Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 24 September 2024 – Friday 4 October 2024

Virtual Hearing

Name of Registrant:	**Jacqueline Uche-Kaine**
NMC PIN	09F1532E
Part(s) of the register:	RNMH: Mental health nurse, level 1 (12 September 2009)
Relevant Location:	Essex
Type of case:	Misconduct
Panel members:	Sue Heads (Chair, Lay member) Rashmika Shah (Registrant member) Alex Forsyth (Lay member)
Legal Assessor:	Angus Macpherson (24 September – 27 September 2024) John Moir (30 September – 4 October 2024)
Hearings Coordinator:	Anya Sharma
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Ms Uche-Kaine:	Not present and not represented
Facts proved:	Charge 1 (in relation to Patient B, Patient C, Patient E, Patient F, Patient H, Patient I and Patient M), 2 (in its entirety), 3, 4, 5, 6, 7, 8, 9 ,10, 11, 12(c), 12(d), 12(g), 12(h), 12(j) and12(k)
Facts not proved:	Charge 1 (in relation to Patient G), 12(a), 12(b), 12(e), 12(f) and 12(i)
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 Ms Uche-Kaine was not in attendance and that the Notice of Hearing letter had been sent to Ms Uche-Kaine's registered email address by secure email on 15 August 2024.

Mr Radley, 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.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Uche-Kaine's 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 Ms Uche-Kaine 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 Ms Uche-Kaine

The panel next considered whether it should proceed in the absence of Ms Uche-Kaine. It had regard to Rule 21 and heard the submissions of Mr Radley, who invited the panel to continue in the absence of Ms Uche-Kaine. He submitted that Ms Uche-Kaine had voluntarily absented herself.

Mr Radley referred the panel to the NMC Proceeding In Absence bundle, which includes email correspondence between the NMC and Ms Uche-Kaine. He submitted that Ms Uche-Kaine has not asked for an adjournment of these proceedings, she is not represented, and no representative has come forward on behalf of Ms Uche-Kaine to

ask for an adjournment of these proceedings either. Mr Radley submitted that there have been a number of attempts to make contact and try to engage Ms Uche-Kaine in relation to these proceedings. Mr Radley referred the panel to an email response from Ms Uche-Kaine dated 3 April 2024 sent to the NMC, which simply stated 'FUCK OFF' in the subject matter. He submitted that the contents of that email make Ms Uche-Kaine's feelings in the circumstances clear.

Mr Radley also referred the panel to further email correspondence sent from the NMC to Ms Uche-Kaine, asking if she has received the hearing bundles, if she is going to attend the hearing and confirming dates of the hearing. It also made available the case worker's contact details in case Ms Uche-Kaine needed any help regarding the process.

Mr Radley submitted that the NMC has performed its public duty effectively and Ms Uche-Kaine is fully aware of these proceedings. He submitted that the NMC has taken all steps to try and engage Ms Uche-Kaine and invited the panel to proceed in her absence.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Ms Uche-Kaine;
- Ms Uche-Kaine has had limited engagement with the NMC;
- There is no reason to suppose that adjourning would secure Ms Uche-Kaine's attendance at some future date;

- A number of witnesses have attended today to give live evidence, others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Uche-Kaine in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC 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 Ms Uche-Kaine's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not 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 Ms Uche-Kaine. The panel will draw no adverse inference from Ms Uche-Kaine's absence in its findings of fact.

Details of charge (as amended)

That you, a registered nurse:

1) On one or more occasions, as set out in Schedule A, you failed to ensure that relevant clinical information was recorded within patient records;

2) On one or more occasions, as set out in Schedule B you failed to:

a) conduct risk assessments; and/or
b) follow up assessments as required; and/or
c) update patient records;

3) On one or more occasions, as set out in Schedule C, without justification, failed to attend mandatory multi-disciplinary meetings that had been arranged to discuss patient risk assessments;

4) Failed to attend and/or engage in mandatory supervision sessions with your supervisor and/or line manager;

5) On 8 September 2020, you failed to make reasonable adjustments for Patient D by refusing to remove your face mask despite being told that Patient D had a hearing impairment and needed to be able to lip read to understand what was being said;

6) On 15 September 2020 and/or 18 September 2020, having conducted a welfare check on Patient F, you failed to complete a safeguarding form and/or seek advice;

7) Between 15 September 2020 and 29 September 2020, you failed to conduct welfare checks on Patient G and/or conduct follow up calls;

8) On 14 October 2020, you failed to complete a social circumstances report and/or update Patient K’s clinical record;

9) On 13 August 2020, you conducted a welfare check on Patient L over the telephone when it should have been conducted in person;

10) On one or more occasions, failed to follow the discharge process in that you did not complete and/or send out outcome letters to one or more patients;

11) Failed to follow guidelines for closing patient records in that you did not finalise patient documentation to allow for care records to be closed;

12) Bullied, harassed and/or intimidated one or more colleagues, causing distress and/or fear in that:
a) On 31 July 2020, you behaved in an inappropriate and aggressive manner towards Colleague A;
b) On 17 August 2020, you drove a vehicle towards Colleague A in the staff car park;
c) On 19 August 2020, you shouted at Colleague A in the presence of others;
d) On 19 August 2020, you shouted at Colleague B in the hearing or presence of others;
e) On 20 August 2020, you behaved in an inappropriate and/or aggressive manner towards Colleague C;
f) On 20 August 2020, you behaved in an inappropriate and/or aggressive manner towards Colleague A;
g) On 9 September 2020, you shouted at Colleague B in the presence of others;
h) On 9 September 2020, you shouted at Colleague D in the hearing or presence of others;
i) On 9 September 2020, you called Colleague E a “nosy cow” or words to that effect;
j) On or before 9 September 2020, you refused to wear a face mask whilst sitting with Colleague F despite being aware that Colleague F was clinically vulnerable;
k) On or before 9 September 2020, you deliberately coughed in the direction of Colleague F at least once without a face mask on, being aware that Colleague F was clinically vulnerable;

Schedule A

Patient B: 19 October 2020 – *did not note whether an initial assessment had taken place;*
Patient C: 8 September 2020 – *did not note whether an initial assessment had taken place;*
Patient E: 21 September 2020 – *no letters sent following the initial assessment;*

Patient F: 17 August 2020 – *insufficient information recorded from the assessment;*
Patient G: 15 September, 23 September 2020 and 29 September 2020 – *did not document concerns in much detail; did not pursue safeguarding concern;*
Patient H: 11 September 2020 – *did not note whether an initial assessment had taken place;*
Patient I: 17 September 2020 – *no record of initial assessment;*
Patient M: 14 October 2020 – *insufficient record made of contact*

Schedule B

Patient A:
Patient C:
Patient D:
Patient G:
Patient H:
Patient I:
Patient J:
Patient K:

Schedule C:

12 August 2020
19 August 2020
26 August 2020
9 September 2020
16 September 2020
23 September 2020
7 October 2020

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

Decision and reasons on application to amend the charge

On day 1 of the hearing, it was noted by the panel that there were some typographical inaccuracies in the charges. Mr Radley made an application to correct those inaccuracies, namely to amend the wording of charge 2, to add the word ‘or’ in charge 4 and to amend the wording in charge 12(j) from Colleague E to Colleague F.

