Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 9 - Tuesday 17 December 2024
Monday 24 - Friday 28 February 2025

Virtual Hearing

Name of Registrant:	**Karuru Satala (Also known as Olivia Satala)**
NMC PIN	03Y0279O
Part(s) of the register:	Registered Nurse – Adult – RN1 (14 August 2003)
Relevant Location:	Stoke-on-Trent
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair, lay member) Rachel Carter (Registrant member) Margaret Wolff (Lay member)
Legal Assessor:	Michael Hosford-Tanner
Hearings Coordinator:	Sharmilla Nanan (9-14 December 2024) Rebecka Selva (24- 28 February 2025)
Nursing and Midwifery Council:	Represented by Ilana Hirschberg, Case Presenter
Mrs Satala:	Present and represented by Mansoor Fazli, instructed by the Royal College of Nursing (RCN) (9-14 December 2024) Not present and not represented (24-28 February 2025)
Facts proved:	Charges 1d, 2a, 2b, 2c, 2d and 3
Facts not proved:	Charges 1a, 1b and 1c
Fitness to practise:	**Impaired**

Sanction:	**Suspension order with review (6 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse, working a day shift on 17 October 2021:

1. During one-to-one observation of Resident A, failed to maintain constant eyesight observation in that you:

    a) Wrote up and/or reviewed the notes of other patients and/or the notes of Resident A and/or

    b) Sat faced in the opposite direction of Resident A and/or

    c) Deliberately positioned yourself and/or the chairs in the room to facilitate falling asleep

    d) Slept on duty

2. Failed to provide Resident A with the requisite care in that you did not:

    a) Monitor Resident A's breathing and/or

    b) Monitor the development of secretions and/or

    c) Remove the saliva Resident A had secreted and/or

    d) Monitor Resident A's risk of choking

3. Your actions as particularised at 1 – 2 above exposed Resident A to the risk of aspiration and/or choking and/or harm

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

Admissions to the charges

The panel invited your representative to indicate if you made any admissions to the charges.

Mr Fazli, on your behalf, informed the panel that you deny all the charges.

Background

The events giving rise to the charges whilst you were employed as a registered nurse at Scotia Heights Care Home (the Home) on 17 October 2021. You began working in the Home in 2019 and started permanent employment there in 2020.

It is alleged that you attended work at the Home and took over a one to one supervision for a severely vulnerable resident, Resident A, who is diagnosed with motor neurone disease. Resident A is at risk of choking. The observation of Resident A involved maintaining eyesight observation and regularly attending to any of her needs such as suctioning their saliva.

It is alleged that Person B, Resident A's son, allegedly found you asleep. It is therefore alleged that you failed to attend to Resident A's needs during your observation period. Further, it is alleged that you were reviewing and taking notes instead of focusing your attention on Resident A.

A local investigation was conducted by the Home. You were interviewed by Witness 2, Deputy Home Manager, and a disciplinary meeting was held after the investigation was completed. You have stated that you were offered the opportunity to resign, which you did on 5 November 2021, in circumstances where you state you had little option.

The matter was later referred to the Care Quality Commission (CQC) and the NMC.

Decision and reasons on application on whether to admit paragraph 15 of Witness 2's written NMC statement

Witness 2 conducted the initial internal investigation by the Home, very shortly after the incident and produced an Investigation Report dated 1 November 2021. The panel heard an application made by Ms Hirschberg under Rule 31 to redact paragraph 15 of Witness 2's written NMC statement. Part of paragraph 15 had already been redacted by agreement of both parties. Ms Hirschberg noted that Witness 2 is commenting and giving subjective opinion when speculating on facts that she did not witness and that this evidence inadmissible because she is commenting on something that is not within her knowledge. She submitted that this evidence is not fair or relevant. Further, she submitted that Witness 2 states that she cannot recall how she came to the conclusions in this paragraph.

Mr Fazli submitted that he opposed this redaction of paragraph 15 of Witness 2's NMC statement. He submitted that the evidence of this witness appears to undermine the evidence of Witness 1 in relation to the duration of time and her opinion is helpful to the panel.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. The legal assessor referred the panel to the case of *Enemuwe v NMC* (2015) EWHC 20 81. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered the NMC's guidance on *'Evidence' (DM6)* dated 2 December 2024. The panel took into consideration that Witness 2 states that she did not recall how she came to the conclusions that she made in paragraph 15 of her NMC witness statement. The panel took into account that statements in paragraph 15 of Witness 2's statement are Witness 2's opinions. The panel considered that Witness 2 would be attending the hearing to provide live evidence and that it would be able to ask her questions to clarify her evidence regarding the investigation report that she authored and the facts which she elicited. The panel bore in mind that it is a matter for the panel to consider and evaluate

the evidence before it as to whether you had fallen asleep whilst on duty and if so, for what duration, bearing in mind that the burden of proving such matters rests on the NMC. The panel considered that it should not be influenced by the opinions of others as it is for the panel to assess the evidence before it and come to its own conclusions. The panel therefore determined to accept the NMC's application and redact paragraph 15 of Witness 2's NMC statement.

Decision and reasons on application on whether to admit the notes of the local disciplinary meeting

Ms Hirschberg submitted that there is a dispute between the parties regarding the admissibility of the notes of the local disciplinary meeting held by Ms 4. The meeting was conducted by Ms 4 interviewing you over the telephone. The Notetaker and as such the author of the note of the meeting was Ms 5. The note of the interview was not shown to you.

She submitted that it is the NMC's position that the notes are admissible as professional hearsay. She referred the panel to the relevant law and case law in respect of what she asserted was professional hearsay, meaning documents made in some official capacity.

She submitted that the NMC has made various attempts to reach Ms 4 and Ms 5 to encourage them to engage in these proceedings, but these attempts have been unsuccessful. She submitted that Ms 5 appears to be uncontactable, and Ms 4 has cited her alleged need to think of [PRIVATE], considering alleged difficulties in her time when she worked for the owners of the Home as the reason why she is unable to engage or attend in these proceedings.

She referred to the principles set out in the judgment of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). She also referred the panel to other relevant case law.

