Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday, 10 December 2024 – Friday, 13 December 2024

Virtual Meeting

Name of Registrant:	Mini Koottala Johny
NMC PIN	04J0371O
Part(s) of the register:	Registered Nurse – Sub Part 1 RN1: Adult nurse, level 1 (11 October 2004)
Relevant Location:	Surrey
Type of case:	Misconduct
Panel members:	Sarah Lowe (Chair, lay member) Dorothy Keates (Registrant member) Julia Cutforth (Lay member)
Legal Assessor:	Robin Hay
Hearings Coordinator:	Catherine Blake
Facts proved:	Charges 1 (in its entirety), 2 (in its entirety), 4 (in its entirety), 5 (in its entirety), 6 (in its entirety)
Facts not proved:	Charge 3
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Johny's registered email address by secure email on 4 November 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date and the fact that this meeting was heard virtually.

In the light of the information available, the panel was satisfied that Mrs Johny has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Decision and reasons to amend charges 5 and 6

It appeared that charge 5 is repetitious and did not reflect the evidence in the bundle. Further, there are some minor typographical errors in charge 6.

The panel decided to amend charge 5 to provide clarity and more accurately reflect the documentary evidence, and charge 6 to ensure clarity:

'That you, a registered nurse:

…

5) *On or around 1 December 2020, failed to preserve a patient's dignity and/or privacy in that you:*
    a. *did not attempt to facilitate a patient with independence with continence and/or washing;*
    ~~*b. On or around 1 December 2020:*~~
        ~~*i. did not attempt to facilitate a patient with independence with continence and/or washing;*~~

b. *took a patient to the toilet without covering their genital area.*

6) Failed to work cooperatively with others in that:

…

*g. on or around 4 December 2020, you ~~should~~ shouted at and/or shook a Covid 19 patient to wake them up to take their blood pressure when this was not required and/**o**r you were not wearing PPE.'*

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

The panel determined that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Johny and no injustice would be caused to either party by the amendment being made. It was therefore appropriate to amend the charge to ensure accuracy and best reflect the evidence.

Details of charge

That you, a registered nurse:

1) On 4 December 2019, in respect of Patient B, failed to:
    a. follow instructions to undertake an ECG;
    b. make a record of their condition, observation and/or NEWs score;
    c. seek medical advice.

2) On 10 December 2020, increased the oxygen level of Patient A on 2 or 3 occasions to 15 litres in the absence of:
    a. a medical review and/or
    b. doctor's instructions.

3) On an unknown date between October 2020 and April 2021, failed to clean an observation machine between use for patients.

4) Between March 2020 and April 2021, failed to comply with Covid-19 guidance by:
    a. Not wearing PPE on at least 10 occasions;
    b. not removing PPE on coming out of a Covid bay;
    c. not washing your hands;
    d. not maintaining social distancing with colleagues.

5) On or around 1 December 2020, failed to preserve a patient's dignity and/or privacy in that you:
    a. did not attempt to facilitate a patient with independence with continence and/or washing;
    b. took a patient to the toilet without covering their genital area.

6) Failed to work cooperatively with others in that:
    a. when asked by Colleague A, you did not assist with discharge tasks;
    b. you followed a patient after they had indicated they did not want their blood taken;
    c. on 10 October 2020, you refused to take a hand over for a patient;
    d. on 10 December 2020, you did not respond to Colleague A when asked what instructions you had completed on planned discharges;
    e. on 2 November 2020, attended a patient's room;
        i. when you were told not to by Colleague B and/or
        ii. offered the patient water and a water soaked gauze.
    f. you woke a patient to give them water without having a handover and/or when it was not required;
    g. on or around 4 December 2020, you shouted at and/or shook a Covid 19 patient to wake them up to take their blood pressure when this was not required and/or you were not wearing PPE.
    h. In respect of Colleague C:
        i. when they told you that you should be washing your hands and wearing PPE, you told them that it was none of their business and/or they were only a HCA;
        ii. you shoved an observation machine at them;
        iii. you punched them in the arm;

i. you scraped an infected area of a patient's ear despite being told by them to stop;
j. you prepared IV fluids without checking with Colleague D that this was necessary.

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

Background

Mrs Johny was referred to the NMC by Walton Community Hospital (the Hospital), where she was working as a band 5 registered nurse. It is alleged that she failed to satisfactorily complete an informal and then formal capability process.

In December 2019, concerns were raised about her behaviour and conduct, her willingness to engage with support and supervision on the ward, and her clinical practice. A four-week supervision plan was undertaken from December 2019 and from August 2020, an informal capability process was commenced and continued until January 2021.

It is alleged that Mrs Johny resigned with immediate effect on 28 May 2021 and did not attend a Capability Hearing scheduled for the 9 June 2021.

The concerns appear wide-ranging around:

- Management and escalation of patient health;
- Fundamental nursing care;
- Record keeping;
- Working as part of a multi-disciplinary team;
- Infection prevention and control procedures;
- Respecting dignity, privacy and independence of patients;
- Failing to work cooperatively and follow instructions;
- Unsafe practice; and
- Communication.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence together with the representations made by the NMC. The NMC has not been provided with any information from Mrs Johny in relation to this meeting.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Colleague A/staff nurse at the Hospital at the time of the charges.
- Witness 2: Inpatient Occupational Therapy and Physiotherapy Manager at CSH Surrey at the time of the charges.
- Witness 3: Colleague B/band 6 nurse at the Hospital at the time of the charges.
- Witness 4: Healthcare Assistant at the Hospital at the time of the charges.
- Witness 5: Night staff nurse at the Hospital at the time of the charges.
- Witness 6: Colleague C/Healthcare Assistant at the Hospital at the time of the charges.