On 30 September 2024, the panel raised concerns with Mr Radley about the ambit of charge 2, Schedule B, and charge 7. It then invited Mr Radley to consider making an application to further amend. The panel then heard an application made by Mr Radley on behalf of the NMC to further amend the wording of charge 2, to amend charge 7, and to remove the dates in Schedule B. He submitted that the proposed amendments would rectify the panel’s concerns, as to whether it is the NMC’s case for the panel to look at all of the sub-charges individually or collectively in relation to Schedule B. Mr Radley further submitted that removing the dates in Schedule B would eliminate any confusion caused and remove any potential restriction to the panel’s consideration of all the evidence heard.

Mr Radley also made an application to amend the wording of Charge 7, which would remove a duplication.

It was submitted by Mr Radley that the proposed amendments, as seen below, would provide clarity and more accurately reflect the evidence.

> “That you, a registered nurse:
>
> *2)* On one or more occasions, as set out in Schedule B you **failed to**:
>
> a) ~~failed to~~ conduct risk assessments; **and/or**
> b) follow up assessments as required; **and/or**
> c) ~~failed to~~ update patient records;
>
> 4) Failed to attend and/or engage in mandatory supervision sessions with your supervisor and/**or** line manager;

Schedule B

Patient A: ~~15 October 2020~~

Patient C: ~~8 September 2020~~

Patient D: ~~8 September 2020~~

Patient G: ~~15 September, 23 September 2020 and 29 September 2020~~

Patient H: ~~11 September 2020~~

Patient I: ~~17 September 2020~~

Patient J: ~~9 October 2020~~

Patient K: ~~1 September 2020~~

7) Between 15 September 2020 and 29 September 2020, you failed to conduct welfare checks on Patient G and/or conduct follow up calls ~~and/or assessments~~;

12) Bullied, harassed and/or intimidated one or more colleagues, causing distress and/or fear in that:

j) On or before 9 September 2020, you refused to wear a face mask whilst sitting with Colleague F despite being aware that Colleague ~~E~~ **F** was clinically vulnerable;

The panel accepted the advice of the respective legal assessors and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). The panel noted in particular the principles set out in the case of *'The Professional Standards Authority for Health and Social Care v The Nursing and Midwifery Council, Ms Winifred Nompumelelo Jozi [2015] EWHC 764 (Admin)'*

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Ms Uche-Kaine and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit written statement of Colleague D

The panel heard an application made by Mr Radley under Rule 31 to allow the written statement of Colleague D into evidence. Colleague D was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, Colleague D was unable to attend today [PRIVATE].

Mr Radley referred the panel to an email dated 12 September 2024 sent by Colleague D to the NMC, [PRIVATE].

Mr Radley submitted that the application is therefore made on the basis that Colleague D is [PRIVATE] unable to attend the hearing to give evidence as a result. He referred the panel to Rule 31 and the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)* and submitted that there are sufficient grounds to allow the written statement of Colleague D to be read in the circumstances.

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

The panel noted that in the preparation of this hearing, the NMC had indicated to Ms Uche-Kaine in an email dated 19 September 2024 that a hearsay application would be made for the statement of Colleague D to be admitted into evidence, and they would not be attending the hearing [PRIVATE].

The panel gave the application in regard to Colleague D serious consideration. The panel noted that Colleague D's witness statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement, consisting of eight pages, is true to the best of my knowledge and belief'* and signed by Colleague D.

The panel considered whether Ms Uche-Kaine would be disadvantaged by the change in the NMC's initial position of moving from reliance upon the live testimony of Colleague D to that of a written statement.

The panel considered that as Ms Uche-Kaine had been provided with a copy of Colleague D's statement and, as the panel had already determined that Ms Uche-Kaine had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. There is also a public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Colleague D and the opportunity of questioning and probing that testimony.

In these circumstances, the panel concluded that it would be fair and relevant to accept into evidence the written statement of Colleague D, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The NMC received a referral from Essex Partnership University NHS Foundation Trust (The "Trust") on 2nd June 2021, reporting wide ranging concerns relating to Ms Uche-Kaine's fitness to practise as a Community Mental Health Nurse. Ms Uche-Kaine was first registered on 12 September 2009 as a registered Mental Health Nurse. At the time of the concerns raised in the referral, Ms Uche-Kaine was employed as a Band 6 Community Mental Health Nurse at Rectory Lane Health Centre and was responsible for a patient group with varying vulnerabilities and risks, including those with personality disorders, acute anxiety and mental health difficulties.

Ms Uche-Kaine worked in the access and assessment service, which primarily deals with referrals that have come in from GPs requiring assessments by the department. Most of the assessments were conducted over the telephone due to it being the height of Covid-19 at the time. This involved having a conversation with the referred patient, establishing basic background information including medical history, family history, social circumstances and any concerns that were highlighted by the referrer. It would

then be for the nurse to provide advice and support to the patient and signpost them to other services should this be required.

The assessment should be documented, and an outcome letter sent to the patient and their GP. It would then be for the nurse to discuss the patient in the weekly Multi-Disciplinary Team (MDT) meetings that took place discussing cases and referrals. Despite it being a mandatory requirement of her role to attend weekly MDT meetings, it was alleged that Ms Uche-Kaine would regularly fail to attend.

Between March 2020 and 1 November 2020, concerns were raised by Ms Uche-Kaine's employer about her clinical practice and professional conduct. The following alleged areas of concerns were investigated:

a. Poor record keeping in the period between July and October 2020.
b. Failure to provide care in a timely manner, including failure to complete care plans, risk assessments, or otherwise contact patients as required; and
c. Failure to work co-operatively with colleagues, including inappropriate and aggressive responses to feedback and failure without good excuse to attend meetings on clinical performance

It is alleged that there were multiple examples of record keeping errors over a significant period of time which included a failure to record care plans, risk assessments, mental health clusters and failures to draft letters to patients and GP's. There were alleged failures to record details of what was discussed at appointments or to record outcomes.

In addition, several colleagues made complaints about Ms Uche-Kaine's attitude and behaviour towards them. It is alleged that Ms Uche-Kaine was unable to work with others, created a hostile and confrontational environment and made many of her colleagues scared and in fear due to her aggressive and unpredictable nature. In addition, Ms Uche-Kaine refused to be supervised.

There has been limited engagement from Ms Uche-Kaine during the course of the NMC investigation. In an email received on 4 January 2024, Ms Uche-Kaine indicated that

she disagreed with the regulatory concerns in their entirety. Prior to this, Ms Uche-Kaine had suggested that the referral was sent in spite and was without merit. Ms Uche-Kaine chose not to engage with the Trust's investigation at local level, despite being given several opportunities to do so.

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 Mr Radley.

The panel has drawn no adverse inference from the non-attendance of Ms Uche-Kaine.