Mr Fazli submitted that he opposed the admission of the notes of the local disciplinary meeting held by Ms 4. He referred the panel to the judgement of *Thorneycroft* and applied them to the circumstances of this case. He submitted that Ms 4 has not provided any evidence to support the concerns regarding [PRIVATE]. He submitted that Ms 4 appears to demonstrate a reluctance to participate in the hearing. He noted that Ms 5 has not engaged at all with the proceedings.

Mr Fazli provided submissions and examples on the nature and the extent of the challenge with respect to the issues of the evidence on your behalf. He acknowledged that the NMC have sent a number of emails to Ms 4 and Ms 5 but could have made a witness summons to require them to attend. He submitted that charges are serious and that to admit the notes of the local disciplinary meeting into evidence would be prejudicial to you without an opportunity to cross examine Ms 4 and Ms 5.

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

The panel was of the view the notes of the local disciplinary meeting held by Ms 4 are relevant to the case. It took into consideration that it has Witness 1’s contemporaneous local statement made at the material time and that it would hear live evidence from Witness 1, Witness 2 and Witness 3. It took into consideration that it has heard evidence from Person B. The panel concluded that it was not sole and decisive evidence.

The panel considered the nature and extent of the challenge of the contents of the notes of the local disciplinary meeting. The panel bore in mind the numerous challenges to the notes made on your behalf in respect of key parts of the notes. The panel took into consideration that the parties to that meeting have decided not to attend or engage with the NMC process. It was satisfied that the NMC had made reasonable attempts to contact

each of the witnesses. There was no suggestion that Ms 4 or Ms 5 had any reason to fabricate this evidence. The panel took into consideration the seriousness of the charge and the impact that any findings and any sanction may have on you.

The panel took into consideration that it did not have information regarding the provenance of the notes of the local disciplinary meeting and that you were not provided a copy of the notes at the material time to confirm or challenge their accuracy. The panel took into consideration that it was not apparent that the note was taken at the material time and the note does not record that you were informed of it being made. It also took into consideration that you did not have any opportunity to challenge this evidence or the witnesses to whom it relates. The panel determined that the prejudicial effect that this document would have outweighs the evidential value. The panel took into account that there is no evidence to establish the reliability of the document and therefore no weight can be attached to the document. In these circumstances the panel refused the NMC's application and decided to exclude from evidence the notes of the local disciplinary meeting held by Ms 4.

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 Hirschberg on behalf of the NMC and by Mr Fazli on your behalf.

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

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

- Person B: Resident A's son.

- Witness 1: Employed by the Home as a Senior Health Care Assistant. She worked with you at the Home.
- Witness 2: Employed by the Home as a Deputy Home Manager. She did not work directly with you. She conducted the local investigation.
- Witness 3: Employed by the Home as the Home Manager. He did not work with you. His employment began with the Home after you had left.

The panel also heard evidence from you under affirmation.

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

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

Charge 1

> That you, a registered nurse, working a day shift on 17 October 2021:
> 1. During one-to-one observation of Resident A, failed to maintain constant eyesight observation in that you…

The panel first considered the stem of the charge. It noted that '*failed to'* necessitates a corresponding duty to do something. The panel took into account the evidence of Person B, Witness 1, Witness 2 and your evidence.

The panel heard evidence from Person B who said that he understood that 'constant eyesight observation' meant that someone was looking at his mother at all times.

The panel took into consideration that Person B was a relative of Resident A and a lay person who was not employed as a care giver.

The panel took into consideration that Witness 1, who was a Senior Care Assistant at the Home, said in her evidence that *'constant eyesight observation'* means that you cannot leave the resident's room and that it would be intrusive and not in line with the resident's privacy to be staring at them all the time. She accepted that sometimes it would be necessary to have your back to the resident and completing tasks around the resident's room but that you had to be alert and checking the resident all the time. She stated that you could be completing the forms to record the care that you had provided for the resident.

The panel considered the evidence of Witness 2, a registered nurse and the Deputy Home Manager. In her NMC statement she stated that '*As a nurse, when you are doing a one-on-one observation, it is policy that you never leave during this time. The resident involved in this incident required eyesight observations, which means that the nurse or carer would need to be in the resident's bedroom. One-on-one observations have a critical purpose and are a very restrictive practice, so we avoid them where we can.'* Witness 2's oral evidence corroborated Witness 1's evidence that *'constant eyesight observation'* means being able to see a resident, providing them with your undivided attention although you are not always constantly looking at the resident. She said that you need to understand the needs and risks of the resident you are observing and write up what you observed.

The panel considered that *'Shift Allocation Day'* dated *'17-10-21'*. It noted the column on the document the resident's initials and the 'shifts' for those providing one to one care for the resident and this demonstrated that one to one care was being provided to Resident A.

The panel considered your evidence. In your witness statement, you stated *‘I offered to relieve the 1-2-1 caregiver to allow for breaks, and she was grateful’*. The panel was of the view that this statement infers that you understood that *‘constant eyesight observation’* was required.

The panel determined that there was a duty to provide *‘constant eyesight observation’*. The panel considered that Witness 1 and Witness 2 were consistent in their evidence that there is a duty when providing *‘constant eyesight observation’* to ensure the resident has your undivided attention but not to be too intrusive to the resident by constantly staring at them. Witness 1 and Witness 2 were clear in their evidence that it was reasonable to complete other tasks around the room whilst providing *‘constant eyesight observation’*. The panel concluded that there was a duty when providing one to one observation that *‘constant eyesight observation’* was maintained of Resident A.

Charge 1)a)

> That you, a registered nurse, working a day shift on 17 October 2021:
> 1. During one-to-one observation of Resident A, failed to maintain constant eyesight observation in that you:
> a) Wrote up and/or reviewed the notes of other patients and/or the notes of Resident A and/or

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Person B, Witness 1, Witness 2 and your evidence. The panel had regard to its findings in relation to the stem of the charge as outlined above.

The panel considered the evidence of Person B. In his NMC witness statement he stated *‘I walked further into the room and saw Mrs Satala sitting in a high-backed, comfortable chair…On the side table, I saw that there were some open notes and case files. Typically*

when I visit my mother in her room, we only see her case file, however on this occasion, there was a pile of paperwork.'