- Witness 7: Staff nurse at the Hospital at the time of the charges.
- Witness 8: Colleague D/Ward Sister at the Hospital at the time of the charges.

Before making any findings on the facts, the panel accepted the advice of the legal assessor. It considered all the documentation before it. The panel drew no adverse inference from the lack of information from Mrs Johny in relation to this meeting.

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

Charge 1

On 4 December 2019, in respect of Patient B, failed to:

a. follow instructions to undertake an ECG
b. make a record of their condition, observation and/or NEWs score;
c. seek medical advice.

This charge is found proved.

The panel has considered each sub charge separately, and will present findings together as the sub charges stem from a single incident and all the evidence in relation to these sub charges is the same.

In reaching its decision, the panel took into account Witness 2's written statement, the Datix Incident Review Form dated 4 December 2019, the patient notes for Patient B, and Witness 2's report referencing the internal investigations.

The panel bore in mind that this charge and all sub charges relate to Mrs Johny not following instructions to complete an ECG as requested by the Matron during her shift for a patient suffering with chest pain. The charges set out that no record was made in the clinical notes of this request or any observations taken including NEWs score of Patient B,

or that a medical opinion was sought. Instead, Mrs Johny handed over this task to the day staff at the conclusion of her shift.

In order to find this charge proved Mrs Johny must have had a duty to undertake the ECG expediently, including recording observations, instead of handing it over to the day staff and therefore delaying the treatment. In determining whether Mrs Johny had a duty under each sub charge, the panel took account of her job description, which required nursing staff:

> '*To have responsibility for assessing, planning, implementing and evaluating programmes of care with minimal supervision.*
>
> *…*
>
> *'To work as a member of the multi-disciplinary team without direct supervision, supporting the senior nursing staff in promoting health, independence and maximining the quality of life of patients, clients and carers.*
>
> *…*
>
> *'To report and act on any changes in the patients[sic] condition and situation as appropriate.'*

In respect of sub charge 1a, the panel determined that undertaking the ECG was part of Mrs Johny's duty to implement a programme of care.

The panel took into account the Datix Incident Review Form of 4 December 2019:

> *'Inappropriate clinical action taken for a patient with chest pain overnight. I advised staff nurse to complete an ECG x 4 which she did not complete.'*

Also from Patient B's notes:

> *'was handed over by night nurse that Patient B was complaining of tight feeling on the chest … Called 999…*
> *'Ambulance crew came, Patient B was taken to A+E'*

The panel found these to be contemporaneous accounts that indicate Patient B required hospital admission and that this was delayed due to the ECG not being carried out when it was requested on the night shift. Accordingly, sub charge 1a is found proved.

In respect of sub charge 1b, the panel determined that assessing and making a record of Patient B's condition was part of Mrs Johny's duty to record observations and to act on the findings. The panel further took into account the following from the Datix Incident Review Form dated 4 December 2019:

> *'In addition no record was made in the patient's records of patient's condition/obs/news score'*

The panel found this to be a contemporaneous account that indicates Mrs Johny did not make a record of Patient B's condition. Accordingly, sub charge 1b is found proved.

In respect of sub charge 1c, and having determined Mrs Johny had a duty to undertake the ECG, the panel determined that she then had a duty to seek advice from a doctor to meet her duty to maximize the quality of life of Patient B. The panel further had regard to the following from the Datix Incident Review Form:

> *'no medical advice sought from out of hours doctor system'*

The panel found this to be a contemporaneous account indicating that Mrs Johny did not seek medical advice. Having regard to the fact that Patient B required hospital admission, and that this was delayed because the ECG was not completed, the panel determined that Mrs Johny failed in her duty. Accordingly, sub charge 1c is found proved.

The panel found consistency in all reports before it. There is no evidence that any of these reports have been challenged. The panel therefore found the documentation to be reliable, and accepted the evidence that Mrs Johny failed in her duty at each sub charge in respect of Patient B.

Accordingly, the panel determined this charge proved in its entirety.

Charge 2

On 10 December 2020, increased the oxygen level of Patient A on 2 or 3 occasions to 15 litres in the absence of:

a. a medical review and/or
b. doctor's instructions.

This charge is found proved.

The panel has considered each sub-charge separately, and will present its findings together due to the overlap in the evidence relating to the sub charges.

The panel took into account the following direct evidence from Witness 5's statement:

'There was an incident with a patient on oxygen. The doctor gave us strict orders during handover on how to monitor the patient's oxygen level. We were told the patient was to be on 4 litres of oxygen through a nasal cannula. When we went to the patient Mini came without handover as she was late and heard us talking about the oxygen levels. Mini put the oxygen up to 15 litres and the patient was gasping. My colleague shouted at Mini and put it back to 4 litres which had been prescribed by the doctor. The doctor then came back and told Mini not to touch the patient but she went and did it again putting it to 15 litres'

The panel next considered the following from Witness 1's statement regarding Patient A's observation chart:

'The chart tells us that the day before the incident at 6am the patient's oxygen saturation level was 88% and at 11:40am he was put on 4L of oxygen. This continues until 8:10am the next day 10 December 2020 when Mini turns it up to 15L with the rebreathable mask. The oxygen saturation level at this time is noted as 87%. I turned the level back down to 4L. I told Mini that we need to speak with the doctor before changing the oxygen levels. I then went to speak with the doctor.

'I recognise the signature for the next entry on the 10 December 2020 as it is the ward doctor who worked 10am – 6pm. The entry is after the entries made by Mini in the observation chart and is telling us that the patient is on end-of-life care and the oxygen level was to maintain comfort as the patient had deteriorated.