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:

- Colleague A: Band 5 CPN Community Psychiatric Nurse at the time of the concerns
- Colleague B: Clinical Manager in Adult Community Services at the Trust
- Colleague E: Senior Community Psychiatric Nurse at the Trust
- Colleague F: Community Mental Health Nurse at the Trust

- Dr 1: Associate Specialist Psychiatrist at the Trust at the time of the concerns

- Colleague G: Senior HR Advisor at the Trust

The panel also had sight of the written witness statement of the following NMC witness:

- Colleague D: Band 7 Advanced Nurse Practitioner at the Trust at the time of the incidents

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.

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

Charge 1

1. On one or more occasions, as set out in Schedule A, you failed to ensure that relevant clinical information was recorded within patient records;

Schedule A

Patient B: 19 October 2020 – *did not note whether an initial assessment had taken place;*

Patient C: 8 September 2020 – *did not note whether an initial assessment had taken place;*

Patient E: 21 September 2020 – *no letters sent following the initial assessment;*

Patient F: 17 August 2020 – *insufficient information recorded from the assessment;*
Patient G: 15 September, 23 September 2020 and 29 September 2020 – *did not document concerns in much detail; did not pursue safeguarding concern;*
Patient H: 11 September 2020 – *did not note whether an initial assessment had taken place;*
Patient I: 17 September 2020 – *no record of initial assessment;*
Patient M: 14 October 2020 – *insufficient record made of contact*

This charge is found proved in relation to Patient B, Patient C, Patient E, Patient F, Patient H, Patient I and Patient M.

In reaching this decision, the panel took into account the witness statement, exhibits, and oral evidence of Colleague B. Colleague B confirmed in her evidence that Ms Uche-Kaine's responsibilities included conducting initial and follow-up assessments, making the necessary referrals, completing all documentation, including sending out outcome letters to patients and GPs.

Patient B: 19 October 2020 – *did not note whether an initial assessment had taken place;*

This charge is found proved in relation to Patient B

In reaching its decision, the panel took into account Patient B's telephone contact note dated 19 October 2020 which states the following:

> *'Message sent to Patient B confirming appointment with after no call from [Ms Uche-Kaine] for her initial assessment on Monday 19 October 2020'*

The panel also noted that it had before it Patient B's appointment invite letter dated 1 October 2020, offering a Monday 19 October 2020 appointment. Following this, a message was sent to Patient B, confirming their appointment on Friday 23 October 2020.

The panel considered that this shows that another appointment had to be made as Ms Uche-Kaine had not done the initial assessment.

The panel also took into account Colleague B's witness statement, which sets out the following:

> *'Patient B had been booked to see [Ms Uche-Kaine] for an initial assessment. She had been referred by an integrated mental health worker as there was a feeling that she needed to be stepped up. The initial assessment was booked for 19 October 2020 but we have no idea if Jaqueline saw Patient B as nothing was documented…There was nothing on the system whatsoever'*

This was also confirmed in Colleague B's oral evidence, where she also set out that the initial assessment had not been made.

Patient C: 8 September 2020 – *did not note whether an initial assessment had taken place;*

This charge is found proved in relation to Patient C

In reaching its decision, the panel took into account Patient C's appointment invite letter dated 18 August 2020, offering an appointment on Tuesday 8 September 2020.

The panel also took into account Patient C's file note from Ms Uche-Kaine dated 8 September 2020, which sets out the following:

> *'Patient C attended Rectory Lane Health Centre today for an initial assessment'*

The panel noted that whilst it had a letter before it dated 8 September 2020 in relation to Patient C, the letter was blank. Colleague B in her witness statement explained the following:

'… a letter dated 8 September 2020 that is generated on the file but is blank. Unless the nurse drafts an outcome letter to the GP, they don't know that the patient has been seen. Unless we arrange the appointment, the medical secretaries do not know to follow up appointment. None of this had happened.'

In her oral evidence, Colleague B told the panel that it is the responsibility of the clinician (Ms Uche-Kaine) to complete the communication letters.

Patient E: 21 September 2020 – *no letters sent following the initial assessment;*

This charge is found proved in relation to Patient E

In reaching its decision, the panel took into account that it had before it two blank letters, prepopulated with the addresses of Patient E and their GP, both dated 21 September 2020.

Patient F: 17 August 2020 – *insufficient information recorded from the assessment;*

This charge is found proved in relation to Patient F

In reaching its decision, the panel had sight of Patient F's letter dated 23 July 2020 offering an appointment on Monday 17 August 2020, as well as two blank letters in relation to Patient F both dated 17 September 2020.

The panel additionally had sight of Patient F's telephone contact note dated 15 September 2020, where it can be seen that the telephone assessment did take place between Patient F and Ms Uche-Kaine, but the corresponding documents were not completed by Ms Uche-Kaine.

Patient G: 15 September, 23 September 2020 and 29 September 2020 – *did not document concerns in much detail; did not pursue safeguarding concern;*

This charge is found NOT proved in relation to Patient G

In reaching its decision, the panel took into account two telephone contacts with Patient G made by Ms Uche-Kaine on two separate occasions, namely 15 September 2020 and 23 September 2020. Both letters stated the following:

> *'Failed telephone contact to Patient G for the purpose of welfare check.*
>
> *Plan*
>
> *To retry contact for the purpose of welfare check'*

The panel noted that Ms Uche-Kaine had failed to follow up the unsuccessful telephone contacts to Patient G, it did not find that she had failed to ensure that relevant clinical information was recorded and therefore found this charge not proved in respect of Patient G.

Patient H: 11 September 2020 – *did not note whether an initial assessment had taken place;*

This charge is found proved in relation to Patient H

In reaching its decision, the panel took into account Patient H's appointment confirmation letter dated 20 August 2020, offering Patient H an appointment with Ms Uche-Kaine on Friday 11 September 2020.

The panel had sight of Patient H's record of initial assessment made on 11 September 2020. However, it does not appear that this assessment was followed up and the panel has before it two letters that are generated on file to Patient H and their GP dated 11 September 2020 but are both blank. Accordingly, the panel was satisfied that the heading of the charge ' failed to ensure that relevant clinical information was recorded' was met and therefore find this charge proved.

Patient I: 17 September 2020 – *no record of initial assessment;*

This charge is found proved in relation to Patient I

In reaching this decision, the panel took into account the two letters generated on file to Patient I and their GP dated 20 October 2020 but are both blank.

The panel also took into account a telephone contact with Patient I completed by Colleague B dated 2 February 2021, which sets out the following:

> *'…the GP had contacted to establish what was happening re: referral that was made to our service in August 2020. Reviewed case notes and established that [Ms Uche-Kaine] had undertaken an initial telephone assessment in September 2020 however no letter to GP or care plan.'*

The panel was of the view that based on the information before it that whilst Ms Uche-Kaine had done the initial assessment with Patient I, she had made no record in relation to it, nor had she sent out any follow up letters. Accordingly, the panel was satisfied that the heading of the charge ' failed to ensure that relevant clinical information was recorded' was met and therefore find this charge proved.

Patient M: 14 October 2020 – *insufficient record made of contact*

This charge is found proved in relation to Patient M

In reaching this decision, the panel took into account the two letters generated on file to Patient M and their GP dated 14 October 2020 but are both blank.

