Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 13 November 2023 &
Tuesday 21 May 2024 – Wednesday 22 May 2024

Virtual Hearing

Name of Registrant:	Emeka Jude Umerah
NMC PIN	19B1426E
Part(s) of the register:	RNA: Adult nurse, level 1 February 2019
Relevant Location:	Berkshire
Type of case:	Misconduct
Panel members:	Debbie Hill (Chair, lay member) Linda Tapson (Registrant member) John Kelly (Lay member)
Legal Assessor:	Jayne Salt
Hearings Coordinator:	Jessie Miller
Nursing and Midwifery Council:	Represented by Grace Khaile, Case Presenter
Mr Umerah:	Present and represented by Selena Jones, counsel, instructed by Royal College of Nursing (RCN)
Facts proved:	Charges 1a, 1b, 1c, 2a, 2b
Facts not proved:	Charges 2c, 3, 4
Fitness to practise:	Impaired
Sanction:	Strike off
Interim order:	Interim suspension order, 18 months

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

At the outset of the hearing, Ms Khaile, on behalf of the Nursing and Midwifery Council (NMC) made a request that parts of this case be held in private on the basis that [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Jones did not oppose the application.

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

The panel determined to hold parts of the hearing in private and go into private session when reference to [PRIVATE].

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Khaile under Rule 31, to allow the written statement of Witness 1 into evidence. Witness 1 was not present at this hearing and informed the NMC five days before commencement of the hearing that they would not be attending due to work commitments. Ms Khaile submitted that despite their non-attendance, the evidence is highly relevant in this case. She further stated that there would be no injustice to you by admitting the hearsay evidence of Witness 1, as the panel would be able to test some of the evidence that concurs with other witness evidence who will be attending.

Ms Jones invited the panel to exclude this evidence. She further stated that given Witness 1 is not present, there is no way to cross examine the witness of this evidence, which would be crucial to your case. She went on to note that there have been numerous

unsuccessful attempts to secure Witness 1's attendance, noting that the NMC failed to update the RCN with any attendance developments. She submitted that this deprived you of the opportunity to prepare a response to the hearsay evidence. She therefore concluded that it would be unfair to you to allow the addition of the hearsay evidence.

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

The panel determined that the content of the hearsay evidence was relevant and not sole and decisive. However, it determined to exclude the statement of Witness 1 as there is no way to fairly test or cross examine Witness 1 on their evidence in the statement provided. Further, the panel accepted Ms Jones submission that there was some unfairness to you due to the late notice of a hearsay application by the NMC.

In these circumstances the panel refused the application.

Details of charge

The panel noted that charges 1 and 2 did not record a year. This was clarified by Ms Khaile and confirmed as being 2020. This was accepted by the panel as an obvious omission and no formal application to amend the charges was made. No objection to this was made by Ms Jones.

The charges are as follows:

That you, a registered nurse;

1) *On 6th September 2020, failed to record and communicate Resident A's fall as required;*

a) *Failed to record in the 'discussion with significant others' section of the care plan that family had been contacted and at what time.*

b) *Failed to contact Resident A's family for at least 3 hours.*

c) *Failed to make accurate records at the time of the incident.*

2) *On 6th September 2020, after colleague 1 informed you of Resident A's fall, you failed to provide leadership;*

a) *By failing to direct the carer to remain with Resident A after her fall.*

b) *By delaying calling an ambulance.*

c) *By not assisting in providing the paramedics with Residents A's medical history or notes.*

3) *On 25 September 2021 did not effectively communicate with colleagues in relation to an unknown patient's deterioration.*

4) *On 25 September 2021 whilst at Royal Berkshire Hospital, offered minimal support to a crash team and colleagues in relation to an unknown patient.*

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

Background

The charges arose whilst you were employed as a registered nurse by Hungerford Nursing Home (the Home) and later by Royal Berkshire Hospital NHS Trust (the Trust).

