was completed soon after the events.
    iii. In respect of some charges, they are decisive.

Ms Kay submitted in conclusion that the NMC should be allowed to rely upon the hearsay statement of Witness 3.

You opposed the application and stated that you do not agree with the contents of Witness 3's written statement as it contradicts your position. You also indicated that it would be unfair for the hearsay application to be granted as you will not have the chance to cross examine Witness 3.

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

The panel first considered whether the statement of Witness 3 was relevant. It was satisfied that it was. It contained her eyewitness account about the presence or otherwise of a second checker, and was therefore relevant to number of charges which are in dispute.

The panel next considered whether it would be fair to admit Witness 3's statement. It reached the following conclusions:

- Witness 3's evidence is the sole and decisive evidence in relation to a number of charges.

- The allegations in dispute, to which Witness 3's evidence relates, are serious. If those charges are found proved, this will open a gateway to possible findings of dishonesty. Such matters, if proved, could have significant consequences for you.

- You confirmed that you dispute Witness 3's evidence in its entirety and that her account contradicts your own account of events. The admission of this evidence as hearsay will deprive you of any opportunity to challenge Witness 3's about her account of events.

- It was apparent from the information in the hearsay bundle that Witness 3 does not wish to assist the NMC with its investigation. She had understood that these matters had been dealt with at local level, and she did not wish to participate further. The panel found this to be a compelling reason for her non-attendance.

- The panel was satisfied that the NMC has made significant efforts to secure Witness 3's attendance at the hearing. The NMC has made repeated efforts to correspond with Witness 3 directly, and it has also made attempts to correspond with her manager in an endeavour to encourage her to engage.

The panel noted that Witness 3's statement was produced during the local investigation. There is no information before the panel to suggest that Witness 3 is an unreliable witness, or that her statement was made in circumstances which would render it unreliable. Her statement is signed, and dated, and was made within a reasonable time of the events to which it relates. The panel will hear from Witness 5, who can give evidence about the local investigation and the disciplinary hearing. He confirms in his witness

statement that he spoke to Witness 3 before the disciplinary hearing to *"double check"* her account, and to test the veracity of her statement. It will be open to you to cross-examine Witness 5 in relation to Witness 3's account and the panel will have an opportunity to clarify any matters on this issue. The panel will also hear from Witness 2 who conducted the local investigation and obtained the statement from Witness 3. Again, it will be open to you to cross-examine Witness 2 about the way in which Witness 3's statement was made, and the panel will have an opportunity to clarify any matters arising from that evidence.

The panel weighed the factors above. It concluded that the prejudice to the NMC if the statement is not admitted would be greater than the prejudice to you if the statement is admitted. The panel acknowledged that there may be some unfairness to you, as you will not be able to challenge Witness 3's account. However, it was satisfied that there will be safeguards in place to address any unfairness to you. In particular you will able to question Witness 5 and Witness 2 about Witness 3's statement, and ultimately the panel will be able to assess what weight to attach to Witness 3's statement, bearing in mind that it will not have heard from her.

In these circumstances, the panel came to the view that Witness 3's evidence is relevant and that it would be fair to accept it into evidence as hearsay. The panel will assess what weight to attach to this evidence when reaching its decision on the disputed facts.

Background

The charges arose whilst you were employed as a registered nurse by Ecclestone Court Care Home ('the Home'), owned by Community Integrated Care ('the Organisation').

It is alleged that on 10 June 2021, Witness 1, audited the Controlled Drugs (CD) stock for the Home and identified discrepancies with some of the entries made by you in the CD register on 31 May 2021, 1 June 2021, and 2 June 2021. It was noted that there were two medication patches in stock for Patient A, rather than three as you had documented.

The correct process at the Home for CD checking is for two suitably competent colleagues to each count the number of CDs in stock, agree on the number counted, and record this and sign the CD register. In accordance with the Home's Medication - Controlled Drugs Policy. This should be done at the change of the shift at least once a day. The purpose of the count is to check the amount of medication within the CD cupboard corresponds with the amount recorded in the CD register.

On 18 June 2021, Witness 3, who was the signatory for 31 May 2021, and 1 June 2021, provided a signed statement stating that you had approached them and asked Witness 3 to be the second signature for your entries. It is alleged by Witness 3 that you had already counted the CDs and asked her to countersigned them. Witness 3 said that "*she trusted that this was correct from the nurse in charge and proceeded to sign the CD book".*

The correct procedure would have been that two competent members of staff should be present to count the stock medication, agree on the amount there, and make a record of this in the appropriate CD register. It is alleged that on a number of occasions you failed to follow this procedure in that you failed to physically count the patches within the box correctly in the presence of Witness 3 as documented in the CD register.

You provided a statement on 9 June 2021 admitting that you had miscounted the patches on 31 May 2021. You said, *"I miscounted those patches and recorded that there were 3 in error on the Daily CD Check. As she has a patch every Thursday I was complacent in counting these patches and wrongly recorded that there were 3 on the next checks."*

During an investigatory interview on 24 June 2021, you said you had failed to take the patches out properly and failed to count them correctly.

During the local investigation, the Home found that during CD checks undertaken by you, there was a second counter signatory in the CD register that could not be identified

You were unable to provide the name of the individual who had signed the CD register on those occasions, but you denied forging the signatures.

Following the conclusion of the investigation, you were dismissed from the Home on 29 July 2021.

Admissions to charges

At the outset of the hearing, you admitted charges 1c, 3, 4c(i), 4c(ii), 6i, 6ii, 7c, and 9. You denied all other charges.

Therefore, the panel found charges 1c, 3, 4c(i), 4c(ii), 6i, 6ii, 7c, and 9 proved by way of admission. The panel noted that it would move on to consider the outstanding charges in its deliberation on facts, after having received all the evidence in this case.

Prior to the NMC closing their case, this hearing went part heard and was due to resume on 20 November 2023 until 24 November 2023.

Decision and reasons on service of Notice of Resuming Hearing

The panel was informed at the start of this hearing that Mr Houseby was not in attendance and that the Notice of Hearing letter had been sent to Mr Houseby's registered email address on 16 October 2023.