In Person B's oral evidence, he said that he saw some files were open on a table in Resident A's room. The panel noted that Person B's evidence was consistent in each of his accounts.

The panel considered the evidence of Witness 1. In her NMC witness statement she stated *'I recall going into the resident's room to check on Mrs Satala…. About two to three minutes after I left the room, a family member of the resident entered. Whilst Mrs Satala was in the resident's room doing the one-on-one observation, she was going through paperwork as there is often a lot of paperwork for the nurses to fill out. I had carried the paperwork and folders into the room for her as she was unable to carry them herself.* The panel was of the view that Witness 1's evidence was ambiguous as to whether these folders related to Resident A, other residents or other general paperwork.

The panel considered the evidence of Witness 2. In her NMC witness statement she stated, *'It is my understanding that Mrs Satala was writing patient notes during the observation. Generally, it is not good practice to do this when conducting a one-to-one observation, but nurses have to write many notes for patient files.'* In her oral evidence, she said that it was not unreasonable to make notes of your care for Resident A when completing *'constant eyesight observation'* of Resident A.

The panel had regard to the *'Consolidated observation chart and behaviour frequency (hourly checks)'* dated week commencing '*11/10/21*' which did not contain your signature for the date of 17 October 2021.

The panel considered your evidence. In your witness statement you stated *"As [Witness 1] Left, I leaned down to the file and opened it. I held my pen and as I was about to write, Resident A's son had come in. At this point, I had not written anything in that file. I would*

say the time between me holding the pen and the file and the resident A's son walking into the room was no more than 20 seconds."

You said in your oral evidence, that you had completed some notes for Resident A whilst you were providing 'constant eyesight observation', including ticking the suction sheet. The suction sheet had not been provided to the panel. You said that you were reviewing notes whilst with Resident A but that you did not have an opportunity to write them up before Person B appeared.

The panel considered the evidence before it. The panel noted that it was not disputed that there were case files in Resident A's room. The panel was of the view that there was an intention to update notes but that there was no documentary evidence before it that any notes had been updated including Resident A's notes. The panel placed particular weight on Witness 2's evidence that while it was not good practice to write up resident notes during one-to-one observations it was acceptable to do so provided the carer maintained attention to the resident. It also found that had you been reviewing notes of Resident A or other residents whilst maintaining attention to Resident A that would not a be a breach of your duty. The panel determined while working a day shift on 17 October 2021, during one-to-one observation of Resident A, you did not fail to maintain constant eyesight observation by writing up or reviewing the notes of Resident A. The panel was not satisfied that the NMC had discharged its burden of proof that by writing up or reviewing the notes of other patients you had failed to maintain constant eyesight observation. The panel therefore found charge 1a not proved.

Charge 1)b)

> 1. During one-to-one observation of Resident A, failed to maintain constant eyesight observation in that you:
> b) Sat faced in the opposite direction of Resident A and/or

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Person B, Witness 1 and your evidence. The panel had regard to its findings in relation to the stem of the charge as outlined above.

The panel considered the evidence of Person B. In his NMC witness statement he stated *'Mrs Satala's chair was positioned towards the television which is opposite my mother's bed, so even if Mrs Satala had been awake, she would have been looking in the opposite direction of my mother.'* He repeated this account in his oral evidence.

The panel took into consideration that Person B did not mention in his initial complaint that you were facing away from Resident A when he came into the room. The panel noted that the first time that he mentioned your position in the room was when he made his NMC witness statement which is dated 9 November 2022.

The panel considered the evidence of Witness 1. She stated in her NMC witness statement '*I recall going into the resident's room to check on Mrs Satala as she had* [PRIVATE] *I saw her resting her foot on the side of her bed in order to elevate her ankle.'* The panel noted that she did not mention the orientation of where you were sitting, but this does not indicate that you were facing in the opposite direction to Resident A.

In Witness 1's oral evidence, she said that she saw you resting your feet on the rail of the bed which would indicate that your body was facing the bed. Further, she stated that you were *'sitting where most staff sit when doing a one to one'*.

The panel considered your evidence. In your witness statement, you stated *'I positioned myself to face the resident, sitting on the right side, near the resident, with the door behind me. I put the stool down and raised my left foot to rest it. This is a small stool and* [PRIVATE] *only one foot could fit.'*

In your oral evidence, you said that you were sat in the small chair in the room and not facing away from Resident A. You stated that your feet were resting on the footstool. You said that you could not sit on the armchair as it was broken.

The panel considered the evidence before it. It noted that Person B, Witness 1 and yourself had differing views of the layout of the room but that everyone agreed that it was a small room. It had regard to the different sketches provided by Person B and you of Resident A's room however noted that these were not to scale and sketched during the hearing which was three years after the material time. The panel took into consideration that the evidence that the NMC has provided is not contemporaneous to the incident, and that the allegation of facing in the opposite direction to Resident A was not made at the time. The panel was not satisfied that the evidence before it was cogent or persuasive to find the charge proved on the balance of probabilities. The panel determined that while working a day shift on 17 October 2021, during one-to-one observation of Resident A, you did not fail to maintain constant eyesight observation in that you sat faced in the opposite direction of Resident A. The panel therefore found charge 1b not proved.

Charge 1)c)

> 1. During one-to-one observation of Resident A, failed to maintain constant eyesight observation in that you:
> c) Deliberately positioned yourself and/or the chairs in the room to facilitate falling asleep

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Person B, Witness 1 and your evidence. The panel had regard to its findings in relation to the stem of the charge as outlined above.

The panel considered the evidence of Person B. In his oral evidence, he said that the door was almost closed which was suspicious as he said that it is always wide open. It was only ever shut for personal care.

The panel considered the evidence of Witness 1. She stated in her NMC witness statement '*I recall going into the resident's room to check on Mrs Satala as she* [PRIVATE]' In her oral evidence, she said that she told [PRIVATE].

The panel considered your evidence. In your witness statement, you stated *"I offered to relieve the 1-2-1 carer to allow for breaks, and she was grateful.* [PRIVATE]"

The panel considered the evidence before it. The panel was of the view that you did not deliberately position yourself or the furniture to facilitate falling asleep [PRIVATE]. The panel determined that while working a day shift on 17 October 2021, during one-to-one observation of Resident A, you did not deliberately position yourself and/or the chairs in the room to facilitate falling asleep. The panel therefore found charge 1c not proved.