The panel noted that the patient had attended a telephone assessment on 14 October 2020, but no follow up letter was sent by Ms Uche-Kaine. Accordingly, the panel was satisfied that the heading of the charge ' failed to ensure that relevant clinical information was recorded' was met and therefore find this charge proved.

Charge 2)

2) On one or more occasions, as set out in Schedule B you failed to:

a) conduct risk assessments; and/or
b) follow up assessments as required; and/or
c) update patient records;

Schedule B

Patient A:

Patient C:

Patient D:

Patient G:

Patient H:

Patient I:

Patient J:

Patient K:

This charge is found proved.

Patient A

In reaching this decision, the panel took into account the following from Colleague B's witness statement:

> *'On 9 October 2020 [Ms Uche-Kaine] attempted to conducted Patient A's assessment… the assessment did not go ahead so there would have been an expectation that [Ms Uche-Kaine] would follow up with Patient A.'*

The panel also had sight of a failed telephone contact note with Patient A on 9 October 2020, with Ms Uche-Kaine noting that the plan would be to retry telephone contact for the purpose of an initial assessment. Colleague B's witness statement however sets out that this was not done by Ms Uche-Kaine:

'It was recorded that the plan was to retry on 15 October 2020 however [Ms Uche-Kaine did not follow up with Patient A…two weeks after the initial appointment Patient A phoned the service and complained that [Ms Uche-Kaine] had not called her back'

The panel had sight of the telephone call note on 23 October 2020, where Patient A complained about Ms Uche-Kaine not calling her.

Patient C:

The panel had sight of Colleague B's witness statement, which refers to a letter sent by Colleague B to Patient C dated 10 November 2020, which sets out that an initial assessment had been undertaken on 8 September 2020 by Ms Uche-Kaine, but no follow up had taken place as Ms Uche-Kaine had not provided an outcome letter to Patient C or the GP

'I spoke with Patient C on 10 November 2020… I was able to determine that the assessment did occur. I sorted out the follow up consultant appointment, so I know for sure that [Ms Uche-Kaine] had not followed up or acted upon this assessment. Patient C waited for 2 months until I spoke to her…'

The panel accepted that whilst an initial assessment was completed by Ms Uche-Kaine for Patient C, there was no follow-up.

Patient D:

The panel had sight of a telephone contact note created by Ms Uche-Kaine for Patient D dated 8 September 2020, which confirms that Patient D had attended for an initial assessment.

The panel also had sight of care activity notes for Patient D dated 9 September 2020, 16 September 2020, 23 September 2020 and 9 October 2020 which states that no updates have been provided by Ms Uche-Kaine to date.

Patient G:

The panel took into account the following extract from the witness statement of Colleague B:

> *'On 15 September 2020 and 23 September 2020, [Ms Uche-Kaine] was asked to undertake welfare checks… [Ms Uche-Kaine] would have then been required to call Patient G to make sure that she was ok.'*

The panel also had sight of two failed telephone contacts dated 15 September 2020 and 23 September 2023 to Patient G by Ms Uche-Kaine, and it is noted that the plan was to retry contact with Patient G for the purpose of a welfare check.

The panel also have before it a further failed telephone contact dated 29 October 2020 from Ms Uche-Kaine.

The panel also noted the following from Colleague B's witness statement, where it is detailed that another clinician picked this up:

> *'On 29 September 2020 [Ms Uche-Kaine] was again asked to undertake further welfare check… telephone contact dated 29 October 2020 confirming that she attempted to call Patient G but was unsuccessful… another clinician picked this up on the same day… other people were constantly having to pick up all the work after [Ms Uche-Kaine] which is why we did not have any serious incidents.'*

Patient H:

The panel had sight of Patient H's care activity document dated 11 September 2020, which confirms that Patient H was seen by Ms Uche-Kaine for an initial assessment. Ms

Uche-Kaine had noted that Patient H's care and risks would be discussed in further team meetings.

The panel also had sight of further care activity documents confirming Ms Uche-Kaine did not attend the MDTs on 16 September 2020, 23 September 2020 and 30 September 2020 and no further discussions took place in relation to Patient H's care.

The panel also had sight of Colleague B's witness statement, which states:

> *'When we reviewed Patient H we identified there was no care plans, no initial assessment and no follow up… two letters dated 11 September that are generated on the file to Patient H and their GP but both are blank.'*

Patient I:

The panel had before it a copy of Patient I's appointment letter dated 25 August 2020, and a copy of Patient I's care activity document which confirms that Patient I attended for his initial assessment with Ms Uche-Kaine on 17 September 2020.

Colleague B also mentioned this in her witness statement as follows:

> *'[Ms Uche-Kaine] carried out the assessment but there was no record of this or any follow up… two letters dated 20 October 2020 that are generated on the file to Patient I and their GP but both are blank*
>
> *…*
>
> *Patient I's GP phoned to find out what was happening with him. This is rare, so the GP must have been extremely concerned for Patient I to call us directly, its unheard of. This phone was 5 months after the initial assessment, and nothing had been done… I phoned Patient I and followed up with him and arranged a medical review.'*

Patient J:

The panel had sight of Colleague B's witness statement, which states:

> *'[Ms Uche-Kaine] was due to see Patient J for his initial assessment on 21 September 2020…appointment confirmation letter dated 27 August 2020. Patient J then cancelled as feeling unwell…message sent to [Ms Uche-Kaine] from admin…attempt made to rebook Patient J which would have come from admin…new appointment date of 8 October 2020…On 9 October 2020 [Ms Uche-Kaine] completed a telephone note confirming the appointment had been rearranged to 12 October 2020.*
>
> *…*
>
> *There is then nothing on the file or no attempt was made to rebook Patient J until I made contact on 10 November 2020..We had no idea what went on with this patient.*
>
> *…*
>
> *I established that Patient J had not been seen or followed up since his referral in August 2020.'*

The panel concluded that Patient J had not been seen for an initial assessment and no follow ups had taken place.

Patient K:

The panel had sight of a telephone note dated 14 August 2020, which confirms that Ms Uche-Kaine had made telephone contact with Patient K. Following this, a telephone contact document dated 19 August 2020 also suggest that Ms Uche-Kaine spoke to Patient K with updated information.

The panel had sight of the following from Colleague B's witness statement:

> *'Patient K had been detained under the Mental Health Act but [Ms Uche-Kaine] never completed this report… telephone contact form dated 1 September 2020 confirms that [Ms Uche-Kaine] attempted to contact Patient K but was unsuccessful. [Ms Uche Kaine] records that she will attempt to contact him again, but she does not follow through with this so no report was ever completed*
>
> *…*
>
> *Another clinician picked up this piece of work'*

The panel therefore found this charge proved in respect of all patients referred to in Schedule B.

Charge 3)

3) On one or more occasions, as set out in Schedule C, without justification, failed to attend mandatory multi-disciplinary meetings that had been arranged to discuss patient risk assessments;

Schedule C:
12 August 2020
19 August 2020
26 August 2020
9 September 2020
16 September 2020
23 September 2020
7 October 2020

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's written witness statement and oral evidence, as well as Colleague D's written witness statement.