Ms Kay submitted that it had complied with the requirements of Rules 32(3) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the time, and dates of the resuming hearing and that the hearing was to be held virtually.

In the light of all of the information available, the panel was satisfied that Mr Houseby has been served with the Notice of the resuming hearing in accordance with the requirements of Rules 32 (3) and Rule 34.

Decision and reasons on proceeding in the absence of Mr Houseby

The panel next considered whether it should proceed in the absence of Mr Houseby. It had regard to Rule 21 and heard the submissions of Ms Kay who invited the panel to continue in the absence of Mr Houseby. She submitted that Mr Houseby had voluntarily absented himself.

Ms Kay referred the panel to the documentation concerning proceeding in absence and summarised the contact with Mr Houseby chronologically.

Mr Houseby's case officer emailed him on 13 November 2023, asking him if he can confirm whether he would be attending the resuming hearing. In his response he stated:

> *"Hi [Case Officer]…*
>
> *I am unable to attend as I am leading a funeral service that day*
> *I have applied to be removed from the register as I no longer plan to work as a registered nurse any more or ever in the future*
> *Kind regards Chris"*

Further, on 15 November 2023, Mr Houseby's case officer sought further reasons for his non-attendance in which he replied:

> *"Hi [Case Officer],*
>
> *I can confirm*

1…
2 I will not be attending any of the hearing due to church commitments
3 I am happy for you to proceed in my absence
Kind regards Chris"

The panel decided to continue in the absence of Mr Houseby. In reaching this decision, the panel considered the submissions of Ms Kay and the advice of the legal assessor. The panel noted that Mr Houseby informed the NMC that he has applied to be removed from the register and that he no longer intends to work as a registered nurse. The panel further noted that Mr Houseby is content for the panel to proceed in his absence and concluded that he had voluntarily absented himself. There is no reason to suppose that adjourning would secure his attendance at some future date. The panel was also of the view that there is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel decided that it is fair and appropriate to continue in the absence of Mr Houseby.

Decisions and reasons on which stage to consider Mr Houseby's application for Agreed Removal from the register

Ms Kay informed the panel that Mr Houseby made an application for agreed removal from the NMC register in October 2023. She referred the panel to the guidance on agreed removal at hearings. Reference: DMA-8 and *'How does the agreed removal process work?'* Reference: CMT-5a.

Ms Kay submitted that it is a matter for the panel to decide at what stage it considers the application and makes its recommendations to the Assistant Registrar (AR). However, she submitted that it would be appropriate for the panel to do so at least after it has made its decisions on the facts.

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

The panel considered the NMC's guidance on procedure when there is an application for agreed removal whilst a fitness to practise substantive hearing is ongoing which stated:

> *"The panel will consider how best to minimise the disruption caused to the hearing. This will usually mean waiting until the end of the finding of facts or impairment stage of the hearing, unless there is an urgent reason for the application to be considered earlier."*

The panel decided that the appropriate time for the AR to consider the application for agreed removal and make recommendations would be after it makes its decision on facts. It could identify no urgent reason to refer this matter to the AR any earlier. The decisions on facts made by the panel in due course will ensure that the panel is better informed to make a recommendation to the AR.

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 Kay and you.

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

The panel has drawn no adverse inference from the non-attendance of Mr Houseby at the resumed hearing.

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

- Witness 1: Clinical Nurse Specialist for the Organisation
- Witness 2: Service Manager for the Organisation
- Witness 4: Regional Manager at the Organisation
- Witness 5: Clinical Nurse Specialist for the Organisation
- Witness 6: Registered Nurse at the Home

The panel also heard evidence from you under oath.
The panel then considered each of the disputed charges and made the following findings.

Charge 1a

On 31 May 2021, failed to

a) ensure that a second person/checker conducted/completed the evening controlled drugs check with you, for one or more of the residents listed in Schedule 1;

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy, Witness 5's written statement and oral evidence, Witness 3's hearsay evidence and the Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 19:30 on 31 May 2021.

Charge 1 alleged that Mr Houseby had *"failed to"* act as set out in paragraphs 1a), and 1b). The panel therefore considered whether the NMC had proved that Mr Houseby was under a duty to ensure that a second checker conducted/completed controlled drugs checks with him, and signed the controlled drugs register in his presence.

The panel was provided with the policies entitled, "Medication - Controlled Drugs" policy, and "Medication Administration in registered services".

The panel noted that the Medication - Controlled Drugs policy states:

> *(3) 'Only trained care workers who are trained and designated to give Controlled Drugs and also to those who will act as a 'witness' should be involved with the administration of Controlled Drug's [sic]'*
>
> *'(26) Staff must follow the 'Administration of Medicines' Procedure CG7.1*
>
> *(27) Administration and recording within care home services - Two staff (in Nursing Homes at least one staff must be a Registered Nurse) must always be involved in the administration and recording of Controlled Drugs. One staff to prepare and administer the dose(s) and the other to witness these actions. In Supported Living Services it is good practice for two staff to be involved in the administration and recording of Controlled Drugs, however it is recognised that this may not always be possible.'*

Witness 5 confirmed in oral evidence that these requirements applied to controlled drugs checks as well as to the administration of medications. In light of the policies set out above, and Witness 5's evidence, the panel was satisfied that Mr Houseby was under a duty to have a second checker when conducting stock checks, and that a second checker was also required to sign the CD register.

In relation to paragraph 1a), the NMC relied on the hearsay statement of Witness 3, and the CD register sheets.

The CD register sheets provided to the panel, show that at 19:30 on 31 May 2021, stock checks had been carried out for Residents A, B, D, E, F and G. The panel was provided with a CD register sheet which was untitled, which may have been for Resident C, however this was unclear.

The charts showed that stock checks for Residents A, B, D, E, F and G, were carried out and signed for by Mr Houseby, a matter which was not disputed by him, and were also signed for by *"Witness 3"*.