On 6 September 2020, whilst working at the Martin Unit at the Home, a concern was raised by a colleague regarding your actions after a resident's fall at 11.46AM and your subsequent behaviour towards visiting paramedics.

The concerns raised related to your leadership skills and response after Resident A fell:

- Failing to facilitate paramedics arrival by choosing to take your break;
- Failing to follow the Home's policy regarding carrying out neurological observations after a suspected head injury or unwitnessed fall;
- Failing to make adequate records and completing written documentation in the resident's Care Plan;
- Failing to contact Resident A's family in a timely manner;
- Failing to communicate and direct care staff in relation to actions after Resident A's fall; and
- Failing to assist the paramedics in providing Resident A's medical history and notes.

You were invited to attend a meeting by the management team of the Home on 15 September 2020 to discuss this incident, but chose not to attend. You had resigned from your post with immediate effect on the day of the incident. Therefore, these concerns were not addressed with you by your employer directly.

Further concerns were raised about your practice when it was alleged that you were involved in another incident on 25 September 2021, whilst employed by the Trust. It is alleged that you failed to communicate effectively with colleagues in relation to a patients

deterioration, and further, provided minimal support to a crash team when dealing with this deterioration.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Khaile and Ms Jones.

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

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

- Witness 2: Registered Nurse that worked at the Home at the time of the event in September, 2020.
- Witness 3: Care Assistant attending to residents care needs at the Home at the time of the event in September, 2020.
- Witness 4: Registered Nurse that worked at the Trust as a Ward Sister at the time of the event in September, 2020.
- Witness 5: Registered Nurse that worked as a Junior Sister at the Trust at the time of the event in September, 2021.

- Witness 6: Registered Nurse that worked as a Senior Staff Nurse and mentor to you at the Trust at the time of the event in September, 2021.

- Witness 7: Registered Nurse that worked as a Senior Staff Nurse at the Trust at the time of the event in September, 2021.

- Witness 8: Regional Support Manager at the Home who undertook the disciplinary investigation.

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC and Ms Jones, on your behalf.

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

Charge 1a:

On 6th September failed to record and communicate Resident A's fall as required;

a) Failed to record in the 'discussion with significant others' section of the care plan that family had been contacted and at what time.

This charge is found proved.

You told the panel that you recorded in the 'Discussions with Significant Others' section of the care plan that Resident A's family had been contacted and at what time. The panel had regard to the physical evidence produced. It took particular note of the 'Discussions with Significant Others' section which documented communications between the Home staff and Resident A's family between 18 April 2020 to 28 September 2020. There was no entry or record of any communication on or near 6 September 2020. In your oral evidence, you said that you did write it in the 'Discussions with Significant Others' section of the care plan. When taken to the evidence, and it was highlighted that there was no record of any communication from you, you told the panel that you wrote it on another sheet of paper that must have been lost or archived. You gave no reasoning as to why you would do this when it would disrupt the chronology of the patient's overall care.

The panel further noted the witness statement of Witness 8 who undertook a disciplinary investigation into your actions. It is stated that:

> *'The Registrant also failed to document on the Care Plan Discussion of Significant Others that Resident A's family had been contacted.'*
>
> and
>
> *'…However, he had not recorded the required information in the correct sections where it would have been expected.'*

The panel did not accept your account as to why you had not documented your contact with the family in the 'Discussions with Significant Others' section of the care plan. It determined that on the balance of probabilities, it was more likely that you did not document the fuller details of the contact with the resident's family in the appropriate place. It therefore found this charged proved.

Charge 1b:

On 6th September failed to record and communicate Resident A's fall as required;

b) Failed to contact Resident A's family for at least 3 hours.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, including a note of a phone call between Witness 8 and Resident A's daughter that took place on 9 September 2020.

