Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Friday 16 August 2024 – Friday 23 August 2024

Nursing and Midwifery Council

2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Mavelyn Machabvunga**
NMC PIN	14D1497E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (5 November 2014)
Relevant Location:	England, Epsom
Type of case:	Misconduct
Panel members:	Tracy Stephenson (Chair, lay member) Donna Green (Registrant member) Gary Trundell (Lay member)
Legal Assessor:	Richard Ferry-Swainson
Hearings Coordinator:	Hazel Ahmet Samara Baboolal (Friday, 23 August 2024)
Nursing and Midwifery Council:	Represented by Matthew Cassells, Case Presenter
Ms Machabvunga:	Present physically at 2SP, represented by Aparna Rao (instructed by the RCN). Present virtually on Friday 23 August.
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e, 1f.
Facts not proved:	N/A
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse,

1. On 14 November 2020, left Patient A:

a. In a freezing cold room.
b. On a bed tipped so far back that her head was tilted down and feet were tilted up.
c. With her gown open.
d. With no pad on.
e. On soaking wet sheets.
f. With her leg tied to the bedrail.

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

Background

On 17 November 2020, the NMC received a referral from the Director of Nursing Medicine and Emergency Care at Epsom & St Helier NHS Trust ("the Trust"). You were employed by Day Webster Nursing Agency at the time of the allegations against you and were assigned to work for the Trust as a Registered Nurse on the Acute Medical Unit (AMU) of Epsom Hospital. It is alleged that whilst on shift, you had left Patient A in a freezing cold room with her gown open and no pad on, on soaking wet sheets with her feet tilted upwards and with her leg tied to the bed rail.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Rao, who informed the panel that you will be providing an agreed statement of facts, which has been signed and agreed by both yourself, and Mr Cassells. Within this agreed statement of facts, you made admissions to Charges 1a, 1b, 1c, 1d, 1e, and 1f.

The statement of facts read as follows:

*‘**Charges***

1. *The Registrant admits the following charges:*

That you, a registered nurse,

1. *On 14 November 2020, left Patient A:*

a. *In a freezing cold room.*

b. *On a bed tipped so far back that her head was tilted down and feet were tilted up.*

c. *With her gown open.*

d. *With no pad on.*

e. *On soaking wet sheets.*

f. *With her leg tied to the bedrail.*

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

Background

2. *The Registrant joined the NMC register on 5 November 2014 as an Adult Nurse.*

3. *On 17 November 2020 the NMC received a referral from the Director of Nursing Medicine and Emergency Care at Epsom & St Helier NHS Trust (“the Trust”).*

4. *The Registrant was an agency nurse employed by Day Webster. She was assigned to work for the Trust as a Registered Nurse on the Acute Medical Unit (AMU) of Epsom Hospital.*

Facts

It is agreed that the facts underlying the above charges are as follows:

5. *On 13 November 2020, the Registrant worked the overnight shift (from 7.30pm on 13 November to 8am on 14 November) on the AMU. She was responsible for the care of Patient A.*

6. *On 13 November the Registrant noticed that Patient A's leg was wrapped in a bedsheet and secured to the bedrail. This was how Patient A had been received from the shift before. The bedsheet was in place to prevent Patient A from removing the cannula in her foot. The Registrant did not act upon this. It is not the NMC's case that the Registrant tied the Patient's foot to the bedrail but she did not act upon this.*

7. *The Registrant administered IV antibiotics to Patient A at 10pm on 13 November and continued IV fluids.*

8. *At 10.30pm, the Registrant was informed by a Healthcare Assistant (HCA) that Patient A had pulled out her IV line. The Registrant attended to Patient A to secure the line with a dressing. Within minutes, Patient A removed the dressing.*

9. *The Registrant took another dressing and with the help of the HCA, put some tape over the dressing. After a few minutes Patient A managed to remove the tape but the dressing was still intact.*

10. *Patient A then fell asleep and the Registrant and HCA took turns to keep an eye on Patient A whilst she slept.*

11. *The Registrant attended to Patient A at 6am on 14 November to administer her IV antibiotics. Patient A was fully awake with her dressing completely off and her cannula exposed. The Registrant*

applied a new dressing and instructed the HCA to secure the dressing with tape and tidy up the room.