The hearsay statement of Witness 3, which was made for the purposes of the local investigation, was signed by her and dated 18 June 2021. It stated as follows:

> *"Regarding the concerns raised on the 31/5/2021 and 1/6/2021.*
>
> *Around 18.00 CH approached me to say that he had already counted and signed the CDs, and that when I had a minute could I counter sign them. I trusted that this was correct from the nurse in charge and proceeded to sign the CD book. I realize that this is also my responsibility to check the CDs thoroughly, going forwards I will learn from my mistake."*

Mr Houseby refuted the version of events set out by Witness 3 in her local statement. he maintained that he was aware of the CD procedures, and that a second checker had always been present and completed the CD checks with him. Mr Houseby also stated that he would not "*risk his registration"* by failing to follow the CD policy. Mr Houseby also maintained that the keys for the CD cupboards were split between two members of staff, and that it would not have been possible for him to access the CD without another nurse or advanced carer being present.

In determining whether the NMC has proved the charge to the required standard, the panel decided what weight to attribute to the hearsay statement made by Witness 3. In doing so, it took account of the following factors:

- Witness 3's statement was not made for the purpose of these proceedings and she chose not to participate in the NMC process.
- The panel has not had the opportunity of seeing and hearing from Witness 3 and assessing her as a witness.
- Witness 3's statement was not made or verified on oath and does not contain a statement of truth.
- Witness 3's account is disputed in its entirety by Mr Houseby, and he has not had any opportunity to challenge her account and put his own version of events to her.

Witness 5 told the panel that during the local investigation, he had asked Witness 3 questions to test the veracity of her account and was satisfied from her responses that her account was accurate. However, the veracity of her evidence in these proceedings is a matter for the panel only, and should not be decided on the conclusion of the local investigation. The panel therefore discounted his evidence on this issue.

For the reasons set out above, the panel decided that it could attribute no weight to the hearsay evidence of Witness 3. The NMC adduced no other evidence to support charge 1. Witness 3's evidence was therefore the sole and decisive witness evidence for this charge.

Given that Mr Houseby has denied the charge and the panel has discounted the hearsay evidence of Witness 3, the panel concluded that the NMC has not proved charge 1a to the required standard and it found charge 1a not proved.

Charge 1b

b) ensure that a second person/checker signed the controlled drugs log for the evening controlled drugs check, in your presence for one of more of the residents listed in Schedule 1;

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy, Witness 5's written statement and oral evidence, Witness 3's hearsay evidence and the Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 19:30 on 31 May 2021.

The panel noted, paragraph 36 in relation to Medication - Controlled Drugs Policy states:

> *"(36) Both the member of staff administering the Controlled Drug and the witness should sign the Controlled Drug Register. Only the member of staff administering the Controlled Drug should sign the MAR chart."*

Witness 5 confirmed in oral evidence that these requirements applied to controlled drugs stock checks as well as to the administration of CD medications. In light of the policy set out above, and Witness 5's evidence, the panel was satisfied that when undertaking CD stock checks Mr Houseby was under a duty to have a second person sign the CD register in his presence.

The panel had sight of the relevant CD register sheets and noted that both Mr Houseby and Witness 3 had signed for the evening stock check. Mr Houseby has consistently maintained throughout the proceedings that Witness 3 was present during the check and signed accordingly which was disputed by Witness 3.

The NMC relied on the evidence of Witness 3 and there was no other evidence in support of this charge. Given that Mr Houseby has denied the charge and the panel has

discounted the hearsay evidence of witness 3, the panel concluded that the NMC has not proved charge 1b to the required standard and it found charge 1b not proved.

Charge 2

2) On, or around, 31 May 2021, inaccurately recorded, or caused to be recorded, that a second person/checker had undertaken the evening controlled drugs check with you, when they had not done so, for one or more of the residents listed in Schedule 1.

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy and the Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 19:30 on 31 May 2021.

The panel have interpreted this charge as similar in nature to charge 1b in that it relates to Mr Houseby stating that he signed the CD registers in the presence of Witness 3 which Witness 3 disputed.
The panel had sight of the relevant CD register sheets and noted that both Mr Houseby and Witness 3 had signed for the evening stock check. Mr Houseby has consistently maintained throughout the proceedings that Witness 3 was present during the check and signed accordingly which was disputed by Witness 3.

The NMC relied on the evidence of Witness 3 and there was no other evidence in support of this charge. Given that Mr Houseby has denied the charge and the panel has discounted the hearsay evidence of witness 3, the panel concluded that the NMC has not proved charge 2 to the required standard and it found charge 2 not proved.

Charge 4ai

On 1 June 2021, failed to:

a) ensure that a second person/checker conducted/completed the controlled drugs check with you for one or more of the residents listed in Schedule 1, for;
   i) the morning check;

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy, Witness 5's oral evidence, Witness 2's written statement, oral evidence and his local investigation, Witness 4's written statement, oral evidence, her local statement and Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 07:30 on 1 June 2021.

The panel noted that the Medication - Controlled Drugs policy states:

> *(3) 'Only trained care workers who are trained and designated to give Controlled Drugs and also to those who will act as a 'witness' should be involved with the administration of Controlled Drug's [sic]'*
> *'(26) Staff must follow the 'Administration of Medicines' Procedure CG7.1*
>
> *(27) Administration and recording within care home services - Two staff (in Nursing Homes at least one staff must be a Registered Nurse) must always be involved in the administration and recording of Controlled Drugs. One staff to prepare and administer the dose(s) and the other to witness these actions. In Supported Living Services it is good practice for two staff to be involved in the administration and recording of Controlled Drugs, however it is recognised that this may not always be possible.'*

Witness 5 confirmed in oral evidence that these requirements applied to controlled drugs stock checks as well as to the administration of CD medications. In light of the policies set out above, and Witness 5's evidence, the panel was satisfied that Mr Houseby was under

a duty to have a second checker when conducting stock checks, and that a second checker was also required to sign the CD register.

The panel had sight of the CD register sheets dated 1 June 2021, signed by Mr Houseby and an unknown individual. Whilst the panel noted the evidence of Witness 2 and Witness 4, who were unable to verify whom this signature belonged to, the panel were not satisfied that this proved that there had not been another competent individual involved in this CD stock check.

