Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday 3 July - Tuesday 9 July 2024

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

Name of Registrant:	**Juliana Ngozika Sydes**
NMC PIN	08H1568E
Part(s) of the register:	RNMH: Registered Nurse – (sub part 1) Mental Health – Level 1-11 October 2008
Relevant Location:	Coventry
Type of case:	Misconduct and Police Caution
Panel members:	Patricia Richardson (Chair, lay member) Christine Wint (Registrant member) Lynne Vernon (Lay member)
Legal Assessor:	Peter Jennings
Hearings Coordinator:	Hanifah Choudhury
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter
Mrs Sydes:	Not present and unrepresented
Facts proved:	Charges 1c, 2a, 2b
Facts not proved:	Charges 1a, 1b
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Sydes was not in attendance and that the Notice of Hearing letter had been sent to Mrs Sydes' registered email address by secure email on 21 May 2024.

Mr Joshi, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor concerning the requirements of service.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Sydes' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Sydes

The panel next considered whether it should proceed in the absence of Mrs Sydes. It had regard to Rule 21 and heard the submissions of Mr Joshi who invited the panel to continue in the absence of Mrs Sydes. He submitted that Mrs Sydes had voluntarily absented herself.

Mr Joshi outlined to the panel Mrs Sydes' communication with the NMC, including her application for removal from the register, which was refused, and her response to the charges.

Mr Joshi invited the panel to proceed in Mrs Sydes' absence. He submitted that any further delay to proceedings would impede the course of justice.

The panel accepted the advice of the legal assessor concerning the approach it should take to the exercise of its discretion to proceed in Mrs Sydes' absence.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution.'*

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

- No application for a postponement has been made by Mrs Sydes;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness is scheduled today to give oral evidence.
- Not proceeding may inconvenience the witness, their employer and the clients who need their professional services;
- The charges relate to events that occurred in 2021;
- Further delay may have an adverse effect on the ability of witness accurately to recall events; and
- There is a public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Sydes in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own

volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Sydes' decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and not to provide evidence or make submissions on her own behalf.

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

Details of charge (misconduct)

That you, a Registered Nurse:

1) On or around the 21 October did not adequately record in relation to resident A;
    a) The reason they were transferred to hospital.
    b) Detail of any observations and or care provided to Resident A.
    c) An incident report.

2) On or around 22 December 2021 for one or more residents;
    a) Pre potted medication.
    b) Signed for medication having been administered before it had been.

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

Decisions and reasons on the panel proceeding with the hearing with knowledge of the caution charge

The chair informed the hearing that the panel had been sent a copy of a further head of charge which related to a caution. This was not in accordance with the procedure set out in Rule 29 (2). The panel knew nothing about this further matter beyond the wording of the charge itself. It invited Mr Joshi's submissions in respect of this.

Mr Joshi submitted that, as it is a professional panel used to dealing with facts and law, the NMC's view was that the panel's knowledge of the caution charge was not a reason for the panel to recuse itself.

The panel accepted the advice of the legal assessor in relation to the approach the panel should take to whether it should recuse itself.

The panel noted that it was unfortunate that it had sight of this other charge in relation to Mrs Sydes.

The panel considered that it was not biased or prejudiced towards Mrs Sydes and was able to put the separate charge out of its mind and focus solely on the relevant issues put in front of it. It was also of the view that a reasonable and informed observer would recognise that today's panel is an experienced, professional panel, well able to put irrelevant matters out of its mind, and would not be of the view that the panel was biased as a result of the inadvertent disclosure of the further charge.

The panel therefore decided that it was not necessary to recuse itself and that it was appropriate to proceed.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Joshi under Rule 31 to allow the written statement of Witness 1 into evidence. Witness 1 was not present at this hearing and he submitted that, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend today [PRIVATE]. Mr Joshi submitted that the NMC had made all efforts to secure Witness 1's attendance.

In the preparation of this hearing, the NMC had indicated to Mrs Sydes in the Case Management Form (CMF), that it was the NMC's intention for Witness 1 to provide oral evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 1, Mrs Sydes made the decision not to attend this hearing. On this

basis Mr Joshi advanced the argument that there was no lack of fairness to Mrs Sydes in allowing Witness 1's written statement into evidence.

