Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 10 February 2025 – Wednesday, 26 February 2025

Virtual Hearing

Name of Registrant:	**Emelyn Bebet Enad**
NMC PIN:	21A1103O
Part(s) of the register:	Registered Nurse - Sub part 1 Adult nurse, level 1 (29 January 2021)
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Patricia Richardson (Chair, Lay member) Richard Luck (Registrant member) Alison James (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Eyram Anka
Nursing and Midwifery Council:	Represented by Anna Rubbi, Case Presenter
Mrs Enad:	Present and unrepresented (10 February 2025) Not Present and unpresented (11 - 26 February 2025)
Facts proved:	Charges 1a, 1b, 1c, 5a, 5b, 7a, 7b
Facts not proved:	Charges 2, 3, 4a, 4b, 4c, 4d, 4e, 4f, 4g, 4h, 4i, 6a, 6b ,6c
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**

Interim order: **Interim suspension order (18 months)**

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

Ms Rubbi, on behalf of the Nursing and Midwifery Council (NMC), made an application for this hearing to be held partly in private on the basis that proper exploration of your case involves some reference [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You agreed with the application.

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

Having heard that there will be some reference to [PRIVATE], the panel determined to go into private session as and when such matters arise in order to protect your privacy.

Application for a postponement

[PRIVATE].

You tried to inform the NMC last week that you would not be able to attend and participate in this hearing, as your laptop was broken. [PRIVATE].

Ms Rubbi outlined the steps the NMC have taken to try to contact you and secure engagement with this hearing. She told the panel that notice was sent to you on 17 December 2024, and it was her submission that notice was compliant with Rule 11 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). Rule 11 sets out that you can appear and give evidence, you can be represented, but the case can go on in your absence. It also states that adjournment is a possibility.

Ms Rubbi put to the panel that since receiving notice of this hearing, you have not been in contact with NMC until this morning, 10 February 2025. It was her submission that you have not sufficiently explained why you could not have sought postponement prior to your application this morning. [PRIVATE].

Ms Rubbi said that although you expressed that you experienced issues with your laptop, there was no suggestion that you made any other efforts to inform the NMC of the issues or to seek a postponement using other equipment such as a phone or a friend/family member's laptop. It was Ms Rubbi's submission that in these circumstances, a postponement would be prejudicial to the NMC, and it would not be in the interest of justice to grant it.

Ms Rubbi took the panel through the NMC guidance on 'When we postpone or adjourn hearing' (CMT-11) and outlined the various factors the panel should consider, one of them being the potential inconvenience of allowing a postponement. She reminded the panel that there are seven witnesses who have been warned for this case which is due to take place over a period of three weeks. Ms Rubbi said that there would be a significant number of people who would be affected by a postponement, and it would be of real inconvenience to them and the NMC to reschedule them. Further, she submitted that it would be unfair to the witnesses to change the plans at this time when there has not been sufficient explanation as to why it has taken so long for this application to be made. Additionally, she put to the panel that if the witnesses were not able to be rescheduled at the same time, which would adversely impact the NMC's case, potentially calling into question the fairness of such a postponement.

As to the fairness to you in proceeding today, Ms Rubbi submitted that regardless of your application, you have been aware of the issues which have arisen in your case for several years. She told the panel that you have had an interim order in place for two and a half years and you have known about the fitness to practise concerns for a significant period of time, having received the Case Examiners decision in August 2023. In Ms Rubbi's submission, the matters which are at issue today are not novel and you have not had representation in the last three to four years. As such, Ms Rubbi said that you have had ample time to come to terms with the fact that it is for

you to represent yourself or take the steps to obtain representation, although it is noted that you have struggled with this.

Further, Ms Rubbi informed the panel that you have had the relevant documents for this hearing for two months. Her submission was that you have had every opportunity to familiarise yourself with those documents. She further submitted that it is also not clear that your position would improve materially if a postponement were granted. Ms Rubbi told the panel that you have not secured representation in the time in which these matters have been considered, you have not given the panel concrete indication that you would be able to obtain legal representation by a postponement being granted or that the [PRIVATE] would be mitigated by a postponement. Ms Rubbi therefore submitted that in these circumstances, proceeding today would not be unfair you.

Ms Rubbi submitted that there is public interest in the efficient disposal of the case in the allotted time, given that the allegations are almost four years old. [PRIVATE].

The panel put some questions to you based on Ms Rubbi's submissions.

You told the panel that when you return to the Philippines, [PRIVATE]. You said that you anticipate that your legal representation, once secured, will need four to six months to familiarise themselves with your case.

You explained to the panel that although you have been aware of this case since 2023, you were not employed at the time, and [PRIVATE]. You said that your union could not represent you [PRIVATE].

[PRIVATE].

[PRIVATE].

You first contacted the NMC to inform them that you would have difficulty engaging and/or participating in this hearing on Friday, 7 February 2025.

The panel accepted the advice of the legal assessor with reference to the relevant NMC guidance on ‘When we postpone or adjourn hearings’ (CMT-11) and Rule 32 of the Rules.

The panel determined that it is in the public interest to dispose of this case expeditiously. It took the view that it is also in your own interest to proceed, bearing in mind the time that has passed since these allegations were raised and the uncertainty that will persist if the panel was to agree to a postponement. The panel also took into account the inconvenience to the witnesses, considering that there are seven witnesses who have been waiting since 2021 for this matter to be heard and concluded. The panel therefore decided that it would be fair to all parties involved for this hearing to proceed.

[PRIVATE].

The panel had regard to the case history. It considered that, originally this case was scheduled to be heard from 5 July 2024, when it was cancelled due to panel availability. In the panel’s view, you would have been aware at that time that this matter was proceeding to a substantive hearing. You were then asked to provide your date of availability. You responded to your NMC case officer on 29 August 2024 asking for the hearing to be postponed until February 2025. On 6 September 2024, your NMC case officer informed you that the substantive hearing was scheduled for Monday 10 February 2025 to Thursday 27 February 2025.

The panel accepts that you appear to have a number of issues ongoing, [PRIVATE]. However, the panel concluded that you have had sufficient time to consider the paperwork and prepare for this hearing. The panel does not see that there is anything to be gained by postponing this matter to an uncertain date when you hope that you will be ready. For these reasons, the panel refused your application for a postponement.

Prior to hearing the advice of the legal assessor, the panel adjourned until 14:00 to allow Mrs Enad time to [PRIVATE]. She indicated that she would be able to join at the time proposed. However, when the hearing resumed at 14:00 Mrs Enad did not reengage. The panel then heard the advice of the legal assessor and went into

camera to make its decision on the postponement application. During that time, the Hearings Coordinator sent several emails to Mrs Enad, prompting her to join, asking for an update about her circumstances and informing her that the panel was proceeding with the hearing. At the request of the panel, the Hearing Coordinator also advised Mrs Enad that if her circumstances were such that she was unable to engage virtually, it would be prepared to consider any written submissions that she wished to make to support her case. Ms Enad did not respond to any of the emails sent to her. The panel decided to proceed in her absence for the same reasons as set out above.

Details of charge (as amended)

That you, a Registered Nurse:

1. On 31 July 2021 during a night shift:

    a) Fell asleep while feeding Patient A.

    b) Fell asleep while feeding Patient B.

    c) Fell asleep while writing up patient notes.

2. On 2 August 2021:

    a) Failed to adequately communicate with the parents of a patient.

3. On an occasion between 1 and 9 August 2021 failed to communicate with a colleague while carrying out a car seat challenge.

4. On 19 August 2021:

    a) Failed to administer Cobeneldopa to Resident B.

    b) Failed to administer one or more prescribed medication to Resident C on time.

    c) Failed to administer Resident D’s Seretide inhaler in the morning.

    d) Failed to administer a Rivastigmine patch to Resident A.

e) Failed to administer one or more medication prescribed to Resident E in the morning.

f) Administered two Sanatogen tablets to Resident F instead of one.

g) Failed to administer one or more prescribed medication to Resident H in the morning.

h) Failed to administer Resident I's medication in the morning.

i) Failed to administer Apixaban to Resident J in the morning.

5. During a nightshift on 31 August/1 September 2021:

   a) Left Patient C unsupervised in an isolation cubicle.

   b) Did not ask another member of staff to take over observations of Patient C.

6. On 14 September 2021:

   a) Did not know the correct process for a blood transfusion despite receiving training.

   b) Failed to take Patient D's blood sugar level prior to feeding the patient.

   c) Did not escalate to a member of staff your failure to take Patient D's blood sugar level.

7. On 2 February 2022:

   a) Administered the incorrect breast milk to Baby A.

   b) Failed to tell the nurse in charge and/or doctor you had administered the incorrect breast milk.

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

Background

On 5 November 2021, the NMC received a referral from Oak Lodge Care Home, ("the Home") where Mrs Enad worked as an agency nurse. Mrs Enad was employed by Geometric Results International ("the Agency").

On 19 August 2021, Mrs Enad was asked to leave early following a number of concerns and allegations around the failure to administer medications to various patients. It is alleged that Mrs Enad either failed to administer the medication at all, administered the medication at the wrong time or administered incorrect doses.

Mrs Enad had also been working as a Band 5 nurse on the Neonatal Unit at Queen Alexandria Hospital ("the Hospital"), Portsmouth University NHS Trust ("the Trust") between 29 January 2021 and 19 June 2022.

After receiving the referral from the Home in November 2021, the NMC inquired with the Hospital in February 2022 about Mrs Enad's practice. The Hospital reported a number of concerns alleged to have occurred between July 2021 and February 2022, including poor communication with staff members and parents of patients, poor observation skills, a failure to identify deteriorating patients, a failure to escalate concerns, incorrect breastmilk administered to a baby, not correctly reporting and/or escalating the error and falling asleep on shift whilst feeding babies. The Hospital indicated that those concerns were being investigated at a local level, however Mrs Enad resigned on 19 June 2022, before the investigation was completed.