In making this decision the panel took into account the fact that neither Witness 2 or Witness 4 were experts in handwriting analysis and therefore could not verify that this signature did not belong to a member of staff who was working on that shift. The outcome of the local investigation could not be taken into consideration in these proceedings in any event. In addition, the panel noted that the Home held a signature log sheet for the purpose of verifying signatures in the CD register, however this document was not supplied for these proceedings.

Mr Houseby has consistently maintained that he had a second checker with him and that he could not recall the identity of this person.

Given the fact that Mr Houseby has denied the charge and the panel have discounted the evidence of Witness 2 and Witness 4 on the origin of the signature, the panel concluded that the NMC has not proved charge 4ai to the required standard and it found charge 4ai not proved.

Charge 4aii

> a) ensure that a second person/checker conducted/completed the controlled drugs check with you for one or more of the residents listed in Schedule 1, for;
> ii) the evening check.

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy, Witness 5's written statement and oral evidence, Witness 3's hearsay evidence and the Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 19:30 on 1 June 2021.

The panel have already found that Mr Houseby was under a duty to have a second checker present when conducting stock checks and that a second checker was also required to sign the CD register.

The NMC relied on the hearsay statement of Witness 3, and the CD register sheets.

The CD register sheets provided to the panel, show that at 19:30 on 1 June 2021, stock checks had been carried out for Residents A, B, D, E, F and these were signed for by Mr Houseby and *"Witness 3"*.

The panel have already decided that it could attribute no weight to the hearsay evidence of Witness 3. The NMC adduced no other evidence to support charge 4aii.

Given that Mr Houseby has denied the charge and the panel has discounted the hearsay evidence of Witness 3, the panel concluded that the NMC has not proved charge 4aii to the required standard and it found charge 4aii not proved.

Charge 4bi

b) ensure that a second person/checker signed the controlled drugs log in your presence, for one or more of the residents listed in Schedule 1 for;
   i) the morning controlled drugs check;

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy, Witness 5's oral evidence, Witness 2's written statement, oral evidence and his local investigation, Witness 4's written statement, oral evidence, her local statement and the Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 07:30 on 1 June 2021.

The panel have already found that Mr Houseby was under a duty to have a second checker present when conducting stock checks and that a second checker was also required to sign the CD register.

The panel had sight of the CD register sheets dated 1 June 2021, signed by Mr Houseby and an unknown individual. Whilst the panel noted the evidence of Witness 2 and Witness 4, who were unable to verify whom this signature belonged to, the panel were not satisfied that this proved that there had not been another competent individual involved in this CD stock check. In making this decision the panel took into account the fact that neither Witness 2 or Witness 4 were experts in handwriting analysis and therefore could not verify that this signature did not belong to a member of staff who was working on that shift. The outcome of the local investigation could not be taken into consideration in these proceedings in any event. In addition, the panel noted that the Home held a signature log sheet for the purpose of verifying signatures in the CD register, however this document was not supplied for these proceedings.

Mr Houseby has consistently maintained that he had a second checker with him and that he could not recall the identity of this person.

Given the fact that Mr Houseby has denied the charge and the panel have discounted the evidence of Witness 2 and Witness 4 on the origin of the signature, the panel concluded that the NMC has not proved charge 4bi to the required standard and it found charge 4bi not proved.

Charge 4bii

ii) the evening controlled drugs check.

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy, Witness 5's written statement and oral evidence, Witness 3's hearsay evidence and the Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 19:30 on 1 June 2021.

The panel have already found that Mr Houseby was under a duty to have a second checker present when conducting stock checks and that a second checker was also required to sign the CD register.

The panel had sight of the relevant CD register sheets and noted that both Mr Houseby and Witness 3 had signed for the evening stock check. Mr Houseby has consistently maintained throughout the proceedings that Witness 3 was present during the check and signed accordingly which was disputed by Witness 3.

The NMC relied on the evidence of Witness 3 and there was no other evidence in support of this charge. Given that Mr Houseby has denied the charge and the panel has discounted the hearsay evidence of witness 3, the panel concluded that the NMC has not proved charge 4bii to the required standard and it found charge 4bii not proved.

Charge 5i

5) On, or around, 01 June 2021, inaccurately recorded, or caused to be recorded, that a second person/checker had undertaken a controlled drugs check with you, when they had not done so, for one or more of the residents listed in Schedule 1 for;

i) the morning check;

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy and the Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 07:30 on 1 June 2021.

The panel have interpreted this charge as similar in nature to charge 4b in that it relates to Mr Houseby stating that he signed the CD registers in the presence of an unknown individual which the NMC disputes.

The panel had sight of the CD register sheets dated 1 June 2021, signed by Mr Houseby and an unknown individual. Whilst the panel noted the evidence of Witness 2 and Witness 4, who were unable to verify whom this signature belonged to, the panel was not satisfied that this proved that there had not been another competent individual involved in this CD stock check. In making this decision the panel took into account the fact that neither Witness 2 or Witness 4 were experts in handwriting analysis and therefore could not verify that this signature did not belong to a member of staff who was working on that shift. The outcome of the local investigation could not be taken into consideration in these proceedings in any event. In addition, the panel noted that the Home held a signature log sheet for the purpose of verifying signatures in the CD register, however this document was not supplied for these proceedings.

Mr Houseby has consistently maintained that he had a second checker with him and that he could not recall the identity of this person.

Given the fact that Mr Houseby has denied the charge and the panel have discounted the evidence of Witness 2 and Witness 4 on the origin of the signature, the panel concluded that the NMC has not proved charge 5i to the required standard and it found charge 5i not proved.

Charge 5ii

ii) the evening check.

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy and the Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 19:30 on 1 June 2021.

The panel have interpreted this charge as similar in nature to charge 1b in that it relates to Mr Houseby stating that he signed the CD registers in the presence of Witness 3 which Witness 3 disputed.

The panel had sight of the relevant CD register sheets and noted that both Mr Houseby and Witness 3 had signed for the evening stock check. Mr Houseby has consistently maintained throughout the proceedings that Witness 3 was present during the check and signed accordingly which was disputed by Witness 3.