'If low oxygen levels are identified, then you would check what the normal oxygen levels are for the patient in their records as they might have a low level anyway. If it was lower than their normal limits, then you would contact the doctor and if the doctor was unavailable then you would call 111.'

This account is corroborated in Witness 1's contemporaneous handwritten note dated 10 December 2020:

'[MEDICAL Feasible]

'Patient noted not to be saturating higher than 80% though on nasal pumps O_2 @ 5L/min'

The panel also considered supporting evidence in the doctor's note dated 17 January 2021 in respect of Mrs Johny:

'She has forcibly performed observations and forcibly administered oxygen to a dying patient who was not supposed to have observations.'

The panel also considered the Datix entry of 17 December 2020 regarding the incident on 10 December 2020:

'Oxygen had been administered to a patient (by a member of staff) at the rate of 15L'

The panel considered that the incident is consistent across all these reports. There is no evidence that the information in any of these reports has been challenged. The panel therefore considered the evidence in relation to this charge to be reliable.

The panel determined that, having seen MDT Progress notes, Medical Progress notes, and the statements of Witness 1 and Witness 5, that the correct level of oxygen for Patient A was between four and five litres.

The panel determined that there is evidence that Patient A's oxygen was consistently being decreased to the correct level by other members of staff, and evidence that Mrs Johny was consistently increasing the oxygen to 15 litres. The panel has seen no evidence that 15 litres was an appropriate level of oxygen for Patient A, and no explanation for why Mrs Johny would have increased Patient A's oxygen to this level repeatedly.

The panel determined that Mrs Johny increased Patient A's oxygen level to 15 litres in the absence of a medical review or a doctor's instruction.

Accordingly, the panel found this charge proved in its entirety.

Charge 3

> On an unknown date between October 2020 and April 2021, failed to clean an observation machine between use for patients.

This charge is found NOT proved.

In reaching this decision, the panel took into account the written statements of Witness 3 and Witness 6.

In order to find this charge proved Mrs Johny must have had a duty to clean the observation machine.

The panel had regard to the following from Witness 3's statement:

> '*I asked Mini to clean the machine as she was just going to leave it there. I then showed her how to clean the machine.'*

Bearing in mind that Witness 3 was a band 6 supervisor at the time of this incident, the panel determined that this interaction suggests there was an expectation that Mrs Johny would clean the machine herself.

The panel also considered Mrs Johny's job description, and that she had a duty to support senior nursing staff in promoting the health of patients, and that this included infection control. The panel was satisfied that cleaning the machine was a basic tenet of nursing practice, and so determined Mrs Johny had a duty to clean the observation machine in line with infection control procedures.

Further, the panel was satisfied that there is no evidence that, following the interaction with Witness 3, Mrs Johny did not clean the machine only that she was shown how, nor that the machine required cleaning at that time.

The panel also had regard to the following from Witness 6's statement *'When I went to the observation machine to clean it'*, which implies that the machine had not been cleaned. However, there is no evidence of the exact date on which this happened, nor evidence of the specific date on which Mrs Johny allegedly did not clean the observation machine. The panel was not satisfied that this section from Witness 6's statement related to the incident described in Witness 3's and therefore did not find Witness 6's statement to be corroborative.

Despite the evidence of a duty, the panel was not satisfied on the evidence before it that Mrs Johny failed to clean the observation machine in the time span set out in this charge. The panel determined the evidence was too vague for the panel to be satisfied this charge is proved.

Accordingly, this charge is found not proved.

Charge 4

Between March 2020 and April 2021, failed to comply with Covid-19 guidance by:

a. not wearing PPE on at least 10 occasions;
b. not removing PPE on coming out of a Covid bay;
c. not washing your hands;
d. not maintaining social distancing with colleagues.

This charge is found proved.

The panel has considered each sub charge separately, and will present its findings together due to the overlap in the evidence relating to the sub charges.

In order to find this charge and all related sub charges proved Mrs Johny must have had a duty to comply with the COVID-19 guidance. In determining this, the panel had regard to the Hospital's infection control policy:

> *'All Healthcare Workers including clinical staff*
> *Must adopt national evidence based practice in order to ensure patients are treated according to best practice'*

The panel also had regard to numerous editions of the Hospital's internal newsletter, *The Buzz*, which made reference to updated COVID-19 guidance within the prescribed period. It also had regard to Mrs Johny's duties within her job description and determined that infection control was an integral aspect of providing patient care.

Given the time period and that it was during the peak of the UK's COVID-19 response, the panel concluded that compliance with COVID-19 guidance was an integral part of infection control at the time. The panel therefore determined that Mrs Johny did have a duty to comply with COVID-19 guidance.

In relation to sub charge 4a, the panel considered the following from Witness 3's statement:

> *'It was very common for Mini not to wear PPE. I witnessed her going into the rooms of covid positive patients without PPE. She should have been wearing an apron, gloves, and visor. This created a risk to patients as half of the ward at that time were covid positive and the other weren't. It was handed over at the start of a shift which patients had covid. There were also labels by the rooms to identify this. There were 19 patients in total on the ward. I spoke with Mini about infection control however she continued to go into covid positive patients' rooms with no PPE. I am not sure how many times but it was definitely more than ten.'*

Witness 6's statement:

> *'Through Covid-19 on the ward she was going from one place to another without washing her hands and without wearing PPE. She didn't like when I told her she should be washing her hands and wearing PPE.*

There were no observations to be taken but Mini came in with no PPE and tried to wake the patient up.'

