Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday, 21 August 2024 – Friday, 30 August 2024
Friday, 6 September 2024

Virtual Hearing

Name of Registrant:	**Sophia Sebadduka**
NMC PIN	06C1253E
Part(s) of the register:	Nurses part of the register – sub part 1 RNA: Adult nurse, level 1 (25 March 2010)
Relevant Location:	Camden
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair, lay member) Gillian Tate (Registrant member) David Anderson (Lay member)
Legal Assessor:	Gillian Hawken (21 August 2024 – 30 August 2024) Nigel Ingram (6 September 2024)
Hearings Coordinator:	Catherine Blake
Nursing and Midwifery Council:	Represented by James Wilson, Case Presenter
Miss Sebadduka:	Not present and not represented at the hearing
Facts proved:	Charges 1, 2, 3 (in its entirety), 4 (in its entirety), 5, 6a, and 8 (in its entirety).
Facts not proved:	Charges 6b and 7.
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 Miss Sebadduka was not in attendance and that the Notice of Hearing letter had been sent to Miss Sebadduka's registered email address by secure email on 22 July 2024.

Mr Wilson, 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 allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Sebadduka'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 Miss Sebadduka 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 Miss Sebadduka

The panel next considered whether it should proceed in the absence of Miss Sebadduka. It had regard to Rule 21 and heard the submissions of Mr Wilson who invited the panel to continue in the absence of Miss Sebadduka.

Mr Wilson referred the panel to the documentation from Miss Sebadduka which included an email sent to the NMC on 24 July 2024 stating:

'I will not be attending the hearing…I would like the hearing to go ahead in my absence for a decision to be made…'

Mr Wilson submitted that there is no indication that adjourning would secure Miss Sebadduka's attendance at a future date, and that it would be appropriate and proportionate for 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 Miss Sebadduka. In reaching this decision, the panel has considered the submissions of Mr Wilson and the representations from Miss Sebadduka, 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 Miss Sebadduka;
- Miss Sebadduka has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A witness has attended today to give live evidence, and 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;
- 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 Miss Sebadduka in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Sebadduka's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make oral submissions on her own behalf.

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

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

At the outset of the hearing, Mr Wilson made a request that this case be held partly in private on the basis that proper exploration of Miss Sebadduka's case may involve reference to her health or personal circumstances. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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 go into private session in connection with Miss Sebadduka's health or personal circumstances as and when such issues are raised in order to protect her privacy.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Wilson under Rule 31 to allow the hearsay of an unknown patient and Patient D into evidence. He submitted that the evidence of the unknown patient concerning charges 5 and 6 is referred to in the statement of Witness 5. Mr Wilson further submitted that, regarding charge 8, the hearsay evidence of Patient D is referred to in Witness 1's exhibits.

Mr Wilson referred to the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and submitted that this hearsay evidence is capable of being tested during the live evidence of other witnesses. He submitted that the panel would be able to properly explore this hearsay evidence via Witness 1 and Witness 5.

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. The legal assessor also referred the panel to the judgements in the cases of *Mansaray v NMC* [2023] EWHC 730 (Admin), *El Karout v NMC* [2020] EWHC 3079 (QB), and *Thorneycroft*. The court in the case of *Mansaray* found that there is *'no blanket prohibition on hearsay evidence, but it requires a consideration of the evidence carefully in line with* Thorneycroft *principles, the quality of the evidence, [and] how it is obtained …'*

The panel noted that, although Miss Sebadduka had chosen not to attend this hearing, she was not aware at the time of making that decision of this application to have the hearsay evidence admitted.

The panel first considered the nature and quality of the hearsay evidence in support of charge 6. The only evidence in support of this charge is Witness 5's evidence that *'One of the patients on the Ward, who was under our care, told me he was unhappy with the nurse (Miss Sebadduka) looking after him because she had not given him pain medications promptly when they were due'*. The panel was of the view that Witness 5's evidence can only give contextual information of what the unknown patient told her, and that the exhibit simply relays what the patient said to her. The panel has seen no other evidence in support of the unknown patient's statements in relation to this charge. In these circumstances, the panel was not satisfied of the quality of the hearsay evidence. Accordingly, the panel refused the application in respect of charge 6.

The panel next considered the nature and quality of the hearsay evidence in support of charge 5. The panel was of the view that, similar to charge 6, Witness 5's evidence can only give contextual information of what the unknown patient told her and the panel has seen no other evidence in support of the unknown patient's statements in relation to this charge. The panel note that the hearsay evidence in respect of charge 5 is quite removed from the original source in that it was multiple hearsay: an unknown patient who told Witness 5 about an incident with Patient F. In light of the lack of any direct evidence from the unknown patient or Patient F (who passed away shortly after the incidents in the charges), the panel was not satisfied of the quality of the hearsay evidence. Accordingly, the panel refused the application in respect of charge 5.

The panel next considered the nature and quality of the hearsay evidence in support of charge 8. Witness 1 states *'Patient D had complained about being left unattended for 11.5 hours… I remember the patient verbally informed me'*. This is the totality of the hearsay evidence relating to charge 8. The panel was of the view that, similar to charges 5 and 6,

Witness 1 can only give contextual information of the hearsay evidence, but there is no direct evidence of the alleged failing and no other evidence in support. The panel note that the hearsay evidence was relayed verbally to Witness 1, and in the lack of an opportunity to test the evidence of Patient D, the panel was not satisfied of its quality. Accordingly, the panel refused the application in respect of charge 8.

The panel will not rely on this hearsay evidence in making their decision on facts.

Decision and reasons on NMC application to offer no evidence

The panel considered an application from Mr Wilson that there is no evidence in respect of charges 5, 6 and 8.

In relation to this application, Mr Wilson submitted that, following the panel's decision in relation to hearsay evidence, there was now no evidence in support of these charges. In these circumstances, it was submitted that these charges should be removed.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor who advised the panel in relation to the case of *PSA v NMC and X* [2018] EWHC 70 (Admin) and the NMC's own guidance called Offering no evidence (DMA-3).

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented such that it could find the facts proved in charges 5, 6, and 8.