The panel accepted the advice of the legal assessor on the provisions of Rule 31 and the principles which would inform its approach to the admission of hearsay evidence.

The panel gave the application in regard to Witness 1 serious consideration. The panel noted that Witness 1's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement … is true to the best of my information, knowledge and belief'* which was signed by her.

In reaching its decision the panel took into account the seriousness of the charge and the impact which any adverse finding may have on Mrs Sydes, and also the fact that she did not have any prior notice of the intention to rely on the statement as hearsay.

The panel considered whether Mrs Sydes would be disadvantaged by the change in the NMC's position of moving from reliance upon the oral testimony of Witness 1 to that of a written statement.

The panel noted the correspondence between Witness 1 and the NMC, [PRIVATE]. The panel was satisfied that there were reasonable grounds for Witness 1's non-attendance. The panel was also satisfied that the NMC had made proper efforts to secure Witness 1's attendance. The NMC had not sought a court order requiring her attendance, but in the circumstances the panel regarded that as reasonable.

The panel next considered the nature of the evidence provided by Witness 1. The panel took into consideration that part of the information in Witness 1's statement was itself based on hearsay in relation to Resident A rather than being within her own knowledge, and that it was not always clear whether the person who provided the information had direct knowledge of the matters described. The panel further noted that in relation to some other matters there was also documentary evidence so

that Witness 1's statement was not the sole and decisive evidence upon which the NMC was relying.

In these circumstances, the panel came to the view that it would not be fair to accept into evidence the entire written statement of Witness 1. It therefore allowed the application in respect of parts only of the statement. The passages which the panel did not receive in evidence are listed in an annex to this determination. The panel was satisfied that the passages which it allowed in evidence met the requirements of relevance and fairness.

Background

The charges arose whilst Mrs Sydes was employed as a registered nurse by Prime Life Care Home (the Home). The Home raised concerns over Mrs Sydes' record keeping and her lack of detail in her notes.

On the night of 21 October 2021 an incident occurred at the Home which resulted in Resident A being taken to hospital. Mrs Sydes was the nurse on the night shift. The documents relating to what occurred, which are before the panel, contain very limited reference to what happened other than a brief entry which stated *'hospital'*. As a result, the manager of the Home arranged record keeping training for Mrs Sydes, but she allegedly failed to attend.

On Mrs Sydes' last shift on 22 December 2021, the nurse taking handover from Mrs Sydes found pre-potted medication for one of the residents. The nurse reported that Mrs Sydes had signed for the morning medication in advance of administering it.

Mrs Sydes resigned from her position at the Home on 17 February 2022.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case, including the written responses provided by Mrs Sydes, together with the submissions made by Mr Joshi.

The panel drew no adverse inference from the non-attendance of Mrs Sydes.

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. It bore in mind that the seriousness of what is alleged may mean that the facts need to be examined more critically before the panel is satisfied that a charge is proved on the balance of probabilities.

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

- Witness 2: Nurse at Prime Life Care Home

The panel received in writing the witness statement of Witness 1, redacted in accordance with its ruling on admissibility, and various documentary exhibits.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor on the principles it should have in mind in reaching its decisions.

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

Charge 1a)

1) On or around the 21 October did not adequately record in relation to Resident A;
    a) The reason they were transferred to hospital.

This charge is found not proved.

In reaching this decision, the panel took into account the statement from Witness 1 and the observation and other records exhibited. The panel also considered the document sent by Mrs Sydes to the NMC on 13 June 2024 which contained her response to the charges.

The panel noted that the only information provided to it in relation to Resident A being admitted to hospital at the time of the incident was contained in the 'observation record.' Witness 2, who was not involved in this incident, said in her oral evidence that this record is completed by the carers, as opposed to the nurse. It stated:

'0700-HOSPITAL'

The panel took into account the evidence of Witness 1 which suggests Mrs Sydes was on duty at this time. The panel noted that the carer's observation record, which should have recorded hourly observations of activity, mood and wellbeing of the resident, made no reference to any incident that occurred prior to the note recording transfer to the hospital.

The panel heard evidence from Witness 2 that there would have been a separate record made by staff at the Home detailing the time the ambulance was called for and the reason for it which was known as the ambulance log. This document was not presented to the panel.