The NMC relied on the evidence of Witness 3 and there was no other evidence in support of this charge. Given that Mr Houseby has denied the charge and the panel has discounted the hearsay evidence of witness 3, the panel concluded that the NMC has not proved charge 5ii to the required standard and it found charge 5ii not proved.

Charge 7a

7) On 02 June 2021, failed to:

a) ensure that a second person/checker conducted/completed the morning controlled drugs check with you, for one or more of the residents listed in Schedule 1;

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy, Witness 5's oral evidence, Witness 2's written statement, oral evidence and his local investigation, Witness 4's written statement, oral evidence, her local statement and Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 07:30 on 2 June 2021.

The panel have already found that Mr Houseby was under a duty to have a second checker present when conducting stock checks and that a second checker was also required to sign the CD register.

The panel had sight of the CD register sheets dated 2 June 2021, signed by Mr Houseby and an unknown individual. Whilst the panel noted the evidence of Witness 2 and Witness 4, who were unable to verify whom this signature belonged to, the panel were not satisfied that this proved that there had not been another competent individual involved in this CD stock check. In making this decision the panel took into account the fact that neither Witness 2 or Witness 4 were experts in handwriting analysis and therefore could not verify that this signature did not belong to a member of staff who was working on that shift. The outcome of the local investigation could not be taken into consideration in these proceedings in any event. In addition, the panel noted that the Home held a signature log sheet for the purpose of verifying signatures in the CD register, however this document was not supplied for these proceedings.

Mr Houseby has consistently maintained that he had a second checker with him and that he could not recall the identity of this person.

Given the fact that Mr Houseby has denied the charge and the panel have discounted the evidence of Witness 2 and Witness 4 on the origin of the signature, the panel concluded

that the NMC has not proved charge 7a to the required standard and it found charge 7a not proved.

Charge 7b

b) ensure that a second person/checker signed the controlled drugs log for the morning controlled drugs check, in your presence, for one of more of the residents listed in Schedule 1;

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy, Witness 5's oral evidence, Witness 2's written statement, oral evidence and his local investigation, Witness 4's written statement, oral evidence, her local statement and the Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 07:30 on 2 June 2021.

The panel have already found that Mr Houseby was under a duty to have a second checker present when conducting stock checks and that a second checker was also required to sign the CD register.

The panel had sight of the CD register sheets of the morning dated 2 June 2021, signed by Mr Houseby and an unknown individual. Whilst the panel noted the evidence of Witness 2 and Witness 4, who were unable to verify whom this signature belonged to, the panel were not satisfied that this proved that there had not been another competent individual involved in this CD stock check. In making this decision the panel took into account the fact that neither Witness 2 or Witness 4 were experts in handwriting analysis and therefore could not verify that this signature did not belong to a member of staff who was working on that shift. The outcome of the local investigation could not be taken into consideration in these proceedings in any event. In addition, the panel noted that the

Home held a signature log sheet for the purpose of verifying signatures in the CD register, however this document was not supplied for these proceedings.

Mr Houseby has consistently maintained that he had a second checker with him and that he could not recall the identity of this person.

Given the fact that Mr Houseby has denied the charge and the panel have discounted the evidence of Witness 2 and Witness 4 on the origin of the signature, the panel concluded that the NMC has not proved charge 7b to the required standard and it found charge 7b not proved.

Charge 8

8) On, or around, 02 June 2021, inaccurately recorded, or caused to be recorded, that a second person/checker had undertaken the morning controlled drugs check with you, when they had not done so, for one or more of the residents listed in schedule 1;

This charge is found NOT proved.

In reaching this decision, the panel took into account the Policy and the Home's CD register sheets for Resident A, B, D, E, F and G that contained details of the check performed at 07:30 on 2 June 2021.

The panel have interpreted this charge as similar in nature to charge 5i in that it relates to Mr Houseby stating that he signed the CD registers in the presence of an unknown individual which the NMC disputes.

The panel had sight of the CD register sheets of the morning dated 2 June 2021, signed by Mr Houseby and an unknown individual. Whilst the panel noted the evidence of Witness 2 and Witness 4, who were unable to verify whom this signature belonged to, the

panel was not satisfied that this proved that there had not been another competent individual involved in this CD stock check. In making this decision the panel took into account the fact that neither Witness 2 or Witness 4 were experts in handwriting analysis and therefore could not verify that this signature did not belong to a member of staff who was working on that shift. The outcome of the local investigation could not be taken into consideration in these proceedings in any event. In addition, the panel noted that the Home held a signature log sheet for the purpose of verifying signatures in the CD register, however this document was not supplied for these proceedings.

Mr Houseby has consistently maintained that he had a second checker with him and that he could not recall the identity of this person.

Given the fact that Mr Houseby has denied the charge and the panel have discounted the evidence of Witness 2 and Witness 4 on the origin of the signature, the panel concluded that the NMC has not proved charge 8 to the required standard and it found charge 8 not proved.

Charge 10

Your conduct at any and/or all of charges 2 and/or 5 and/or 8 above was dishonest in that you:

a) Knew that a second person/checker had not undertaken a controlled drugs check with you;
b) Intended to create the misleading impression that a second person/checker had undertaken a controlled drugs check with you when they had not done so;
c) Intended to create the misleading impression that you had followed the controlled drug procedures when you knew that you had not done so;

In light of the panel's decision regarding charges 2, 5 and 8, it determined that this charge falls away and therefore is not proved in its entirety.

Charge 11a, 11b and 11c

11) Your conduct at any and/or all of charges 3 and/or 6 and/or 9 was dishonest in that you:

a) Knew that you had not physically counted the controlled drugs;
b) Intended to create the misleading impression that you had physically counted the controlled drugs when you had not done so;
c) Intended to create the misleading impression that you had followed the controlled drug procedures when you knew that you had not done so.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account Mr Houseby's oral evidence, local statement and his responses in the local investigation interview and Witness 4's local statement, oral evidence and the CD register sheets for Resident A for 19:30 check on 31 May, 1 June and 2 June 2021.