Decision and reasons on application to admit hearsay evidence

Ms 1's email dated 1 September 2024

The panel heard an application made by Ms Rubbi under Rule 31 in relation to an email from Ms 1 to Witness 7 on 1 September 2021. Ms Rubbi informed the panel that Ms 1 was the nurse in charge on 31 August 2021. This email was provided to the NMC by Witness 7 (who is scheduled to give oral evidence) and sets out concerns pertaining directly and entirely to charge 5. Ms Rubbi asked the panel to

adduce this evidence, given that the NMC has not been able to secure Ms 1's attendance at this hearing.

Ms Rubbi referred the panel to three emails from the NMC to Ms 1 dated 8 April 2021, 15 April 2021 and 19 April 2021. Ms Rubbi submitted that the NMC made reasonable efforts to secure her attendance and cooperation when this hearing was due to take place in July 2024. Ms Rubbi told the panel that Ms 1's email address was provided by Professional Standards at the Trust. Unfortunately, Ms 1 did not respond to those emails and did not give any indication or reason as to why she would be reluctant to cooperate with these proceedings.

However, in alignment with the guidance in *Thorneycroft v The Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), Ms Rubbi submitted that it would be correct to admit this evidence as hearsay evidence bearing in mind the principles outlined in this case. It was Ms Rubbi's submission that admitting this evidence does not jeopardise the fairness of the proceedings. The evidence is clearly very relevant to one of the seven charges as it underpins charge 5 entirely. It demonstrates that someone observed Mrs Enad directly leaving the observation cubicle without arranging cover in their absence and it is the best evidence before the panel that confirms that this took place. Ms Rubbi put it to the panel that it is therefore consistent with Rule 31 of the NMC Rules in the sense that it is relevant.

Ms Rubbi expanded, submitting that the email is not anonymous or multiple hearsay, and the recipient of the email (Witness 7) will be giving evidence before the panel and can be questioned as to the sender of the email. Ms Rubbi submitted that the credibility of the email is bolstered by the fact that Witness 7 can attest to its contents and to the sender. Ms Rubbi told the panel that Ms Enad did not challenge the contents of the email locally or in correspondence with the NMC.

Ms Rubbi therefore submitted that even though Ms 1's email would be the primary evidence for this charge as hearsay evidence, it is not especially controversial to admit it, considering that its contents have not been disputed. In her submission, the contents of the email is demonstrably reliable within the meaning of the *Thorneycroft* guidance on hearsay. Ms Rubbi further submitted that any reservations the panel

might have as to reliability can be reflected in the panel choosing to limit the weight it places on evidence, taking into account particular the context in which the evidence comes, including Witness 7's response to the evidence and the broader evidence concerning Mrs Enad's performance in the same time period at the Trust.

Ms Rubbi submitted that if Mrs Enad is not in a position to challenge the evidence, this is due to her own choice to engage to a limited degree with these proceedings, and therefore this should not be a factor which the panel places weight on in considering whether or not to admit the evidence.

Ms 2's email of concerns dated 2 August 2021

Ms Rubbi made another application under Rule 31 to admit Ms 2's email to Witness 7 dated 2 August 2021 into evidence as hearsay evidence. She informed the panel that Ms 2 was a senior charge nurse at the relevant time. Ms Rubbi told the panel that this email confirms the account which Witness 5 will give and has set out in her witness statement with respect to the incident which forms charge 1. Ms Rubbi took the panel through the email which sets out that Mrs Enad had to be supervised by Witness 1.

Ms Rubbi submitted that the fairness of these proceedings would not be adversely affected by admitting this evidence. It was her submission that the email itself was not sole and decisive evidence as it is simply corroborating the contents of other witnesses and providing further context as to events which took place after the fact and underpins charge 1. Ms Rubbi therefore submitted that there is nothing to suggest that this evidence is not demonstrably reliable, and it should be admitted into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

In reaching its decision in relation to Ms Rubbi's hearsay applications, the panel had regard to the principles laid out in *Thorneycroft.* The questions the panel considered are as follows:

1. Whether the statement is the sole and decisive evidence in support of the charges;
2. The nature and extent of the challenge to the contents of the statement;
3. Whether there was any suggestion that the witness had reason to fabricate their allegation;
4. The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;
5. Whether there was a good reason for the non-attendance of the witness;
6. Whether the regulator had taken reasonable steps to secure the witness's attendance; and
7. Whether the registrant did not have prior notice that the witness statement would be read.

Ms 1's email dated 1 September 2024

The panel was satisfied that Ms 1's email is relevant to charge 5. The panel considered fairness and noted that it is the sole and decisive evidence for this charge. The panel found that it is demonstrably reliable evidence because the email was written contemporaneously and sent to a senior nurse the following day.

Although the actual evidence is not capable of being tested, Witness 7 is attending and can be questioned further as to the circumstances in which she received that email. The panel had no reason to believe that Ms 1 or Witness 7 would fabricate the allegation. It considered this allegation to be serious, relating to leaving a patient unsupervised.

In relation to the non-attendance of Ms 1, the panel had sight of the emails that show that prior to the previous hearing date in July 2024, three attempts were made by the NMC to contact Ms 1, without any response. The panel found that in the circumstances, those were reasonable steps taken.

For these reasons, the panel decided that it would be fair and relevant to accept into evidence Ms 1's email dated 1 September 2021 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Ms 2's email of concerns dated 2 August 2021

The panel then considered whether to admit Ms 2's email to Witness 7 into evidence as hearsay evidence. The panel determined that Ms 2's email is relevant to charge 1. The panel noted that this email is not the sole and decisive evidence for charge 1 as it is corroborated by evidence from Witnesses 1 and Witness 5.

The panel took the view that even though it had no information before it as to the attempts the NMC made to secure Ms 2's attendance, it does not mean that it would be unfair to Mrs Enad to admit this email into evidence.

The panel noted that Ms 2's email is a contemporaneous note of a discussion that was had with Mrs Enad and provides further context about actions taken after the alleged incident on 31 July 2021. The panel bore in mind that there are two other witnesses who are attending to give evidence and can be questioned about the contents of this email. The panel therefore decided that it would be fair and relevant to accept into evidence Ms 1's email dated 2 August 2021 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

Ms Rubbi made an application under Rule 28 of the Rules to amend the wording of charge 2.

Mr Rubbi submitted that the proposed amendment is necessary to reflect the evidence with respect to the scope of time in which those alleged communication failures took place. It was her submission that the fairness of the proceedings wouldn't be adversely affected by allowing the proposed amendment. She put to the

panel that the evidence the NMC is relying on is materially the same, which Mrs Enad was given with the notice of hearing on 17 December 2024. Further, she submitted that the substance of the charge is almost identical. Ms Rubbi therefore submitted that there is no injustice in amending the charge because Mrs Enad is fully aware of the allegations and charge 2 is simply being narrowed.

Original charge 2

"That you, a Registered Nurse:

2. On 2 August 2021:

a) Failed to introduce yourself to the parents of patients.

b) Failed to communicate with the parents of patients about the care given."

Proposed amendment to charge 2

"That you, a Registered Nurse:

2. On 2 August 2021:

a) *Failed to adequately communicate with the parents of a patient."*

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

NMC opens case on facts

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

- Witness 1: Band 6 Sister in charge of the Unit in the Hospital, at the relevant time
- Witness 2: Student Nurse at the relevant time (not employed at the Home at the relevant time)
- Witness 3: Band 6 Sister in charge of the Unit in the Hospital
- Witness 4: Mother in the Neonatal Intensive Care Unit at the Hospital
- Witness 5: Band 6 Sister in charge of the Intensive Care Unit in the Hospital

Decision and reasons on application to admit hearsay evidence

Emails from Mr 1 to Ms 3, Ms 4 and Witness 6 from 20 – 23 August 2023

Prior to Witness 6's oral evidence, Ms Rubbi made an application under Rule 31 to admit emails dated 20 August 2023 and 23 August 2023. The emails are from Mr 1 (Interim Regional Director for Bupa Homes) to Ms 4 (Contract & Performance Manager for the Agency), Ms 3 (former Clinical Deputy Manager of the Home) and Witness 6. Ms Rubbi said that in summary they are emails asking the Agency not to assign Mrs Enad to the Home in the future. In the email, there is a statement about medication administration errors which are alleged and in her submission is multiple hearsay. Ms Rubbi therefore made an application to adduce that hearsay in support

of the other evidence that is provided from other witnesses such as Witness 2 and Witness 6.

Ms Rubbi submitted that this hearsay is not the sole and decisive evidence for charge 4 or the sub-charges therein, however, it is relevant evidence to those points and provides contextual evidence. Taking into consideration the principles of Thorneycroft and Rule 31 of the NMC Rules, it was Ms Rubbi's submission that it would be fair to admit this evidence.

Ms Rubbi told the panel that further efforts were not made to secure Mr 1's attendance as the NMC did not deem it necessary, given that his notification with respect to the alleged medication errors was not based on his own direct perception but rather on reports made by other witnesses.

Ms Rubbi further submitted that admitting this evidence would not prejudice Mrs Enad as it is corroborated by other evidence before the panel. Ms Rubbi put to the panel that the hearsay itself does not directly contradict any of Mrs Enad's responses to the allegations. She argued that Mrs Enad is also aware of this evidence as she received it in the notice of hearing when this hearing was originally schedule for July 2024.