The panel was of the view that it is clear from the following extracts in Colleague B's witness statement that Ms Uche-Kaine failed to attend mandatory multi-disciplinary meetings that had been arranged to discuss patient risk assessments on more than one occasion:

> *'At the following weekly MDT meeting [Ms Uche-Kaine] did not attend so no update was provided on Patient A. [Ms Uche-Kaine] simply chose not to attend this meeting, this is despite its attendance being a mandatory requirement unless a nurse is on annual leave/sick or has training.*
>
> *…*
>
> *During these meetings… patients are colour graded dependant on their risk… If you are not in the meeting, you cannot share the risks in your caseload. We are clear that it is the MDT that hold the risk, but this can only happen if the nurse attends the MDT to share the risk in the first place. Despite frequent reminders [Ms Uche-Kaine] refused to attend these meetings. I do not recall her every attending one of them…poses a risk to our patients'*

The panel also noted the following from Colleague B's witness statement, which makes reference to Ms Uche-Kaine's non-attendance at the weekly multi-disciplinary meetings on four of the dates set out in Schedule C:

> *'[Ms Uche-Kaine] did not attend four consecutive weekly MDTs on 9 September 2020, 16 September 2020, 23 September 2020 and 7 October 2020'*

The panel took into account that it also has before it Patient C's care activity documents dated 9 September 2020, 16 September 2020, 23 September 2020 and 7 October 2020, as well as the MDT meeting minutes dated 12 August 2020, 19 August 2020, 26 August 2020, 9 September 2020, 16 September 2020, 23 September

2020 and 30 September 2020, where it can be seen who was in attendance at the meetings.

The panel also noted Colleague D's statement, which supports Colleague B's witness statement that Ms Uche-Kaine did not attend any of the MDT meetings:

> *'[Ms Uche-Kaine] attended the MDT meeting on her first day at Rectory Lane, when she had no caseload and no patients to speak about. [Ms Uche-Kaine] did not attend any further MDT meetings, despite being told to do so.'*

The panel was therefore satisfied that Ms Uche-Kaine failed to attend mandatory multi-disciplinary meetings that had been arranged to discuss patient risk assessments and find this charge proved.

Charge 4

4) Failed to attend and/or engage in mandatory supervision sessions with your supervisor and/or line manager;

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's written witness statement and oral evidence, as well as Colleague D's written witness statement.

The panel considered that it heard oral evidence from Colleague B that Ms Uche-Kaine only attended two mandatory supervision sessions on 17 August 2020 and 9 September 2020.

The panel had sight of Colleague D's witness statement, which sets out that the first supervision meeting was on 17 August 2020 and the second on 9 September 2020, and the corresponding supervision record documents.

The panel also noted Colleague B's witness statement, which supports Colleague D's written witness statement:

> *'[Colleague D] was supervising [Ms Uche-Kaine] and she found her incredibly difficult to supervise. [Ms Uche-Kaine] would frequently refuse to attend the supervisions…*
>
> *'I then ended up taking over [Ms Uche-Kaine's] supervision. Despite this she would continuously make excuses as to why she could not attend'*

The panel was therefore satisfied that Ms Uche-Kaine had failed to attend and/or engage in mandatory supervision sessions with her supervisor and/line manager and found this charge proved.

Charge 5

5) On 8 September 2020, you failed to make reasonable adjustments for Patient D by refusing to remove your face mask despite being told that Patient D had a hearing impairment and needed to be able to lip read to understand what was being said;

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's written witness statement, which states:

> *'…I followed up with Patient D who confirmed the appointment and complained about [Ms Uche-Kaine's] conduct towards her during the assessment…*
>
> *…*
>
> *Patient D needed reasonable adjustments, but she told me when I followed up with her that [Ms Uche-Kaine] refused to make these.'*

The panel also had sight of the call note between Colleague B and Patient D, which confirms what Colleague B sets out in her written statement:

> *'I was really sorry to hear that you found the assessment process uncomfortable due to your hearing impairment and the clinician refusing to make adjustments, re: mask wearing, to accommodate your needs.'*

The panel also heard live oral evidence from Colleague F, where she described the complaint that Patient D had made directly to her.

The panel was therefore of the view, that on the balance of probabilities, Ms Uche-Kaine failed to make reasonable adjustments, this charge is found proved.

Charge 6

6) On 15 September 2020 and/or 18 September 2020, having conducted a welfare check on Patient F, you failed to complete a safeguarding form and/or seek advice;

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's written witness statement, in particular:

> *'On 15 September 2020 [Ms Uche-Kaine] … contacted Patient F for a welfare check… [Ms Uche-Kaine] said there was a safeguarding concern and was going to complete a form but this never happened. [Ms Uche-Kaine] talks about Patient F wanting to harm her neighbour and records that she needs to seek advice but there was no evidence that she done this*

The panel also had sight of Patient F's telephone note dated 18 September, which was completed by Ms Uche-Kaine, where she had phoned Patient F for a further welfare

check. Colleague B's witness statement mentions the below in her witness statement in relation to this.

> *'[Ms Uche-Kaine] phones Patient F for a further welfare check and advises she will complete a safeguarding form. However this was never completed. It is extremely serious that she raised a safeguarding with Patient F but failed to follow up on it'*

The panel took into account that Colleague B had picked this up in November 2020, as set out in her witness statement, where she made contact with Patient F. *'I had to be honest with her and tell her that there was no documentation from [Patient F]'s assessment with [Ms Uche-Kaine]'.* The panel also had before it Colleague B's telephone note dated 17 November 2020, which reinforces what is stated in her witness statement.

The panel therefore found this charge proved.

Charge 7

7) Between 15 September 2020 and 29 September 2020, you failed to conduct welfare checks on Patient G and/or conduct follow up calls;

This charge is found proved.

In reaching this decision, the panel took into account the following extracts from the witness statement of Colleague B:

> *'On 15 September 2020 and 23 September 2020, [Ms Uche-Kaine] was asked to undertake welfare checks…[Ms Uche-Kaine] would have then been required to call Patient G to make sure that she was ok.'*

The panel had sight of two failed telephone contacts dated 15 September 2020 and 23 September 2023 to Patient G by Ms Uche-Kaine, and it is noted by Ms Uche-Kaine on

the note that the plan was to retry contact for the purpose of a welfare check. The panel also have before it a further failed telephone contact dated 29 October 2020 from Ms Uche-Kaine.

The panel also noted the following from Colleague B's witness statement, where it is detailed that another clinician picked this up:

> *'On 29 September 2020 [Ms Uche-Kaine] was again asked to undertake further welfare check… telephone contact dated 29 October 2020 confirming that she attempted to call Patient G but was unsuccessful… another clinician picked this up on the same day… other people were constantly having to pick up all the work after [Ms Uche-Kaine] which is why we did not have any serious incidents.'*

The panel had sight of the successful telephone contact made on 29 October 2020 where it can be seen that a joint visit and allocation to another nurse had been arranged.

The panel determined that Ms Uche-Kaine had a duty to conduct welfare checks on Patient G and had failed to do so. The panel therefore found this charge proved.