You told the panel that you contacted Resident A's family on numerous occasions, but initially they did not answer your call and you therefore left a voicemail message. The note confirmed that Resident A's daughter said that she received a call from the Home at 15:09 (3.15PM) on the day of the fall. She further confirmed that her brother also received a call from the Home after 15:09 that day and responded.

In the Home's Investigation Report findings, dated 10 September 2020, it is stated that:

> *'Failure to record in the discussion with significant others that family had been contacted and at what time. The delay in contacting the family about the fall, with the call being made by the nurse after prompting from the paramedics at least 3 hours after the resident had fallen.'*

In your evidence, you stated that you had attempted to contact Resident A's family members on a number of occasions. However, you did not produce any evidence to support your claims that you had in fact either made, or attempted to make contact with them before 15:09, neither did you give any sound explanation as to why this was not recorded. The panel noted that the only evidence produced relating to telephone communications with Resident A's family, was a

care plan entry made by you and timed at 15:40 (3:40PM) on 6 September 2020 which stated that Resident A's next of kin had been contacted.

On balance, the panel determined it unlikely that you had made or attempted to make contact with Resident A's family as you stated and therefore found this charged proved.

Charge 1c:

On 6th September failed to record and communicate Resident A's fall as required;

c) Failed to make accurate records at the time of the incident.

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence before it. It had particular regard to Resident A's care plan.

The panel noted that the reference to Resident A's fall in section 3 of their care plan was made at 15:40 (3:40PM) on 6 September 2020, some four (4) hours after the incident. The note included reference to observations which you claim in evidence had been taken by Witness 2 soon after the fall. These observations were not timed, not marked as retrospective, nor did they attribute the taking of the observations to Witness 2.

In your evidence, you claimed to have made a number of calls to Resident A's family in the immediate aftermath of the incident, however, the only reference to any contact with their family was included in this note and simply said *'NOK informed'*. The 'Discussions with Significant Others' section of the care plan did not contain any notes made by you.

You claimed to have conducted observations of Resident A during the period that the ambulance was awaited, however, the contemporaneous documents before the panel show no record of such observations.

You claimed that whilst there is no evidence to support this, you recorded a number of observations on a Glasgow Coma Scale observation sheet, which is a separate sheet of paper. You stated that it must have been archived or lost. Ms Jones submitted on your behalf that it was entirely possible for loose documents to have become lost, misplaced or mis-filed.

Whilst the panel acknowledged that it is possible for documents to be lost, the panel noted that this was your reasoning for all of the separate pieces of paper you claimed to have used to record aspects of care following Resident A's fall, but were unable to produce. Whilst the panel acknowledge it is possible that other pieces of paper can be used in the event of an emergency and for them to be lost, it considered it less likely that all of your extra documentation had been lost or archived. Further, the panel determined that it is your responsibility to ensure all documentation is secured in patient's notes following an emergency event.

The panel determined that, on balance, it was more likely than not that you did not discharge your duty by making accurate and appropriate records in line with the Home's policy.

The panel therefore found this charged proved.

Charge 2a:

On 6th September after colleague 1 informed you of Resident A's fall, you failed to provide leadership;

a) By failing to direct the carer to remain with Resident A after her fall.

This charge is found proved.

In reaching this decision, the panel took into account your oral evidence, witness oral evidence, witness statements, the Disciplinary Investigation Report and interview notes.

You told the panel that you did not ask Witness 3 and the Health Care Assistant to stay with Resident A after the fall because they told you they would take it in turns to stay. You said that you did not need to ask them as they volunteered to do this of their own volition. You further told the panel that you instructed them not to restrain Resident A if they wished to walk around, and not to let them eat anything, just in case surgery was required. You told the panel you did not ask them to call you should there be any deterioration in Resident A's condition. You said you were conducting your medication round in various areas of the unit.