Witness 5's statement:

'I saw Mini go from bay to bay with the same PPE and not washing her hands. The PPE should have been changed when seeing each patient and her hands also washed. I saw this happening 2 or 3 times.'

The panel also considered the following from the Confidential Management Report in relation to Mrs Johny's clinical practice:

'IPC team did a teaching session with MKJ to demonstrate how she should don/doff PPE. The IPC nurse reported that during the session, MKJ had to be shown more than once how to complete the task properly'

The panel found that these accounts are direct witness evidence and consistent throughout. The evidence is corroborative, there is no challenge to it and no reason to believe that it is not a reliable account. The panel determined that Mrs Johny consistently failed to adhere to the COVID-19 guidance, and was satisfied with Witness 3's account that this happened on more than ten occasions. Accordingly, the panel determined sub charge 4a proved.

In relation to sub charge 4b, the panel regarded the following from the supervision notes:

'I demonstrated and discussed putting on and most importantly removing contamination[sic] personal protective equipment. I discussed the order of putting on PPE but expressed that now you/we remove contaminated PPE after the episode of care with the patient is most important.

'She needed to be instructed more than once to complete the task properly'

The panel determined that this evidence is consistent, there is nothing to challenge to it and no reason to believe that it is not a reliable account. Therefore, the panel accepted the evidence and found sub charge 4b proved.

In relation to sub charge 4c, the panel considered the following from Witness 6's statement:

> *'Through Covid-19 on the ward she was going from one place to another without washing her hands and without wearing PPE. She didn't like when I told her she should be washing her hands and wearing PPE.'*

Witness 5's statement:

> *'I saw Mini go from bay to bay with the same PPE and not washing her hands. The PPE should have been changed when seeing each patient and her hands also washed. I saw this happening 2 or 3 times.'*

Witness 4's handwritten note dated 1 December 2020 in respect of Mrs Johny:

> *'She has also been seen coming out of Covid bay with full PPE where [a colleague] had to bring it to her attention that she needs to Doff inside the bay and wash'*

The panel determined that this evidence is corroborative, there is nothing to challenge to it and no reason to believe that it is not a reliable account. Therefore, the panel accepted the evidence and found sub charge 4c proved.

In relation to sub charge 4d, the panel considered the following from Witness 7's statement:

> *'At the time we were social distancing because of Coronavirus and Mini would try and give you a cuddle.'*

This was corroborated by Witness 7's written feedback:

> *'MJ has not been social distancing on the ward'*
>
> *'Colleague was speaking on the telephone this afternoon, but MJ came close to her, not maintain social distancing.'*

The panel determined Witness 7's evidence to be reliable. There is no challenge to its veracity and no reason to believe that it is not a reliable account. Therefore, the panel found sub charge 4d proved.

Accordingly, this charge is found proved in its entirety.

Charge 5

On or around 1 December 2020, failed to preserve a patient's dignity and/or privacy in that you:

a. did not attempt to facilitate a patient with independence with continence and/or washing;
b. took a patient to the toilet without covering their genital area.

This charge is found proved.

The panel has considered each sub charge separately, and will present findings together as the sub-charges stem from a single incident and all the evidence in relation to these charges is the same.

In order to find this this charge and all related sub-charges proved Mrs Johny must have had a duty to preserve patient dignity. The panel had regard to Mrs Johny's job description:

'To work as a member of a multi-disciplinary team without direct supervision, supporting the senior nursing staff in promoting health, independence and maximizing the quality of life of patients, clients and carers.

…

'To ensure promotion of patients' privacy and dignity at all times.'

The duty to treat patients with dignity and respect is also a fundamental tenet of nursing. Accordingly, the panel determined Mrs Johny's duty under this charge established.

The panel had regard to the witness statement of Witness 4, who directly witnessed the incident:

'As I remember, I was asked to take Mini with me to do personal care for patients and it was really stressful for me. There was one patient where Mini took him to the

toilet without wearing any pyjama bottoms, his genitals were completely exposed. There were two other patients in the bay that saw what was happening. This was really concerning as Mini wasn't protecting the patient's privacy and dignity.

'If I was attending to a patient I would check if they were wearing pyjama bottoms as some patients prefer not to. If they weren't I would pull the curtain and allow them to put some bottoms on before taking them to the toilet. In Mini's case I witnessed her pulling the blanket off the patient and getting him up to take him to the toilet. The patient had mental capacity but didn't say anything. When I told Mini, she needs to cover him up she got a blanket and put it around him. She didn't say anything, but she made a facial expression as if to say 'so what' to the fact he wasn't wearing bottoms.'

The panel determined this to be consistent with Witness 4's handwritten contemporaneous account dated 1 December 2020:

'I explained to her that he is only one person for personal care and with mobility as he can walk to the toilet and be assisted with personal care. She then went filled[sic] up a washing bowl put it on his table. The patient then started to ask why is the water on the table. She said to him because I'm going to wash you in bed he replied I don't want to be washed in bed I want to go to the toilet. Mini replied toilet is busy and I'm going to wash you in bed. The patient got upset and said I don't want to get washing in bed at the moment.'

The panel determined Witness 4's evidence to be reliable. There is no challenge to its veracity and no reason to believe that it is not a reliable account. Accordingly, the panel determined this charge proved in its entirety.

Charge 6a, 6b, 6c, 6d

That you, a registered nurse:

Failed to work cooperatively with others in that:

a. when asked by Colleague A, you did not assist with discharge tasks;

b. you followed a patient after they had indicated they did not want their blood taken;
c. on 10 October 2020, you refused to take a hand over for a patient;
d. on 10 December 2020, you did not respond to Colleague A when asked what instructions you had completed on planned discharges

These sub charges are found proved.