As advised the panel had regard to the case of Ivey v Genting Casinos [2017] UKSC 67, in which Lord Hughes stated:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

Mr Houseby has admitted in numerous charges to failing to physically count the CDs for Resident A when doing a CD stock check and to inaccurately recording in the evening CD drug check that he had physically count the CDs for Resident A when he had not done so.

In Mr Houseby's oral evidence, he denied that he was dishonest in his actions. He stated that he made an error by just looking inside the box and miscounting the information sheet as a medication patch. Witness 4 gave evidence which contradicted Mr Houseby's account. She explained that when she discovered the inaccuracy, she asked him to explain the discrepancy and he informed her that he had mistakenly carried over the total from the previous CD register sheet. He said in his local investigation interview and oral evidence that his actions were due to a lack of due diligence on his behalf.

The panel therefore found that the accounts given by Mr Houseby were inconsistent, however he accepted throughout this hearing and in his admissions that he did not physically count the CDs for Resident A and that he inaccurately recorded in the CD register sheets that he had.

The panel has derived from his admissions that he knew he had not physically counted the CDs or accurately recorded that he had in accordance with the policy which he understood and was fully aware of.

By Mr Houseby signing the CD register sheet for Resident A he was knowingly stating that he had conducted a physical stock check and that the accurate total of medication was three. However, Mr Houseby did not conduct a physical check as admitted by him and therefore he could not confirm that the total was three as recorded by him. He continued to do this on two further occasions as per the charges.

The panel were therefore not satisfied that this was a genuine error as stated by Mr Houseby. From the facts presented to the panel it concluded that it was reasonable to infer that Mr Houseby intended to create the misleading impression that he had physically counted the CDs and followed the CD procedure when he had not done so.

The panel went to consider the second limb of the Ivey test and concluded that an ordinary decent person being presented with these facts would find Mr Houseby's actions dishonest.

Therefore, on the balance of probabilities the panel found this charge proved in its entirety.

Agreed Removal Application and Recommendation

Following the announcement of the panel's findings on facts, Ms Kay addressed the panel on Mr Houseby's application for Agreed Removal.

Ms Kay informed the panel that the NMC sanction bid would have been between a suspension order of 9 months with a review and a strike off. She made no specific submissions as to what recommendation the panel ought to make to the AR.

The panel heard and accepted the advice of the legal assessor who referred to the NMC guidance reference CMT-5a and DMA-8.

The panel considered the documentation received in respect of Mr Houseby's Agreed Removal application which included his completed application form signed and dated 2 October 2023 and correspondence from the referrer who confirmed he had no formal response.

The panel noted that Mr Houseby has indicated on his Agreed Removal application form that he no longer wishes to pursue being a registered nurse and is looking for work a as a permanent Deacon. He further stated that he has worked in the care sector for 32 years and feels that he has nothing left to offer. Mr Houseby did not provide any additional evidence in support of his application.

The panel had regard to its findings on facts, specifically its findings on dishonesty which had occurred in the course of Mr Houseby's clinical practice. The panel was of the view, having regard to the NMC's overarching objective, that the facts found proved are sufficiently serious that they could lead to a finding of fundamental incompatibility with continued registration as a nurse.

In the circumstances, the panel therefore recommends to the AR that Mr Houseby's application for agreed removal should not be granted.

31 January 2024

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Houseby was not in attendance and that the Notice of Hearing letter had been sent to Mr Houseby's registered email address on 7 December 2023.

Ms Kay, submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the time, dates and that the hearing was to be held virtually.

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

Decision and reasons on proceeding in the absence of Mr Houseby

The panel next considered whether it should proceed in the absence of Mr Houseby. It had regard to Rule 21 and heard the submissions of Ms Kay who invited the panel to continue in the absence of Mr Houseby. She submitted that Mr Houseby had voluntarily absented himself.

Ms Kay referred the panel to the email dated 31 January 2024 from Mr Houseby to his case officer which stated:

> *"Hi […]*
> *I will not be attending*
> *Kind regards*
> *Chris"*

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Mr Houseby;
- Mr Houseby has informed his case officer that he will not be attending the resuming hearing;
- Mr Houseby had not explained the reason for his absence;

- There is no reason to suppose that adjourning would secure his attendance at some future date;
- There is a strong public interest in the expeditious disposal of the case.

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

Fitness to practise

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

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

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

Submissions on misconduct and impairment

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

Ms Kay invited the panel to take the view that the facts found proved amount to misconduct. She directed the panel to the terms of ''The Code: Professional standards of practice and behaviour for nurses and midwives (2018) (the Code) and to the specific paragraphs where, in the NMC's view, Mr Houseby's actions amounted to a breach of those standards.

Ms Kay moved on to the issue of impairment. She referred the panel to the relevant NMC guidance and submitted that Mr Houseby's fitness to practise is currently impaired. She 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. Reference was made to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Kay referred the panel to the Fitness to Practise Library, specifically the NMC's Guidance on Impairment (DMA-1), updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is: "Can the nurse, midwife or nursing associate practise kindly, safely and professionally?" If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Ms Kay submitted that although Mr Housby's misconduct caused no harm to patients, he failed to properly count CD medication and to make an accurate record of this count which raises a risk of harm to patients. She further submitted that Mr Housby's conduct in respect of medication administration and poor record keeping put vulnerable residents at risk of harm.

Ms Kay submitted that Mr Houseby breached the fundamental tenet of providing safe and effective care for patients by failing to ensure that his actions in medication administration were of the required standard and that these failings relate to basic nursing duties.

In relation to dishonesty, Ms Kay submitted that Mr Houseby's intention was to create a misleading impression that he had physically counted the controlled drugs and followed the controlled drug procedure. She submitted that Mr Houseby's misconduct continued over a period of three days on four separate occasions.

In terms of insight, Ms Kay submitted that the NMC accepted that Mr Houseby had some insight in that he had accepted he had not been diligent. However there has been no evidence of reflection provided demonstrating his understanding of the potential impact of his errors which could have caused patients harm under his care.