In their statement, Witness 3 stated:

> *'When the registrant left to go on his break and call ambulance, he did not ask me or any fellow carers to remain with Resident A, or leave any instructions...'*

In the Disciplinary Investigation Report dated 10 September 2020, it is stated that:

> *'No communication with the care team by the nurse that the emergency services had been called. No direction from the nurse for a carer to remain with the resident whilst waiting for the paramedics.'*

In these circumstances, the panel determined that you were lacking the fundamental elements of leadership in nursing care. It was of the view that a registered nurse should demonstrate skills of leadership by being available to oversee, instruct and offer support if required. In your evidence, you conceded that the extent of your communication with

Witness 3 was to nod in agreement, and say *'good'* when responding to their statement regarding observing Resident A.

For these reasons, the panel finds this charge proven and determined that you failed to exercise leadership that is expected of you as a registered nurse.

Charge 2b:

On 6th September after colleague 1 informed you of Resident A's fall, you failed to provide leadership;

b) By delaying calling an ambulance.

This charge is found proved.

The panel had regard to an email from an Information Governance Officer with South Central Ambulance Service NHS Foundation Trust to Witness 8, sent at 09:46 (9:46AM) on 25 September 2020 which stated:

> *'There was only one call made to us and the time recorded on our system was 12:04 pm and we arrived on scene at 14:47 pm.'*

In your oral evidence, you stated that you contacted the ambulance services immediately upon knowing that Resident A had fallen. You stated that Witness 2 undertook initial checks and observations of Resident A whilst you were at the scene. However, you were unable to give an account for what you did during the period from when the fall occurred and the call being made to the ambulance service.

The panel noted the statement of Witness 3 in which they stated:

'The Registrant delayed calling the ambulance as he did not believe that Resident A needed to go to hospital initially…'

The panel noted that the fall was times at 11:46AM, with the call being made to the ambulance service at 12:04PM. The panel was of the view that there was an undue delay when taking into account that Resident A had suffered from an obvious head injury and was bleeding from another wound.

The panel therefore found this charge proved.

Charge 2c:

On 6th September after colleague 1 informed you of Resident A's fall, you failed to provide leadership;

c) By not assisting in providing the paramedics with Residents A's medical history or notes.

This charge is found NOT proved.

The panel had regard to the email from an Information Governance Officer with South Central Ambulance Service NHS Foundation Trust to Witness 8, sent at 09:46 (9:46AM) on 25 September 2020 which stated:

'We have checked our records and the crew did not raised [sic] any safe guarding concerns. They did comment, however, that there was a delay in getting the patients medical history and notes from the nursing staff.'

The panel took account of the evidence of Witness 2. They told the panel that, having been contacted by a Care Assistant who expressed concerns about their

ability to give sufficiently detailed information to the paramedics in response to their questions, they found you and told you that you needed to attend. Witness 2 went on to explain that once they called you, you went immediately to see the paramedics and give them further information about Resident A.

The panel has found this charge not proved on the basis that you did in fact assist in providing paramedics with Resident A's medical history and notes, despite the time it took to do so.

Charge 3:

On 25 September 2021 did not effectively communicate with colleagues in relation to an unknown patient's deterioration.

This charge is found NOT proved.

In reaching this decision, the panel noted Witness 6's oral evidence and witness statement. It is stated:

> *'The Registrant did recognise the deteriorating condition of the patient as he escalated the patient's condition to the outreach team (ICU nurses who support the wards with deteriorating patients). This was the correct thing to do and the Outreach team confirmed that the female patient was deteriorating very quickly and was in respiratory distress.'*

Witness 6 told the panel that they were on their break and that staff should not disturb them, even in the event of an emergency. They further told the panel that after coming back from break, they saw the Outreach Team straight away and came over to ask you why they were there. Witness 6 said it was at this point that you told them why they had been called.

The panel was of the view that based on the oral evidence of Witness 6, you did in fact communicate with your colleague as soon as it was practicable.

The panel therefore found this charge not proved.

Charge 4:

On 25 September 2021 whilst at Royal Berkshire Hospital, offered minimal support to a crash team and colleagues in relation to an unknown patient.