Charge 1)d)

> 1. During one-to-one observation of Resident A, failed to maintain constant eyesight observation in that you:
> d) Slept on duty.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Person B, Witness 1, Witness 2 and your evidence. The panel had regard to its findings in relation to the stem of the charge as outlined above.

The panel considered the evidence of Person B. Person B sent an email to the Home on 17 October 2021 which stated *'Firstly relates to an incident on my visit today (17th October*

@1530.) As we were let on to Portmerion ward and entered Resident A room on the ward, the nurse on duty, I was told her name is [PRIVATE] *(who was also providing mum's 121 care) was fast asleep with her shoes off and feet up on a chair. She was so sound asleep I had to wake her up. Resident A was wide awake,*[PRIVATE] *I can only assume by how sound asleep this nurse was, and how comfortable her set up was (feet up, shoes off) that she had been asleep quite a while…'*

In Person B's oral evidence, he said that he had found you asleep and that he had to talk to you to wake you up.

The panel considered Witness 1's evidence. In an undated contemporaneous local statement made at the time of the incident she stated *'[Resident A]'s family arrived to see Resident A. 10 min later [PRIVATE] came to see me and explained that Person B had seen her with her feet on the bed* [PRIVATE]*. Her eyes were closed – no more than 5 minutes* [PRIVATE]*.'* Witness 1 confirmed in her oral evidence that she made the statement the same day as the incident.

In Witness 1's NMC statement, dated 24 November 2022, she stated *"Shortly after the family member entered the resident's room, Mrs Satala came to me and told me that they had thought she had been sleeping. Mrs Satala told me that she had not been asleep. I spoke to her about this and then wrote a statement, in which I clarified that Mrs Satala had not been sleeping when I was in the room with her. I do not know if Mrs Satala had her eyes closed when the relative entered the resident's room."*

The panel had regard to the 'Investigation documents' specifically the *'Minutes of meeting between [Witness 2] and Karuru Satala dated 23 October 2021*'. During this meeting you said *'I perhaps fell asleep for a few seconds but I honestly do not know, I acknowledged the relative quickly, I feel that it would have been a quick moment and completely accidental as I was making myself alert writing… I promise you that I had no intention to sleep but if I nodded off an accident."*

The panel considered your evidence. You said in your oral evidence that you '*nodded off*' but had not fallen asleep.

The panel considered the evidence before it. The panel was of the view that you had '*nodded off'* and that it was not deliberate. The panel considered that to 'nod off' was a brief unintentional sleep. The panel took into consideration that you had taken [PRIVATE] before going into Resident A's room which can make you drowsy and you stated in oral evidence that you were feeling drowsy.

The panel determined that while working a day shift on 17 October 2021, during one-to-one observation of Resident A, you failed to maintain constant eyesight observation in that you slept whilst on duty. The panel therefore found charge 1)d) proved.

Charge 2

That you, a registered nurse, working a day shift on 17 October 2021:

2. Failed to provide Resident A with the requisite care in that you did not…

The panel first considered the stem of the charge. The panel took into account the evidence of Witness 2.

The panel noted that the care plan that it had before it was dated *'1/3/22'* and that this was not the applicable care plan for the incident at the material time. It did not have the applicable care plan that was in force at the time for Resident A.

The panel considered the evidence of Witness 2. She said that the care plan dated *'1/3/22'* is what she would have expected to be in place at the time of the incident, namely, 17 October 2021. She said that she did not know what was precisely in the care plan that was in place for Resident A at the material time but was satisfied that it included one to one care and the specific requirements in the care plan dated '*1/3/22'.*

The panel bore in mind that the care plan dated '1/3/22' states *'Resident A is funded for 1:1 care at Level four observations (within arms reach), 24 hours during the day as of 20/10/21 as authorised by … Regional Manager.* [PRIVATE]*. This should be documented when given and any concerns reported to the nurse in charge.'* The panel noted that it outlines the support that Resident A requires namely

> *'- 1:1 at Level four observations 24hours a day.*
> - [PRIVATE]'

The panel determined that the *'requisite care'* relates to the support outlined, as above, in the care plan dated *'1/3/22'*.

Charges 2)a), 2)b), 2)c) and 2)d)

> 2. Failed to provide Resident A with the requisite care in that you did not:
> a) Monitor Resident A's breathing and/or
> b) Monitor the development of secretions and/or
> c) Remove the saliva Resident A had secreted and/or
> d) Monitor Resident A's risk of choking"

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Person B, Witness 1, Witness 2, Witness 3 and your evidence. The panel had regard to its findings in relation to the stem of the charge as outlined above.

The panel considered the evidence of Person B. Person B sent an email to the Home on 17 October 2021 which stated *"Resident A was wide awake,* [PRIVATE] *her top was drenched through…"*

In his NMC witness statement he stated [PRIVATE]*. From my observation,* [RESIDENT A's] *top was quite wet."*

Person B said in his oral evidence that when he came into the room, Resident A was drenched with saliva.

The panel considered the evidence of Witness 1. In her oral evidence she said that she did not see any secretions on Resident A when she went in to check on you. She said that there would be a *'Suction sheet'* to record notes on for secretions.

The panel considered the evidence of Witness 2. In her evidence she said that she would expect to see on Resident A's *'Day in the Life'* and *'Mouth Care'* care notes if the resident had been suctioned.

In her NMC witness statement she stated *'The resident required regular suctioning, as she was at risk of choking and aspirating on her saliva, which could result in death. If a nurse or carer falls asleep and is not watching a high-risk resident, and they then stop breathing, the consequences can be severe.'*

The panel considered the evidence of Witness 3. In his NMC witness statement he stated *'On February 2024, I received an enquire from the NMC asking if I'm able to confirm that the documents sent to the NMC on 5 and 9 February were the complete records for Resident A for 17 October 2021. In response, I confirmed that the records sent on the 5 and 9 February 2024 were records belonging to Resident A. These records we requested and received for year 2021 period September – December. Unfortunately given that some of the documents do not contain a date / year stamp I am unable to 100% confirm if it relates to 2021.'* In his oral evidence, he added that the records were not organised appropriately, there were *'mixed dates'* and the records were not *'organised correctly'*.