The panel considered the note made by Mrs Sydes in the nursing notes for Resident A:

'*Kept checks observations, she was okay throughout the night.'*

It also took into account Mrs Sydes' response:

'…there should have always been two nurses on the ward, but I was invariably left on my own and I also had to do dressings and a peg feed on another ward that I should not have been responsible for.'

The panel noted Witness 1's statement which stated:

'At the beginning of the shift, there is a handover period where the nurse could ask the nurse on the next shift to assist with completing the report.'

The panel also noted Mrs Sydes' response which stated:

'I reported an incident at handover, and they did not request a further detailed report.'

The panel determined that whilst there is evidence that Mrs Sydes became aware that an incident had occurred on her shift, there was insufficient evidence to be satisfied on a balance of probabilities that Mrs Sydes was aware of the transfer of the resident to hospital at the time her notes were made. In the panel's view it is probable that Mrs Sydes made that note before the incident took place. The panel accepted the evidence of Witness 2 that there would have been an entry in the ambulance log, which the panel has not seen, relating to Resident A being taken to hospital and why. It accepted Mrs Sydes' response, that she reported the incident at handover, and the evidence of Witness 1 that a nurse could ask the nurse to whom she handed over to assist with reporting the incident.

The panel also took into consideration the ambiguities in the nursing notes for Resident A, in that the notes that were written after the notes attributed to Mrs Sydes appear to have been written retrospectively as they refer to observations that took place on the day shift of 21 October 2021 and should have been written before Mrs Sydes' notes on the night shift of 21 October 2021. Instead they were apparently written by the day shift nurse after she was told at handover that Resident A had been taken to hospital. In their deliberations, this caused some concern to the panel as to the reliability of the notes provided in evidence.

In the light of those matters the panel was not persuaded that the NMC had discharged its burden of proof. The panel therefore found this charge not proved.

Charge 1b)

1) On or around the 21 October did not adequately record in relation to Resident A;
   b) Detail of any observations and or care provided to Resident A.

This charge is found not proved.

In reaching this decision, the panel took into account the nursing notes and other records and Witness 2's oral evidence.

The panel was aware, having heard from Witness 2, that in addition to the nursing notes there would also be a clinical observation chart completed by the nurse on duty and recording their observations of blood pressure, temperature, respiration and other signs of a resident. Witness 2 informed the panel that this document would go alongside the nursing notes. The panel was not provided with this document. It is not the same as the 'observation record', which is in evidence. The latter records activities such as whether the resident is in bed and asleep and is completed by the carers rather than by the nurses. Witness 2 also told the panel that the Home was moving to computerised records, and that there would be computerised records alongside the handwritten records. The panel was not provided with any of these.

The panel took into account the nursing notes made by Mrs Sydes for Resident A, which included a blood sugar level reading and notes on the care she provided to Resident A. The notes stated:

> *'Her BM was 18.9 mmols. At about 20:15 Resident A went to bed and by 21:00 she appears asleep. Taking her to bed she was asleep. So did not take her meds. Kept checks observations, she was okay throughout the night.'*

The panel was satisfied that there was care provided to Resident A by Mrs Sydes and this had been adequately recorded in the notes. The panel considered that further observations would have been recorded and reflected in the clinical observations chart and in computerised records but these records were not provided to the panel. The panel also took into account that the care provided to Resident A on the night of 21 October 2021 had been recorded by her carer on the observation record and had been initialled by the carer.

The panel was not satisfied that the NMC has proved on the balance of probabilities that Mrs Sydes did not detail any observations or care provided to Resident A. The panel therefore found this charge not proved.

Charge 1c)

1) On or around the 21 October did not adequately record in relation to Resident A;
    c) An incident report.

This charge is found proved.

In reaching this decision the panel took into account Witness 2's oral evidence. Witness 2 said that an incident resulting in an ambulance being called should be recorded in an incident report. The panel was not provided with this as evidence.

The panel also had regard to Mrs Sydes' response which stated:

> *'I reported an incident at handover, and they did not request a further detailed report.'*

The panel is satisfied that this suggests that Mrs Sydes was aware that an incident had occurred on her shift and that an incident report was not written by her. The panel therefore found this charge proved.

Charge 2a)

2) On or around 22 December 2021 for one or more residents;

a) Pre potted medication.

This charge is found proved.