This charge is found NOT proved.

In reaching this decision, the panel noted Witness 6's oral evidence and witness statement. It is stated:

> *'…I did not want the room to be too crowded so I told the nurses, including the Registrant to wait outside.'*

In oral evidence, Witness 6 said that they told everyone, including you, to leave the room in which the deteriorating patient was being accommodated.
The panel noted that you were a junior registered nurse and this was your first experience of a deteriorating patient in an acute hospital environment and in these circumstances, were not as experienced as Witness 6. The panel accepted that, as a junior nurse, fairly new to environment, you might not have such a developed understanding of what was required of you. Further, the panel noted that after asking you to leave the room, Witness 6 said they did not ask you to return. You told the panel that you carried on with other nursing duties.

The panel therefore determined that you followed instruction of a senior nurse, which reasonably explained your absence.

The panel therefore found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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 adopt a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

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.'*

Ms Khaile invited the panel to take the view 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.

Ms Khaile 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. She reminded the panel that with regards to impairment, it is important to not only look at past actions, but to also look forward as the aim of these proceedings is to protect the public rather than punish the registrant. 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. Ms Khaile the panel to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *Cohen* v. General Medical Council [2008] EWHC 581 (Admin)

Ms Khaile submitted that whilst the panel may consider the misconduct remediable, in this case, due to attitudinal concerns, the failures on your part are not easily remediable as these issues arose when working with fellow nurses or healthcare assistants and relate to accepting challenge and feedback.

Ms Khaile submitted that you have denied the charges that have been found proved and sought to blame others. She went on to state that you have not illustrated any self-awareness and have not taken accountability for your actions. She stated that as a result, there remains a risk of repetition of the misconduct and a risk to patient safety.

Ms Khaile concluded by stating that there has been nothing produced in either oral or written evidence to suggest that these issues would not be repeated, nor any indication of accountability taken for the issues identified.

Ms Jones invited the panel to find that your practice is not currently impaired. She stated that you have demonstrated remediation, which is highly important in the context of this case. She further stated that you are entitled to challenge the charges made against you, as well as witness evidence, and that this should not be disadvantageous to you or your case.

Ms Jones submitted that you, upon your own initiative, have undertaken numerous training courses since the allegations. She went on to state that you have attended other care homes in order to gain an appreciation of best practice and to improve your own practice, and gain an understanding of how policies and procedures should be applied within the workplace setting. Ms Jones noted that you have continued working as a nurse since these allegations arose and no new allegations or concerns have been raised. She therefore concluded that there is no risk of repetition of the misconduct.

Ms Jones concluded by stating that the conduct found proven in this case is not so serious that a finding of impairment should be made. She stated that you have demonstrated remediation, particularly given that a lot of the case relates to policies and procedures, and that you have demonstrated a strengthening of your knowledge through re-certification and attending other care homes.

The panel accepted the advice of the legal assessor which included reference to the NMC Guidance and a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Remedy UK Ltd v General Medical Council [2010]* EWHC 1245 (Admin), *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cheatle v GMC* [2009] EWHC 645 (Admin).

Decision and reasons on misconduct and impairment

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

The panel was of the view that your actions fell significantly short of the standards expected of a registered nurse, and that your actions amount to a breach of the following areas of the Code:

'…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.

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice. To achieve this, you must:

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

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported…

… 13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment is required

' ***15 Always offer help if an emergency arises in your practice setting or anywhere else***

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly, and

20 Uphold the reputation of your profession at all times
To achieve this, you must:

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

20.8 act as a role model of professional behaviour…'

The panel appreciated that whilst breaches of the Code do not automatically result in a finding of misconduct, in this case, the panel formed the view that your actions fell

seriously short of the conduct and standards expected of a registered nurse. It therefore determined that these actions amounted to misconduct.