Charge 8

8) On 14 October 2020, you failed to complete a social circumstances report and/or update Patient K's clinical record;

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's written witness statement, in particular:

> *'Patient K had been detained under the Mental Health Act but [Ms Uche-Kaine] never completed this report… telephone contact form dated 1 September 2020 confirms that [Ms Uche-Kaine] attempted to contact Patient K but was*

unsuccessful. [Ms Uche Kaine] records that she will attempt to contact him again, but she does not follow through with this so no report was ever completed

…

Another clinician picked up this piece of work'

The panel also heard oral evidence from Colleague B which reinforces what she had written in her witness statement.

The panel also had sight of the telephone contact form dated 1 September 2020 mentioned by Colleague B in her witness statement, which confirms that there was a failed telephone contact to Patient K made by Ms Uche-Kaine.

The panel therefore found this charge proved.

Charge 9

9) On 13 August 2020, you conducted a welfare check on Patient L over the telephone when it should have been conducted in person;

This charge is found proved.

In reaching this decision, the panel took into account the following extract from the witness statement of Colleague B:

'…When a patient is referred to our inpatient services irrespective of being detained we must see them in the home environment within 48 hours… it was [Ms Uche-Kaine's] job to assess [Patient L]'

Colleague B also confirmed in her oral evidence to the panel that the procedure would be that on discharge the patient would be seen within 48 hours.

Colleague B in her witness statement referred to a copy of the telephone contact dated 13 August 2020, which confirms that Ms Uche-Kaine undertook a welfare check over the telephone. The panel had sight of the telephone call note dated 13 August 2020 in respect of Patient L, completed by Ms Uche-Kaine. Colleague B in their witness statement went on to state that there was no further involvement with Patient L until 23 September 2020, which is *'massively too long'.*

The panel had sight of a telephone note from 23 September 2020 for the purpose of a welfare check with Patient L. Colleague B sets out in her witness statement that *'[Ms Uche-Kaine] would have required to see this patient face to face so telephone contact would not have even been appropriate in these circumstances.'*

The panel therefore found this charge proved.

Charge 10

10) On one or more occasions, failed to follow the discharge process in that you did not complete and/or send out outcome letters to one or more patients;

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Colleague B, in particular:

> *'[Ms Uche-Kaine] would have been required to put in details of what was discussed during the appointments and the outcomes in this document… she did not do this.*
>
> *…*
>
> *[Ms Uche-Kaine] was not following the discharge process. She could not discharge her patients when their care had ended because she had not completed their outcome letter or finalised the documentation on the case files.*

They were just sitting on her case load so as the discharge process was not being followed.'

The panel noted that Colleague B also mentioned in her oral evidence that Ms Uche-Kaine's caseload stayed on the record, as she did not close any files down.

The panel also had sight of an email dated 15 October 2020 sent by Colleague D to Colleague B in relation to outstanding patients on Ms Uche-Kaine's caseload:

'… it needs to be addressed…she cannot complete the risk assessments and close the patient down. I am concerned that she still have patients on her caseload and not follow up.'

The panel was of the view that it is clear that Ms Uche-Kaine had failed to follow the discharge process and therefore found this charge proved.

Charge 11

This charge is found proved.

In reaching this decision, the panel took into account its findings in respect of charge 10 and therefore found this charge proved.

Charge 12(a)

12) Bullied, harassed and/or intimidated one or more colleagues, causing distress and/or fear in that:

a) On 31 July 2020, you behaved in an inappropriate and aggressive manner towards Colleague A;

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Colleague A.

Colleague A's witness statement states the following in relation to what had happened on 31 July 2020:

> *'On 31 July 2020, there was a patient who was meant to come in for an injection, but they had not turned up the day before. The standard process would be to call the person on duty who would ring them or arrange for them to come in the following day. [Ms Uche-Kaine] was the person on duty that day. I asked admin to put me through to the duty so I could ask that she caught up with this person.*
>
> *When I was put through to [Ms Uche-Kaine] I was met with hostility. I cannot remember the exact conversation, but it made me feel awful. I remember saying "Hi, it's [Colleague A]" and she responded very abruptly by saying "Do I know you?". She knew exactly who I was, we had been introduced and I had tried speaking to her on many occasions before. I explained the situation with this patient to her and she responded by saying "what am I supposed to do about this information?". Yet this was something we all had to do, and she knew exactly what was required of her. She was a nurse in a more senior position, but she was not helpful. She made me feel like she had an issue with me and was genuinely intimidating and nasty towards me.'*

The panel noted that Ms Uche-Kaine was senior to Colleague A, and Colleague A in her witness statement above also spoke about feeling intimidated, and that Ms Uche-Kaine had been 'nasty' to her.

The panel considered that the way Ms Uche-Kaine acted towards Colleague A was inappropriate, given that this is a professional relationship where Ms Uche-Kaine is senior to Colleague A. The panel was of the view that to act in such an inappropriate manner to a colleague is not what would be expected of a nurse, particularly a senior nurse, towards a fellow colleague, especially in the absence of any apparent reason.

The panel was however of the view that the way Ms Uche-Kaine acted towards Colleague A did not meet the elements of the charge to the extent that the panel had not been satisfied to the required standard that Ms Uche-Kaine had the necessary intent to bully, harass or intimidate Colleague A, causing her distress and fear.

Charge 12(b)

12) Bullied, harassed and/or intimidated one or more colleagues, causing distress and/or fear in that:

b) On 17 August 2020, you drove a vehicle towards Colleague A in the staff car park;

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement and oral evidence of Colleague A.

The panel noted that Colleague A in her oral evidence to the panel explained that she had been walking across the car park and had seen Ms Uche-Kaine coming towards her, in her car. Colleague A said that she had waved her arms, but Ms Uche-Kaine had continued to come towards Colleague A in her car, and she had to as a result quickly step away. Colleague A went on to say that Ms Uche-Kaine had continued to drive past her and looked in her rear mirror and saw her. Colleague A in her oral evidence told the panel that she found this to be intimidating, although she accepted that she cannot be sure this was intentional.

The panel accepted, based on what Colleague A has written in her witness statement, that she could not be certain whether it was Ms Uche-Kaine's intention to hit her with her car, or that Ms Uche-Kaine had seen her.

> *'She was staring blankly in my direction. I don't know if there was intention to hit me or if she just did not see me. However, afterwards she just drove off and did not apologise or acknowledge me.'*

The panel was of the view that it did not have sufficient evidence before it to conclude that Ms Uche-Kaine's behaviour was intentional and therefore find this charge not proved.

Charge 12(c)

c) On 19 August 2020, you shouted at Colleague A in the presence of others;

This charge is found proved.

In reaching this decision, the panel took into account the witness statements and oral evidence of Colleague A and Colleague B.

The panel noted the following from Colleague A's witness statement:

> *'[Ms Uche-Kaine] immediately started to shout at me. She told me I was making a serious allegation and I should go to the police. I don't recall much of the shouting, but I do vividly recall her saying that I was mental and should be one of the patients.*
>
> *[Colleague B] asked [Ms Uche-Kaine] to leave the room however she totally ignored this and continued to gesticulate and shout at me. I was terrified at the time, I was hyperventilating. It had a massive impact on my mental health and anxiety'*

The panel was of the view that Ms Uche-Kaine did have an intention to intimidate Colleague A whilst shouting at her.