Ms Kay submitted that there has been no information placed before the panel which indicates that Mr Houseby has taken steps to strengthen his practise. She submitted that there has been no evidence of any courses in medication administration and therefore a risk of repetition and a continuing risk to the public if there are no restrictions on his practice. She further submitted that as Mr Houseby's dishonesty was directly linked to his role, this demonstrates attitudinal issues and is difficult to remediate.

For all of the reasons mentioned above, Ms Kay invited the panel to make a finding on misconduct and impairment on the grounds of public protection and public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council (No 2) [2000] 1 A.C. 311, Nandi v General Medical Council [2004] EWHC 2317 (Admin), R (Remedy UK Ltd) v GMC [2010] EWHC 1245 (Admin), R (Calhaem) v GMC [2007] EWHC 2606 (Admin), Johnson & Maggs v NMC (No. 2) [2013] EWHC 2140 (Admin), Cohen v GMC [2008] EWHC 581 (Admin), and CHRE v NMC & Grant [2011] EWHC 927 (Admin).*

Decision and reasons on misconduct

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

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

> ***10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.***
> *To achieve this, you must:*
> ***10.3*** *complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
>
> ***20 Uphold the reputation of your profession at all times***
> *To achieve this, you must:*
> ***20.1*** *Keep to and uphold the standards and values set out in the Code*
> ***20.2*** *act with honesty and integrity at all times, …*
> ***20.3*** *Be aware at all times of how your behaviour can affect and influence the behaviour of other people'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel noted that the proven charges consisted of four separate incidents of failing to count controlled drugs and four separate instances of inaccurately recording the fact that Mr Houseby had carried out that count when he had not. The additional charges of

dishonesty are intrinsically linked to the inaccurate recording and therefore the panel considered the charges cumulatively.

The panel first considered the four charges relating to your failure to count Resident A's controlled drugs when doing the stock checks.

Charge 1c

The panel concluded that Mr Houseby's actions in relation to this charge were a sufficiently serious departure from expected standards to amount to misconduct. It considered that this charge involved a lack of diligence and a failure to adhere to procedures in relation to management of controlled drugs. The panel noted that it was poor practice, in a procedure which is designed to protect patients from the significant risk of harm associated with controlled drugs. The panel also noted that no reasonable or cogent explanation has been provided by Mr Houseby for this conduct. In fact Mr Houseby provided conflicting reasons during the local investigation and hearing as to why he had not counted the drugs. The panel considered that Mr Houseby's conduct in relation to this charge would be regarded as deplorable by fellow members of the profession and represented a serious departure from required standards. It considered that Mr Houseby's conduct in relation to this charge, even viewed in isolation, was sufficiently serious to amount to misconduct.

Charge 4ci and 4cii

For the same reasons as in relation to charge 1c, the panel considered that Mr Houseby's conduct in relation to each of these charges was sufficiently serious to amount to misconduct.

Charge 7c

For the same reasons as in relation to charge 1c, the panel considered that Mr Houseby's conduct in relation to this charge was sufficiently serious to amount to misconduct.

The panel next considered the four charges in relation to Mr Houseby inaccurately recording that he had physically counted the medication when he had not done so.

As advised by the legal assessor, when considering each of these charges, the panel regarded each charge together with the finding of dishonesty made under charge 11, treating the dishonesty as an aggravating factor of the inaccurate recording.

Charge 3

The panel concluded that Mr Houseby's actions in relation to this charge were a sufficiently serious departure from expected standards to amount to misconduct. It considered that this charge involved Mr Houseby deliberately and dishonestly completing a record, seeking to create a misleading impression that he had followed controlled drugs procedures in order to conceal the fact that he had not done so.

Mr Houseby by admission was aware that he had not counted the drugs when he signed the CD register. Mr Houseby has not provided a reasonable explanation for signing. The panel concluded at the fact finding stage that these actions by Mr Houseby were deliberate and calculated to mislead and therefore dishonest. The panel bore in mind that honesty forms a fundamental part of nursing practice and is important for maintaining public confidence in the profession. It considered that Mr Houseby's conduct in relation to this charge would be regarded as deplorable by fellow members of the profession and represented a serious departure from required standards. It considered that Mr Houseby's conduct in relation to this charge, even viewed in isolation, was sufficiently serious to amount to misconduct.

Charge 6

For the same reasons as in relation to charge 3 above, the panel concluded that Mr Houseby's actions in relation to charge 6 were sufficiently serious to amount to misconduct.

Charge 9

For the same reasons as in relation to charge 9 above, the panel concluded that Mr Houseby's actions in relation to charge 6 were sufficiently serious to amount to misconduct.

Charge 11

As advised by the legal assessor, as the panel had already taken into account Mr Houseby's dishonesty in relation to charges 3, 6 and 9, which it had found to amount to misconduct in each case, therefore it was not necessary in the circumstances to reach a separate decision in relation to charge 11 because to do so would be reaching two separate conclusions in respect of the same conduct.

The panel found that Mr Houseby's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

patients' and the public's trust in the profession and be able to practice kindly, safely and professionally.

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

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

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

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

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

The panel found that all limbs of the test outlined in Grant are engaged.

Mr Houseby's conduct in failing to follow the CD medication policy and then deliberately and dishonestly recording that he had followed the policy, resulted in a potential risk of harm to a group of vulnerable patients. The panel was of the view that:

- Mr Houseby's actions breached the fundamental tenets of the profession by failing to follow safe procedures in relation to the management and administration of controlled medication;
- Mr Houseby failed to act with honesty and integrity; and
- Mr Houseby acted dishonestly, and therefore his actions were liable to bring the profession into disrepute.

The panel went on to consider whether Mr Houseby was liable, or likely, to act in a similar way in future. In doing so, it assessed the risk of repetition. This in turn would be informed by matters such as any evidence of reflection and insight, or of any steps taken to address past failings or strengthen practice.

The panel acknowledged that there was no evidence of any similar concerns being raised about Mr Houseby's practice in the past, and that the incidents in this case took place over a short period of time. However, the panel noted that Mr Houseby's actions involved the same breach of procedure, poor practice and dishonesty in recording what he had done on four separate occasions during that short period of time.