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

In coming to its decision, the panel had regard to the NMC Guidance, 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 whilst discharging their duties in an effective, efficient and safe manner. 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 exercise leadership skills, apply clinical skills and ensure that their conduct at all times, justifies both their patients' and the public's trust in the profession.

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

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

undermined if a finding of impairment were not made in the particular circumstances.'

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

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

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

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

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

d) *…'*

The panel found that the first three (3) legs of the Grant test are engaged in relation to your actions in this case. The panel was of the view that you put Resident A at unwarranted risk of suffering further harm and in doing so, brought the profession into disrepute. Your disregard for the standards set out in the Code amount to breaches of fundamental tenets of the profession relating to prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

The panel was of the view that your misconduct is remediable through effort, time and by demonstrating insight and understanding into your misconduct. After careful consideration, the panel determined that you have not demonstrated any level of insight into your

actions. The panel did not see a reflective piece or hear evidence from you regarding your developing insight and lessons learnt. Neither did the panel receive any evidence of a workplace appraisal, peer review or testimonials to show a strengthening of your practice or any understanding of how your actions have led to a fitness to practice hearing. Whilst the panel acknowledges the completed training certificates supplied, it noted that more than half of these certifications are now expired.

The panel noted Ms Jones's submission that you have visited a number of care homes in order to help your remediation and insight. However, the panel did not see any evidence of when these visits were made, nor a reflective log of what took place and the learning that came from the visits.

The panel carefully considered the evidence before it in determining whether or not you have taken steps to remediate your actions. It is not satisfied that the misconduct in this case has been addressed. The panel noted that you disputed the charges against you, however were of the view that you could nevertheless show a level of insight and understanding whilst still maintaining your position.

Several witness submissions indicate deep-seated attitudinal concerns relating to accepting feedback and challenge, and this has not been addressed or remedied in any way. The panel determined that in this case, you failed to carry out a crucial component of your role as a registered nurse which is to keep members of the public safe. As a result, and having regard to your lack of insight and remediation, it concluded that there remains a risk of repetition which presents a risk to patient safety. It therefore determined that a finding of impairment on public protection grounds is required.

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

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Hearing resumed 21 May 2024

Sanction

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

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

Submissions on sanction

Ms Khaile informed the panel that in the Notice of Hearing, dated 28 September 2023, the NMC had advised you that it would seek the imposition of a strike off order if it found your fitness to practise currently impaired.

Ms Khaile stated that, having consulted the SG, taking into account the findings of serious misconduct and impairment along with the severity of the charges against you, that a strike off order is the only appropriate sanction in this case. She took the panel through each available sanction and submitted that none of these would be sufficient to address the public protection or public interest concerns in this matter.

Ms Khaile submitted that your actions found proved demonstrate serious behavioural and attitudinal issues which further training will not address or remedy. She went on to state that the panel should consider the NMC guidance which sets out three key points for it to consider before imposing a striking off order;

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

Ms Khaile submitted that the charges found proved raise fundamental questions about your practice and professionalism with colleague and patients. She went on to note that despite being told that there would be a local investigation and NMC referral made at the time of the incident, you stated that you did not want to honour or participate in that investigation. Ms Khaile went on to submit that it is unlikely that any further training or education will improve the concerns raised and noted that you have demonstrated a concerning attitude towards vulnerable and elderly patients who required your help and leadership. Ms Khaile went on to note your reflection in which you state that you do not accept the decision of the panel in respect of the charges.

Ms Khaile submitted that the former co-worker who provided the testimonial ceased working with you prior to the events that gave rise to this investigation and therefore cannot serve to provide insight into your behaviour and conduct during the relevant time.

Ms Khaile noted your recent training courses and highlighted that these were only undertaken following the fact finding, misconduct and impairment stages of your hearing. She went on to state that the training does not address the concerns surrounding your understanding of appropriate patient care and collaborative work environments. Ms Khaile

concluded by submitting that you do not fully recognise why the charges have been found proved and as such, have not been able to demonstrate insight into your failings.