The panel also took into account the following from Colleague B's witness statement:

> *'…[Ms Uche-Kaine] flung the door open, she was shouting at [Colleague A] to call the police and gesticulating at her. I asked her multiple times to leave the*

room as I thought [Colleague A] was going to hyperventilate, she was very scared… All the time she was shouting at [Colleague A] even though she said she did not know her… was not acting appropriately.. later advised that lots of service users had indeed heard her outburst and commented to other staff about it.'

The panel was of the view that, based on the evidence before it, Ms Uche-Kaine had shouted at Colleague A in the presence of others, and the panel was satisfied that based on Ms Uche-Kaine's actions, that they were sufficiently reckless to amount to an intention to bully, harass and/or intimidate Colleague A, a more junior member of staff, causing distress and/or fear.

Charge 12(d)

d) On 19 August 2020, you shouted at Colleague B in the hearing or presence of others;

This charge is found proved.

In reaching this decision, the panel took into account the witness statements and oral evidence of Colleague A and Colleague B. The panel also noted its findings in relation to charge 12(c).

The panel considered that Colleague B, unlike Colleague A, was a more senior member of staff to Ms Uche-Kaine. The panel noted the following from Colleague B's witness statement in relation to Ms Uche-Kaine:

'It was a really hard conversation to have, we were going around in circles, and she was unbelievably difficult. [Ms Uche-Kaine] was shouting at me, and services users and staff could hear…'

The panel therefore found this charge proved.

Charges 12(e) and 12(f)

e) On 20 August 2020, you behaved in an inappropriate and/or aggressive manner towards Colleague C;
f) f) On 20 August 2020, you behaved in an inappropriate and/or aggressive manner towards Colleague A;

These charges are found NOT proved.

In reaching this decision, the panel took into account the witness statement of Colleague B.

The panel had sight of email correspondence between Colleague B and Colleague C dated 19 and 20 August 2020. One of the emails dated 19 August 2020 sent by Colleague C to Colleague B stated the following:

> *'[Ms Uche-Kaine] was walking down the corridor, and tutted and said 'intimidating' and tutted at myself, This made me feel even more intimidated and caused me anxiety'*

Colleague A had also sent an email dated 20 August 2020 to Colleague B, in which Colleague C had been copied into, which stated:

> *'[Ms Uche-Kaine] walking in the oncoming direction walked passed and kissed her teeth very loudly'*

Colleague B also responded to the email, stating that *'this was directed at both of us as we walked back from the kitchen'*

The panel was of the view that there was not sufficient evidence before it to say that this incident constituted Ms Uche-Kaine acting in a bullying, harassing or intimidating manner towards Colleague B and Colleague A.

Charges 12(g) and 12(h)

g) On 9 September 2020, you shouted at Colleague B in the presence of others;
h) On 9 September 2020, you shouted at Colleague D in the hearing or presence of others;

These charges are found proved.

In reaching this decision, the panel took into account the witness statements of Colleague B and Colleague D, as well as the witness statements of Colleague A, Colleague E, Colleague F and Dr 1.

The panel noted the following from Colleague B's witness statement:

> *'[Colleague D] was supervising [Ms Uche-Kaine] and she found her incredibly difficult to supervise…supervision…dated 9 September 2020 which had to be terminated due to [Ms Uche-Kaine]'s behaviours and shouting during the sessions…I met with [Ms Uche-Kaine] on 9 September 2020…she spent most of this meeting shouting at me and being generally intimidating.'*

The panel noted that Colleague F in her oral evidence that a patient had asked her what was happening, as shouting could be heard, and Colleague F had intervened.

The panel also had sight of Dr 1's local statement dated 6 November 2020, in relation to what had taken place on 9 September 2020, which states:

> *'[Ms Uche-Kaine] became more animated and was shouting at [Colleague B]…I found her manner quite intimidating…'*

The panel had sight of an email sent by Colleague F to Colleague B on 9 September 2020 titled 'Complaint' which stated the following:

'…[Ms Uche-Kaine] was heard shouting (in room 1 with Colleague D), patient looked surprise by this, she could be heard shouting in the admin office…This situation is intolerable. She is intimidating and grossly unprofessional.'

The panel had sight of all of the evidence before it in relation to these charges and was satisfied that Ms Uche-Kaine had the intention to bully, harass or intimidate, causing distress and fear. The panel therefore find these charges proved.

Charge 12(i)

i) On 9 September 2020, you called Colleague E a "nosy cow" or words to that effect;

This charge is found NOT proved

In reaching this decision, the panel took into account the witness statement of Colleague E, in particular:

'[Ms Uche-Kaine] walked into the main reception area and shouted something like 'nosey cow' at me, before leaving the area'

The panel had sight of a contemporaneous email sent by Colleague E to Colleague B on 9 September 2020:

'[Ms Uche-Kaine] was walking past and said she as going for lunch… as she approached the door into the patient area she shouted 'nosy people' in an abrupt and aggressive manner and left the building.'

The panel also took into account Colleague E's oral evidence, where she had told the panel that she was not sure about the term used by Ms Uche-Kaine and who it was directed towards.

The panel was of the view that Ms Uche-Kaine had acted inappropriately in the presence of patients, but could not be satisfied that her actions met the wording of the charge and therefore find this charge not proved.

Charge 12(j)

j) On or before 9 September 2020, you refused to wear a face mask whilst sitting with Colleague F despite being aware that Colleague F was clinically vulnerable;

This charge is found proved

In reaching this decision, the panel took into account the witness statement of Colleague F, in particular:

> *'… [Ms Uche-Kaine] sat opposite me without a facemask on. I asked [Ms Uche-Kaine] to wear a facemask or to move away from me because I was immunosuppressed. [Ms Uche-Kaine] kissed her teeth at me, refused to wear a facemask or to move, then periodically coughed, glancing at me each time afterwards. I felt this was deliberate given the circumstances and spoke to the office administrator, who suggested I move to another desk further away.'*

The panel heard oral evidence from Colleague F, who explained that she was immunosuppressed, which Ms Uche-Kaine was aware of, and that Ms Uche-Kaine sat opposite her at a desk which was marked off with caution tape. Colleague F also said in her oral evidence that she does not remember Ms Uche-Kaine ever wearing a face mask.

The panel determined that on the balance of probabilities that Ms Uche-Kaine did not wear a face mask whilst sitting at a desk opposite Colleague F, with the intention to be intimidating and cause distress. Accordingly, the panel found this charge proved.

Charge 12(k)

k) On or before 9 September 2020, you deliberately coughed in the direction of Colleague F at least once without a face mask on, being aware that Colleague F was clinically vulnerable;

This charge is found proved

In reaching this decision, the panel took into account the oral evidence it heard from Colleague F, who explained that every time Ms Uche-Kaine coughed, she was looking at Colleague F.