Email from Mrs Enad to the Home staff dated 3 September 2021

Ms Rubbi made an application under Rule 31 to admit an email from Mrs Enad to staff at the Home on 3 September 2021. Ms Rubbi stated that from Witness 6's evidence it is apparent that an internal investigation was not conducted following the alleged incidents of 19 August 2021 because Mrs Enad was an agency nurse. However, a Medicines Incident Root Cause Analysis was undertaken and as part of this, Mrs Enad was invited to make a statement, hence the email.

Ms Rubbi submitted that Mrs Enad, in her email, characterises the statement as *'…my explanation to the incident happened in Oak lodge…*'. Ms Rubbi submitted that in Mrs Enad's email, there are a mixture of partial admissions and mitigation, including [PRIVATE]. Ms Rubbi put to the panel that this evidence is demonstrably

reliable as it was written by Mrs Enad herself as an explanation as to the alleged incidents that took place on her shift at the Home. Even if the evidence does include partial admissions, it was Ms Rubbi's submission that it is not the sole and decisive evidence for charge 4, it is simply another form of supporting evidence. It has not been directly challenged and there is nothing to suggest that this evidence is not demonstrably reliable. Therefore, Ms Rubbi submitted that this email should be admitted into evidence.

Medicines Incident Root Cause Analysis Form dated 20 October 2021

Ms Rubbi made an application under Rule 31 to admit the Medicines Incident Root Analysis Form completed on 20 October 2021. She told the panel that this document concerns charge 4 and purports to outline what led to the alleged incidents on 19 August 2021, in the view of the person who completed the form. Ms Rubbi explained that the author of this form, Ms 5 (the Deputy Manager of the Home who took over from Ms 3 shortly after the alleged incident) completed this form two months later. Ms Rubbi said that this form was also completed after Mrs Enad's email to staff at Home, dated 3 September 2021.

Ms Rubbi submitted that this form is multiple hearsay as Ms 5 was not present at the time of the event and the form is an account which was given to Ms 5 via the witness statement of Ms 3 (former Deputy Manager).

Ms Rubbi said that the form contains an analysis of contributory factors, which, in the view of Ms 5, led to the incidents on 19 August taking place. In Ms Rubbi's submission, the evidence is admissible and in accordance with the principles of *Thorneycroft*. She submitted that the evidence is not sole or decisive in respect of charge 4 but can be taken together with the evidence of two live witnesses and multiple exhibited MAR charts. Further, Ms Rubbi asked the panel to consider that this form was part of an analysis carried out by the Home with a view of understanding and establishing lessons to be learnt from the incident which lends to its reliability as an official document. In her submission, bearing in mind the context of the document, the author and its consistency with other information before the

panel, this form is demonstrably reliable, and its admission would be fair and consistent with Rule 31.

Paragraphs 17 – 20 of Witness 6's NMC statement

Ms Rubbi made an application under Rule 31 to admit paragraphs 17 – 20 of Witness 6's NMC statement as those paragraphs relay what was communicated to him by Ms 3 at the time of the alleged incidents on 19 August 2021. Those paragraphs summarise an interaction between Mrs Enad and Ms 3.

Ms Rubbi submitted that the NMC were unable to secure Ms 3's involvement because she had moved abroad. Nevertheless, Ms Rubbi put to the panel that the evidence in the way that it is contained in Witness 6's statement is admissible within what is permissible under Rule 31 and *Thorneycroft*. Ms Rubbi submitted that this is not the sole and decisive evidence with respect to charge 4 and can be taken together with Witness 6's live evidence and the MAR charts. Further, Ms Rubbi told the panel that what Witness 6 put in his witness statement is consistent with what Ms 3 put in her local witness statement at the time, which was then transcribed by Ms 5 into the Medicines Incident Root Cause Analysis Form.

Ms Rubbi submitted that this evidence is entirely corroborated and can be tested to some degree when Witness 6 gives oral evidence. Ms Rubbi said that the evidence is to some degree at odds with Mrs Enad's perception set out in her email responding to the allegations dated 3 September 2021. She argued that Mrs Enad's evidence as to the issue of support in the Home cannot be tested any more than Ms 3's evidence can. Nevertheless, it was Ms Rubbi's submission that these paragraphs are demonstrably reliable, given the context and the MAR charts. She therefore asked the panel to admit these paragraphs into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

Emails from Mr 1 to Ms 3, Ms 4 and Witness 6 from 20 – 23 August 2023

The panel found that the emails are demonstrably reliable and relevant to charge 4. The panel considered the content of the emails and determined that there is no unfairness or prejudice to Mrs Enad in admitting it into evidence. Further, the panel accepts the NMC's submissions as to why they had not made efforts to secure the attendance of this witness. The panel determined that it would be fair to admit these emails into evidence.

Email from Mrs Enad to the Home staff dated 3 September 2021

The panel bore in mind the legal advice and concluded that this email from Mrs Enad does not fall under the hearsay rules as this is a document that the panel is satisfied was sent by Mrs Enad herself. However, the panel determined that it would be fair to admit this email into evidence, particularly because Mrs Enad is not present at this hearing.

Medicines Incident Root Cause Analysis Form dated 20 October 2021

The panel considered that this form may not be the sole and decisive evidence for charge 4 but it was concerned that it cannot be challenged, it is multiple hearsay, and it was completed a couple of months after the alleged incident.

Further, the panel does not know who provided the information to the author of the report and therefore there is limited opportunity to challenge the information within the report. The panel also determined that there are some inconsistencies with other evidence before it. As such, the panel decided that it would not be fair to Mrs Enad to admit this into evidence.

Paragraphs 17 – 20 of Witness 6's NMC statement

The panel was satisfied that this evidence is corroborated by the MAR charts and Mrs Enad's statement, therefore admitting this evidence would not prejudice Mrs Enad. It determined that this evidence is relevant. Further, the panel already

accepted the NMC's explanation as to the non-attendance of Ms 3 (former Deputy Manager of the Home).

In these circumstances, the panel came to the view that it would be fair and relevant to admit paragraphs 17 to 20 of Witness 6's NMC statement. However, it will be given what the panel deems appropriate weight once it has heard and evaluated all the evidence before it.

The panel then heard evidence from a witness called on behalf of the NMC:

- Witness 6: Manager of the Home at the relevant time

Decision and reasons on application to admit hearsay evidence

Paragraph 79 of Witness 7's NMC statement

Prior to Witness 7's oral evidence, Ms Rubbi made an application under Rule 31 to admit paragraph 79 of Witness 7's NMC statement into evidence as hearsay evidence. Ms Rubbi told the panel that this evidence relates to charges 6b and 6c.

Ms Rubbi informed the panel that Witness 7 discussed these allegations with Mrs Enad in a meeting on 14 September 2021 and there is a contemporaneous record of that meeting before the panel. In Ms Rubbi's submission, Witness 7 can speak to the conversation that she had with Mrs Enad at that meeting and give further evidence around the basis of her concerns around Mrs Enad's alleged failure to take Patient D's blood sugar levels and the course of action she took after that.

Ms Rubbi explained that Witness 7 was told about these incidents by a nurse who is alleged to have seen Mrs Enad fail to take Patient D's blood sugar level and then proceed to feed Patient D without escalating the issue. The nurse who witnessed then spoke to Witness 7 and explained what she saw. Witness 7 was then shown a record of Patient D's blood sugar readings, which she confirmed were what she was told. This record is not before the panel and is now unavailable. Ms Rubbi asked the

panel to consider that although the original information may be hearsay, Witness 7 had sight of the record which confirmed that a reading was not taken and then she herself saw Mrs Enad feed Patient D.

Ms Rubbi put it to the panel that it is not prejudicial for the matter to be discussed in evidence, or for those points to be admitted as evidence given that they are not the sole and decisive evidence for charges 6b and 6c. Ms Rubbi submitted that the evidence is demonstrably reliable because it is corroborated by the contemporaneous record of a meeting Witness 7 had with Mrs Enad on 14 September 2021 to discuss these allegations. It was Ms Rubbi's submission that there is no evidence from Mrs Enad to suggest that the matters contained in the record of meeting are untrue or inaccurate.

Paragraphs 68 – 70 of Witness 7's NMC statement and a note dated 14 September 2021 detailing shift feedback Witness 7 received about Mrs Enad

Ms Rubbi made an application under Rule 31 for the above to be admitted as hearsay evidence. Ms Rubbi told the panel that the note dated 14 September 2021 is contemporaneous feedback received by Witness 7 in an email. The sender explained in the email that they saw Mrs Enad carry out a blood transfusion incorrectly.

Witness 7 confirmed that the information in the email was transposed into a word document record that Witness 7 would keep for each of her supervisees. Ms Rubbi informed the panel that Witness 7 does not have the original email and does not recall who told her about the issue. Witness 7 clarified that the email came on 14 September 2021, however it came after the meeting she had with Mrs Enad on the same date, consequently it was not put before Mrs Enad at the time.

Ms Rubbi submitted that the panel will appreciate that this is the sole and decisive evidence in respect of charge 6a. It was her submission that the panel should nevertheless admit it as it is in line with the requirements of Rule 31, in that it is relevant evidence to the charge and is fair, in accordance with *Thorneycroft*. In Ms Rubbi's submission, this evidence is demonstrably reliable. It was transcribed by Witness 7 and kept contemporaneously. Ms Rubbi reminded the panel that Mrs

Enad has had these exhibits for at least seven months and chose not to challenge it. Further, Ms Rubbi submitted that there is no indication that there would be any reason for Witness 7 to fabricate this evidence.

For these reasons, Ms Rubbi submitted that this evidence should be admitted.