Ms Jones submitted that you are able to return to safe practice with sufficient conditions in place and went on to state that you have demonstrated self-reflection, remediation and expressed a willingness to comply with any such conditions, if imposed, upon your practice.

Ms Jones submitted that you have undergone a period of self-reflection over the three (3) years since the incident which can be seen in your reflective piece and recent re-training which does not support the notion of having an attitudinal issue. [PRIVATE]. [PRIVATE].

Ms Jones went through each available sanction with the panel and submitted that a conditions of practice order is appropriate in these circumstances. She stated that this would adequately address the concerns identified as a result of the charges found proved and would address the public protection and public interest concerns as well as allow you to strengthen your practice and continue in your nursing career.

The panel noted that you worked as a delivery driver, however, [PRIVATE]. It queried what, if any, roles your had applied for in a healthcare setting and how you have been able to strengthen your practice in the role you were in. Ms Jones submitted that despite applying for several jobs within the healthcare sector, you have been unsuccessful due to the disclosure of this current NMC investigation.

The panel queried whether or not your colleague who provided the testimonial was aware of your NMC referral. Ms Jones submitted on your behalf that they were, however you would seek to provide an addendum statement confirming this for the panels benefit. This was received by the panel.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any

sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Failure to act in a position of leadership;
  You were in a leadership role but failed to give appropriate guidance or act in any way which demonstrated a willingness to take responsibility in a serious situation
- Consistent lack of insight into failings;
  Your insight is limited with a reflective piece confined to considering the events of 6 September 2020 in only general terms and restated the facts as you see them
- Deep seated attitudinal issue;
  You demonstrated an attitudinal disregard towards Patient A's wellbeing and the need for your staff to be properly led, adopting an almost 'bystander role' throughout
- Concerns relate to basic aspects of nursing care
- Not being open and transparent by attempting to deflect the blame elsewhere

The panel took into account the following mitigating features:

- Relevant online training

The panel carefully considered your personal circumstances as outlined by Ms Jones on your behalf. [PRIVATE]

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

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. Whilst the panel noted that some of the misconduct identified in this case could be addressed through retraining, it did not consider that this alone would adequately address the concerns found proved in regard to the deep-seated attitudinal issues identified. The panel is of the view that there are no practical or workable conditions that could be formulated to address the attitudinal concerns identified. The panel therefore concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

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

- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel concluded that only the first and third bullet points above are engaged in this case, such that a suspension order may be appropriate. However, it noted that whilst the misconduct occurred on one date, it contained multiple instances of misconduct, over a protracted period of time and involving inadequate attention to the needs of an elderly and vulnerable patient who had suffered obvious injury.

The panel determined that the conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. It is not satisfied that you have demonstrated insight and therefore, determined there remains a risk of repetition of the misconduct. The panel further found evidence of an attitudinal problem in relation to patient care, your working relationships with other colleagues, working as a team and to accepting feedback. The panel therefore determined that this serious breach of the fundamental tenets of the profession evidenced by your actions, is fundamentally incompatible with you remaining on the register.

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

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

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

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

Your actions were significant departures from the standards expected of a registered nurse, and raise fundamental questions around your professionalism. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. The panel noted that it has been over three (3) years since this misconduct took place and it saw no evidence of satisfactory reflection, insight, strengthening of practise or an understanding of how your actions have impacted patient safety and undermined public confidence in the nursing profession.

The panel was of the view that, to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulator.

The panel gave careful consideration to the principal of proportionality, and therefore bore in mind your personal circumstances. However, the primary duty of the panel is to protect the public and maintain public confidence in the profession.

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

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

This will be confirmed to you in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Khaile. She submitted that the NMC request an 18-month suspension order to cover the 28-day appeal period.

Ms Jones stated that she had no submissions to make.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to the seriousness of the case and cover any appeal proceedings.

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

That concludes this determination.