The panel also took into account Colleague F's witness statement, which sets out the following:

> *'[Ms Uche-Kaine] kissed her teeth at me, refused to wear a facemask or to move, then periodically coughed, glancing at me each time afterwards. I felt this was deliberate given the circumstances and spoke to the office administrator, who suggested I move to another desk further away.'*

The panel took into account the circumstances at the time in light of the Covid-19 pandemic, where facemasks were mandatory, and that Colleague F was immunosuppressed, which Ms Uche-Kaine was aware of. In the absence of any other information, the panel on the balance of probabilities found this charge 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 Ms Uche-Kaine's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that

there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

Mr Radley invited the panel to take the view that the facts found proved amount to misconduct and identified the specific, relevant standards where Ms Uche-Kaine's actions amounted to misconduct in his written submissions.

Mr Radley referred the panel 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.

Submissions on impairment

Mr Radley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Radley referred the panel to his written submissions in relation to impairment and submitted that Ms Uche-Kaine's fitness to practice is impaired on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), and *Cohen v General Medical Council [2008] EWHC 581 (Admin).*

Decision and reasons on misconduct

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

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

> *1 Treat people as individuals and uphold their dignity*
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> *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*
> *2.6 recognise when people are anxious or in distress and respond compassionately and politely*
>
> *7 Communicate clearly*

To achieve this, you must:
7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

8 Work co-operatively
To achieve this, you must:
8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.4 work with colleagues to evaluate the quality of your work and that of the team
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk
8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

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, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.2 make a timely referral to another practitioner when any action, care or treatment is required

16 Act without delay if you believe that there is a risk to patient safety or public protection To achieve this, you must:
16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
To achieve this, you must:
17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse
17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

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

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms Uche-Kaine's actions, in light of the seriousness of the charges found proved did fall seriously short of the standards expected of a nurse and went against the fundamental tenets of the nursing profession.

Further, the panel was of the view that Ms Uche-Kaine's conduct in relation to her missed appointments and subsequent failure to complete assessments, poor record keeping, lack of compassion, lack of cooperation and teamwork with her colleagues and supervisors/managers was unacceptable for a nurse of her seniority who worked with vulnerable service users.

The panel determined that Ms Uche-Kaine's conduct, and her actions caused and had the potential to cause serious and significant consequences and raised safeguarding issues. Further harm was prevented in a number of cases by the intervention of Ms Uche-Kaine's colleagues. The panel noted that Ms Uche-Kaine's actions had resulted in at least one complaint from a vulnerable service user and left at least another vulnerable service user distressed. Ms Uche-Kaine's hostile behaviour also caused colleagues to be emotionally distressed.

The panel therefore concluded that Ms Uche-Kaine's actions amounted to serious professional misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Uche-Kaine's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on Impairment, Reference DMA-1, Last Updated 27 February 2024, which states:

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. Nurses must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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

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

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

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

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

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

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

d) *...'*

The panel was of the view that the first three limbs of the test were engaged in this case. The panel finds that vulnerable service users and colleagues suffered emotional harm as a result of Ms Uche-Kaine's misconduct. Ms Uche-Kaine's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that it has no information before it from Ms Uche Kaine as to any steps taken to develop her insight into the regulatory concerns. Ms Uche-Kaine's engagement with the NMC has been limited. The panel was satisfied that the misconduct in this case is capable of being addressed. However, the panel noted that it has no evidence before it of any acceptance from Ms Uche-Kaine in relation to any understanding of how her actions put patients at a risk of harm or why what she did was wrong and how this impacted negatively on the reputation of the nursing profession.

The panel also considered that Ms Uche-Kaine's behaviour and attitude towards senior and junior members of staff, her colleagues, vulnerable service users and her lack of cooperation in relation to teamwork and collaboration is difficult to remediate.

In addition, the panel considered that it has no information before it in relation to any remediation or reflection undertaken, by way of training courses undertaken by Ms Uche-Kaine, and no references from past or current employers or a reflective piece in respect of the regulatory concerns. The panel took into account that Ms Uche-Kaine had failed to cooperate with the local investigation at the Trust, as well as the NMC investigation.

The panel is of the view that there is a risk of repetition based on Ms Uche-Kaine's failure to demonstrate any insight, reflection or remediation into the regulatory concerns, which are serious and wide-ranging. Additionally, there is a lack of acceptance or understanding that Ms Uche-Kaine's actions has put vulnerable service users at a risk of harm.

The panel did also have sight of a witness statement from an Associate Director of Inpatient and Urgent care services in NE and West Essex Partnership University NHS Foundation Trust. [PRIVATE]

The panel also had sight of Ms Uche-Kaine's telephone attendance note with the NMC dated 23 June 2021, in particular:

> *'…[Ms Uche-Kaine] feels that the Trust have sent in this referral in spite. She discussed the Trust having an unhealthy work culture in the way they treated some nurses including herself.'*

Whilst the panel noted Ms Uche-Kaine's assertion, it did not have any evidence before it to substantiate this.

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; 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 determined that a finding of impairment on public interest grounds is required as an informed member of the public would be concerned if Ms Uche-Kaine were permitted to practise unrestricted, particularly in light of the attitudinal concerns raised and her limited lack of cooperation and engagement at a local level and with the NMC.

In addition, 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 Ms Uche-Kaine's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Uche-Kaine's fitness to practise is currently impaired.

Sanction

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

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

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

Submissions on sanction

Mr Radley informed the panel that in the Notice of Hearing, dated 15 August 2024, the NMC had advised Ms Uche-Kaine that it would seek the imposition of a strike-off if the panel found Ms Uche-Kaine's fitness to practise currently impaired.

Mr Radley referred the panel to his written submissions in relation to sanction.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Ms Uche-Kaine's lack of insight into the regulatory failings
- Lack of remorse into the impact of her actions on colleagues
- Lack of remorse into the impact of her actions on service users, who are vulnerable members of society
- Lack of engagement at a local level with the Trust, and with the NMC
- No evidence of any reflection or steps taken to remediate the regulatory concerns
- A pattern of misconduct over a relatively significant period of time
- Ms Uche-Kaine's conduct caused vulnerable service users and colleagues actual substantial harm and also put them at risk of suffering harm
- Ms Uche-Kaine was in a position of seniority at the Trust

The panel also took into account the following mitigating features:

- [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 Ms Uche-Kaine's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Uche-Kaine's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Uche-Kaine's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Ms Uche-Kaine's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that 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;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *…*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel found that conduct to be indicative of a harmful deep-seated attitudinal problem. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Ms Uche-Kaine's actions is fundamentally incompatible with Ms Uche-Kaine 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?*

Ms Uche-Kaine's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Uche-Kaine's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

The panel 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 Ms Uche-Kaine 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 Ms Uche-Kaine's own interests until the striking-off sanction takes effect.

The panel heard and accepted the advice of the legal assessor, who referred the panel to Article 31(2) of the Nursing and Midwifery Order 2001.

Submissions on interim order

The panel took account of the submissions made by Mr Radley. He submitted that in light of the panel's decision to strike-off Ms Uche-Kaine, it is the NMC's application that an interim suspension order for a period of 18 months should be imposed on the basis that this would cover any appeal period should Mc Uche-Kaine appeal against the panel's decision.

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 to cover any appeal period.

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

That concludes this determination.