The panel has considered sub-charges 6a, 6b, 6c, and 6d separately, and will present its findings together as these sub charges stem from the evidence of Witness 1/Colleague A.

In order to find this charge and all related sub-charges proved Mrs Johny must have had a duty to work cooperatively. The panel had regard to Mrs Johny's job description, and that it involves numerous references to working as part of a multi-disciplinary team. The duty to work cooperatively with colleagues is also a fundamental tenet of nursing. Accordingly, the panel determined Mrs Johny's duty under this charge established.

In regard to 6a and 6d, the panel determined that the evidence in relation to these sub charges is the same.

The panel had regard to the following from Witness 1's statement:

'I was asked on occasions to supervise Mini depending on what staff were available on what days. A rota had been drawn up at the time. Predominately there was a ward sister with her and if not, it was a band 6 nurse which was sometimes me but frequently it was the ward staff supervising her.

'Mini was a very knowledgeable person but she didn't follow instructions you gave her. She used to go off and do her own thing a lot. She would become argumentative when asked to give a rationale for what she had been doing. If I were supervising, I would ask Mini to help me with discharge tasks such as body maps and letters. Mini would go off and do her own thing rather than help and she wouldn't report back to you. If you asked why she did something then she would have an answer for everything. She wouldn't apologise, she would just give her

rationale for why she was doing something but the rational wasn't always correct or related to the task you'd given her to complete.'

The panel also took into account Witness 1's contemporaneous note of 10 December 2020:

'The patient was now in the care of the doctor and the ward staff nurse. So I asked Mini to help me with the planned discharges for the following day. I gave her step by step instructions on what she should check. TTOs, transport, discharge letter, home access and inform the families. She wrote this down and I explained she should come and find me if she has any concerns or questions.

'I had to leave the ward shortly after this as I needed to continue with my discharge co-ordinator roll[sic]. I told Mini where she could find me and I provided my work mobile number to the ward.

'I returned to the ward at 1pm and asked Mini what she had managed to achieve from the step by step instructions that were given. Her reply was nothing. I have no clue what she did after I left the ward for the CDH MFFD call.'

As above, the panel determined Witness 1 to be a reliable direct witness. There is no challenge to the veracity of her statement and no reason to believe that it is not a reliable account. Accordingly, the panel determined sub charges 6a and 6d proved.

In regard to sub charge 6b the panel considered the following from Witness 1's witness statement:

'The morning after her night shift Mini wouldn't go home. She would say that she hadn't finished work or that she felt she had an obligation to complete what she was doing. An example of this was when she tried to take blood from a patient in the morning, she followed the patient, but they had made it clear that they didn't want their blood taken at that time. We had to tell Mini to go home as it was clear the patient didn't want their bloods taken.'

Having determined Witness 1 to be a reliable witness, the panel accepted this evidence and therefore found sub charge 6b proved.

In regard to sub charge 6c the panel considered the following from Witness 1's contemporaneous local statement dated 10 December 2020:

> *'On Saturday Mini refused to take a hand over from SPH for a patient… I called Mini back and reminded her as a trained nurse you have responsibility[sic] to take a hand over.'*

Having determined Witness 1 to be a reliable direct witness, the panel accepted this evidence and therefore found sub charge 6c proved.

Accordingly, the panel found sub charges 6a, 6b, 6c and 6d proved.

Charge 6e

That you, a registered nurse:

Failed to work cooperatively with others in that:

e. on 2 November 2020, attended a patient's room;
    i. when you were told not to by Colleague B and/or
    ii. offered the patient water and a water soaked gauze.

This sub charge is found proved.

The panel has considered each sub charge separately, and will present its findings together as these sub charges arise from the same incident and all the evidence in relation to that is the same.

As above, Mrs Johny had a duty to work cooperatively with others.

The panel had regard to the following from Witness 3's statement:

> *'There was another incident I witnessed where Mini gave a patient inappropriate mouth care. I remember the patient was in a side room and they were on end-of life care as a person from the church had attended the hospital. The patient was dehydrated, and I remember Mini was worried a lot about the patient. I told her*

many times not to go into the room as the person from the church was in there. She said she wouldn't but then I would find her in the room. She continued to say the patient needed a drink and attention. She was obsessed with the patient and not listening to what I was saying. Mini had been allocated other tasks but focused on this patient.

'I witnessed Mini use a gauze to give the patient water. She either tried to put it on the patient's lips or inside of the mouth. This was dangerous and not appropriate. I am not sure if a Datix was completed. What Mini did caused a risk to her and the patient. The patient could have bitten down on Mini's finger when she put the gauze in the mouth. There was also a very easy chocking[sic] risk and risk to infection control. Patients are supposed to sip from a cup of water to hydrate.'

The panel also viewed a detailed STEP plan dated 2 November 2020, which contained Witness 3's contemporaneous supervision notes detailing this incident.

The panel determined Witness 3 to be a reliable direct witness. Her account set out in her witness statement and supervision notes is consistent. There is no challenge to the veracity of these documents and no reason to believe that it is not a reliable account. The panel determined this account depicts a lack of cooperation by Mrs Johny in respect of her colleagues.

Accordingly, the panel determined sub charge 6e proved in its entirety.

Charge 6f

That you, a registered nurse:

Failed to work cooperatively with others in that:

f. you woke a patient to give them water without having a handover and/or when it was not required;

This sub charge is found proved.

In reaching this decision, the panel took into account the statements of Witness 4 and Witness 5.

