Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 03 February 2025 – Wednesday, 12 February 2025

Virtual Hearing

Name of Registrant:	Irena Sluszniak	
NMC PIN	07H0065C	
Part(s) of the register:	Nursing – Sub Part 1 RN1: Adult nurse, level 1 (21 August 2007)	
Relevant Location:	East Sussex	
Type of case:	Misconduct	
Panel members:	Rachel Childs Timothy Kemp David Raff	(Chair, lay member) (Registrant member) (Lay member)
Legal Assessor:	Guy Bowden	
Hearings Coordinator:	Rebecca Wagner	
Nursing and Midwifery Council:	Represented by Bibi Ihuomah, Case Presenter	
Irena Sluszniak:	Not present and unrepresented	
Facts proved:	1a), 1d), 3a), 3b), 3c), 3d), 3e), 3f)	
Facts not proved:	1b), 1c), 2)	
Fitness to practise:	Impaired	
Sanction:	**Suspension order with review (12 months)**	
Interim order:	**Suspension Order (18 months)**	

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Sluszniak was not in attendance and that the Notice of Hearing letter had been sent to Ms Sluszniak's registered email address by secure email on 19 December 2024. The panel was provided with a copy of this email.

The panel also had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Ms Sluszniak's address, as provided in the Trace report dated 22 January 2025, on 24 January 2025. It was signed for against the printed name of '*Irena Sluszniak'*.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Ms Sluszniak

The panel next considered whether it should proceed in the absence of Ms Sluszniak. It had regard to Rule 21 and heard the submissions of Ms Ihuoma who invited the panel to continue in the absence of Ms Sluszniak.

Ms Ihuomah submitted that there had been no engagement at all by Ms Sluszniak with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

Ms Ihuomah submitted that the NMC has made all reasonable efforts to serve Ms Sluszniak with the Notice of the Hearing and said that the panel is satisfied that all reasonable efforts have been to made to secure her attendance.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Ms Sluszniak;
- Ms Sluszniak has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- Ms Sluszniak has not provided the NMC with details of how she may be contacted other than her registered email address;

- The NMC obtained a Trace report so that the Notice of Hearing could be posted to Ms Sluszniak's residential address;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Seven witnesses are due to attend over the course of the hearing to provide live evidence before the panel, including the parent of the late Patient A;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019 and 2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Sluszniak in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to her, at her registered address, she has made no response to the allegations. Ms Sluszniak will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Sluszniak's decision to absent herself from the hearing, waive her right to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

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

At the outset of the hearing, Ms Ihuomah made a request that this case be held partly in private on the basis that proper exploration of Ms Sluszniak's case touches on matters involving [PRIVATE] and matters raised in this hearing would concern details relating to sensitive information of vulnerable patients. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel considered that Ms Ihuomah's application to have the hearing held partly in private was on two grounds:

1. As there may be references that relate to [PRIVATE]; and
2. As there may be references that relate to sensitive information of Patient A regarding their [PRIVATE] and circumstances of their death.

The panel determined that the second ground of Ms Ihuomah's application also involves consideration of a third party's wishes to have this information public. It considered that since Witness 1 is a parent of Patient A, it should take into account Witness 1's views as to whether they wish the panel to hold hearing in private.

The panel therefore sought the views of Witness 1 through the NMC Case Presenter. Witness 1 advised Ms Ihuomah that their preference is to hold any discussion relating to their child in public session, stating '*I want it all out there*.' The panel determined that to make a decision against Witness 1's wishes had the potential of taking away their agency and their right to a public hearing about the circumstances of their child's case.

In light of the above, the panel determined to hold the hearing partly in private only insofar as it pertains to matters relating to [PRIVATE]. It directed that the hearing would go into private session when matters relating to [PRIVATE]. However, it rejected Ms Ihuomah's application on ground two, given Witness 1's request to hear the case in public.

Details of charges (as amended)

That you, a registered nurse,

1. On 14 December 2019, in relation to Patient A,
    a. Did not call an ambulance and this was a failure.
    b. Left him in urine-soaked clothing and bed sheets.
    c. Left him in an unwashed state.
    d. Did not document the record of events in enough detail.

2. On 20 December 2019, made a retrospective entry to the record of events from 14 December 2019 in Patient A's daily notes when you should not have done so.

3. On the nightshift from 17 July 2020 to 18 July 2020, in relation to Patient B, did not,
    a. Record in the nursing care notes, the reason for administering a sedative.
    b. Monitor blood sugars regularly throughout the night.
    c. Record why you took a sugar reading at 07.00 hours.
    d. Document his symptoms or your actions.
    e. Escalate high blood sugar levels to the on-call doctor or NHS 111.
    f. Carry out and/ or document, observations.