The panel was of the view that, taking account of Mr Wilson's submissions, there was no evidence in support of charges 5, 6, and 8 and therefore no realistic prospect that it could find the facts of these charges proved. The panel accepted Mr Wilson's application of no evidence in respect of these charges and they will be removed from the charges.

Details of charge

That you, a registered nurse:

1. On 24 May 2017 administered intramuscular Morphine instead of Pethidine to Patient A.

2. On the night shift of 20 July 2017 supervised the administration of 4 additional units of insulin Noveomex 30 to Patient B, without clinical justification.

3. Between 1 and 3 December 2017 failed to treat Patient C and/or their family with kindness or respect, in that you:
    a. during a medication round stated '*oh God help me, God help me, please help me God, where are you God' I am looking for you but I cannot find you, please help me God',* or words to that effect
    b. did not provide any support to the toilet.
    c. asked a family member to administer an Tinzaparin (subcutaneous) injection.
    d. failed to escalate the family's concern that Patient C was struggling to walk.

4. On 19 March 2022 failed to provide adequate care to Patient E, in that you failed to:
    a. identify clinical signs of severe dehydration.
    b. observe Patient E was laying in excrement.
    c. recognise and/or escalate Patient E's deteriorating condition.

5. On the night shift of 15 June 2022 slept whilst on duty.

6. On 13 September 2022 failed to:

a. administer and/or ensure administration of IV Fluids to Patient H
b. administer and/or ensure administration of insulin to Patient G at the prescribed time.

7. On 13 September 2022 recorded incorrectly within Patient G's records that insulin had been administered at 13.59 when it had not.

8. On one or more occasions failed to assist colleagues with patient care, in that:
    a. in August 2018, you did not assist with washing and changing a patient with dementia, when asked to do so by a colleague.
    b. on 15 June 2022, you did not respond to a patient's call bell and allowed a colleague to do so despite having capacity to respond yourself.

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

The panel heard an application made by Mr Wilson to amend the wording of charge 2.

The proposed amendment was to remove the phrase *'the night shift of'* from the start of the charge. It was submitted by Mr Wilson that the proposed amendment is minor and would provide clarity and more accurately reflect the documentary evidence before the panel:

'That you, a registered nurse:

…

2. *On ~~the night shift of~~ 20 July 2017 supervised the administration of 4 additional units of insulin Noveomex 30 to Patient B, without clinical justification.*

…

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Sebadduka and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure accuracy and best reflect the evidence.

Background

The charges arose whilst Miss Sebadduka was employed as a registered nurse by Barnet Hospital ("the Hospital"), part of Royal Free London NHS Foundation Trust ("the Trust"), where she had worked as a Band 5 nurse since 21 March 2011.

Ms Sebadduka was referred to the NMC on 14 September 2022. The Trust confirmed there were long standing issues with Ms Sebadduka's conduct and/or practice including:

i. Showing a lack of respect to patients, doctors, students, colleagues and her line manager;
ii. Poor team work and communication with the multidisciplinary team;
iii. Not being willing to assist with patient care when requested to do so by colleagues.

During the course of the NMC's investigation, the following additional concerns were raised:

i. Failure to work cooperatively with colleagues;
ii. Failure to treat patients and/or their family members with dignity and respect;

iii. Failure to attend to call bells appropriately;
iv. Sleeping whilst on duty; and
v. Did not respond appropriately to deteriorating patients.

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 Wilson on behalf of the NMC and by Miss Sebadduka's written response to the regulatory concerns.

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 1: Senior Sister on the ward at the time of the alleged incidents.
- Witness 2: Healthcare Assistant at the Hospital at the time of the alleged incidents.
- Witness 3: Patient C's daughter in law.
- Witness 4: Junior Sister on the ward at the time of the alleged incidents.
- Witness 5: Doctor at the Hospital at the time of the alleged 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 both the NMC and Miss Sebadduka.

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

Charge 1

> *'That you, a registered nurse on 24 May 2017 administered intramuscular Morphine instead of Pethidine to Patient A.'*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1.

The panel considered the evidence of Witness 1 to be consistent across her written and oral statements.

The panel took account of the following from Witness 1's statement:

> *'On 24 May 2017, a controlled drug check was undertaken. Controlled drug checks are undertaken by two nurses on a twice daily basis, In the Controlled Drug book, it was noted that there was an extra vial of pethidine, and a morphine vial was missing when the check was performed on this day. It was then discovered that a wrong drug has been given to a patient, Patient A.'*

The panel noted that it has not seen the Controlled Drugs book or the Medication Administration Record (MAR) chart associated with this charge.

Witness 1's statement continues:

'*A Datix was raised by Miss Sebadduka on the day of the incident after a routine controlled drug check was completed.'*

The panel took account of this Datix report of 24 May 2017 in which Miss Sebadduka recorded that she administered Morphine to Patient A instead of Pethidine:

'Morphine injection appears to have been given instead of Pethidine injection that was prescribed.'

The panel considered this to be evidence that the error had occurred and that Miss Sebadduka was jointly responsible for the error alongside the other signatory.

The panel has also seen a series of letters sent to Miss Sebadduka from Witness 1 regarding this error and advising that Miss Sebadduka would be put on a medicines' competency plan.

The panel further noted the following entry from the above Datix on 6 June 2017:

'Nurses requested to complete statements for reflection and learning. Medicines competencies to be re-done.'

Witness 1's statement confirms that:

'Miss Sebadduka completed the competency and agreed it was required.'

The panel was able to place reliance on this consistent evidence.

The panel further noted that in Miss Sebadduka's response to the regulatory concerns she said her only drug error was in 2017. No further information was provided so the panel was not sure if she was referring to the incident in this charge.

The panel preferred the evidence of Witness 1 and the related exhibits and was satisfied that Miss Sebadduka administered intramuscular Morphine instead of Pethidine to Patient A, and accordingly found this charge proved.

Charge 2

> *'That you, a registered nurse on 20 July 2017 supervised the administration of 4 additional units of insulin Noveomex 30 to Patient B, without clinical justification.'*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 as well as the oral evidence of Witness 4.