In reaching this decision, the panel had particular regard to Witness 2's statement which stated:

> *'I then went into the clinic room and noted that there was some medication in pots on the trolley. There were resident's names written on pieces of paper. I then found a pot with tablets in there with a name,'*

The panel also gave regard to Mrs Sydes' statement which said:

> *'Regarding the alleged medication irregularities these were not mentioned to me at the time either.'*

In her oral evidence Witness 2 explained that the nurse should prepare the medication for one resident, and then administer it to the resident and record it, before proceeding to do the same for the next resident. There is a medication trolley and an iPad on which it is intended that the administration is recorded. Witness 2 said that the signal to the iPad tended to fail with the result that, instead of taking the trolley and the iPad around the home, the nurse had to take the medication to the resident individually and then return to the nurse's office to record the administration and to check and prepare the medication for the next resident. While the panel understood that this may be the reason why a nurse would be tempted to pre pot medication, the panel accepted Witness 2's evidence that it is never acceptable to pre pot medication.

Having read Witness 2's statement, which was corroborated by her oral evidence, the panel was satisfied that Mrs Sydes had pre potted medication for residents. This charge is therefore found proved.

Charge 2b)

2) On or around 22 December 2021 for one or more residents;

b) Signed for medication having been administered before it had been.

This charge is found proved.

In reaching this decision, the panel took into account the written statement from Witness 2 and her oral evidence. Witness 2's statement said:

> *'I then found a pot with tablets in there with a name, I looked on the Medical Administration Records ("MAR") for the resident and these had been signed as given by Mrs Sydes, despite them still being in the pot.'*

The panel accepted Witness 2's evidence, in that she saw the MAR chart pre-signed although the medication had not yet been administered to the residents. The panel therefore found this charge proved.

Caution charge

That you, a Registered Nurse:

3) Received an adult Conditional Caution for child neglect contrary to s1(1) of The Children and Young Persons Act 1933

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

Decisions and reasons on facts in relation to the caution charge

Following its decision and reason on facts in relation to the misconduct charges, Mr Joshi informed the panel that there is an additional charge that concerns Mrs Sydes' fitness to practise which needs to be considered at the hearing. This additional charge concerns a police caution received by Mrs Sydes in 2022.

The panel considered the certificate of caution from West Midlands Police which had been signed by Mrs Sydes on 19 September 2022. The panel also took into account Mrs Sydes' response to the caution charge which stated:

> *'I signed for a conditional caution under duress because the policeman kept coming back to me to sign as requested [PRIVATE]. The policeman said it would be highly traumatic [PRIVATE] if went to court so eventually I signed it [PRIVATE]. I want to apply for removal of the conditional caution [PRIVATE].'*

The panel was informed by Mr Joshi that there had been no application by Mrs Sydes for removal of the conditional caution to date.

The panel therefore found the caution charge proved in its entirety.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mrs Sydes' fitness to practise is currently impaired in relation to misconduct and her police caution. 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. 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.

With regard to the misconduct allegation the panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved under charges 1 and 2 amounted to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Mrs Sydes' fitness to practise is currently impaired as a result of the misconduct.

Submissions on misconduct

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

Mr Joshi identified the specific, relevant standards in 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015 (the Code)' where the NMC alleges that Mrs Sydes' actions amounted to misconduct.

Submissions on impairment

Mr Joshi 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.

Mr Joshi submitted that there has been no acknowledgement from Mrs Sydes of her wrongdoings nor have there been any reflections or additional training completed by her.

Mr Joshi invited the panel to make a finding of current impairment on the basis of Mrs Sydes' misconduct and police caution on the grounds of public protection and public interest.

Decision and reasons on misconduct

The panel first considered whether the charges found proved in charges 1c, 2a and 2b amount to misconduct.

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

The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

It took into account all of the material in the case, together with the submissions of Mr Joshi and the representations from Mrs Sydes. The panel accepted the advice of the legal assessor which included reference to the principles in a number of relevant judgements.

The panel considered that the conduct underlying charge 1c did not amount to misconduct. The panel took into account that whilst Mrs Sydes did not complete an incident report for Resident A she did notify the Home that an incident had occurred. Mrs Sydes states that she was not asked for a further report and there is no evidence that she was asked for one. The panel determined that a fellow professional appraised of the facts would not find her failure to complete and incident report deplorable.