12. *At 8am on 14 November, the dayshift nurse, witness Katherine Brown (KB), arrived and was given a verbal handover by the Registrant before commencing bedside handovers. The Registrant handed over Patient A to KB.*

13. *As KB walked towards Patient A's room, she could feel how cold it was. Upon entering Patient A's room, KB found it was freezing cold. The internal and external windows of Patient A's room were open. The approach to the room was, in KB's assessment "cold" and the room itself was "freezing cold".*

14. *Patient A was facing the window, and the bed was tipped down, so her head was tilted down, and her legs were tilted up. Her gown was open, with her back exposed and no pad on. Patient A had pulled her incontinence pad off and it was shredded, lying on the floor.*

15. *Patient A's sheets were soaking wet with several different rings of urine, including dry and wet patches. It was clear that the bedsheet had not been changed for a long time.*

16. *When KB walked around Patient A's bed to close the window, she saw that Patient A's leg was tied to the bedrails. Patient A's bedsheet was knotted and taped around Patient A's ankle. Plaster tape was used to wrap around the sheet to restrict the sheet from coming off and to prevent Patient A from pulling her foot through the loop of the bedsheets.*

17. *Patient A would not have been able to roll onto her right side as there was no slack in the sheet. When KB saw Patient A, she was screaming and crying and had shoulder pain for which medication had to be*

prescribed. Patient A had been laying on that shoulder unable to turn. The bed sheet was tied so tight, it could not be pulled.'

The panel therefore finds Charges 1a, 1b, 1c, 1d, 1e, and 1f, proved in their entirety, by way of your admissions.

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

Ms Rao made a request that part of the hearing be held in private on the basis that [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Cassells indicated that he supported the application to the extent that [PRIVATE].

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

The panel accepted the application [PRIVATE].

Fitness to practise

The panel took into account the documentary and oral evidence you provided under affirmation.

You then answered questions by both Mr Cassells and the panel, whereby you further expanded on your reflective piece and your account of what had occurred during the time of the matters raised against you.

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 ability to practise kindly, safely and professionally.

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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Mr Cassells invited the panel to take the view that the facts found proved amount to misconduct and identified the specific, relevant standards where your actions amounted to misconduct. Mr Cassells referenced the specific breaches of the NMC Code of Conduct: *'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)'.*

Mr Cassells submitted your answers to a variety of questions given during your live evidence, were evasive and did not accord with the agreed statement of facts signed by both parties. Mr Cassells submitted that the panel should consider whether or not the evidence it has heard was an honest and sincere attempt to assist the panel at this stage of these proceedings. Mr Cassells submitted that your evidence was not honest, nor was it sincere.

Mr Cassells submitted that your evidence in how Patient A had come to be tied and untied was unclear, as your oral evidence contradicts the agreed statement of facts.

Mr Cassells further submitted that you had stated that Patient A was untied when you went to see her at 6:00am. Further, you said during cross examination that when you went to see Patient A at 10:30pm, she was not tied up then either. Mr Cassells said that this did not accord with the agreed statement of facts which made no mention of Patient A being untied at any point. He said that had it done so, the NMC might not have agreed to this. He further highlighted that the way in which you had left Patient A at 6:00am was not consistent with the agreed statement of facts.

Mr Cassells highlighted therefore, that the cross examination is inconsistent and does not entirely accord with the agreed statement of facts.

Mr Cassells submitted in relation to misconduct that this case is very serious and involves a deeply vulnerable individual who was wholly dependent on others for her care and maintenance of her dignity. Mr Cassells submitted that you did *'nothing'* to remedy the situation of Patient A having been tied to her bed and this is a serious departure from the proper and professional standards expected of a registered nurse.

Mr Cassells submitted that though you claim that Patient A was untied at some time between 10:30pm and 6:00am, you stated that she had done this herself, and that her becoming untied was not through your actions. Therefore, she would have remained tied throughout the night, if she had not extracted herself. Mr Cassells noted that at no point did you consider whether or not the manner in which you were looking after Patient A, could be considered dignified.

Mr Cassells submitted that an individual who is aware of this case may feel upset and even potential anger. He stated that the actions in this case must be found to amount to misconduct.