The panel took account of the following from Witness 1's statement:

> *'Patient B was given the incorrect dose of insulin which resulted in the patients' blood sugar becoming too low. The dose given to the patient was 16 units of insulin, the correct dose was 12 units.*
>
> *…*
>
> *'There was a third-year student… under the supervision of Miss Sebadduka. As the student nurse had not received their NMC PIN, they were not qualified. Miss Sebadduka should have overseen the student performing their role. It was Miss Sebadduka that signed that the insulin had been given.'*

The panel also had regard to Patient B's MAR chart on 20 July 2017 and noted that the required insulin unit is recorded as 12. The panel noted the entry at 0800 recorded 16 units of insulin as administered, and the initials 'SS' next to the entry. Witness 1 and Witness 4 confirmed that the marking of 'SS' next to the record on the MAR chart could be attributed to Miss Sebadduka.

The panel next had regard to the letter of 24 July 2017 which refers to an Informal Capability Counselling Meeting between Witness 1 and Miss Sebadduka regarding this drug error. The outcome of this meeting is that the medication competency plan in place for Miss Sebadduka would be extended, that she would undertake supervised drug rounds, and that a drug administration workbook would be completed. The panel has seen evidence that this workbook was completed.

The panel found the documentary MAR chart and the evidence of Witness 1 and Witness 4 to be compelling in respect of this charge.

The panel noted that in Miss Sebadduka's response to the regulatory concerns she said her only drug error was in 2017. No further information was provided so the panel was not sure if she was referring to the incident in this charge.

The panel was satisfied that Miss Sebadduka supervised the incorrect administration of Noveomex 30 to Patient B, and accordingly found this charge proved.

Charge 3a)

> *'That you, a registered nurse between 1 and 3 December 2017 failed to treat Patient C and/or their family with kindness or respect, in that you:*
>
> *a. during a medication round stated 'oh God help me, God help me, please help me God, where are you God' I am looking for you but I cannot find you, please help me God', or words to that effect'*

This charge is found proved.

The panel noted that the stem of this charge concerns a failure on behalf of Miss Sebadduka, and that in order for this charge to be found proved she must have had a duty to treat people with kindness and respect. The panel bore in mind part 1.1 of the NMC Code of Conduct, which conveys a duty on nurses to treat people with kindness and respect in the course of their practice. The panel was in no doubt, therefore, that should it find that Miss Sebadduka did not treat Patient C and/or their family with kindness and respect, that this would be a failure in her duty as a registered nurse.

The background to these sub-charges is that Patient C was admitted to the ward with dementia and also had poor vision and a spine fractured in three places. Witness 3, Patient C's daughter-in-law, visited Patient C regularly and often with her husband, Patient C's son. The panel relied on an email sent on 4 December 2017 to Witness 1 in which Patient C's son complained to the hospital. The panel heard oral evidence from Witness 3 that the email was written jointly by her and Patient C's son, and that Witness 3 had visited Patient C more regularly. The panel accepted Witness 3's evidence that she had written the email jointly with Patient C's son, and that this was consistent across her written and oral evidence.

In determining these sub-charges, the panel took into account the evidence of Witness 3. The panel was mindful that Witness 3 gave oral evidence that 'the care was horrendous from the nurses on the ward. The doctors wouldn't take me seriously, the nurses wouldn't either'. Although Witness 3 gave evidence around the poor care given on the ward generally that weekend, the panel considered the evidence only in relation to Miss Sebadduka specifically in determining these sub-charges.

In respect of this sub-charge, the panel took into account the following extract from the email of 4 December 2017:

‘When the nurse came into the ward to hand out medication on Friday, she stated loudly: ‘oh God help me, God help me, please help me God, where are you God, I am looking for you, but I cannot find you, please help me God’. I found this behaviour to be extremely unprofessional as she was indicating loudly that her patients were a burden on her.’

The panel noted that this email was sent a few days after the incident and considered it a near-contemporaneous account. The panel also took into account Witness 3’s statement that hearing these words made her feel like the patients were a burden to Miss Sebadduka, and that her behaviour was extremely unprofessional. The panel accepted the evidence of Witness 3, which it considered to be consistent and compelling.

The panel also took into account an email sent by Witness 1 to Miss Sebadduka on 12 January 2018 regarding the incident in this charge, and noted that Miss Sebadduka was put on an improvement plan following the complaints raised by Patient C’s son.

The panel determined that by causing the family of Patient C to feel that the patient was a burden, Miss Sebadduka did not treat Patient C or their family with kindness or respect, that this was a failure on her part, and accordingly found this sub-charge proved.

Charge 3b)

‘That you, a registered nurse between 1 and 3 December 2017 failed to treat Patient C and/or their family with kindness or respect, in that you:

b. did not provide any support to the toilet.’

This charge is found proved.

The panel noted the background to these sub-charges, as above, and the duty of registered nurses to treat people with kindness and respect.

In respect of this sub-charge, the panel took into account the following extract from the email of 4 December 2017:

> *'During this weekend, whenever my wife asked Sophia for help with taking my mother to the toilet she told her in a rude manner while she was carrying out her paperwork that there was no one that could come to help and hence she had to take my mother to the toilet several times and clean her herself.'*

As above, the panel considered this a near-contemporaneous account.

The panel also noted Witness 3's oral evidence. When asked if Miss Sebadduka had ever assisted Patient C, Witness 3 said:

> *'The registrant never assisted my mother that weekend'*

The panel also took into account Witness 1's letter of 12 January 2018 regarding the incident in this charge, and noted that Miss Sebadduka was put on an improvement plan following the complaints raised by Patient C's son.

The panel had regard to Miss Sebadduka's response to the regulatory concerns:

> *'I answered no to this concern because I do not recall having poor patient care. I have always assisted patients and I help those who need to go to the toilet.'*

The panel was of the view that this was a general statement that did not go to the root of this charge. The panel preferred the evidence of Witness 3 in respect of this sub-charge, which was consistent and specific.

The panel determined that Miss Sebadduka did not support Patient C to the toilet, and that in not doing so failed in her duty to treat patients with kindness and respect. Accordingly, this sub-charge is found proved.

Charge 3c)

> *'That you, a registered nurse between 1 and 3 December 2017 failed to treat Patient C and/or their family with kindness or respect, in that you:*
>
> *c. asked a family member to administer an Tinzaparin (subcutaneous) injection.'*

This charge is found proved.