The panel next considered charges 2a and 2b. These charges relate to the administration of medication. The panel took into consideration the seriousness of the charges and the potential risk of harm to residents as a result of Mrs Sydes' actions. The panel bore in mind that the difficulty in obtaining a signal on the iPad increased the amount of work which the nurse would need to do if she completed the medication administration for each patient before preparing the medication for the next patient. However, the panel also took into account the oral evidence from Witness 2 which confirmed that, despite this, the conduct of pre potting medication and pre signing the MAR chart is unacceptable.

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 Mrs Sydes' actions amounted to a breach of the Code. Specifically:

> ***'10 Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
> *10.1 complete records at the time or as soon as possible after an event…*
> *10.3 complete records accurately and without any falsification…*
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***
> *To achieve this, you must:*
> *19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place'*

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

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

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct and caution, Mrs Sydes' fitness to practise is currently impaired.

The panel took into account all of the material before it, the submissions of Mr Joshi and the observations from Mrs Sydes. It accepted the advice of the legal assessor concerning the approach it should take to the question of impairment.

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 and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 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…, caution… 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…’*

The panel finds that the pre potting of medication and signing of the MAR chart prior to the administering of medication to the patients, had the potential to result in medication not being correctly administered to the correct patient and therefore place patients at risk of harm. Mrs Sydes’ misconduct had brought the profession into disrepute and breached the fundamental tenets of the nursing profession in failing to ensure patient safety and minimise the risk of harm to patients.

Regarding insight, the panel considered that Mrs Sydes had not provided it with any information by way of reflective pieces to show that she had insight into her actions or had taken accountability for how her actions could have harmed residents. The panel also concluded that there is a risk of repetition as Mrs Sydes had not provided the panel with any information that she had taken steps to strengthen her practice.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are not only to protect, promote and maintain the health, safety, and well-being of the public and patients, but also 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 noted that Mrs Sydes had accepted a police caution for child neglect. The panel took into account Mrs Sydes' response to the police caution which stated:

'[PRIVATE].'

The panel was concerned that Mrs Sydes has shown no remorse for her actions [PRIVATE] and has shown no insight and no recognition that her behaviour was wrong and unacceptable.

The panel took into account that the nature of Mrs Sydes' police caution is likely to bring the nursing profession into disrepute and that public confidence in the profession would be undermined if a finding of impairment were not made. The panel was of the view that a member of the public would be appalled to know that a nurse responsible for the care of vulnerable patients had received a police caution for neglect of children. The panel therefore determined that a finding of impairment on public interest grounds is required.

Having regard to all of the above, the panel was satisfied that Mrs Sydes' 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 Mrs Sydes off the register. As a result of this order the NMC register will show that Mrs Sydes has been struck off the register.

Submissions on sanction

Mr Joshi invited the panel to impose a striking-off order. He stressed Mrs Sydes' attitude to these charges and submitted that a striking-off order is the only order appropriate to maintain public safety and confidence in the profession.

Mrs Sydes in her response made no express submission on sanction. The panel noted in the response dated 20 May 2024 relating to [PRIVATE]. She denied the further allegations made against her in 2021 saying that the allegations were never substantiated.

Decision and reasons on sanction

Having found Mrs Sydes' 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 decision on sanction is a matter for the panel independently exercising its own judgement.

In reaching its decision, the panel has had regard to all the evidence that has been adduced in this case and to the submissions of Mr Joshi and the response to the allegations from Mrs Sydes. It had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor concerning the approach it should take to the question of sanction.

The panel took into account the following aggravating features:

- [PRIVATE]
- There was no information from Mrs Sydes that shows she had any insight into her behaviour or recognition that she had done anything wrong
- Abuse of a position of trust

The panel determined, in relation to the misconduct charge, that Mrs Sydes was working within the context of unsuitable equipment and a shortage of staff, which afforded some mitigation. It found that there were no mitigating features in relation to the criminal caution.

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 action.

It then considered the imposition of an NMC caution order but again determined that, due to the seriousness of the case, an order that does not restrict Mrs Sydes' practice would not be appropriate in the circumstances. The SG states that an NMC 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 Mrs Sydes' misconduct and police caution were not at the lower end of the spectrum and that an NMC 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 Mrs Sydes' registration would be a sufficient and appropriate response. In respect of [PRIVATE], Mrs Sydes accepted a police caution for offences of neglecting those children [PRIVATE]. In the panel's view such behaviour on the part of a member of a caring profession can only be regarded as extremely serious. The panel concluded that the placing of conditions on Mrs Sydes' registration would not adequately address the seriousness of this case.