The panel took into consideration your oral evidence. In your oral evidence, you said that you did monitor the development of secretions and dabbed Resident A's mouth and undertook some suctioning, shortly after you entered the room. You told the panel that you did not do any of these checks as outlined in the charge when you left the room, after

Person B had arrived. You said that you completed notes on the suction chart. The panel noted that it did not have the suction chart available to it.

The panel took into account that there was no supporting documentary evidence that you had monitored Resident A's breathing, monitored the development of secretions for Resident A, that you removed the saliva Resident A had secreted or that you monitored Resident A's risk of choking.

The panel accepted that when you began your one-to-one observations of Resident A you were conducting the requisite care as outlined in the charge. However, the panel bore in mind its finding at charge 1)d). It follows that for the period of time, whilst you were asleep and before you left the room leaving Resident A with Person B, you failed to provide Resident A with the requisite care in that you did not monitor Resident A's breathing, you did not monitor the development of secretions, you did not remove the saliva Resident A had secreted and you did not monitor Resident A's risk of choking. The panel therefore found charges 2)a), 2)b) 2)c) and 2)d) proved.

Charge 3

> 3. Your actions as particularised at 1 – 2 above exposed Resident A to the risk of aspiration and/or choking and/or harm'

This charge is found proved.

In reaching this decision, the panel took into account its findings at charges 1 and 2.

The panel bore in mind that the care plan dated *'1/3/22'* states *'Resident A is funded for 1:1 care at Level four observations (within arms reach), 24 hours during the day as of 20/10/21 as authorised by … Regional Manager.* [PRIVATE]*. This should be documented when given and any concerns reported to the nurse in charge."*

The panel considered the evidence of Witness 2. In her NMC witness statement she stated '[PRIVATE] *If a nurse or carer falls asleep and is not watching a high-risk resident, and they then stop breathing, the consequences can be severe."*

The panel considered the evidence before it. It bore in mind that you fell asleep whilst on duty and it determined that your actions as particularised at charges 1d – 2 above exposed Resident A to the risk of aspiration and/or choking and/or harm. The panel therefore found charge 3 proved.

Decision and reasons on service of Notice of Hearing

The panel was informed at the resumption of this hearing that Mrs Satala was not in attendance and that the Notice of Hearing letter had been sent to Mrs Satala's registered email address by secure email on 14 January 2025.

Further, the panel noted that the Notice of Hearing was also sent to Mrs Satala's representative at MH Solicitors on 14 January 2025.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Satala's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

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

Ms Hirshberg made a request that her submissions in response to Mrs Satala's adjournment request be made in private given that they explore matters [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Having heard that there will be reference [PRIVATE], the panel determined to hold parts of Ms Hirschberg's submissions in private.

Decision and reasons on proceeding in the absence of Mrs Satala

The panel next considered whether it should proceed in the absence of Mrs Satala, in particular, to consider her application to adjourn. It had regard to Rule 21 and heard the submissions of Ms Hirschberg who invited the panel to continue in the absence of Mrs Satala.

Ms Hirschberg referred the panel to the letter dated 19 February 2025 and email dated 21 February 2024 (contained in Exhibit 11) from Mrs Satala's solicitors requesting an adjournment of today's proceedings.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mrs Satala. In reaching this decision, the panel has considered the submissions of Ms Hirschberg, the written representations made on Mrs Satala's behalf, and the advice of the legal assessor. It had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Satala's representative has made an application that needs to be considered by the panel and therefore there is no risk of unfairness to Mrs Satala if the panel proceeds to consider that application.
- There is a strong public interest in the expeditious disposal of Mrs Satala's application.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Satala confined at this stage to considering her application.

Submissions on application to adjourn

Ms Hirschberg referred the panel to the Exhibits submitted on Mrs Satala's behalf by her representatives: Exhibit 11, Exhibit 12 [PRIVATE] Exhibit 16 (duplication of Exhibit 13 – leaflet).

Ms Hirschberg informed the panel that the position of the NMC is to oppose Mrs Satala's request for adjournment. She submitted that whilst the seriousness of the situation is acknowledged, the [PRIVATE] before the panel is insufficient to justify an adjournment and therefore the panel should continue in Mrs Satala's absence.

Ms Hirschberg referred the panel to NMC Rule 32 (2) and submitted that there would be minimal injustice to Mrs Satala to proceed at this stage in her absence as she has already given evidence. She submitted that there is not any further [PRIVATE].

Ms Hirschberg submitted that it is not in the interest of either party to draw this matter out further, with no guarantee of when the hearing would resume, especially as the allegations took place in 2021.

Ms Hirschberg submitted that continuing the hearing and concluding this matter is in the public interest. She submitted that it is not in the public interest to have this matter adjourned.

Ms Hirschberg submitted that to continue in Mrs Satala's absence includes a broad view of fairness in that it is better to have this case resolved and finalised as opposed to open for an undefined period of time.

Ms Hirschberg referred the panel to *General Medical Council* (GMC) *v Adeogba* [2016] WLR(D) 156 in which the Court considered that fairness fully encompasses fairness to the affected medical professional but also involved fairness to the GMC.

Ms Hirschberg submitted that Exhibit 13 and Exhibit 16 cannot be considered [PRIVATE] or why Mrs Satala is not able to attend the hearing this week.

Ms Hirschberg referred the panel to *GMC v Hayat* [2018] EWCA Civ 2796 [PRIVATE].

Ms Hirschberg submitted that Exhibits 11 – 16 do not outline sufficiently why Mrs Satala is unable to attend this remote hearing.

Ms Hirschberg submitted that contrary to *Hayat* and NMC Guidance CMT-11, the panel has limited information before it today.

Ms Hirschberg submitted that the panel has the power to continue the case under NMC Rule 21.

Ms Hirschberg submitted that it is in the interest of both parties and the public interest to conclude the case this week as previously planned.

In response to panel questions, Ms Hirsberg clarified that there has been an updated position on the NMC's sanction bid in the light of the panel's decision on facts. She clarified that she is unaware at this time whether this has been communicated to Mrs Satala and her representatives.