The panel noted the background to these sub-charges, as above, and the duty of registered nurses to treat people with kindness and respect.

In respect of this sub-charge, the panel took into account the following extract from the email of 4 December 2017:

> *'Sophie[sic] hardly came in the bay during the weekend, when she did to give the medication she asked my wife to put the eye drops in my mothers[sic] eyes which she did not mind doing, but then she told me that she should also inject her, which she did object too[sic]. Sophie[sic] then asked her in a sarcastic manner why my wife wouldn't do it. She repeated again that she was not going to inject my mother as she do[sic] not have any medical training … My wife then had to tell her for the third time that she would not inject her and she does not live with her.'*

As above, the panel considered this a near-contemporaneous account. This was corroborated in Witness 3's witness statement.

The panel also noted the following in Witness 3's statement:

> *'Miss Sebadduka then did do the injection, and chuckled while they did so. I almost felt like they were mocking me.'*

The panel accepted Witness 3's evidence in respect of this sub-charge.

The panel noted that Witness 3 describes Miss Sebadduka's tone as mocking and sarcastic, and determined that this kind of demeanour would have the effect of being unkind to Patient C and their family member. Further, Miss Sebadduka asking an untrained and unwilling family member to perform a clinical task in front of a patient belies a disregard for their care. The panel concluded this was a lack of respect for Patient C.

The panel determined that Miss Sebadduka did ask Patient C's family member to administer a Tinzaparin injection, and that in doing so failed in her duty to treat Patient C and her family member with kindness and respect. Accordingly, this sub-charge is found proved.

Charge 3d)

> *'That you, a registered nurse between 1 and 3 December 2017 failed to treat Patient C and/or their family with kindness or respect, in that you:*
>
> *d. failed to escalate the family's concern that Patient C was struggling to walk.'*

This charge is found proved.

The panel noted the background to these sub-charges, as above, and the duty of registered nurses to treat people with kindness and respect. The panel also noted that Miss Sebadduka had a duty to escalate the health concerns of Patient C as she was in charge of her care whilst on shift.

The email of 4 December 2017 states that Miss Sebadduka was alerted to the concern multiple times by Witness 3, over three days, but still did not escalate it to a doctor herself. Witness 3 states:

'On Friday 1 December 2017, I noticed my mother-in-law was struggling to walk and their feet were swollen. Because of their dementia, they could not express themselves. I told Miss Sebadduka that I had noticed this. Miss Sebadduka brushed off my concerns stating their feet must be swollen as they were lying down all day. I asked Miss Sebadduka to notify the doctor…Miss Sebadduka did not take my concern seriously by first blaming my mother-in-law for being bed ridden all day and then Miss Sebadduka said 'ok'. This was never done.'

Witness 3's written statement, confirmed in oral evidence, states that she then took it upon herself to notify the doctor and upon investigation an x-ray showed Patient C had a 'pubic raymus fracture'.

The panel had regard to Miss Sebadduka's response to the regulatory concerns:

'I answer patient bells, make appropriate referrals and I monitor, conduct observations and / or treat all deteriorating patients under my care.'

The panel was of the view that this was a general statement that did not go to the root of this charge.

The panel preferred the evidence of Witness 3 and determined that Miss Sebadduka did not respect the concerns of the family and did not escalate the concerns to a doctor in a timely fashion.

The panel determined that Miss Sebadduka failed to escalate the concerns of Patient C's family, and that in not doing so failed in her duty to treat Patient C and her family member with kindness and respect. Accordingly, this sub-charge is found proved.

Charge 4a)

'That you, a registered nurse, on 19 March 2022 failed to provide adequate care to Patient E, in that you failed to:

a. identify clinical signs of severe dehydration.'

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 and Witness 5.

The panel saw evidence that Patient E was severely dehydrated. It noted the email sent from Witness 5 to Witness 1 on 31 March 2022 which stated:

'I had found one of our ward patients under [Miss Sebadduka's] care severely dehydrated and with a fissured, sore, and dry mouth.'

The panel also noted the following from Witness 5's statement:

'This incident could have been avoided if the nursing staff had recognised that the patient was unable to drink and ask for fluids.'

The panel determined that Miss Sebadduka ought to have recognised Patient E was dehydrated as the dehydration was observable and Patient E was under her care. The panel was satisfied that a registered nurse is expected to have done more in these circumstances.

Witness 1 met with Miss Sebadduka to discuss the complaint of Witness 5. The panel has seen evidence of this meeting in a letter from Witness 1 to Miss Sebadduka in which the following is recounted:

'When discussing with you in the meeting, you were 'ranting' that' Karma will get the better of this Dr' and her 'come-up-ans'[sic] will come. You stated that 'what

goes around comes around'. And 'How could she (Dr) make a complaint about someone of a caring profession?' These comments were most disturbing to hear and unprofessional and is not acceptable language in accordance with the Trust values.'

The panel had regard to Miss Sebadduka's response to the regulatory concerns:

'I answer patient bells, make appropriate referrals and I monitor, conduct observations and / or treat all deteriorating patients under my care.'

The panel was of the view that this was a general statement that did not go to the root of this charge.

The panel preferred the clear evidence of Witness 1 and Witness 5.

The panel is satisfied that Miss Sebadduka failed to provide adequate care in failing to identify the signs of dehydration in Patient E. Accordingly this sub-charge is found proved.

Charge 4b)

'That you, a registered nurse, on 19 March 2022 failed to provide adequate care to Patient E, in that you failed to:

b. observe Patient E was laying in excrement.'

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 and Witness 5.

The panel saw evidence that Patient E was lying in her excrement. It noted the email sent from Witness 5 to Witness 1 on 31 March 2022 which stated:

‘I had found one of our ward patients under [Miss Sebadduka’s] care severely dehydrated and with a fissured, sore, and dry mouth. She was also lying in her own excrement.’

The panel determined that Miss Sebadduka ought to have recognised Patient E was lying in excrement as this was observable and Patient E was under her care. The panel was satisfied that a registered nurse is expected to have done more in these circumstances. The panel has seen no evidence that the ward was understaffed or uncommonly busy at the time of this charge.