As above, Ms Johny had a duty to work cooperatively with others.

The panel had regard to the following from Witness 5's statement:

> *'I saw Mini go to patients without handover as she was always late. One time I saw her walking a patient without their Zimmer. When the patient complained Mini said don't worry I will help you. We aren't supposed to support patients with walking. I also saw Mini waking up a patient to give them water. This was early in the morning and Mini said she was doing it as the patient would be dehydrated. The patient didn't need to be woken up.'*

Witness 4's statement:

> *'There was another time when Mini came onto the ward to start her shift at 9am and without having a handover I saw her go straight over to a patient to wake him up and give him water as she said he was dehydrated. The patient didn't sleep well that night and so I told Mini to please go and have a handover as the patient hasn't slept all night but Mini argued with me that he was dehydrated. The matron who was new to the ward and didn't know Mini's behaviour got involved agreeing the patient needed water but it appeared she was just going along with what Mini was saying. I had to argue with both of them to tell them that the patient shouldn't have been woken up as he wasn't dehydrated and hadn't slept all night.'*

The panel determined Witness 4 and Witness 5 to be reliable direct witnesses. Their accounts are consistent, there is no challenge to their veracity and no reason to believe that it is not a reliable account. The panel determined these accounts depict a lack of cooperation by Mrs Johny in respect of her colleagues.

Accordingly, the panel determined sub charge 6f proved.

Charge 6g

That you, a registered nurse:

Failed to work cooperatively with others in that:

g. on or around 4 December 2020, you shouted at and/or shook a Covid 19 patient to wake them up to take their blood pressure when this was not required and/or you were not wearing PPE.

This sub charge is found proved.

In reaching this decision, the panel took into account Witness 6's documentary evidence.

As above, Ms Johny had a duty to work cooperatively with others.

The panel had regard to the following from Witness 6's statement:

'There was another incident where a patient with covid was on end of life care which meant we were not doing anything for him other than bath him every now and then. There were no observations to be taken but Mini came in with no PPE and tried to wake the patient up and was shouting at him. I told Mini to leave the patient alone, but she said she needed to take his blood pressure, but I told Mini we weren't doing observations. Mini walked away from him with the observation machine and went to another patient. I told Mini that none of the patients needed anything as I had done everything. Mini shoved the observation machine at me and said I couldn't tell her what to do as she was the nurse. I then went to the doctor who came in and asked Mini to leave. Mini said 'don't tell me what to do I know what I'm doing'. When I went to the observation machine to clean it Mini punched me in the arm and this was witnessed by [the ward administrator].'

The panel also viewed supportive contemporaneous note of 4 December 2020, which contained Witness 6's handwritten statement detailing this incident.

The panel determined Witness 6 to be a reliable direct witness. Witness 6's account set out in her statement and handwritten statement is consistent. There is no challenge to the veracity of these documents and no reason to believe that it is not a reliable account. The panel accepted Witness 6's evidence in relation to this charge and determined their account depicts a lack of cooperation by Mrs Johny in respect of her colleagues.

Accordingly, the panel determined sub charge 6g proved.

Charge 6h

That you, a registered nurse:

Failed to work cooperatively with others in that:

h. In respect of Colleague C:
    i. when they told you that you should be washing your hands and wearing PPE, you told them that it was none of their business and/or they were only a HCA;
    ii. you shoved an observation machine at them;
    iii. you punched them in the arm

This sub charge is found proved in its entirety

In reaching this decision, the panel took into account Witness 6's documentary evidence.

The panel has considered each sub charge separately, and will present its findings together as these sub charges arise from the same incident and all the evidence in relation is the same.

As above, Ms Johny had a duty to work cooperatively with others.

The panel had regard to the following from Witness 6's statement:

'I didn't like working with Mini as she was always doing things she shouldn't be doing. Through Covid-19 on the ward she was going from one place to another without washing her hands and without wearing PPE. She didn't like when I told her she should be washing her hands and wearing PPE. She was quite rude and told me it was none of my business and that I was only an HCA. She said I couldn't tell her what she could or couldn't do.

…

‘There was another incident where a patient with covid was on end of life care which meant we were not doing anything for him other than bath him every now and then. There were no observations to be taken but Mini came in with no PPE and tried to wake the patient up and was shouting at him. I told Mini to leave the patient alone, but she said she needed to take his blood pressure, but I told Mini we weren’t doing observations. Mini walked away from him with the observation machine and went to another patient. I told Mini that none of the patients needed anything as I had done everything. Mini shoved the observation machine at me and said I couldn’t tell her what to do as she was the nurse. I then went to the doctor who came in and asked Mini to leave. Mini said ‘don’t tell me what to do I know what I’m doing’. When I went to the observation machine to clean it Mini punched me in the arm and this was witnessed by [the ward administrator].’

This account is supported by Witness 6’s contemporaneous handwritten note dated 4 December 2020.

As above, the panel determined Witness 6 to be a reliable direct witness. Her account set out in her written statement and contemporaneous handwritten note is consistent. There is no challenge to the veracity of these documents and no reason to believe that it is not a reliable account. The panel accepted Witness 6’s evidence in relation to this charge and determined her account depicts a lack of cooperation by Mrs Johny in respect of her colleagues.

Accordingly, the panel determined sub charge 6h proved in its entirety.

Charge 6i

That you, a registered nurse:

Failed to work cooperatively with others in that:

i. you scraped an infected area of a patient’s ear despite being told by them to stop

This sub charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

As above, Ms Johny had a duty to work cooperatively with others.