Ms Rao submitted in relation to misconduct that you take responsibility for the state in which you allowed Patient A to remain throughout your shift. She submitted that

you accept that the conditions in which Patient A was left were appalling and what had happened was serious. You accepted that this amounts to misconduct. She further submitted that the assessment of what went wrong in this case and why it went wrong is relevant for the panel to consider.

Ms Rao submitted that you gave an account in a local interview to the Trust in April 2022 and that you have been consistent when comparing your statement in relation to Patient A being untied at 6:00am with your live evidence before the panel. This was confirmed by Mr Cassells.

Ms Rao drew the panels attention to the fact that in admitting the facts you are not admitting impairment.

Ms Rao submitted that in respect of the Code breaches identified by Mr Cassells, all are accepted apart from 20.8: *['act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'],* as this results in an impermissible *'chain of speculation that is unfair on the evidence'*. She submitted that there is no evidence of any of your colleagues having tied up Patient A, as a result of your influence. This particular Code provision, therefore, cannot be considered to have been breached.

Submissions on impairment

Mr Cassells 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).

Mr Cassells submitted that in this case, there was a real risk of actual physical, mental and emotional harm. He stated that leaving Patient A tied to the bed, as written in your own reflective piece, could have led to a real risk of physical harm, risk of skin break down, infection, physical discomfort, hypothermia, circulation

problems, and long-term damage to the limb. Further, he noted that the risk of emotional harm was also present as Patient A was at a risk of feeling helplessness, anxiety and fear.

Mr Cassells submitted that this is the type of case that brings the nursing profession into disrepute. Mr Cassells submitted that the fundamental tenets of the profession have been breached and that you have failed to treat Patient A with fairness, kindness and professionalism. You have failed to uphold the proper standards expected of a registered nurse.

Mr Cassells submitted that leaving Patient A tied to a bed for hours on end, is *'so obviously wrong'* that these matters which would normally be relevant to remediation, may be considered less significant in this case. He submitted that deep reflection and training should not be required of a nurse, in order to comprehend that leaving a patient tied to a bed, is not good patient care.

Mr Cassells highlighted, however, that you have provided admissions which had initially provided some insight. However, he submitted that you, during your evidence, provided *'confused, evasive, and inconsistent'* information relating to the charges raised against you. He further submitted that your reflective piece provided *'no real insight'*. You were unable to answer *'the most basic'* questions, such as why you had failed to untie Patient A.

Mr Cassells further noted that the panel have received a number of relevant training certificates, which he highlighted were all mandatory and required by your current employer. He submitted that there is no sense of you having sought out any other training in light of your failings, in this case.

Finally, Mr Cassells acknowledged the references you have provided the panel and noted that these do include colleagues who speak positively of you and your recent practice. He did submit, however, that it is unclear what details your referees know about this case.

Mr Cassells submitted therefore that a finding of impairment should be found on the ground of public protection, as the patient faced a real risk of physical, emotional and mental harm. He noted that the patient did experience physical harm, in the pain she felt due to having been tied up, and further highlighted that the patient was vulnerable. He submitted that your actions are not what is expected of a registered nurse.

Mr Cassells submitted that the panel should consider the public interest, the need to uphold proper standards the public confidence in the nursing profession. He submitted that, therefore, a finding of impairment on the ground of public interest is required in this case. A well-informed member of the public would be discontent if they were to hear of the conditions that Patient A was faced with and endured.

Consequently, Mr Cassells invited the panel to find your fitness to practise currently impaired.

Ms Rao submitted that Mr Cassells presented an *'emotive plea'* on behalf of the NMC, relating to the image of Patient A on the day in question, which can potentially lead to an erroneous conclusion. She stated that the panel should consider whether or not you are able to practise safely and effectively today and not focus deeply on what had occurred four years ago. This was a forward-facing stage.

Ms Rao submitted that you are a better nurse today due to what had occurred four years ago and that you have learned from it. She submitted that you no longer believe yourself to be impaired. Ms Rao submitted that an individual does not need to accept that their practice is impaired, in order to demonstrate insight and remediation.