The panel had regard to Miss Sebadduka’s response to the regulatory concerns:

‘I do not recall having poor patient care… I answer patient bells, make appropriate referrals and I monitor, conduct observations and / or treat all deteriorating patients under my care.’

The panel was of the view that this was a general statement that did not go to the root of this charge.

The panel preferred the clear evidence of Witness 1 and Witness 5.

The panel is satisfied that Miss Sebadduka failed to provide adequate care in failing to observe that Patient E was lying in excrement. Accordingly, this sub-charge is found proved.

Charge 4c)

‘That you, a registered nurse, on 19 March 2022 failed to provide adequate care to Patient E, in that you failed to:

c. recognise and/or escalate Patient E’s deteriorating condition.’

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 5.

The panel saw evidence that Patient E's condition was deteriorating. It noted the email sent from Witness 5 to Witness 1 on 31 March 2022 which stated:

> *'I had found one of our ward patients under [Miss Sebadduka's] care severely dehydrated and with a fissured, sore, and dry mouth. She was also lying in her own excrement. When discussing the state of the patient with her and requesting her assistance, she seemed very dismissive and made little attempts to correct the situation'*

The panel also took into account Witness 5's statement:

> *'In terms of Miss Sebadduka, it would depend on how long Miss Sebadduka was caring for the patient. I do not know with certainty how long Miss Sebadduka was caring for the patient, however, it will have been from at least the start of the day, given that she was the day nurse caring for the patient... [Miss Sebadduka] did have an opportunity to recognise how dehydrated the patient was and escalate this to a member of the orthopaedic team, thereby rectifying the situation sooner. For example, they could have asked a doctor to prescribe an IV fluid bag if they were concerned about the patient's ability to take fluid orally. They could have also responded to my concerns and helped me rectify the situation which they did not.'*

The panel had regard to the following email from Witness 5 to Witness 1 on 29 April 2022 regarding Patient E's deteriorating condition:

‘I tried to draw this to the attention of Sophia and ask for her assistance in assessing and treating [Patient E]… however, Sophie[sic] was dismissive and unresponsible to my concerns and did not come and help me.

…

‘I understand there are often staff shortages and the nurses are doing important jobs under these conditions. Nonetheless, I feel the situation could have been avoided if the nursing staff had been more vigilant…’

The panel has seen no evidence that the ward was understaffed or uncommonly busy at the time of this charge.

The panel determined that Miss Sebadduka ought to have recognised Patient E’s condition was deteriorating. The panel was satisfied that a registered nurse is expected to have done more in these circumstances, and that Miss Sebadduka ought to have been more vigilant.

The panel had regard to Miss Sebadduka’s response to the regulatory concerns:

‘I do not recall having poor patient care… I answer patient bells, make appropriate referrals and I monitor, conduct observations and / or treat all deteriorating patients under my care.’

The panel was of the view that this was a general statement that did not go to the root of this charge.

The panel preferred the evidence of Witness 1 and Witness 5.

The panel is satisfied that Miss Sebadduka failed to provide adequate care in failing to observe that Patient E was deteriorating. Accordingly, this sub-charge is found proved.

Charge 5

‘That you, a registered nurse, on the night shift of 15 June 2022 slept whilst on duty.’

This charge is found proved.

In reaching this decision, the panel took into account the written and oral statements of Witness 1 and Witness 2.

The panel took into account the following from Witness 2’s statement:

‘I could clearly see Ms Sebadduka sleeping. I was sitting outside Bay 2 area bordering the nurse’s station where Miss Sebadduka was seated. The Site Manager saw Miss Sebadduka sleeping, and asked if they were okay. Miss Sebadduka told the Site Manager that they had taken paracetamol as they had a headache… Once the Site Manager left, Miss Sebadduka turned to [PRIVATE] and I and said that they had lied about having a headache as they had been caught red handed. Miss Sebadduka then went back to sleep.’

This was confirmed in oral evidence.

The panel noted that Witness 2 made an incident report on 19 June 2022, and that this is a near-contemporaneous account. It states:

‘…the site manager had walked in whilst Sophia was asleep and asked her if she was alright. Sophia told her that she had taken paracetamol as she had a headache. After the site manager left, Sophia told… and I about the site manager’s visit and how she had lied about the headache as she was caught sleeping red handed. She then when on to sleep again.’

The panel also considered the email from Witness 1 to Miss Sebadduka on 8 September 2022:

> *'*[PRIVATE] *had advised an occupational health referral following the incident when the site manager reported that you had been asleep at the nurse's station whilst on duty. You said it had only happened once and that you are fed up with keep*[sic] *talking about it so declined the referral.'*

The panel took account of the email sent by Miss Sebadduka on 12 July 2022:

> *'…it has been alleged that I was asleep at the nurses[sic] station and this is to reiterate that I wasn't sleeping.'*

The panel had regard to Miss Sebadduka's response to the regulatory concerns:

> *'I do not sleep while on duty and like I previously stated, I had a headache on the day in issue and informed my colleague about the same.'*

The panel preferred the evidence of Witness 2. The panel noted that Witness 2 has been consistent across her written and oral statements, and reported the incident just a few days after the event.

The panel is therefore satisfied that Miss Sebadduka did sleep while on duty on the night of 15 June 2022. Accordingly, this charge is found proved.

Charge 6a)

> *'That you, a registered nurse, on 13 September 2022 failed to:*
>
> *a. administer and/or ensure administration of IV Fluids to Patient H'*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 and Witness 4.

At the outset of their deliberations, the panel noted that, as a registered nurse allocated to this patient, Miss Sebadduka had a duty to administer IV fluids to Patient H. In this regard the panel noted the following from Witness 1's statement:

> *'I gave Miss Sebadduka the instructions that morning following the board round that the patient required fluids… the response of Miss Sebadduka was that she listened to my instructions.'*

The panel also noted the following from Witness 4's statement:

> *'The doctors gave an instruction to administer the IV fluids during the 9:00 round…Miss Sebadduka was the nurse looking after this patient in that bay…'*

The panel has seen evidence that IV fluids were prescribed to Patient H. It also considered the nursing notes of 13 September 2022 in which administration of these fluids to Patient H is not recorded.