The panel had regard to the following from Witness 6's statement:

> *'I remember a time when I was taking a patient to hospital to see a specialist as he had what we thought was cancer on his ear. The affected area on his ear was scabby and inflamed and Mini was scraping it off, I think it was a pair of scissors and it was bleeding. The patient said it was hurting him and he said to stop but she didn't. When I arrived at the hospital the doctor was surprised and asked what had happened to his ear. She said she was going to contact the matron at the hospital. I also reported it to the matron at the time...'*

As above, the panel determined Witness 6 to be a reliable direct witness. The panel accepted Witness 6's evidence in relation to this charge and determined that her account depicts a lack of cooperation by Mrs Johny in respect of her colleagues.

Accordingly, the panel determined sub charge 6i proved.

Charge 6j

That you, a registered nurse:

Failed to work cooperatively with others in that:

j. you prepared IV fluids without checking with Colleague D that this was necessary.

This sub charge is found proved.

As above, Ms Johny had a duty to work cooperatively with others.

Colleague D is not identified in the key to the NMC's Case Management Form. However, the panel has taken account of the evidence matrix, which identifies the statement of Witness 8 as the only evidence in support of this charge. The panel had regard to Witness 8's statement where she refers explicitly to the incident in this charge and identifies herself as the colleague who should have been consulted before the IV fluids were prepared. The panel was therefore satisfied that Witness 8 is Colleague D.

The panel had regard to the following from Witness 8's statement:

> *'There was another incident concerning IV fluids where a patient was prescribed IV fluids and Mini was getting this ready as well as dealing with other things such as dressings. I asked her what she was doing as she was working with me under supervision and I had not told her to prepare the IV fluids. She said I am getting everything ready. I told her that she was under supervision with me and if she needed to do anything she should ask if I had done it first or not. There was a risk to patient safety by Mini not checking as the patient may already have been given the fluids and there is a risk to overload the patient with fluids.'*

The panel determined Witness 8 to be a reliable direct witness. There is no challenge to the veracity of their statement and no reason to believe that theirs is not a reliable account. The panel accepted Witness 8's evidence and determined their account depicts a lack of cooperation by Mrs Johny in respect of her colleague.

Accordingly, the panel found sub charge 6j proved.

Fitness to practise

The panel next considered whether the facts found proved amount to misconduct and, if so, whether Mrs Johny'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 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. Second, and only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Johny's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

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

The NMC's submission was that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Mrs Johny's actions amounted to misconduct. In particular, the following sections of the Code: 1.1, 1.2, 4, 8.5, 10.1, 10.2, 10.3, and 20.1.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC submitted that Mrs Johny's behaviour put patients at unwarranted risk of harm by her failings in record-keeping, following instructions, seeking medical advice, and working with others to ensure safe and effective care. Mrs Johny also failed to wear PPE when required and failed to preserve a patient's dignity. The NMC submitted that there is a risk that Mrs Johny will repeat this behaviour in the future.

The NMC submitted that Mrs Johny failed to act with integrity and promote a high standard of care, and in doing so brought the nursing profession into disrepute. In particular, the NMC referred to the incident in which Mrs Johny scraped the infected area of a patient's ear despite being told by the patient to stop, and also concerns about her behaviour towards colleagues.

The NMC submitted that Mrs Johny's behaviour breached fundamental tenets of the nursing profession. The NMC submitted that the charges pertain to wide-ranging failings which raise concerns regarding Mrs Johny's ability to practice safely as a nurse.

The NMC submitted that there is no information before the panel that Mrs Johny has reflected on her behaviour or taken steps to strengthen her practice. She has shown little or no genuine insight into her misconduct and limited awareness of the implications her actions had on patient safety. The NMC submitted that there are underlying attitudinal problems which have not been addressed. Further, there would be a significant risk of harm to the public if Mrs Johny were allowed to practise without restriction, and a finding of impairment should be made on the ground of public protection.

The NMC submitted that the public would be appalled to learn that a registered nurse with such wide-ranging failures were permitted to practise unrestricted, especially in the light of Mrs Johny's underlying attitudinal concerns, and her disregard for patient safety. Therefore a finding of impairment should also be made on the ground of public interest.

The panel 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 determined that Mrs Johny's actions fell significantly short of the standards expected of a registered nurse, and amounted to significant breaches of each of the four areas of the Code. Specifically:

'Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity

- ***1.1*** *treat people with kindness, respect and compassion*
- ***1.2*** *make sure you deliver the fundamentals of care effectively*
- ***1.3*** *avoid making assumptions and recognise diversity and individual choice*
- ***1.4*** *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

2 Listen to people and respond to their preferences and concerns

- ***2.1*** *work in partnership with people to make sure you deliver care effectively*
- ***2.2*** *recognise and respect the contribution that people can make to their own health and wellbeing*
- ***2.3*** *encourage and empower people to share decisions about their treatment and care*
- ***2.4*** *respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care*
- ***2.5*** *respect, support and document a person's right to accept or refuse care and treatment*
- ***2.6*** *recognise when people are anxious or in distress and respond compassionately and politely*

3. Make sure that people's physical, social and psychological needs are assessed and responded to

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

4. Act in the best interests of people at all times

4.1 *balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*

4.2 *make sure that you get properly informed consent and document it before carrying out any action*

5. Respect people's right to privacy and confidentiality

5.1 *respect a person's right to privacy in all aspects of their care*

8. Work cooperatively

8.1 *respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*

8.2 *maintain effective communication with colleagues*

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

8.4 *work with colleagues to evaluate the quality of your work and that of the team*

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

10. Keep clear and accurate records relevant to your practice

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

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

13 Recognise and work within the limits of your competence

13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

13.2 *make a timely referral to another practitioner when any action, care or treatment is required*

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

19.3 *keep to and promote recommended practice in relation to controlling and preventing infection*

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

20. Uphold the reputation of your profession at all times

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

20.3 *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'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the charges proved relate to failures in fundamental areas of nursing practice. The panel has not seen anything from Mrs Johny to suggest that she has reflected on her behaviour, nor taken any steps to strengthen her practice. The panel took account of the NMC's guidance on seriousness and determined that Mrs Johny's behaviour and poor practice indicates a dangerous attitude to the safety of patients, particularly as patients under her care were vulnerable requiring end of life care.