Ms Rao submitted that it is important for the panel to note that you are now very careful before and after every shift, to ensure that all of your patients are well cared for and safe. You no longer rely on what others tell you, but rather consider all safety measures yourself. Ms Rao noted that in every paragraph of your reflection you explain in great detail your shame and shock of what you had allowed to happen to Patient A, and the consequences of your inaction. You actively stated that your

actions were a *'clear lapse'* and acknowledged that the correct course of action would have been to immediately untie Patient A's leg.

Ms Rao therefore submitted that, when considering impairment, the panel should consider whether or not it is satisfied that your misconduct will not be repeated; she submitted this is not likely. Ms Rao highlighted that you have not challenged the charges raised against you and have provided training certificates, positive references and a detailed reflective piece. Ms Rao submitted that although the training you have completed is not optional, it is still evidence that you have undergone training.

Ms Rao submitted that there have been no other problems or referrals against you during the recent period of your practice. You have been working again as a registered nurse since October 2023. She submitted that your actions have already been remediated and were never the result of *'malice'* or any intention to cause deliberate harm.

Ms Rao invited the panel to find that your fitness to practise is not currently impaired.

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

Decision and reasons on misconduct

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

The panel was of the view that 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:

> *1.1) treat people with kindness, respect and compassion*
> *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*

1.5) respect and uphold people's human rights
3.4) act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care
4.3) keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process
8.5) work with colleagues to preserve the safety of those receiving care
19.1) take measures to reduce as far as possible, […], harm and the effect of harm if it takes place
20.1) keep to and uphold the standards and values set out in the Code
20.3) be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5) treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
25.1) identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that taken as a whole, your conduct falls far short of what would have been considered proper in the circumstances. The panel noted that your conduct presented a serious risk to a vulnerable patient who had difficulty communicating, was left in a freezing cold room with her gown open, no pad on, on a bed so far back that her head was tilted down and her feet were tilted upwards, laying on soaking wet bedsheets, whilst also having her leg tied to the bed.

Further, the panel noted that Patient A was caused actual harm and distress, due to your lack of fundamental care as a registered nurse. Due to her having been tied to the bed for a long period of time, Patient A experienced shoulder pain for which medication had to be prescribed.

The panel considered that this conduct is a serious departure from the standards expected of you and were of the view that any reasonable professional nurse would consider your actions to be deplorable, as would the public. The panel highlighted that you were the nurse responsible and had a duty to check in on Patient A and ensure that she was cared for safely and comfortably.

The panel found that your actions did fall seriously short of the conduct and standards expected of a registered nurse 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.

In coming to its decision, the panel had regard to the Fitness to Practise Library, 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.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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, acting with kindness to all patients, and integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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

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

d) *[…]'*

The panel finds that Patient A was put at a real risk of physical and emotional harm as a result of your misconduct, and indeed was harmed. Your misconduct had breached the fundamental tenet of the nursing profession to put the health and welfare of patients first, and therefore brought its reputation into disrepute.

The panel noted that you failed to provide fundamental basic nursing care in that you did not act with kindness and compassion towards Patient A, nor did you act safely and professionally. The panel were of the view that you did not take action as the nurse responsible for caring for Patient A and found that the three limbs of Grant are engaged.

The panel needs to be satisfied that the conduct in this case is remediable, that it has been remedied and that it is highly unlikely to be repeated. The panel was in no doubt that the conduct was remediable since it related to basic nursing care, the sort of behaviour that anyone would expect from every nurse. It would involve ensuring the patients in your care are properly looked after and that their basic needs are being met, such as ensuring they are not lying on urine-soaked sheets, that they were not cold, that their dignity was preserved and that they were not tied to their bed in any way, shape or form. These are all things that can easily be put right, but they require the nurse in question to fully acknowledge their responsibility. To be satisfied of this the panel would need to be persuaded that you have demonstrated good insight into your failings, which is crucial when determining the issue of current impairment.

The panel was provided with an agreed statement of facts. However, when you gave your oral evidence, your account differed significantly from the agreed statement of facts and left the panel feeling you were not really accepting responsibility for the state Patient A was left in at all. Instead, you were essentially saying that others were responsible, whereas you did nothing wrong, other than perhaps not checking the patient closely enough, or untying her when you took over at 8pm.