Decision and reasons on application to adjourn

The panel accepted the advice of the legal assessor.

The panel is mindful that it is directed by Rule 32 to the fact that it is in the interest of the public to dispose of cases expeditiously bearing in mind fairness to the registrant.

The panel had regard to NMC Guidance CMT-11:

[PRIVATE]

The panel considered the submissions made by Ms Hirschberg and the Exhibits 11- 16 sent on behalf of Mrs Satala. The Exhibits 12-16 indicate that [PRIVATE].

It is also apparent that Mrs Satala still has legal representation, and the panel was assisted by the attendance of her legal representative as well as Mrs Satala at the first stage of her hearing. It was only on 22 February 2025 that the NMC was informed that Mrs Satala's representative would not be attending today.

The panel has been informed today by Ms Hirschberg that the NMC sanction bid has changed in the light of the panel's finding on facts, but this was not stated in the Notice sent on 14 January 2025 to Mrs Satala. In addition, Ms Hirschberg is unclear whether Mrs Satala has been informed of the change of the sanction bid and the panel considered that she is entitled to know of the updated sanction position.

The panel decided to defer the final consideration of Mrs Satala's adjournment application until 9am on Wednesday 26 February 2025 to allow the following steps to be taken:

- [PRIVATE]
- The NMC to inform the Panel, Mrs Satala and her representatives of their updated sanction bid.

An adjournment until 9am Wednesday 26 February 2025 will also give Mrs Satala the opportunity to consider whether she should be represented.

Continued submissions on application to adjourn

On Wednesday 26 February 2025, the panel had before it, [PRIVATE].

Ms Hirschberg reminded the panel of the adjournment requirements as set out in the NMC Guidance CMT-11 and *Hayat.*

[PRIVATE]

Ms Hirschberg invited the panel to reject Mrs Satala's application to adjourn on three grounds. She submitted that:

- It is in the public interest to swiftly resolve this matter involving allegations and proven charges from 2021.

- There is minimal prejudice or unfairness, if any, to Mrs Satala as she has already given evidence and there is no information before the panel to suggest that she intended to do so at the later stages.
- The adjournment application contains insufficient evidence, all of which were provided at the last minute. Proceedings have been considerably disrupted.

Continued decision and reasons on application to adjourn

The panel bore in mind NMC Guidance CMT-11.

The panel started from a very careful point of consideration as Mrs Satala did attend and engage with the first stage of the hearing in December 2024. However, as of today, the panel has not received any indication that Mrs Satala would like to give evidence or provide any written representations for the next stages of the hearing.

[PRIVATE]

The panel considered that this matter has been ongoing since 2021 and there is a strong public interest in concluding this case in a timely manner.

Therefore, the panel decided to refuse Mrs Satala's application to adjourn, based on the evidence before it.

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 Satala'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 Satala's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Hirschberg referred the panel to *Roylance v GMC (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 Hirschberg invited the panel to take the view that the facts found proved amount to misconduct.

Ms Hirschberg referred the panel to Charge 1 d which was found proved. She submitted that in considering the stem of the charge, '*The panel determined that there was a duty to provide 'constant eyesight observation'. The panel considered that Witness 1 and Witness 2 were consistent in their evidence that there is a duty when providing 'constant eyesight observation' to ensure the resident has your undivided* attention *but not to be too intrusive to the resident by constantly staring at them.*'

Ms Hirschberg reminded the panel that it found that Mrs Satala did sleep whilst on duty, although unintentionally, and thus breached her duty to provide constant observation for Resident A.

Ms Hirschberg referred the panel to Charge 2 which was found proved in its entirety.

Ms Hirschberg referred the panel to Charge 3 which was also found proved.

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

Ms Hirschberg identified the specific, relevant standards where, in her submission, Mrs Satala's actions amounted to misconduct:

> ***'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*
>
> ***13 Recognise and work within the limits of your competence***
> *To achieve this, you must, as appropriate:*
>
> > *13.4 take account of your own personal safety as well as the safety of people in your care*
>
> ***20 Uphold the reputation of your profession at all times***
> *To achieve this, you must:*
>
> > *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'*

Ms Hirschberg reminded the panel that while the NMC code makes it clear that not all breaches of the code will be a matter of regulatory concern, it will be a matter of concern where the breach amounts to serious misconduct.

Ms Hirschberg referred the panel to Witness 2's statement:

'As a nurse, when you are doing a one-on-one observation, it is policy that you never leave during this time. The resident involved in this incident required eyesight observations, which means that the nurse or carer would need to be in the resident's bedroom. One-on-one observations have a critical purpose and are a very restrictive practice, so we avoid them where we can. A resident would have to have a very high risk for behaviour of have significant health risks for one-on-one observations to be implemented.

…

I think the company policy on falling asleep on duty is fair as it is considered to be gross misconduct'.

Ms Hirschberg referred the panel to *Roylance v GMC* [1999] UKPC 16 in which it defined serious misconduct as:

'*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.*'

Ms Hirschberg referred the panel to the definition of misconduct as identified in *R (Remedy UK Ltd) v GMC* [2010] EWHC 1245:

'Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur out with the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession. (…) Deficient performance or incompetence, like misconduct falling within the first limb, may in

principle arise from the inadequate performance of any function which is part of a medical calling.'

Ms Hirschberg also referred the panel to the definition of misconduct as set out in *Nandi v GMC* [2004] EWHC 2317 (Admin):

'*What amounts to professional misconduct has been considered by the Privy Council in a number of cases. I suppose perhaps the most recent observation is that of Lord Clyde in Rylands v General Medical Council [1999] Lloyd's Rep Med 139 at 149, where he described it as "a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious". The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners*.'

Submissions on impairment

Ms Hirschberg 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) NMC (2) and Grant* [2011] EWHC 927 (Admin)*, Cohen v GMC* [2008] EWHC 581 (Admin) and *Nicholas-Pillai v GMC* [2009] EWHC 1048 (Admin)

Ms Hirschberg submitted that Mrs Satala's fitness to practise is currently impaired due to her misconduct. She referred the panel to NMC Guidance DMA-1.