Datix entry report dated 3 February 2022 about alleged incident on 2 February 2022

Ms Rubbi made an application under Rule 31 for the above to be admitted as hearsay evidence. Ms Rubbi told the panel that she was informed by Witness 7 that the name of the person that created this report, Ms 6, is written in the 'other contacts' section of the report. Ms Rubbi said that Ms 6 is also the name which appears in Witness 3's evidence as the person who directly witnessed the incorrect feed at charge 7 and is the one who confronted Mrs Enad initially.

Ms Rubbi explained that the Datix entry does not explicitly attribute the incident to Mrs Enad in the sense that she is not named specifically in the 'event details' section but under the heading 'employees' her name appears. Ms Rubbi told the panel that Witness 7 will give evidence as to that attribution and the fact that where employees are listed on a Datix report, it means that they were involved or responsible.

Ms Rubbi submitted that the NMC seeks to adduce this evidence in support of its case that with respect to charge 7, it was Mrs Enad who was responsible for the incorrect administration of the breastmilk to Baby A. It was her submission that this evidence is relevant, and it would be fair to adduce it. She stated that the entry itself comes from a person who will not be giving evidence in these proceedings, however it is apparent from the Datix report that it is written in a way that there is no attempt to criticise Mrs Enad. Ms Rubbi's submission was that this entry is entirely neutral and factual as to what allegedly took place. Although the evidence is multiple hearsay, she submitted that it is an account which is almost entirely consistent with evidence given by other witnesses but for small inconsistencies. She put to the panel that those inconsistencies would not prejudice Mrs Enad.

Ms Rubbi further submitted that this is not the sole and decisive evidence in respect of charge 7 because the panel have already heard from Witness 3, who gave detailed evidence about the incident and the fact that she saw the incorrect bottle which was administered. Ms Rubbi submitted that Mrs Enad has not challenged the contents of the Datix report despite being in possession of these exhibits for almost seven months. As such, it is reliable and relevant evidence and it is fair that it should be admitted.

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.

Paragraph 79 of Witness 7's NMC statement

The panel found that whilst there is mention of a discussion Mrs Enad had with Witness 7 in the record of meeting dated 14 September 2021, the record of discussion is rather vague as to Mrs Enad's acknowledgment of the allegations which form charges 6b and 6c. Therefore, the evidence provided by Witness 7 is in fact sole and decisive. Additionally, the panel determined that the person who is alleged to have given Witness 7 this information has not been identified therefore there is no opportunity to question them.

Further, the panel noted that the charge relates to Patient D but paragraph 79 of Witness 7's NMC statement merely refers to 'patients', making no reference specifically to patient D. As such, the panel took the view that this evidence is not demonstrably reliable in relation to charges 6b and 6c. The panel therefore decided that it should not be admitted into evidence.

Paragraphs 68 – 70 of Witness 7's NMC statement and a note dated 14 September 2021 detailing shift feedback Witness 7 received about Mrs Enad

The panel determined that the evidence is relevant to charge 6a. On the matter of fairness, the panel decided that it would not be fair to Mrs Enad to admit this evidence because it is the sole and decisive evidence for this charge. The panel considered that the statement made by Witness 7 contains a lot of detail but was dated 18 months after the alleged incident. The panel noted that the note dated 14 September 2021, which preceded the NMC statement, was far less detailed.

It was of concern to the panel that Witness 7 indicated that she could not find the original email that was sent and does not recall who provided her with the information she transposed into the note exhibited. The panel therefore questioned the reliability of the information.

The panel has no opportunity to question the person who brought the information to Witness 7. The panel was unaware of any steps that were taken to secure this person.

In all circumstances, the panel concluded this evidence relates to a very serious matter and therefore it would not be fair to admit it into evidence.

Datix entry report dated 3 February 2022 about alleged incident on 2 February 2022

The panel was satisfied that the Datix entry report is relevant, fair and clearly goes to charge 7. It took the view that this is an official document on a recognisable database which increases its reliability. The panel found that it is not the sole and decisive evidence to support the charge because it is consistent with Witness 3's oral evidence.

The panel acknowledged that this is multiple hearsay but determined that it is corroborative and consistent with the evidence it heard from Witness 3. In the circumstances, the panel found that there is no unfairness to Mrs Enad who is aware of the evidence and has had the opportunity to comment on or challenge it since she received these exhibits last year, when this hearing was originally scheduled to take place.

The panel then heard evidence from the last witness called on behalf of the NMC:

- Witness 7: Senior Sister and Team Leader at the Hospital

Decision and reasons on facts

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

The panel was asked to draw adverse inferences from Mrs Enad's failure to continue to engage in this hearing. The panel considered their engagement with Mrs Enad on the first day of the proceedings when it became apparent that at the time of that engagement, [PRIVATE].

Mrs Enad informed the panel that for several years she had been unable to work. Whilst she was aware of these proceedings, [PRIVATE]. The panel is aware that the notice of hearing refers to the fact that adverse inference could be drawn in circumstances where there is no engagement. However, the panel is satisfied that whilst Mrs Enad, an unrepresented registrant, had been served with the notice of hearing she may not have been aware of the reference within the documentation as to the consequences of an adverse inference being drawn by her non-engagement in the hearing. The panel noted in particular her current circumstances and was satisfied that there is a reasonable explanation for her limited engagement at this hearing. In the circumstances, the panel concluded that it would be unfair to draw an adverse inference.

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.

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 before it.

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

Charge 1a

"That you, a Registered Nurse:

1. On 31 July 2021 during a night shift:

    a) Fell asleep while feeding Patient A."

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's NMC statement dated 4 May 2023, Witness 5's oral evidence and Witness 7's hearsay evidence (an email she received from Ms 2 on 2 August 2021).

The panel found that Witness 5's evidence was clear as to what she herself observed. Witness 5 described loud alarms sounding in the room they were in and stated that Mrs Enad *"did not move an inch*". The panel also heard from Witness 5 that she had to call Mrs Enad twice before she awoke.

The panel had regard to Mrs Enad's response to Ms 2 when they spoke about the incident a couple of days later. In Ms 2's email to Witness 7 dated 2 August 2021, she stated that Mrs Enad told her that she was [PRIVATE].

The panel is therefore satisfied on the balance of probabilities, that you fell asleep while feeding Patient A. In light of the above, the panel found charge 1a proved.

Charge 1b

“That you, a Registered Nurse:

1. On 31 July 2021 during a night shift:

    b) Fell asleep while feeding Patient B.”

This charge is found proved.

In reaching this decision, the panel had regard to the evidence before it, including Witness 5’s NMC statement dated 4 May 2023, Witness 5’s oral evidence, Witness 7’s hearsay evidence (an email she received from Ms 2 on 2 August 2021) and a record of a meeting between Mrs Enad and Witness 7 dated 3 August 2021.

The panel noted that Witness 5 described the incident in her oral evidence stating that she observed Mrs Enad with *“her eyes closed”,* standing next to the cot with a syringe in her hand. Witness 5, when asked what her actions were following her observation, she said words to the effect of *“I called her and took the care from her and told her that you need to a have a break and a coffee”.* The panel determined that Witness 5’s evidence was clear, consistent and supported by Ms 2’s email to Witness 7.

For these reasons, the panel found charge 1b proved on the balance of probabilities.

Charge 1c

“That you, a Registered Nurse:

1. On 31 July 2021 during a night shift:

    c) Fell asleep while writing up patient notes.”

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it, including Witness 5's NMC statement dated 4 May 2023 and Witness 5's oral evidence.

The panel had regard to Witness 5's oral evidence during which she stated that she observed Mrs Enad writing up patient notes but noticed that she was not moving. Witness 5 explained that she went over to Mrs Enad and saw that she was asleep. According to Witness 5, she had to call and tap Mrs Enad before she woke up, after which Mrs Enad responded with words to the effect of *"Oh I slept".* The panel accepted Witness 5's account which was clear and consistent.

The panel therefore determined that on the balance of probabilities, you fell asleep while writing up patient notes. As such, it found charge 1c proved.

Charge 2

"That you, a Registered Nurse:

On 2 August 2021:

Failed to adequately communicate with the parents of a patient."

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's NMC statement dated 4 April 2023, Witness 1's oral evidence, a record of meeting between Mrs Enad and Witness 7 dated 9 August 2021.

The panel first considered whether Mrs Enad has a duty to communicate with the parents of a patient. The panel have not been provided with any written documentation which explicitly outlines this duty.

In oral evidence, the panel heard from Witnesses 1 and 7 that communication is a requirement continuously learnt at the Trust and updated yearly. However, neither witness could provide information as to any training in relation to communication that

Mrs Enad had undertaken whilst she was employed by the Trust. Nevertheless, the panel found that there is an inherent duty in nursing to communicate with patients as to the care being given and where the patient is a baby, the panel was of the view that the duty must therefore be to communicate with the parent/family.

In her oral evidence, Witness 1 told the panel that when the parent (father) entered, within what appears to have been a short time, she felt uncomfortable that there had been no formal introduction and therefore she introduced both herself and Mrs Enad. Witness 1 further stated that she provided an update as to the status of the patient and that the father did not stay long.

In the circumstances, the panel is not satisfied that there was a breach of duty on Mrs Enad's part as it appears from Witness 1's evidence that she had in fact taken the lead and provided the necessary information to the parent resulting in further communication from Mrs Enad being unnecessary. As such, the panel found charge 2 not proved.

Charge 3

> "That you, a Registered Nurse:
>
> On an occasion between 1 and 9 August 2021 failed to communicate with a colleague while carrying out a car seat challenge."

This charge is found NOT proved.