In the agreed statement of facts there was no reference to Patient A ever being untied during your shift. However, in your oral evidence you claimed that Patient A was untied when you went to re-attach the fluid line at 10:00pm. You next saw Patient A at 6am and again said she was untied at that stage and yet two hours later, when found by Nurse KB, Patient A was tied so tightly to the bed the bed sheet could not be pulled, Patient A was laying on her shoulder unable to turn and was screaming and crying. Patient A then had to be prescribed medication for her shoulder pain.

Furthermore, in your oral evidence you said that when you visited at 6am, Patient A's room was not cold, the windows were not open and she was not tied to the bed. You said you changed her pad and both bedsheets and left Patient A with the bed in its normal position, that is to say not tipped back with her head lower than her feet. However, just two hours later Patient A was found with the windows open, the room freezing cold, her bed tipped back so far her head was tilted down and her feet were tilted up, her gown was open, there was no pad and she was ly#ing on soaking wet bedsheets. Further, the agreed statement of facts recorded that *"Patient A's sheets were soaking wet with several rings of urine, including dry and wet patches. It was clear that bedsheet had not been changed for a long time."* Thus, your account that the bedsheets were changed at 6am is simply not plausible.

The panel was left with the distinct impression that you were trying to minimise your accountability and thereby evade full responsibility for your actions. The panel concluded that you were being less that straightforward in your oral account and this casted doubt upon the veracity of your oral evidence and also the veracity of your written reflective piece. This all led the panel to conclude that your insight is lacking in this case and that there is, therefore, a real risk that you could repeat such behaviour and thereby put patients at risk in the future.

The panel also took into account that although you have provided evidence of having undergone some limited and basic training, this only addresses some of the elements of the original incident, as opposed to demonstrating any further learning at a deeper level. The panel noted that you have only completed the mandatory training which is required of you by your employer.

For all of these reasons, the panel decided that your fitness to practise was not only impaired at the time but continues to be impaired now on public protection grounds.

The panel bore in mind the overarching objectives of the NMC; to protect, promote and maintain the health, safety and well-being of the public and patients and to uphold and protect the wider public interest. This includes promoting and maintaining

public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case where a nurse has failed in such basic fundamental aspects of nursing and has been found to present a future risk to patients.

Therefore, the panel also finds your fitness to practise to be impaired on the grounds of public interest.

Having regard to all of the above, the panel is 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 you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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

Submissions on sanction

Mr Cassells informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired.

Mr Cassells submitted that the NMC's position is that a striking-off order is the appropriate sanction in these circumstances. He submitted that the charges are very serious, and he referred to the importance of upholding public confidence in the profession. He submitted that there are two aggravating features in this matter:

- Your conduct which put Patient A at risk of harm and caused actual harm as both physical and emotional harm was caused to Patient A.
- Your lack of insight.

Mr Cassells submitted that, to your credit, you admitted to the facts.

Mr Cassells submitted that the public interest is too strongly engaged for any other orders, which do not restrict your practice, to be appropriate. Mr Cassells invited the panel to consider a suspension order if it did not find a striking-off order appropriate. He submitted that, in light of your conduct and the nature of the charges found proved, your conduct is incompatible with remaining on the register.

The panel also bore in mind Ms Rao's submissions. Ms Rao acknowledged the distressing nature of the charges; however, she submitted that a striking-off order is not proportionate. She submitted that you have been practising without any restrictions or concerns raised and that your employer is willing to accommodate conditions of practice.

Ms Rao submitted that conditions of practice would allow you to work under supervision and review until the panel is satisfied that you can work without restriction. A suspension would allow you to have a period of time to undergo further training and would mark the concerns that the panel have about the severity and nature of the conduct and therefore meet the public interest.

Ms Rao submitted that it would be wrong to find that your conduct cannot be remedied and that you are essentially *"irredeemable".* She submitted that you have a positive history of good nursing practice. She submitted that, with regards to lack of insight, the panel cannot and should not turn this lack of insight into an aggravating factor which should result in a striking-off order. She submitted that the appropriate sanction should be imposed to address the lack of insight.