The panel was also of the view that there are no practical or workable conditions that could be formulated, given the nature of the matters underlying those two cautions. Further as the panel has already stated, Mrs Sydes has shown no remorse for her actions and has shown no insight and no recognition that her behaviour was wrong. The panel has no information from Mrs Sydes to indicate that she would comply with conditions in relation to this matter.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a 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;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel took into consideration the lack of insight from Mrs Sydes and her lack of accountability for the actions that led to her receiving the police cautions. In the panel's view her actions were a serious breach of the fundamental tenets of the profession which, together with her lack of remorse and insight, indicate a harmful and deep-seated attitudinal problem. Given the nature of the police caution, the panel was of the view that the public interest would not be satisfied by the imposition of a suspension order.

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

Finally, in looking at a striking-off order, the panel considered the NMC's guidance on 'Considering sanctions for serious cases; Abuse or neglect of children or 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 children or vulnerable people will always be treated seriously.*
>
> *…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… 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.'

Mrs Sydes' actions were significant departures from the standards expected of a registered nurse and in the panel's judgement they were fundamentally incompatible with her remaining on the register. The panel was of the view that a member of the public would find it morally reprehensible if a nurse were allowed to practise having received a police caution for neglect of children [PRIVATE].

In making its decision the panel also took into consideration the misconduct found in charges 2a and 2b of pre potting medication and pre signing the MAR chart. The panel was of the view that, faced with a situation not of her own making due to a lack of staffing and lack of functioning equipment, Mrs Sydes made the wrong decision. If these charges had stood alone, a conditions of practice order might have been sufficient in protecting the public and addressing the wider public concerns. In view of the panel's decision in relation to the appropriate sanction in respect of charge 3 it is unnecessary to say more about the misconduct in charges 2a and 2b.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Sydes' actions in bringing the profession into disrepute and breaching the fundamental professional principles of caring for others and observing the law, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary in order to maintain public confidence in the nursing profession and in its regulatory process, and to declare to the public and the profession the standards of behaviour required of a registered nurse.

This will be confirmed to Mrs Sydes 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, until the striking-off sanction takes effect, 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 is in Mrs Sydes' own interests.

Submissions on interim order

The panel took account of the submissions made by Mr Joshi. He submitted that an interim suspension order for a period of 18 months is necessary on the grounds of public protection and is otherwise in the public interest. He also submitted that the length of the interim suspension order should cover any potential period of appeal.

Decision and reasons on interim order

The panel heard and accepted the advice of the legal assessor on the law and principles relating to the makings of interim order.

The panel was satisfied that an interim order is necessary to protect the public and is otherwise in the public interest. In reaching the decision to impose an interim order 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 this decision the panel kept in mind the impact which an interim order will have on Mrs Sydes. The panel was satisfied that the need to protect the public and to meet the public interest outweighed Mrs Sydes' interest.

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. In the panel's judgement to make any order other than an interim suspension order would be inconsistent with the panel's finding that Mrs Sydes' behaviour is incompatible with continued registration. The panel therefore imposed an interim suspension order for a period of

18 months to cover any potential period of appeal. The panel was satisfied that this period was proportionate in the circumstances of the case.

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

That concludes this determination.

ANNEX 1

The panel decided to make the following redactions to the statement of Witness 1:

Witness Statement Bundle- Exhibit 1

- The first sentence of paragraph 5
- The entirety of paragraph 6
- The second sentence of paragraph 7 which starts *'I came to know..'* up until '*was being admitted to hospital.'*
- The sentence of paragraph 8 which starts *'I would have also written'* up until the end of the paragraph.
- The sentence of paragraph 9 which starts *'If a fall was part of the shift I worked'* up until the end of the paragraph.
- The sentence of paragraph 10 which starts *'There should have been sufficient detail'* up until the end of the paragraph.
- The entirety of paragraph 12.
- The second sentence of paragraph 13 which starts *'I spoke to the clinical lead.'*
- The first sentence of paragraph 14 which starts *'Following the incident.'*
- The sentence of paragraph 15 which starts *'At around the same time'* up until the end of the paragraph.