The panel had regard to the evidence before it, particularly Witness 4's NMC statement dated 20 December 2024, Witness 4's oral evidence, Witness 7's NMC statement dated 30 March 2023 and a record of meeting between Witness 7 and 'Mother A' (Witness 4) dated 8 August 2021.

In her oral evidence Witness 4 told the panel that she believes there may have been some conversation between Mrs Enad and her colleague. In Witness 4's NMC statement, she states that,

‘[PRIVATE]’.

Additionally, in oral evidence Witness 4 described the interaction between Mrs Enad and her colleague with words to the effect of *“Mrs Enad was using a couple of hand actions”,* and *“there wasn’t much conversation between them”* and *“there must have been some conversation between them, it didn’t last very long but the nurse walked out of the room”.* She went on to state words to the effect of, *“there was some conversation between them, but I could not hear what the registrant responded… I was sitting down feeding the baby”.* The panel had not been provided with any supporting evidence from the colleague working with Mrs Enad on that day.

The panel was satisfied, on the basis of Witness 4’s oral evidence, as a direct witness, that there was some form of communication between Mrs Enad and her colleague. As such, the panel found charge 3 not proved.

Charge 4

Whilst the panel determined each of these charges separately, it considered them together as they arise from the same set of facts.

The panel was satisfied that as a nurse Mrs Enad had a duty to administer medication. It had sight of the Home’s Medication Management Policy and heard oral evidence from Witness 2 and Witness 6 that speaks to that.

In reaching its decision, the panel first considered whether Mrs Enad had a duty to administer medication to the residents identified in these charges. Whilst the panel accept that Mrs Enad had responsibility for residents on the top and ground floor of the Home, the panel has not been provided with any direct evidence from the NMC as to the details of the residents being cared for on those floors.

The panel considered that in Witness 6’s NMC statement dated 21 April 2023, he states,

'On the same date, Resident B had been admitted to one of the floors which Ms Enad was covering that day. Resident B had [PRIVATE], *so [Ms 3] went to speak to Ms Enad to ascertain whether Resident B's medication had been prepared… I do not know whether Ms Enad answered the question… as I was not present during this conversation. [Ms 3] relayed the conversation to me,'*

As this is hearsay evidence, the panel had to decide what weight to give it, if any. It noted that this evidence was not tested in cross examination. The panel therefore considered the documentary evidence available, in the form of MAR charts. It determined that the MAR charts before it do not provide any details as to the location i.e. floor or room number of the residents or who's care they were under. Whilst Witness 6 acknowledged in his oral evidence that there would have been records detailing which residents were allocated to which floors, he was unable to produce said records. As such, in the absence of any other supporting evidence, the panel found that it could attach little weight to Witness 6's hearsay evidence.

The panel had regard to Mrs Enad's statement to the Home dated 3 September 2021, in which she accepts that she was responsible for residents on the top and ground floors of the Home. The panel noted that there is no indication within the statement that Mrs Enad was informed of or acknowledged that she was responsible for the residents identified in charge 4. The panel did not have the benefit of corroborative or supportive evidence such as room allocations, floor allocations, a staff rota, handover notes or the allocation of other staff in the Home. In these circumstances, there is insufficient evidence for the panel to draw inferences as to where these residents were located in the Home on the day of the incidents.

Accordingly, the panel could not be satisfied that the residents identified in the charges were under the care of Mrs Enad and therefore she had a duty towards them.

Charges 4a, 4b, 4c, 4d, 4e, 4f, 4g, 4h and 4i

"That you, a Registered Nurse:

4. On 19 August 2021:

    a) Failed to administer Cobeneldopa to Resident B.
    b) Failed to administer one or more prescribed medication to Resident C on time
    c) Failed to administer Resident D's Seretide inhaler in the morning.
    d) Failed to administer a Rivastigmine patch to Resident A.
    e) Failed to administer one or more medication prescribed to Resident E in the morning.
    f) Administered two Sanatogen tablets to Resident F instead of one.
    g) Failed to administer one or more prescribed medication to Resident H in the morning
    h) Failed to administer Resident I's medication in the morning.
    i) Failed to administer Apixaban to Resident J in the morning."

These charges are found NOT proved.

In light of the above, the panel did not go on to consider these charges further. Accordingly, it found charge 4 not proved in its entirety.

Charges 5a and 5b

"That you, a Registered Nurse:

5. During a nightshift on 31 August/1 September 2021:

    a) Left Patient C unsupervised in an isolation cubicle.
    b) Did not ask another member of staff to take over observations of Patient C."

These charges are found proved.

Whilst the panel determined each of these charges separately, it considered them together as they arise from the same set of facts.

In reaching this decision, the panel took into account Witness 7's NMC statement dated 30 March 2023, Witness 7's oral evidence and an email of concerns from Ms 1 to Witness 7 dated 1 September 2021 (provided by Witness 7).

In particular, the panel had regard to Ms 1's email, which is as follows:

> *'I just wanted to email you regarding some concerns with Emelyn Enad. I was NIC of 31/08/21 night shift and Emelyn was working in the isolation cubicle. As I was coming out of HDU, I saw Emelyn walking out of the cublicle*(sic) *and down the corridor. [Ms 7] (retrieval nurse) was sat at the nurses station at the time. I asked [Ms 7] if Emelyn asked her to cover the cubicle whilst she was out of the room, [Ms 7] said no and didn't see her go. I went in the cubicle and the baby's red alarm was going off. When Emelyn returned (after approx. 10 minutes) I asked her if she had asked anyone to cover her whilst she was out, she said "no, I forgot". I explained to her that it was unsafe to leave the cubicle unattended and she is accountable for that baby. I informed her that if she needs to leave for any reason then to ask someone to cover her. For the rest of the night she did ask for cover whenever she needed to leave the cubicle.'*

Although Ms 1's email is hearsay evidence, the panel considered that it was from a colleague who directly witnessed the incident and addressed it with Mrs Enad at the time it happened. It was of note to the panel that Ms 1 made Witness 7 aware of her concerns the next morning at 07:04. Bearing in mind the contemporaneous nature of this evidence, made at what appears to be the end of the same shift, by a senior nurse who was responsible for the management of Mrs Enad on the shift, the panel is satisfied as to the reliability of the evidence.

Further, the panel was satisfied as to the credibility of the oral evidence of Witness 7, who was the senior nurse on duty. Therefore, despite this being hearsay evidence, the panel found that it carried sufficient weight to conclude that on the balance of probabilities this incident did occur in the manner described in Ms 1's email.

Accordingly, the panel found charges 5a and 5b proved.

Charges 6a, 6b and 6c

"That you, a Registered Nurse:

6. On 14 September 2021:

    a) Did not know the correct process for a blood transfusion despite receiving training.
    b) Failed to take Patient D's blood sugar level prior to feeding the patient.
    c) Did not escalate to a member of staff your failure to take Patient D's blood sugar level."

These charges are found NOT proved.

The panel decided prior to its consideration of the facts that the sole and decisive evidence for this charge, which was hearsay evidence provided by Witness 7, was inadmissible. The NMC did not provide the panel with any further evidence. As such, the panel found charges 6a, 6b and 6c not proved.

Charge 7a

"That you, a Registered Nurse:

7. On 2 February 2022:

    a) Administered the incorrect breast milk to Baby A."

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's NMC statement dated 25 April 2023, Witness 3's oral evidence, Datix entry completed 3 February 2022, email from Witness 3 to Witness 7 regarding Datix entry dated 3 February 2022, Witness 7's NMC statement dated 30 March 2023, and the Trust's Management of Breast Milk Policy.

The panel had regard to the Management of Breast Milk Policy which outlines the main responsibilities of each team involved in the care of a baby to avoid error. The policy states that the infant feeding team and nursing management team, which Mrs Enad was a part of, must manage and implement the standard operating procedures for the management of mothers expressed breastmilk (MBM). The panel took into account reference within the policy under the heading 'Delivery of MBM to Baby', *'Healthcare professional to check name band matches the labelled milk bottle'* and further that 'Healthcare professional/Nurse', *'To make sure baby has right milk'*. The panel noted the content of the Datix, completed by the nurse in charge of the High Dependency Unit (HDU), to whom the incident was first reported, that *'father was bottle feeding baby and noticed that the incorrect name was on the label. Nurse caring for baby had got the milk out of the fridge'*.

The was a discrepancy with the evidence of Witness 3 who states that Mrs Enad was feeding the baby when the concern was raised. Nevertheless, the panel determined that Mrs Enad had responsibility for retrieving the bottle from the fridge and whether she fed the baby herself or handed the bottle to the father, she had been responsible for the administration of the milk to the baby. The panel noted the evidence of Witness 7, who in her oral evidence stated that words to the effect of *"on NICU breastmilk is treated as serious as a drug… it is a bodily fluid".*

The panel considered the direct evidence of Witness 3 who was shown the bottle that had been used to feed Baby A by Ms 6. Witness 3 gave evidence that the bottle had the name of another patient on the label. The panel noted the response Mrs

Enad gave when this was put to her by Witness 3. In her NMC statement Witness 3 stated that,

> *'Ms Enad's response when asked about the incident was that the milk was in the wrong tray inside the fridge…'*

Witness 3 reiterated this during her oral evidence.

The panel is satisfied, having heard the oral evidence of Witnesses 3 and 7 and having considered the Trust's Management of Breast Milk Policy, that it was Mrs Enad's responsibility to check the name of the patient on the bottle before administering the breastmilk. As such, the panel found charge 7a proved.

Charge 7b

"That you, a Registered Nurse:

7. On 2 February 2022:

    b) Failed to tell the nurse in charge and/or doctor you had administered the incorrect breast milk."

This charge is found proved.