Ms Rao informed the panel that you are currently working as a bank nurse and that your employer is willing to continue employing you under conditions of practice. She invited the panel to consider the following conditions, in tandem with the standard conditions:

- Indirect supervision
- Specific training and coursework
- Logs of interactions with patients
- Checks with supervising nurses
- A reflective practice profile

The panel inquired as to why you have not provided more insight considering that four years have passed since the beginning of these proceedings. Ms Rao submitted that your reflection does show an attempt to accept what has happened, and that you know that what you did was wrong.

Decision and reasons on sanction

Having found your 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:

- Risk of harm and actual harm caused to Patient A; a vulnerable patient
- Took place over the duration of a 12-hour shift
- Limited insight into your multiple failings
- Lack of effective remediation
- Attitudinal failings

The panel also took into account the following mitigating features:

- Admissions to charges
- Previous good character or history

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 your 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 your 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 your registration would be a sufficient and appropriate response. The panel determined that, although there may be some conditions that could be formulated to address some of the conduct identified in this case, there is a more fundamental problem; the misconduct in this case is, essentially, not something that can readily be addressed through retraining, as there are deep-seated attitudinal concerns. The panel further took into account that you have not demonstrated sufficient insight or effective remediation, despite having four years to do so. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public and 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;*

Of these four factors, the panel considered that only one really applied in your case, namely that there has been no repetition. However, although it could be argued that this was a single instance of misconduct, as it occurred on one shift and related to one patient, it did, nonetheless, endure for most of a 12-hour shift. There were many opportunities where you could have untied Patient A and did not do so. Furthermore, the state that Patient A was found in at 8:00 AM suggests that she had been in that way, and no doubt, suffering for some considerable time.

The panel has already indicated that it considers there is evidence of harmful, deep-seated personality or attitudinal problems. This is because anybody, let alone a nurse, would know that it is wrong to leave a patient with her leg tied to their bed. Equally, they would know that it is wrong to leave a patient in a freezing cold room, on a bed, tipped so far back that her head was tilted down and feet were tilted up, with her gown open, with no pad on, lying on urine-soaked sheets.

These are not matters that you should need further training on as they are so basic and fundamental to nursing care, particularly when dealing with a very vulnerable patient. The panel has already referred to what it considers to be your very limited insight and therefore the real risk that you could repeat your behaviour.

The panel also had regard to the NMC sanction guidance, in particular, guidance relating to the abuse and neglect of vulnerable people:

> *'Safeguarding and protecting people from harm, abuse and neglect is an integral part of the standards and values set out in the Code, and any allegation involving the abuse or neglect of […] vulnerable people will always be treated seriously.*
>
> *When considering sanctions in cases involving the abuse or neglect of […] vulnerable adults, panels will, as always, start by considering the least severe sanction first and move upwards until they find the appropriate outcome. However, as these behaviours can have a particularly severe impact on public confidence, a professional's ability to uphold the standards and values set out in the Code, and the safety of those who use services, any nurse, midwife or nursing associate who is found to have behaved in this way will be at risk of being removed from the register.*
>
> *If the panel decides to impose a less severe sanction, they will need to make sure they explain the reasons for their decision clearly and carefully. This will allow people who have not heard all of the evidence in the case, which may include those directly affected by the conduct in question, to properly understand the decision.'*

The panel considered that your serious breach of what is a fundamental tenet of the profession, namely, by neglecting the health and welfare of Patient A, evidenced by your actions, is fundamentally incompatible with your remaining on the register.

Accordingly, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction in your 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?*

Your actions represented a significant departure from the standards expected of a registered nurse and the panel considered that the above three points are all answered in the affirmative. The regulatory concerns in this case do raise fundamental questions about your professionalism. In the panel's view, public confidence in nurses could not be maintained if you were allowed to remain on the register. Therefore, a striking-off is the only sanction that would sufficiently protect patients, members of the public and maintain professional standards.

Balancing all of these factors and 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 your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel recognised the severity of this sanction upon you but 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 you 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 your own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Cassells. He submitted that an interim suspension order for a period of 18-months is necessary to protect the public and meet the public interest during the appeal period.

Ms Rao did not make any submissions on interim order, nor did she support 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 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 due to the seriousness of the charges and the need to protect the public from the risk of harm. The panel determined that the interim suspension order would sufficiently meet the public interest in this matter.

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

That concludes this determination.