Ms Hirschberg referred to the test as set out in *Grant* in identifying impairment. She submitted that in view of the finding that Mrs Satala fell asleep while on duty, she failed to follow the one-to-one supervision required for Resident A, and as a result put Resident A

at risk. She submitted that Mrs Satala acted in a way that put a patient at unwarranted risk of harm. Furthermore, in the absence of any reflection or evidence of training certificates from Mrs Satala, she cannot remedy the issues identified with her practice and therefore she remains liable to put future patients at unwarranted risk of harm.

Ms Hirschberg submitted that the proven charges amount to multiple breaches of the NMC code which sets out the tenets of the profession. She submitted that without evidence of reflection or training before the panel, a substantial risk remains that Mrs Satala could breach the Code again.

Ms Hirschberg submitted that contextual factors must also be considered by the panel. [PRIVATE] there were other contextual factors; failure to follow a one-to-one plan, failure to recognise that she was not well enough to practise safely and failure overall to meet the needs of Resident A. She submitted that these factors point to misconduct and deficiencies in Mrs Satala's practice.

Ms Hirschberg submitted that the likelihood of repetition must also be considered by the panel. She submitted that Mrs Satala cannot demonstrate safe practice without undertaking reflection and training. Therefore, the risk of repetition remains high.

Ms Hirschberg submitted that in consideration of public interest, this is a misconduct case and a case which put a vulnerable patient at risk of harm.

In reference to *Cohen*, Ms Hirschberg outlined for the panel that Mrs Satala's conduct was not easily remediable, nor has she taken any steps to remedy the misconduct.

In reference to *Nicholas-Pillai*, Ms Hirschberg outlined for the panel that Mrs Satala's attitude in pulling back from her duty to engage in this hearing, and her general attitude towards the charges found proved should be taken into account. She submitted that Mrs Satala has not acknowledged that she put Resident A in any danger, nor has she provided an overall reflection on the proven facts.

Ms Hirschberg submitted that Mrs Satala's practice is impaired by reason of her misconduct and her practice is currently impaired given that there is no evidence that she has taken steps to reflect and remedy the deficiencies in her practice to demonstrate that she can practise safely. She submitted that Mrs Satala has not admitted or reflected on her wrongdoing or undertaken any training that the panel is aware of.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Grant, Cohen, Roylance, Nandi, Remedy UK Ltd v GMC, General Dental Council* (GDC) *v Rimmer* [2010] EWHC 1049 (Admin) and *Johnson and Maggs v NMC* [2013] EWHC 2140 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mrs Satala's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Satala'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*
>
> ***13 Recognise and work within the limits of your competence***
> *To achieve this, you must, as appropriate:*
>
> > *13.4 take account of your own personal safety as well as the safety of people in your care*

20 Uphold the reputation of your profession at all times

To achieve this, you must:

> *20.1 keep to and uphold the standards and values set out in the Code*
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people*

The panel appreciated that breaches of the Code do not automatically result in a finding of impairment. The panel accept the circumstances, that according to Witness 2 and Witness 3, the unit was short staffed, and the panel acknowledged that Mrs Satala had offered to carry out Resident A's one-to-one observation and that this would enable a junior colleague to go on a break.

The panel was of the view that Mrs Satala's primary role as a registered nurse was to look after and prioritise patients in her care. The panel considered the nature of Resident A's care requirements, in that they were at danger of choking at any time, hence required one-to-one observation. The panel considered that Mrs Satala undertook the one-to-one observation knowing that she had had little sleep the night before, [PRIVATE]. Mrs Satala also stated in her oral evidence that she was aware that she was '*nodding'* while she was sitting in the room with Resident A.

The panel considered that in the evidence before it, it is suggested that Mrs Satala slept for no more than 10 minutes when observing. However, the panel was concerned that had Person B not walked into Resident A's room and woken Mrs Satala up – Mrs Satala might have slept for longer. In any event the panel has found that falling asleep for even a short period placed Resident A at risk of serious harm.

Mrs Satala had a professional responsibility to decline the one-to-one observation when she was not fit to undertake it. The panel considered that this error of judgement should have been foreseen.

The panel found that Mrs Satala’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 Satala’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. 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 found that Resident A was put at risk of harm as a result of Mrs Satala's misconduct. Mrs Satala's misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. As such, the panel found that limbs a, b and c were engaged.

In assessing whether Mrs Satala is liable in the future to cause unwarranted risk of harm, bring the profession into disrepute and/or breach one of the fundamental tenets of the medical profession the panel applied the test as set out in *Cohen* with regard to impairment:

'a. is the misconduct easily remediable?
b. has the misconduct in fact been remedied?
c. is the misconduct highly unlikely to be repeated?'

The panel considered that the misconduct was remediable. It noted that Mrs Satala in her evidence stated that falling asleep on duty is wrong. However, the panel considered that there is no information before it to show that Mrs Satala has remediated the misconduct. Mrs Satala has not provided any reflections on the incident, nor provided any evidence to the panel of any relevant learning, training or courses she has undertaken since the incident to address the concerns. The panel had no information regarding Mrs Satala's nursing career since she left the Home and Mrs Satala has not produced any testimonials concerning her practice as a nurse in the intervening period since the matters charged.

The panel has not drawn any adverse inference against Mrs Satala on account of her not attending or being represented at this impairment stage.

The panel was concerned that it appears that Mrs Satala has not reflected on the impact of her misconduct on Resident A, their family, colleagues and the wider nursing profession. The panel considered that because Mrs Satala has not shown insight into the impact of her misconduct it was not satisfied that she would handle a similar situation differently in future or therefore that she can practise in a safe manner.

Accordingly, the panel determined that a finding of impairment on the public protection ground is required due to the risk of repetition identified and consequent risk of harm.

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

The panel determined that a finding of impairment on public interest grounds is required because public confidence in the profession would be undermined if a finding of impairment were not made in this case, where on all the facts and circumstances of this case an especially vulnerable patient was exposed to the risk of serious harm. Therefore, it also finds Mrs Satala's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Satala's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order with review for a period of 6 months. The effect of this order is that the NMC register will show that Mrs Satala'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 Hirschberg informed the panel that in the Notice of Hearing, dated 7 November 2024, the NMC had advised Mrs Satala that it would seek the imposition of a striking off order if it found Mrs Satala's fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submits that six to nine month suspension order with review is more appropriate in light of the panel's findings.