The panel had regard to the Trust's Management of Breast Milk Policy. The policy makes it clear that in the event where incorrect breastmilk is administered, nurses or healthcare professionals must notify the nurse in charge and the doctor and inform the parents of the error in administration of milk with the nurse in charge. The panel was therefore satisfied that Mrs Enad had a duty to tell the nurse in charge and/or doctor that she had administered the incorrect breastmilk.

In reaching a decision as to whether Mrs Enad failed in her duty the panel considered that in Witness 3's NMC statement dated 25 April 2023, she said,

'…Upon realising the mistake, Ms Enad did not speak to me as she should have done to notify me of the incident, instead it was [Ms 6] who made me aware of the incident.
… I went to find Ms Enad and took her into a separate room to speak about the incident.'

The panel determined that Witness 3's oral evidence was consistent with her statement. The panel bore in mind that Witness 3 was the nurse in charge of the shift, and it is clear to the panel from the evidence before it that Mrs Enad was not the one that informed Witness 3 about the incident.

As to whether Mrs Enad was aware of the policy at the time, Witness 3 states in her NMC statement that,

'Ms Enad would have known what the correct course of action should have been as she would have undergone training regarding the management of breastmilk and the correct procedure to follow if it was incorrectly handled. This policy would be an accessible document to Ms Enad if she wished to check her understanding, alternatively she could have also asked another member of staff.'

Witness 3 also reiterated this to the panel during her oral evidence. The panel determined that her evidence is clear and consistent.

For these reasons, the panel found charge 7b 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 Mrs Enad'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, Mrs Enad'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.'*

Ms Rubbi invited the panel to take the view that the facts found proved amount to misconduct. She referred to *Roylance*, *Nandi v GMC* [2004] EWHC 2317 and the NMC guidance on 'Misconduct' (FTP-2a).

Ms Rubbi provided the following written submissions on Misconduct:

> *'16. It is submitted that the proven facts amount to misconduct. The conduct – indeed, omissions – amounts to serious breaches of provisions of the Code.*
>
> ***(1) The Code***
>
> *17. The proven facts amount to serious breaches of various aspects of the Code.*

*18. **Section 1.2** "make sure you deliver the fundamentals of care effectively" was breached by her conduct on multiple occasions. The Panel heard evidence that the Registrant fell asleep while feeding two different babies and while writing noted, missing alarms as she slept. Ms Enad was found to have left a premature baby suffering from infection unsupervised for a period of ten minutes, and also to have administered the wrong breastmilk to a baby, and failed to escalate the same. It is submitted that her conduct therefore fell seriously short of what is required by section 1.2 of the Code.*

*19. **Section 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" was not met. In the Registrant holding and feeding baby patients – repeatedly – when she was unfit to do so due to being tired the Registrant failed to promote wellbeing or prevent ill health: Charge 1. The Registrant's failures placed two vulnerable patients in grave danger of being dropped and choking – as confirmed by [Witness 5] and [Witness 7], and amount to misconduct for that reason: Charge 1. The risks of information being incorrectly recorded or forgotten in patients' notes was also plain: Charge 1. As above, leaving a premature baby unattended also demonstrates that special attention was not paid: Charge 5.*

20. Similarly, mis-administering breastmilk (Charge 7) also shows a failure to "pay special attention to promoting wellbeing", and the Registrant's conduct therefore fell seriously short of what is required by section 3.1 of the Code.

*21. **Section 8.2** "maintain effective communication with colleagues". In failing to escalate matters appropriately (Charge 7) and failing to seek support (Charge 5) in two serious situations, the Registrant's performance fell well short of what was expected of her by the Code.*

*22. With respect to the Registrant's approach to the concerns which surfaced from 31 July 2021 onwards, the Registrant did not adequately address the issues raised as is required by **Section 9.2** of the Code which*

requires nurses to "gather and reflect on feedback from a variety of sources, using it to improve your practice and performance".

23. ***Section 13*** *is also at issue.* ***Section 13.2*** *requires nurses to "make a timely referral to another practitioner when any action, care or treatment is required",* ***Section 13.3*** *requires nurses to "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", and* ***Section 13.4*** *requires a nurse to "take account of your own personal safety as well as the safety of people in your care". Plainly at various points reflected in, specifically, Charges 1, 5, and 7, the Registrant failed to escalate issues which had arisen with her practice and which could have been alleviated by the assistance of colleagues. This is particularly serious with respect to Charge 1 (where she continued to work despite being tired); Charge 5 (where she did not get a nurse to relieve her from her supervision of the isolation booth) and Charge 7 (where she failed to escalate the administration of incorrect breastmilk per the relevant protocol). With respect to Charge 1, this also engages* ***Section 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".*

24. In the same vein, ***Section 14.1*** *and* ***Section 14.2*** *have been breached, particularly in respect of Charges 5 and 7. They respectively require a nurse to "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", and "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".*

(2) Serious breaches amounting to misconduct

25. The cumulative effect of this conduct, over a short period of time beginning many months after the Registrant's initial registration as a nurse in the UK, and even longer after her practice as a nurse outside the UK (according to [Witness 7]), amounts to serious breaches of each of the

above sections of the Code. In respect of each Charge, the Registrant was dealing with especially vulnerable individuals – patients with decreased capacity (suffering from diseases such as dementia and Parkinson's) and prematurely-born babies. The fact that the Registrant did not make evidenced efforts to improve her practice and appeared not take the concerns arising from each incident seriously – for example, [Witness 5] gave evidence that she spoke to the Registrant and asked her to take a break, but she appeared to find the concern funny, laughing at [Witness 5] – demonstrates the severity of the misconduct and the Registrant's poor attitude to the same

26. There is limited mitigation [PRIVATE]*. However, it is submitted that these parts of the evidence cannot sufficiently undermine the fact of misconduct, in light of the fact that the Registrant's practice continued to deteriorate after 31 July 2021 and she did not appear to take sufficient steps to address her poor performance.*

(3) Conclusion

27. For the reasons outlined above, it is submitted that the Charges proven, namely Charges 1, 5 and 7 amount to misconduct, her conduct having fallen far below what was expected of her and being correctly characterised as deplorable.'

Submissions on impairment

Ms Rubbi 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2), Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Grant* [2011] EWHC 927 (Admin). Further, Ms Rubbi took the panel through NMC guidance on 'Impairment' (DMA-1).

Ms Rubbi provided the following written submissions on impairment:

'28. It is submitted that the Registrant's fitness to practice is currently impaired by reason of misconduct.

29. With respect to para. 76(a), (b) and (c) of Grant, it submitted that the Panel can be satisfied that the Registrant's fitness to practice is impaired. This is submitted on the basis of the individual proven Charges but also the proven Charges taken together.

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";

30. As outlined above, the Registrant acted in such a way on numerous occasions in a short span of time. Her conduct in Charges 1, 5 and 7 particularly placed patients at unwarranted risk of harm. Regarding Charge 1, she put two patients – and the person with respect to whom she was writing notes – at unwarranted risk of harm by nursing when she could not stay awake, risking the patients falling or choking. The Charge comprised not a one-off incident, but multiple incidents on one shift. The Registrant's attitude was to laugh at the concerns, and then, only after being spoken to by her line manager – who also remarked that she did not take the issue seriously –, did she pledge to take steps to address her tiredness and low mood. We have no evidence on what steps were actually taken.

31. As to Charge 5, plainly the Registrant placed Patient C at unwarranted risk by leaving them unsupervised in an isolation booth. There was no justification in leaving the patient unsupervised; per [Ms 1]'s report [HR/07], the Registrant simply "forgot' – the result of which was a Red Alarm sounding unanswered in the booth. Charge 7 raises a similar problem, the lack of attention meant that Baby A was fed another mother's breast milk, placing them at (unwarranted) risk of infection.

32. *The fact that harm does not appear to have taken place (or was not recorded) does not necessarily mean that the unwarranted risk was not there. If the risk exists, then it is the placement of a patient at risk that must be considered, not just whether the risk manifested in harm on that occasion.*

33. *Similarly, it is submitted that even though there was a gap between Charge 5 and Charge 7 taking place when there does not appear to have been incidents, from Charge 7 (February 2022) to when the Registrant left her employment (without all her competencies completed, per [Witness 7]'s evidence) there was insufficient evidence of remediated or improved practice to assuage concerns.*

34. *More generally, given the lack of insight, remorse or remediation into any of these incidents* – [PRIVATE] – *there is every reason to believe that a concern for repetition is well-founded.*

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

35. *As outlined above, the Registrant acted in such a way on numerous occasions in a short span of time. Her conduct in Charges 1, 5 and 7 brought the profession into disrepute.*

36. *Regarding Charge 1, the Registrant working in a state of tiredness that she would fall asleep and risk the safety of her patients without seeking help – multiple times – is so serious as to bring the medical profession into disrepute. Again, no reflection has been provided by the Registrant to suggest that she understood the gravity of the of her conduct, the severity of the breaches of the Code, or the risks associated with her practice.*

37. *As to Charges 5 and 7, it is clear that a well-informed member of the public would be concerned to learn of the Registrant's mis-administration of breastmilk to the wrong patient, and of her leaving a premature baby with an infection unattended. In each case, the Registrant's attitude adds*

to the concern and casts a negative light on the reputation of the profession.