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

Decision and reasons on impairment

The panel next considered whether as a result of the misconduct, Mrs Johny's fitness to practise is currently impaired.

In reaching 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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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 found that patients were put at risk and were caused physical and emotional harm as a result of Mrs Johny's misconduct. Mrs Johny's misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel therefore determined that limbs a, b and c of the test are engaged.

The panel was satisfied that the misconduct could be addressed. Therefore, the panel considered the evidence before it in determining whether or not Mrs Johny has taken steps to strengthen her practice or provided evidence of insight into her failings. The panel has not seen any information from Mrs Johny in relation to her current clinical practice or level of insight, and she has not engaged with NMC proceedings. Further, the panel has not seen any evidence of remediation or additional training undertaken by Mrs Johny. In the absence of such information, the panel could not be satisfied that the misconduct has been addressed.

Although it was said by some of Mrs Johny's colleagues that she was a knowledgeable nurse and also caring in her attitude towards patients, a number of the factual findings could well indicate that there is an underlying attitudinal problem.

The panel determined there is a risk of repetition based on Mrs Johny's lack of insight and remediation. This risk is exacerbated by information of the extensive support offered to Mrs Johny over a period of at least 12 months, including the STEP plan, and that despite this support her practice and behaviours did not improve. The panel therefore decided that a finding of impairment is necessary on the ground 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 proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required. The panel accepted the NMC submission that an ordinary member of the public would be appalled to learn that a nurse with such wide-ranging failures was permitted to practise unrestricted. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made and therefore also finds Mrs Johny's fitness to practise impaired on the grounds of public interest.

Having regard to all the above, the panel was satisfied that Mrs Johny's fitness to practise is currently impaired.

Sanction

The panel has decided to make a striking-off order. It directs the registrar to strike Mrs Johny off the register. The effect of this order is that the NMC register will show that Mrs Johny has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence before it and to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Representations on sanction

In the Notice of Meeting, dated 4 November 2024, the NMC advised Mrs Johny that it would seek the imposition of a striking-off order if her fitness to practise were found to be currently impaired.

The NMC submitted that Mrs Johny's misconduct involved a number of serious failings in her clinical practice, and raises fundamental questions about her professionalism and integrity. Due to the seriousness of the charges, and in the absence of any meaningful reflection, insight or remediation, the NMC submitted that a striking-off order is the only appropriate sanction that would protect the public and maintain professional standards.

Decision and reasons on sanction

Having found Mrs Johny'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 underlying attitudinal concerns
- Lack of insight into failings
- Abuse of a position of trust
- A pattern of misconduct which put patients at risk of harm
- No acceptance of responsibility
- Limited engagement with STEP plan
- No improvement following STEP plan
- Failure to engage with Occupational Health
- A pattern of repeated misconduct over a period of time
- Wide-ranging nature of the failings

The panel was unable to identify any mitigating factors in the evidence presented.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the serious nature of the misconduct. The panel decided that it would be neither proportionate nor in the public interest to take no further action. Misconduct of this nature demands a sanction.

It then considered the imposition of a caution order but again determined that, due to the serious nature of the misconduct, and the public protection issues identified, an order that does not restrict Mrs Johny's practice would not be appropriate. 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 found that Mrs Johny's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate.

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 Mrs Johny's registration would be a sufficient and appropriate response. The panel determined that there are no practical or workable conditions that could be formulated, given there is no evidence that Mrs Johny would engage with them having failed to improve her clinical practice and behaviours despite the supervision and extensive support provided by the clinical team and the STEP plan. Furthermore, placing of conditions on Mrs Johny's registration would not adequately address the serious nature of the misconduct nor would it protect the public in the light of the attitudinal concerns identified.

The panel therefore considered a suspension order. 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; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel had particular regard to the charges and that Mrs Johny's misconduct is not confined to a single instance of misconduct. The panel found there was a wide range of clinical and behavioural failings, many of which were repeated despite having been brought to her attention and the significant efforts made by the clinical team to support her. Her actions and responses showed a disregard for patients and colleagues. The panel took into account the numerous opportunities provided to Mrs Johny to enable her to remedy and strengthen her practice, and that she has not taken advantage of any of these.

The panel concluded that Mrs Johny's serious breaches of the fundamental tenets of the profession are fundamentally incompatible with her remaining on the register.

The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, when considering a striking-off order, the panel had regard to 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?*

Mrs Johny's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. Mrs Johny's misconduct was so serious that to allow her to remain in practise would undermine public protection, public confidence in the profession and public confidence in the NMC as a regulatory body.

Balancing all these factors and after taking into account all the evidence before it, the panel determined that the only appropriate and proportionate sanction, sufficient to protect the public and to address public interest concerns, is that of a striking-off order.

This order will 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 Mrs Johny 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. 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 Mrs Johny's own interests until the striking-off sanction takes effect. The panel accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that the panel should impose an interim order the same as any substantive order.

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, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow time for any appeal to be resolved.

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

That concludes this determination.