The panel also noted an email sent to Miss Sebadduka from Witness 1 on 14 September 2022:

> *'It was brought to my attention that yesterday, despite me handing over to you that the patient in bed 13 required IV fluids, that they had been prescribed and it was documented by the Drs[sic] that you omitted to put them up.'*

The panel considered this a near-contemporaneous account and accepted it as evidence that Miss Sebadduka had not administered the IV fluids on 13 September 2022.

The panel had regard to Miss Sebadduka's response to the regulatory concerns:

‘I thought there was only one patient that required IV fluids and I administered them… I mentioned and would like to reiterate that I did not knowingly fail to administer the IV fluids. Having established that I did not administer the IV fluids to this other patient, I accept responsibility for this part of concern 1.’

The panel noted this is a partial acceptance by Miss Sebadduka that she failed to administer IV fluids to a patient, although it does not address the specific incident in this charge.

The panel preferred the evidence of Witness 1 and Witness 4, supported by the exhibited documentary evidence.

The panel is satisfied that Miss Sebadduka failed to administer IV fluids to Patient H on 13 September 2022. Accordingly, this sub-charge is found proved.

Charge 6b)

‘That you, a registered nurse, on 13 September 2022 failed to:

b. administer and/or ensure administration of insulin to Patient G at the prescribed time.’

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 and Witness 4.

It was not in dispute from Witness 1 or Witness 4’s evidence, or Miss Sebadduka’s submissions, that it was normal practice for Patient G to administer their own insulin. In live evidence Witness 4 reiterated the importance of continuing autonomy for Patient G self-administering insulin, even while in hospital.

However, noting Miss Sebadduka's duty to patients in her care, the panel concluded that she had a duty to ensure the insulin was administered.

Witness 4's statement describes that she spoke to Patient G at 1400 as a result of a call bell, and immediately after advised Miss Sebadduka that Patient G had requested their insulin. Witness 4 continues that at 1530 she heard Miss Sebadduka ask Patient G what dosage they had taken. The panel accepted this evidence.

The panel took into account the Trust's medication policy and noted that, for the administration of insulin, the policy states:

> *'For patients self-medicating the name of the insulin given, the dose given and the time it was given needs to be confirmed with the patient.'*

The panel has seen evidence that the insulin lunchtime dose was recorded in the Record of Administration of Insulin as administered on 13 September 2022 at 13.59.

Regarding prescribed time, the panel heard evidence from Witness 1 that the prescribed time of 1200 was for the purposes of coinciding with lunchtime, as insulin ought to be administered after a meal, and that this time could be flexible to ensure that the patient had eaten a meal before taking insulin. The panel concluded that flexibility in timing is to be expected. The panel also heard from Witness 1 that insulin being administered a few hours after the prescribed time '*is not an excessive departure'*. The panel therefore concluded there was no evidence to suggest that the administration of insulin to Patient G fell outside the prescribed time.

The panel also had regard to Miss Sebadduka's written response to the regulatory concerns in which she refers to an incident at the end of her shift wherein she completed a handover to night shift staff, advising that she had given a patient insulin for self-administration but that this had not yet happened. The panel did not consider these comments referred to the incident in this charge.

On the evidence before it, the panel was not satisfied that Miss Sebadduka failed in her duty to ensure administration of insulin to Patient G, as Patient G received their insulin within a reasonable timeframe. Accordingly, this charge is found not proved.

Charge 7

> *'That you, a registered nurse, on 13 September 2022 recorded incorrectly within Patient G's records that insulin had been administered at 13.59 when it had not.'*

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 4.

The panel again noted Witness 4's evidence that she spoke to Patient G at 1400 as a result of a call bell, and immediately after advised Miss Sebadduka that Patient G had requested their insulin. Witness 4 continues that at 1530 she heard Miss Sebadduka ask Patient G what dosage they had taken.

The panel also noted that the record of the insulin being given was entered into the system as 13.59. The panel considered it is possible that, had Miss Sebadduka given the insulin to Patient G within minutes of being asked by Witness 4, the margin of error is only a few minutes and that this could be accounted for by a difference between the clocks relied upon by Witness 4 and Miss Sebadduka.

The panel further noted that it has not seen any evidence of the time that Patient G said they took the insulin. In the absence of any compelling evidence of the time the insulin was taken, the panel could not conclude that the time of 13.59 was incorrect. Accordingly, this charge is found not proved.

Charge 8a)

'That you, a registered nurse, on one or more occasions failed to assist colleagues with patient care, in that:

a. in August 2018, you did not assist with washing and changing a patient with dementia, when asked to do so by a colleague.'

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 and Witness 2, who was a health care assistant at the time of the incident.

The panel considered that part of a registered nurse's duty to their patients extends to a duty to assist colleagues with patient care. It also had regard to Witness 1's statement:

'[Miss Sebadduka's] roles and responsibilities include…working with the healthcare assistants as a team.'

The panel took into account the following from Witness 2's near-contemporaneous written complaint about Miss Sebadduka regarding an incident on 7 August 2018:

'I started to wash [the patient] as she had been incontinent and asked [Miss Sebadduka] for help. She told me to ask someone else and that [the patient] could turn herself. She told me to ask someone else and that she could turn herself. She said to me that I speak her language. The other HCAs were also busy washing patients so not able to help.'

The panel also took account Witness 2's statement:

‘Miss Sebadduka and I had an incident in August 2018, whereby I asked Miss Sebadduka for assistance in washing and changing a patient who had dementia. Miss Sebadduka was annoyed that I had asked them to help.’

The panel has seen no evidence that Miss Sebadduka was required to assist with another, more pressing task. Although the panel noted Witness 2’s evidence that Miss Sebadduka eventually did assist her with the patient, she stated that this was after 15-20 minutes and a number of requests. The panel also noted Witness 2’s oral evidence that at the time ‘*Miss Sebadduka was drinking tea and could see me’*.

The panel had regard to Miss Sebadduka’s response to the regulatory concerns:

‘I work cooperatively with colleagues’

The panel was of the view that this was a general statement that did not go to the root of this charge.