38. *Charge 1 was the first in a string of poor performance incidents which the NMC says amounts to misconduct – which demonstrate that this was not a wake-up call following which her conduct improved. The Registrant demonstrated no insight or remediation, and therefore there are serious concerns around repetition and the impact this would have on the profession's reputation.*

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

39. *Her conduct in Charges 1, 5 and 7 was a breach of fundamental tenets of the profession. It is clear that issues such as patient safety, proper escalation, familiarity with procedure and communication are of paramount significance to the profession, particularly given how prominent they are throughout the Code. The Registrant's performance shows a consistent deficiency in each area, as seen through her lack of appreciation for the seriousness of falling asleep while feeding a baby (discussed by [Witness 5] and [Witness 7]), and her failure to seek support when leaving a baby unattended, and not following proper procedure in respect of a serious incident, namely the incorrect administration of breastmilk (confirmed by [Witness 7 and [Witness 3]).*

40. *For the same reasons, it is submitted that the Registrant's fitness to practice is impaired by reference to the public interest, which has been undermined and continues to be undermined by reason of her misconduct as per the Charges.*

(1) Conclusion

41. *It was clear from [Witness 7]'s evidence on the training received by new starters as well as [Witness 5]'s evidence on what the Registrant should have done, that the Registrant knew full well that she should not have*

cared for patients and or carried out administrative duties in that state. Yet her performance clearly fell drastically short of what was required of her.

42. *Considering, the NMC's guidance FTP-3b entitled "Serious concerns which result in harm if not put right", it is submitted that the following applies precisely to this case:*

    The evidence shows that the nurse, midwife or nursing associate has failed to:

    - *recognise and work within the limits of competence, accurately assess signs of normal or worsening physical or mental health, or make timely and appropriate referrals where needed.*

    - *be open and candid with people in their care, or act immediately to put right, explain and apologise when any mistakes or harm have taken place.*

43. *There is nothing to suggest that the risks posed by the Registrant's unrestricted practice are "easily remediable" (see Cohen); those risks stem, it is submitted, from a lack of understanding and appreciation for the gravity of nursing when one is unfit to do so.*

44 *It is submitted, therefore that a finding of impairment is necessary on the grounds of public protection and it is in the public interest, as, per [74] of Grant, the Registrant's practice "continues to present a risk to members of the public" and 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."*

CONCLUSION

45. *For the reasons outlined above, it is submitted that the Registrant's conduct as proved under Charges 1, 5 and 7 amounts to misconduct and is the basis upon which her fitness to practice is currently impaired.'*

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), and *General Medical Council v Meadow* [2007] QB 462 (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 had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision. The panel was of the view that Mrs Enad's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Enad's actions amounted to a breach of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 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.'

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

To achieve this, you must:

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 co-operatively***

To achieve this, you must:

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

8.6 share information to identify and reduce risk.'

*'**13 Recognise and work within the limits of your competence***

To achieve this, you must:

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

13.4 take account of your own personal safety as well as the safety of the people in your care.'

*'**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***

To achieve this, you must:

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

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly'

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

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges found proved are serious.

During Witness 5's oral evidence, the panel heard information about the potential for harm and the risk of aspiration or infection to the babies. Given that Mrs Enad was

responsible for the care of vulnerable babies in the NICU, it was the panel's view that she posed a risk to the safety of vulnerable babies by falling asleep on three occasions while feeding them and writing their notes. The panel considered that there was no evidence to suggest that Mrs Enad identified the risk and requested a break to ensure that she was fit for her duties. The panel took the view that Mrs Enad also put her own personal safety at risk by working in a state of tiredness that could cause accidental injury to herself or others. In being tired to the point of falling asleep, Mrs Enad placed the practice of other nursing staff on the unit at risk. Specifically in relation to Mrs Enad's safety and practice, the risk of errors in administration of care, medication and clinical decision making were significantly increased.

The panel considered the fact that Mrs Enad left Patient C unsupervised in an isolation cubicle and did not ask another member of staff to take over observations. The panel considered the evidence of Witness 7, who had been informed by her colleague that upon noting that Mrs Enad was absent from the isolation cubicle, she looked in and noticed that the red alarm was flashing, which in oral evidence Witness 7 described as *"the most serious alarm and suggests that action is needed."* She further explained that *"in the isolation cubicle, there is only one baby and the baby must never be left unattended."* The panel determined that Mrs Enad's actions resulted in serious breaches of the Code as she failed to communicate effectively, she put at risk the safety of a vulnerable patient and did not take measures to reduce the risk of harm.

Additionally, the panel noted that Mrs Enad's actions at charge 7a and 7b put Baby A at risk of significant harm. The panel heard during Witness 3's oral evidence that viruses could be transferred to a baby if the wrong breastmilk is administered. The panel noted the Management of Breastmilk Policy clearly states the procedure required to ensure that the correct breastmilk was offered to the baby and that it was the responsibility of the nurse to do the necessary checks before administration. The panel noted that Mrs Enad did not act immediately to report the mistake to a senior nurse or doctor as required by the guidance so that the baby's health could be reviewed, to make sure that no harm had been caused by her actions.

For these reasons , the panel found that Mrs Enad'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, Mrs Enad's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

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

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

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

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

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

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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 determined that limbs *a, b* and *c* of *Grant* are engaged in this case and was satisfied that limb *‘d’* is not applicable in these circumstances. The panel had no direct evidence of harm in this case. However, in the panel’s judgment, Ms Enad’s actions in the past put patients at an unwarranted risk of harm. The panel had no evidence of insight, remorse or remediation and noted that Mrs Enad had not provided a comprehensive response to the charges that would lead the panel to find that she no longer poses a risk. The panel was therefore satisfied that Mrs Enad is liable in the future to act in a way that would put patients at an unwarranted risk of harm. Mrs Enad’s misconduct brought the profession into disrepute and breached the fundamental professional tenets of preserving safety and practising effectively. There has been no response from Mrs Enad addressing these concerns, as such the

panel determined that she is liable in the future to bring the nursing profession into disrepute by breaching fundamental tenets.

The panel had no evidence of insight or remorse. Although this incident occurred almost four years ago, there are limited representations from Mrs Enad addressing the seriousness of her actions or how they negatively impacted the nursing profession. Mrs Enad has not demonstrated an understanding of how her actions put patients at a risk of harm or why her conduct was wrong. Further, the panel noted that she made no mention of how she would handle the situation differently in the future.

The panel acknowledged that Mrs Enad engaged for a short time. It considered [PRIVATE] and external circumstances that may have impacted her ability to practise safety and effectively as a nurse. The panel had regard to the statements Mrs Enad made at various points throughout her employment at the Trust. It also heard during witness evidence that conversations were had with Mrs Enad where she reported [PRIVATE] and was referred to Occupational Health (OH). Any report that had been produced following the OH referral was not put before the panel. However, the panel noted that even in the short time Mrs Enad engaged with these proceedings, she expressed [PRIVATE].

The panel considered the context of Mrs Enad's situation. It is aware that when Mrs Enad was present at this hearing, [PRIVATE]. The panel took into account that she is currently unemployed and [PRIVATE]. It was of note to the panel that Mrs Enad's current circumstances differ from the circumstances she was in at the time of the incidents. However, the panel considered the above as part of the process in deciding Mrs Enad's current fitness to practise.

The panel was satisfied that Mrs Enad's misconduct in the charges found proved are remediable. However, in relation to the charges found proved, the panel determined that there were attitudinal concerns. It was of concern to the panel that Mrs Enad's actions, including falling asleep on numerous occasions; administering the wrong breastmilk and then throwing the incorrect bottle away without any consideration as to the potential risk; and leaving an extremely vulnerable baby unsupervised in an

isolation cubicle, demonstrates a lack of respect for the role and responsibilities that come with being a nurse in relation to patient safety. Those are the attitudinal concerns that, in the panel's view, need to be addressed.

The panel carefully considered the evidence before it in determining whether or not Mrs Enad has taken steps to strengthen her practice. The panel has no evidence of relevant training and no recent reflective statement. Without evidence of remediation, the panel could not be confident that matters of the kind found proved would not be repeated in the future. It therefore concluded 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 are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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, in this case, a finding of impairment is also required on public interest grounds. The panel concluded that a member of the public, fully appraised of the facts of the case, would be concerned if a finding of current impairment were not made.

Having regard to all of the above, the panel was satisfied that Mrs Enad's fitness to practise is currently impaired and that she cannot currently practise kindly, safely and professionally.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mrs Enad's registration has been suspended.

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

Submissions on sanction

Ms Rubbi informed the panel that in the Notice of Hearing, dated 17 December 2024, the NMC had advised Mrs Enad that it would seek the imposition of a suspension order for 8 months if it found Mrs Enad's fitness to practise currently impaired.

Ms Rubbi provided the following written submissions on sanction:

> ***'SUBMISSIONS ON SANCTIONS***
>
> *6. It is submitted that a suspension order for 8 months is the appropriate sanction, with reference to the principles Panels should give consideration to when deciding on a sanction. The issues underpinning the finding of an impaired fitness to practice are such that no other order is appropriate.*
>
> ***(1) Applicable principles***
>
> *a) Aggravating features*
>
> *7. The impaired fitness to practice identified in this case is particularly grave due to certain aggravating features. The Registrant operated as a nurse at the material times in the context of a neo-natal unit, where she was charged with caring for premature babies who are, naturally, non-verbal, unable to advocate for themselves, and therefore incredibly vulnerable. It is therefore an inherently greater responsibility to ensure their needs are met and their care is provided with the utmost attention, and relevant policies are strictly adhered to. The Registrant fell far below this standard in respect to each of the charges, which rendered her fitness to practice impaired.*
>
> *8. The Charges took place over a period of eight months, and therefore demonstrate repeated misconduct and a failure to acknowledge and improve*

on poor behaviour during that time. This also ties into the Registrant's lack of insight. Although, as will be discussed below, the Registrant did raise mitigation during internal conversations, at no point did she express any sense of remorse, sympathy or concern. There is also no record of efforts made to address the issues in her performance, particularly in respect of Charges 5 and 7. To the contrary, each witness who gave evidence in respect of the proven Charges noted that her attitude was one of indifference.

b) Mitigating features

9. In mitigation, it is proper to note that, internally and in correspondence with the NMC, the Registrant did raise mitigation. She stated (as an exclusive answer to the allegations) that [PRIVATE]*, and [Witness 7] confirmed that she made an occupational health referral. Though these representations are something the Committee should take into account, it is submitted that without any evidence provided by the Registrant at any point in these proceedings of her health concerns or potential diagnoses, there is only limited weight which can be attached to these factors insofar as mitigation.*

c) Previous interim order

10. On 15 December 2022, an Investigating Committee imposed an interim suspension order 18 months, running to 14 June 2024, on the grounds of public protection and being otherwise in the public interest. The order was reviewed and confirmed on three occasions thereafter (and the Registrant did not attend at any point). On 31 May 2024, the Order was extended to 13 December 2024, and that that was confirmed on 4 October 2024.