The panel noted that there was no evidence of remorse or insight Mr Houseby's part. The panel acknowledged that Mr Houseby made admissions to some of the charges, although he had not admitted dishonesty. To that extent, Mr Houseby had taken some accountability for what he did. However, Mr Houseby had not demonstrated any insight

into the risks associated with his actions, their impact on patients, colleagues and the wider profession, or how he would ensure that they were not repeated. In addition, Mr Houseby did not accept that he had acted dishonestly. The panel was mindful that dishonesty is attitudinal in nature and difficult to remediate, particularly in the absence of insight.

The panel further noted that there was no evidence that Mr Houseby had learned from this incident, or had undertaken any reflection, study or training to remedy his past failings or to strengthen his practice going forward, in order to ensure that he did not repeat his failings.

In the circumstances, the panel concluded that there remained a risk of Mr Houseby acting in a similar way in future. Any repetition of conduct of this type would once again have the potential to cause harm to patients, undermine the reputation of the profession and breach its fundamental tenets, including that of honesty and integrity. The panel concluded on public protection grounds that Mr Houseby's fitness to practice is currently impaired.

For the reasons above, the panel determined that there is a significant current and future risk to of harm to patients should Mr Houseby be permitted to practise unrestricted. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered that this was an abuse of a position of trust and an informed member of the public or any fellow nurse, who knew the particulars of this case would find Mr Houseby's actions unacceptable. The panel concluded that public confidence in the

profession would be undermined if a finding of current impairment was not made and therefore finds Mr Houseby's fitness to practise is also impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Houseby off the register. The effect of this order is that the NMC register will show that Mr Houseby 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 Kay informed the panel that in the Notice of Hearing, dated 7 December 2023, the NMC had advised Mr Houseby that it would seek the imposition of an order of between a 9 month suspension order with a review and a striking off order if it found Mr Houseby's fitness to practise currently impaired.

Ms Kay outlined the aggravating and mitigating features in Mr Houseby's case.

Ms Kay submitted that no further action is clearly not appropriate in Mr Houseby's case as this will not protect the public or uphold public interest. She stated that a caution order is also not appropriate in this case for the same reasons to take no further actions. She referred the panel to the NMC's guidance on considering conditions of practice order Reference: SAN-3c. She submitted that imposing a conditions of practice order would not

sufficiently protect the public as there is evidence of deep-seated attitudinal problems and with the element of dishonesty this order would not protect the public or uphold public interest.

Ms Kay submitted that, in this case, the most appropriate order is a 9 month suspension order with a review. She submitted that is up to the panel to consider whether a striking-off order is appropriate in Mr Houseby's case.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Evidence of attitudinal problems
- Not a single incident, despite it being a short period
- Evidence of repetition
- No evidence of insight, remediation or remorse
- Deliberate act
- Adverse risk of unwarranted harm to vulnerable patients
- Potential adverse effects on colleagues

The panel also took into account the following mitigating features:

- Some admissions

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

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

The panel next considered whether placing conditions of practice on Mr Houseby's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Whilst the issues around medication management and record keeping could, in theory be remedied, the attitudinal dishonesty issue identified in this case was not something that can be addressed through retraining. The panel also noted that Mr Houseby does not intend to return to nursing and that he has disengaged with the proceedings. The panel therefore has no evidence that Mr Houseby is willing or able to comply with a conditions of practice order. Furthermore, the panel concluded that the placing of conditions on Mr Houseby's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel has found a concerning lack of insight, and consequently believe that there is a significant risk of repetition. It was not a single incident but occurred on four separate occasions. The panel found that the misconduct illustrates an attitudinal problem. The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. In this particular case, the panel determined that a suspension order would not be sufficient, appropriate or a proportionate sanction. Further it would not address the risk of harm or protect the public, nor mark the seriousness of this case.

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

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

The panel seriously considered whether a striking-off order would be proportionate. It made a careful assessment of the gravity of the misconduct in this case and whether a

striking-off order would be the only order that would adequately protect the public and address the public interest considerations.

The panel determined that Mr Houseby's actions were a serious departure from the standards expected of a registered nurse, and a breach of the fundamental tenets of the profession. The panel has identified a significant risk of repetition. Despite Mr Houseby's attendance at the beginning of this hearing, he has provided no evidence of remorse, refection or insight. He has not disengaged and made it clear that he does not wish to pursue his nursing career. In the circumstances, the panel considered that there was no evidence that Mr Houseby was willing or able to address his past failings in order to effect a return to safe practice. Any opportunity for reflection or recommendation for future remedial steps appeared unlikely to result in any change in the situation at a future review hearing.

In the circumstances, the panel concluded that suspending Mr Houseby's registration would serve no useful purpose and would not be in the public interest. The panel determined that Mr Houseby's actions, compounded by his absence of insight and disengagement from the proceedings, were fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Houseby's actions were serious and to allow him to continue to practice would not adequately protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body. Taking account of the SG, the panel could not be satisfied that anything less than a striking-off order would keep the public protected and address the wider public interest in Mr Houseby's case.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the only appropriate sanction is that of a striking-off order and that no lesser sanction would be sufficient. It noted the hardship which this may cause Mr Houseby, although it had no specific information, and was mindful that he plans to leave the profession in any event. The panel considered however, that Mr Houseby's

interest were outweighed by the need to protect the public, declare and uphold the professional standard and thereby maintain public confidence in the profession.

The panel considered that a striking off order was necessary to mark the seriousness of Mr Houseby's actions, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse in order to maintain public confidence in the profession.

This will be confirmed to Mr Houseby in writing.

Submissions on interim order

The panel took account of the submissions made by Ms Kay. She submitted that the NMC is seeking the imposition of an interim suspension order for a period of 18 months to cover any appeal period until the substantive strike-off order takes effect.

Ms Kay submitted that given the seriousness of the charge found proved, an interim suspension order is necessary to protect the public and is otherwise in the public interest.

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. It also had regard to its findings that there was an ongoing risk of repetition.

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

unrestricted before the substantive striking-off order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

This decision will be confirmed to Mr Houseby in writing.

That concludes this determination.