The panel preferred the evidence of Witness 1 and Witness 2. In the circumstances the panel determined that Miss Sebadduka ought to have assisted Witness 2 with the patient.

On the evidence before it, the panel was satisfied that Miss Sebadduka failed in her duty to assist colleagues by not helping to wash and change a dementia patient. Accordingly, this charge is found proved.

Charge 8b)

‘That you, a registered nurse, on one or more occasions failed to assist colleagues with patient care, in that:

b. on 15 June 2022, you did not respond to a patient’s call bell and allowed a colleague to do so despite having capacity to respond yourself.’

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Witness 1 and Witness 2, who was a healthcare assistant at the time of the incident.

The panel considered that part of a registered nurse's duty to their patients extends to a duty to assist colleagues with patient care. It also had regard to Witness 1's statement:

> *'[Miss Sebadduka's] roles and responsibilities include…working with the healthcare assistants as a team.'*

The panel took into account Witness 2's incident report dated 19 June 2022. The panel accepted this evidence that Miss Sebadduka was responsible for Bay 1, and that it was her patient's bell that rang:

> *'The bell rang for quite some time but Sophie[sic] did not respond to it. I told her twice to attend to her bay but she just ignored me.'*

The panel also took account Witness 2's statement:

> *'Miss Sebadduka then said they "did not come with the patients". My interpretation of "I did not come with the patients", is that Miss Sebadduka is not responsible for them as they did not come with them or the patients did not come with them.'*

Witness 2 confirmed this in live evidence.

The panel had regard to Miss Sebadduka's response to the regulatory concerns:

> *'I answer patients*[sic] *bells'*

The panel was of the view that this was a general statement that did not go to the root of this charge. It accordingly ascribed little weight to it.

The panel preferred the evidence of Witness 1 and Witness 2, which was clear and compelling.

On the evidence before it, the panel was satisfied that Miss Sebadduka failed in her duty to assist colleagues by not answering a patient's call bell. Accordingly, this charge is found 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 Miss Sebadduka'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, Miss Sebadduka's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Mr Wilson 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.

Mr Wilson identified the specific, relevant standards where Miss Sebadduka's actions amounted to misconduct. Specifically, the following sections of the Code: 1.1, 1.2, 1.4, 2.1, 2.4, 3.1, 6.2, 8.2, 8.4, 8.5, 8.6, 9.2, 11.2, 13.1, 13.2, 13.3, 14.1, 16.1, 16.4, 17.1, 18.1, 18.2, 19.1, 20.3, 20.5, 20.9, and 24.2.

Submissions on impairment

Mr Wilson moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Mr Wilson submitted that there is no evidence of a lack of competence on Miss Sebadduka's part, rather that she showed a failure or unwillingness to do her job.

Mr Wilson submitted that misconduct itself is adequate alone for the panel to make a finding of impairment, but he also reminded the panel that it is entitled to make a finding of impairment if there is a risk to patients. Mr Wilson submitted that patients were put at risk as a consequence of the charges found proved, which included wrong drugs being given, incorrect doses being given, and other failures in patient care. Mr Wilson submitted that these failings created a risk in and of themselves.

Mr Wilson submitted that there is no evidence before the panel of remediation by Miss Sebadduka. He submitted that there is nothing to suggest that Miss Sebadduka has identified the problems and learnt from them such that the panel can be satisfied that she is capable of safe and effective practice.

Mr Wilson submitted that a finding of impairment is needed in order to declare and uphold proper standards of conduct.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgements. These included: *Roylance*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Schodlok v GMC* [2015] EWCA Civ 769, *General Medical Council v Meadow* [2007] QB 462 (Admin), *CHRE v NMC and P Grant* [2011] EWHC 927 (Admin), and *Cohen v General Medical Council [2008] [EWHC] 581 (Admin).* The legal assessor also referred the panel to the NMC's own guidance on misconduct FTP-2a and impairment DMA-1.

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 Miss Sebadduka's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Sebadduka's actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

1.1 *treat people with kindness, respect and compassion*

1.2 *make sure you deliver the fundamentals of care effectively*

1.3 *avoid making assumptions and recognise diversity and individual choice*

1.4 *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.

2. Listen to people and respond to their preferences and concerns

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

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

3.1 *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*

8. Work cooperatively

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*

9. Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

9.2 *gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*

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

11.2 *make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care*

13 Recognise and work within the limits of your competence

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

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

13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1 *act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*

14.2 *explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

18.2 *keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drug*

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

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*

20. Uphold the reputation of your profession at all times

20.3 *be aware at all times of how your behaviour can affect and influence the behaviour of other people*

24 Respond to any complaints made against you professionally

24.2 *use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice'*

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

In relation to charges 1, 2 and 6a, the panel found these charges amounted to misconduct. The panel was of the view that medication administration errors of the kind found proved were extremely serious and well below the standards of an experienced nurse such as Miss Sebadduka. The panel determined that this behaviour contravened the Code, and that Miss Sebadduka's behaviour at each charge amounted to misconduct.

In relation to charge 3, the panel found these sub-charges individually amounted to misconduct. The panel determined that Miss Sebadduka failed to treat Patient C and their family member with kindness and respect, and noted from the live evidence of Witness 3 the impact this had on Patient C's family. The panel determined that this behaviour contravened the Code, and that Miss Sebadduka's behaviour at each sub-charge was serious and amounted to misconduct.

In relation to charge 4, the panel found these sub-charges individually amounted to misconduct. The panel determined that Miss Sebadduka's failure to observe the signs of dehydration in Patient E, that they were lying in excrement, and her failure to escalate their deteriorating condition were extremely serious clinical omissions which fell well below the standards of an experienced nurse such as Miss Sebadduka. The panel determined

that this behaviour contravened the Code, and that Miss Sebadduka's behaviour at each sub-charge amounted to misconduct.

In relation to charge 5, the panel found this charge amounted to misconduct. The panel determined that falling asleep while on shift is a significant departure from the standards expected of a registered nurse. The panel determined that this behaviour contravened the Code, and that Miss Sebadduka's behaviour at this charge was serious and amounted to misconduct.