11. Although those orders were made or confirmed in the context of additional information which is not relevant to this decision – as well as the charges that were proven – it is submitted that the numerous confirmed orders, particularly in light of the Registrant's consistent refusal to engage with the interim proceedings, are relevant to the Committee's decision on sanctions.

12. During the time of the Registrant's suspension, the Investigation Committee in its decision letter of 4 October 2024 (with respect to a review meeting) confirmed that the Registrant provided no new evidence to undermine the need the interim suspension order. This is consistent with the Registrant's lack of meaningful engagement with the allegations, and her lack of insight.

13. The fact that the Registrant was under an interim suspension order for some 24 months does not mean that it would be unjust to impose a suspension order now – there is nothing to suggest that the risk to the public was diminished by that interim order such that it no longer warrants a suspension order. This is particularly so given the Registrant's lack of engagement with the process, and her lack of remediation (or, at least communication of such) with respect to it. The Panel is not required to deduct time spent subject to an interim order form any substantive order it imposes – though such an order is clearly relevant: see GDC v Nabeel Aga [2025] EWCA Civ 68, [49], [57].

d) Clean bill

14. With respect to the Registrant's prior record or "clean bill", though, again, it is relevant, it is submitted that given the Registrant only joined Register in October 2021, her period of time practicing without incident is negligible and should carry little weight. Though there is no evidence of further concern from February 2022 to when she resigned from her position at the hospital in June 2022, the Panel heard from [Witness 7] that the Registrant never completed her necessary competencies under the preceptorship programme, nor has the Registrant provided evidence in these proceedings with respect to her employment after June 2022.

15. There is therefore little which can be drawn from the fact that the Registrant has an otherwise "clean bill" of practice.

e) Proportionality

16. An 8-month suspension order is appropriate given the risks associated with the Registrant's impaired fitness to practice. The Panel must consider the least restrictive order it can impose and stop when the order meets the public protection and public interest impetus, conscious of its overarching objective of public protection. In this case, it is submitted that an 8-month suspension order is the proportionate order.

17. The facts of the case are serious and relate to the repeated misconduct in the care of premature babies, and profound failures in communication and the following of procedure. There are plainly issues with respect to the Registrant's attitude; the Panel noted in its decision on misconduct an impairment that it had "no evidence of insight or remorse" and "Mrs Enad has not demonstrated an understanding of how her actions put patients at a risk of harm or why her conduct was wrong." The Panel is referred to the aggravating factors above.

18. Nevertheless, any order imposed will be subject to review which the Registrant can request if there is a material change of circumstances. 8 months is not an especially long period of time and would allow the Registrant opportunity to consider the significance of the outcome of these proceedings, and how she can reflect on it and demonstrate remediation.

19. It is also important to give due consideration to the fact that the Registrant's lack of meaningful engagement with these proceedings after the first day (or before the first day) has left the Panel with little information as to her professional aspirations, the impact that the interim suspension order has had, or the impact that a suspension order would have on her. Any suggestion that the order sought by the NMC would be disproportionate is therefore speculative and based purely on general assumptions (bar the fact that the Registrant has indicated that her right to work in the UK may be jeopardised).

20. The Registrant has had 24 months during her interim suspension to adapt to her non-nursing practice, and to ensure that she is able to respond to allegations that her fitness to practice is impaired, and / or to adjust her affairs in the alternative. In other words, a suspension order of 8 months would not

be a shock to the Registrant's current circumstances or materially alter her situation from what it has been for the last 24 months (bar the last two months when the order expired).

21. As to other alternative sanctions, it is submitted that a condition of practice order would be entirely inappropriate in circumstances where the Registrant has not indicated from whom she would seek nursing work and the sorts of conditions she would be willing / able to comply with. Per the NMC's guidance SAN-3c "Conditions of practice order", it is submitted that an important relevant factor is a registrant's "potential and willingness to respond positively to retraining", and in this case, the Panel simply has no evidence of this. As the issues do appear to be attitudinal in nature (the Panel noted in its decision on misconduct and impairment that the Registrant "demonstrate[d] a lack of respect for the role and responsibilities that come with being a nurse in relation to patient safety", it is, in any case, difficult to identify areas of clinical practice the Registrant which would benefit from retraining or assessment in.

22. For the same reasons (and, particularly the issues around insight), a caution order is also inappropriate.

23. It is submitted therefore that an 8-month suspension order is the proportionate sanction in the circumstances.

…

CONCLUSION

28. It is submitted that the Registrant ought to be given a suspension order for 8 months…'

Decision and reasons on sanction

Having found Mrs Enad'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:

- Lack of insight into failings
- Attitudinal concerns
- A pattern of misconduct over a period of time
- Conduct which put the most vulnerable patients (premature neonatal babies) at risk of suffering harm

The panel also took into account the following mitigating features:

- Personal mitigation including [PRIVATE]
- Personal and financial hardship at the time of these proceedings

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 given the clear risk to patient safety, significant and attitudinal concerns and the public interest in upholding professional standards.

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 Mrs Enad'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 Mrs Enad's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Enad'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 general incompetence;*

Whilst the panel was of the view that the misconduct found proved is remediable, the panel determined that there are no practical or workable conditions that could be formulated. The panel considered the nature of the charges in this case and the fact that Mrs Enad is currently unable to work due to [PRIVATE]. The panel had no evidence to indicate Mrs Enad's ability and/or willingness to respond to any retraining. The panel determined that conditions on Mrs Enad's practice could not be monitored or assessed bearing in mind her current circumstances. The panel therefore concluded that the placing of conditions on Mrs Enad'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 suspension order may be appropriate where the misconduct was not fundamentally incompatible with remaining on the register, and that a panel must consider whether a period of suspension would be sufficient to protect patients, public confidence in nurses, midwives or nursing associates, or professional standards.

Having reviewed and considered the NMC guidance, the panel noted that this is not a single instance of misconduct, there is evidence of attitudinal issues, and the panel are not satisfied as to the insight shown by Mrs Enad. For these reasons, the panel seriously considered that a striking-off order may have been the only way to protect the public. However, the panel considered the context and the mitigating factors namely, the fact that Mrs Enad was a newly qualified nurse in the UK; that she had engaged to a limited degree prior to the original hearing date and at the beginning of this hearing; [PRIVATE].

The panel heard during witness evidence that Mrs Enad had expressed to her manager that she had [PRIVATE] at the time of the incidents. The panel also heard that Mrs Enad reported [PRIVATE] and as a result had been referred to Occupational Health by her manager. The panel did not have sight of the outcome of the referral. The panel is aware that witnesses in relation to the charges found proved, initially felt that the allegations were to be dealt with in house, although it appears that Mrs Enad resigned prior to the completion of a full investigation.

Balancing all of these factors the panel concluded that a suspension order would be the appropriate and proportionate sanction.

The panel seriously considered whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Enad's case to impose a striking-off order.

The panel noted the hardship such an order will inevitably cause Mrs Enad. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order. A future panel will have the option to impose a striking-off order.

Any future panel reviewing this case would be assisted by:

- A reflective piece demonstrating understanding the role and importance of a nurse from a public and patient safety perspective.
- A reflective piece demonstrating an understanding of managing risk to patient safety
- Testimonials from line manager and/or colleagues.
- References from paid or voluntary work.
- Evidence of training or development addressing the concerns identified

This will be confirmed to Mrs Enad in writing.

Interim order

As the suspension 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 Mrs Enad's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the written submissions Ms Rubbi provided.

> ***'INTERIM ORDER***
>
> *24. Any sanction imposed will not come into effect until after the end of the 28-day appeal period: Article 29 (11) of the 2001 Order.*
>
> *25. For that period of 28 days, therefore, the Registrant's practice is otherwise unrestricted. It is submitted that the Panel can be satisfied that it is necessary for the protection of the public and in the public interest to ensure that during the appeal period, the Registrant is subject to an interim suspension order.*

26. There has been no evidence to suggest that the risks outlined in these submissions or alluded to previously have been assuaged in respect of the interim period between now and the deadline for appeals.

27. For the reasons given above, and particularly in light of a lack of meaningful engagement with her regulator, insight or remediation, it is clear that there are risks of repetition and of reputational damage to the profession and the NMC if the Registrant is allowed to practice unrestricted during this period of time.

CONCLUSION

28. It is submitted that the Registrant ought to be given a suspension order for 8 months, and, in the interim 28-day period between the date of the decision and when it can no longer be appealed, an interim suspension order should also be imposed.'

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 the appeal period. In making this order, the panel considered the impact this order will have on Mrs Enad and was satisfied that this order, for this period, is appropriate and proportionate.

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

That concludes this determination.