Ms Hirschberg referred the panel to its finding on misconduct and impairment.

Ms Hirschberg submitted that the NMC share the panel’s concern of the lack of reflection or remediation by Mrs Satala. Therefore, she submitted that a period of suspension is required as Mrs Satala is not currently able to practice safely.

Ms Hirschberg referred the panel to NMC Guidance SAN-3d on suspension orders, she submitted that the seriousness of the case requires temporary removal from the register, and a period of suspension will be sufficient to protect patients and public confidence in nurses if Mrs Satala takes that time to undertake remediation and reflection.

Ms Hirschberg submitted that while this was a single instance of misconduct, in the sense that all the proven charges happened on one day, due to the severity of the misconduct and the risk of serious harm to Resident A, a lesser sanction is not sufficient.

Ms Hirschberg clarified that the NMC requesting a review before expiry to allow Mrs Satala to put forward any steps she has taken to strengthen her practice to ensure that there will not be an ongoing risk of repetition after the suspension.

Ms Hirschberg addressed the panel on public interest. She submitted that until Mrs Satala is able to demonstrate safe practice, a suspension order is required in order to maintain public confidence in the nursing profession as well as patient safety. Furthermore, she submitted that a reasonable and well-informed member of the public would be concerned if a lesser or no sanction were to be imposed. She referred the panel to *Brennan v Health Professions Council* [2011] EWHC 41 (Admin):

> “*Where the purpose of sanction is to deal with issues other than the primary one of maintaining public safety, and is instead to provide deterrence to others, to maintain confidence in the profession's reputation and standards and in its regulatory process, the reasoning is particularly important in showing that the sanction is proportionate to the misconduct and for the individual.(...) What was required was consideration of how the individual had responded, the sincerity and effectiveness of that response, the reality of repetition in view of his insight*"

Ms Hirschberg submitted that there is at present, a risk of repetition and therefore a suspension order is both necessary, appropriate and proportionate.

Ms Hirschberg submitted the aggravating factors as considered by the NMC in this case:

- Vulnerability of Resident A and the risk of harm to them.
- Lack of engagement from Mrs Satala.
- A lack of insight including no reflection or training towards remediation from Mrs Satala.

Ms Hirschberg submitted mitigating factors as considered by the NMC in this case:

- [PRIVATE]
- There has been reference to the unit being understaffed and therefore busy, however, again Mrs Satala had a duty to turn it down if she was not well.
- This appears to have been an isolated incident in that all the charges proven relate to the same day.

Mrs Hirschberg it is submitted that, without evidence of insight and remediation, there remains a serious risk of harm and it would undermine the public's confidence in the profession if no sanction were imposed.

Ms Hirschberg outlined for the panel that Mrs Satala has no prior referrals to the NMC and there is no Interim order history in this case.

Ms Hirschberg invited the panel to impose a suspension order of six to nine months with a review before expiry for all the reasons submitted.

Decision and reasons on sanction

Having found Mrs Satala’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:

- The extreme vulnerability of Resident A and the particular care that was required by Mrs Satala in providing them one-to one observation.
- No evidence of demonstrable insight by Mrs Satala on the impact of these failings on Resident A, their family and public confidence in the nursing profession.

The panel also took into account the following mitigating features:

- One isolated incident on a singular day that took place four years ago.
- [PRIVATE]
- Mrs Satala felt under pressure to be at work due to staffing issues.
- In Mrs Satala’s evidence she acknowledged that falling asleep whilst on duty is wrong.

In all the circumstances, the panel considered that the aggravating factors outweighed the mitigating factors as the priority was to provide safe care to Resident A.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not

restrict Mrs Satala'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 Satala'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 Satala's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*

The panel is of the view that there are no practical or workable conditions that could be formulated. Mrs Satala has not provided the panel with any insight into these concerns, any testimonials regarding her practice since the incident and the panel has no indication that she has '*potential and willingness to respond positively to retraining'* as identified in NMC guidance SAN-3c. The panel has not been provided with any information about Mrs Satala's current work or her willingness to comply with any conditions.

Therefore, the panel concluded that the placing of conditions on Mrs Satala's registration would not adequately protect the public nor address the public interest concerns.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

In any event, the panel considered the misconduct was serious and aggravated by the fact that Resident A was an extremely vulnerable resident whose safety had been put at risk by Mrs Satala taking on the one-to-one observation when not fit to do so. The panel would have required careful information and meaningful reflection by Mrs Satala before the panel would have been likely to consider that a conditions of practice order was appropriate and proportionate to protect the public and in the public interest. In the absence of any evidence of reflection the panel has already found that there is risk of repetition and therefore a need to protect the public with a suspension order.

It did go on to consider 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 Satala's case to impose a striking-off order.

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

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

The panel considered that this order is also 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 when caring for an extremely vulnerable resident.

The panel determined that a suspension order for a period of six 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.

Any future panel reviewing this case may be assisted by:

- Mrs Satala’s engagement and attendance at NMC proceedings.
- Evidence of completed relevant training/courses on high dependency and critical care, risk assessment and accountability and professionalism.
- Testimonials or character references.
- Detailed reflection addressing patient safety and care, accountability and assessment of priorities and what Mrs Satala has learnt since the incident.
- An update on Mrs Satala’s employment since the incident and her future intentions regarding her nursing career.

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 Satala’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 submissions made by Ms Hirschberg. She submitted that an interim suspension order for a period of 18 months is required on both public protection and otherwise public interest grounds. She invited the panel to impose the interim suspension order on the same factual and regulatory basis as the substantive suspension order.

Ms Hirschberg submitted that Mrs Satala is not currently able to practise safely and effectively and therefore it would be a public safety issue if she were permitted to practise in the interim 28 days.

Ms Hirschberg submitted that a well-informed member of the public would be concerned if a suspended registrant, with the allegations proven in this case, was permitted to practise unrestricted because the suspension order had not, owing to a matter of law, come into effect.

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, owing to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any potential appeal period.

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

This will be sent to Mrs Satala in writing.

That concludes this determination.