In relation to charge 8, the panel found these sub-charges individually amounted to misconduct. The panel determined that Miss Sebadduka failed in her duty to provide patient care by not assisting her colleagues attending to patients nor taking a proactive role in their care. The panel determined that this behaviour contravened the Code, and that Miss Sebadduka's behaviour at each sub-charge was serious and amounted to misconduct.

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

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library Guidance on Impairment DMA-1, updated on 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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) 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

…'

The panel finds that patients were put at risk of harm as a result of Miss Sebadduka's misconduct. In particular that she failed to identify and escalate serious clinical signs of deteriorating conditions in patients, administered incorrect medication, failed to administer required medication, and failed to work cooperatively with colleagues. The panel found that Miss Sebadduka's misconduct breached the fundamental tenets of the nursing profession, including failure to provide the fundamentals of care and failure to treat patients and their families with kindness and respect, and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find these charges extremely serious. The panel found that limbs a, b, and c of the test in *Grant* were engaged.

The panel went on to consider the following elements set out in *Cohen:*

- Whether the conduct which led to the charge(s) is easily remediable;
- Whether the conduct has been remedied; and
- Whether the conduct is highly unlikely to be repeated.

The panel considered that the misconduct in this case stemmed from Miss Sebadduka's attitudinal issues and as such it would be difficult to demonstrate that the misconduct had been remedied. Nevertheless, the panel was satisfied that, although difficult, the misconduct in this case may be capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Miss Sebadduka has taken steps to strengthen her practice. It took account that Miss Sebadduka's behaviour in the charges concerned wide-ranging clinical concerns repeated over a significant period of

time, and that there is no evidence before it as to whether she has taken any steps strengthen her practice or develop any insight into her failings.

The panel noted that the concerns with Miss Sebadduka's practice persisted despite being placed on numerous action plans. The panel further noted the most recent information before it regarding Miss Sebadduka's practice is from April 2023 and indicated that there were still complaints about her attitude towards working with other staff members and a lack of urgency when dealing with very unwell patients. The panel considered that these complaints are consistent with the misconduct giving rise to the charges in this case. Therefore, the panel was not satisfied that the matters were highly unlikely to be repeated, pursuant to the guidance in *Cohen*. In fact, the panel was most concerned about the likely risk of repetition in this case. Accordingly, the panel were not satisfied that the misconduct in this case has been addressed.

The panel therefore decided that a finding of impairment is necessary on the ground 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.

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 Miss Sebadduka's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel has seen no evidence that Miss Sebadduka can practise kindly, safely and professionally. The panel was satisfied that Miss Sebadduka'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 Miss Sebadduka off the register. The effect of this order is that the NMC register will show that Miss Sebadduka 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 accepted the advice of the legal assessor.

Submissions on sanction

Mr Wilson informed the panel that in the Notice of Hearing, dated 22 July 2024, the NMC had advised Miss Sebadduka that it would seek the imposition of a 12-month suspension order if it found Miss Sebadduka's fitness to practise currently impaired. Mr Wilson submitted that it was a matter for the panel as to whether the appropriate sanction would be a suspension or a strike-off given the evidence the panel has heard and the decisions it has reached.

Decision and reasons on sanction

Having found Miss Sebadduka'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:

- That Miss Sebadduka has not shown any insight into her failings;

- That the charges depict a pattern of wide-ranging misconduct over a significant period of time despite evidence of interventions from Miss Sebadduka's employer;
- That the patients in the charges had particular vulnerabilities;
- That Miss Sebadduka has consistently deflected blame and responsibility onto others; and
- That Miss Sebadduka's misconduct put patients at risk of suffering harm.

In addition, the panel found a particular aggravating feature of this case was that the vulnerable patients in Miss Sebadduka's care were not able to seek assistance themselves. This specifically related to Patients C, E and H. Miss Sebadduka was aware of this vulnerability at the time of her misconduct.

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 Miss Sebadduka'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 Miss Sebadduka'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 Miss Sebadduka's registration would be a sufficient and appropriate response. The panel is mindful that any

conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems; and*
- *Potential and willingness to respond positively to retraining.*

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. Though the clinical errors identified in this case could be addressed through retraining, the panel has seen no recent evidence of a willingness from Miss Sebadduka to strengthen her practice in this regard. Furthermore, the panel having identified that the misconduct which led to the charges was the result of deep-seated attitudinal issues, and as there is no evidence that these have been addressed, conditions of practice would not be appropriate.

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

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

The panel has therefore found that the misconduct was wide-ranging and over a significant period of time. The panel found there was harmful deep-seated personality and attitudinal problems underlying Miss Sebadduka's behaviour. The panel has not seen any evidence of Miss Sebadduka's insight and concluded that she is at risk of repeating the behaviour. The panel also considered that there is no evidence to suggest that Miss Sebadduka would demonstrate insight and remorse following a period of suspension.

Miss Sebadduka's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Sebadduka's actions is fundamentally incompatible with Miss Sebadduka 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?*

Miss Sebadduka'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 Miss Sebadduka's actions were serious and to allow her to continue practising would fail to protect patients, and undermine public confidence in the profession and in the NMC as a regulatory body.

In making this decision, the panel carefully considered the submissions of Mr Wilson in relation to sanction. The panel considered the live evidence of the witnesses in this case, including the impact that Miss Sebadduka's misconduct had on patients and their family members. The panel also noted the lack of engagement from Miss Sebadduka, her failure to attend this hearing, and that the latest information it has seen from Miss Sebadduka

was from April 2023, and that this did not contain any evidence of insight or that her practice had sufficiently strengthened. The panel was also concerned that while Miss Sebadduka had previously been subject to an interim conditions of practice order, this had changed to an interim suspension order in March 2024 following further concerns from the Trust. The panel was not satisfied of Miss Sebadduka's commitment to nursing.

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 Miss Sebadduka'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 Miss Sebadduka 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 Miss Sebadduka's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Wilson submitted that in light of the striking-off sanction, an interim suspension order for 18 months would be appropriate to allow time for any appeal to be resolved.

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 allow for any appeal to be resolved, not to impose an interim suspension order would be inconsistent with the panel's earlier decision.

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

That concludes this determination.