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

Decision and reasons on application to amend the charge

The panel, of its own volition, proposed to amend charge 1a) and charge 2. The proposed amendment was to include the wording '*and this was a failure'* at the end of Charge 1a) and '*when you should not have done so*' at the end of Charge 2. In each case, the purpose of the proposed amendments was to clarify the nature of the misconduct that was alleged:

'That you, a registered nurse,

1. On 14 December 2019, in relation to Patient A,
a. Did not call an ambulance **and this was a failure.**

2. On 20 December 2019, made a retrospective entry to the record of events from 14 December 2019 in Patient A's daily notes **when you should not have done so.**

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

Ms Ihuomah did not object to the proposed amendments.

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

The panel determined that its proposed amendments were necessary and that charges 1a) and 2 would be amended. It considered that the original formulation of charge 1a) only required the panel to make a simple factual finding and would not require the panel to make any assessment of any duty or obligation on the part of the Registrant in relation to that fact. Similarly, charge 2, in its original formulation, did not require any assessment of any failure on the part of the Registrant to be addressed by the panel.

The panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to Ms Sluszniak and no injustice would be caused to either party by the proposed amendment. It was therefore appropriate to allow the amendment, to ensure clarity and accuracy.

The panel therefore amended charges 1a) and 2 as set out above.

Background

On 9 October 2020, the NMC received a referral from Witness 1 in relation to the care provided to Patient A at the Mulberry House (the Home), a speciality residential and nursing care home. The referrer raised concerns around the death of Patient A while a resident at the Home.

Ms Sluszniak was employed as a nurse at the Home since 29 December 2017 until 26 May 2021.

Patient A came to the Home for urgent respite care on 8 December 2019. Patient A had the following conditions: hydrocephalus, Cerebral Palsy, epilepsy, mild learning disability and some muscle wastage.

Incident 1

Ms Sluszniak was the only registered nurse on duty at the Home on the night shift of 13 December 2019 to the morning of 14 December 2019. In the early morning of 14 December 2019, Patient A suffered two tonic clonic seizures. Ms Sluszniak attended to Patient A and placed them in the recovery position. Ms Sluszniak did not call an ambulance for Patient A or seek advice from NHS 111. It is alleged that paramedics were called by the day staff on 14 December 2019 at 08:40 and they described on their arrival with Patient A at 08:55, he was unkempt and covered in urine. No one from the home or a relative of Patient A accompanied them to hospital. Patient A later died in the hospital.

The local authority commissioned a safeguarding report following a referral by Witness 3. The Home referred to the National Institute for Health and Care Excellence (NICE) Guidelines for epilepsy, diagnoses and management. This said that seizures of less than five minutes did not always necessitate urgent action. However, the report also noted that it had been at least 12 years since Patient A's last known seizure. The general manager of the Home described Patient A as being generally unkempt and that he neglected his personal care. This was disputed by Patient A's social worker but no further action was taken as a result of this review.

Incident 2

Ms Sluszniak was the registered nurse on duty overnight from 17 July to 18 July 2020 and was providing care to the residents of the Home. This included Patient B. Patient B was described as behaving "*aggressively*" and "*staggering around*" the night of 17/18 July 2020. It was alleged by Witness 4 that this behaviour can be a sign of potential blood sugar irregularities. Ms Sluszniak, in her local interview, had stated that she had taken a blood sugar reading at 9pm on the 17 July 2020, which was high. She said that she decided to administer a sedative. She did not document the medication, the reason for the medication or the blood sugar reading. Patient B later suffered a fall and hurt his wrist. Ms Sluszniak took his blood sugar levels at 7am on 18 July 2020, which were dangerously high. Patient B was then taken to the Accident and Emergency (A&E) ward of the local hospital. Ms Sluszniak's account of the night and clinical rationale and decision-making were not documented. There was no evidence to suggest that she did called the on duty doctor or NHS 111.

Ms Sluszniak was suspended on 22 July 2020 while an internal investigation was conducted.

Ms Sluszniak has stopped engaging with the NMC.

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 Ihuomah.

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

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

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

- Witness 1: Parent of Patient A;
- Witness 2: Deputy Manager of the Home at the time of the incidents;
- Witness 3: Paramedic who attended the Home for the incident of Patient A;
- Witness 4: Manager of the Home at the time of the incidents;
- Witness 5: Registered nurse at the Home at the time of the incidents;
- Witness 6: Night carer at the Home at the time of the incidents; and

- Witness 7: Senior Support Worker (Health Care Assistant) at the Home at the time of the incidents.

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

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

Charge 1a)

"That you, a registered nurse,

1. On 14 December 2019, in relation to Patient A,
   a. Did not call an ambulance and this was a failure."

This charge is found proved.

In reaching this decision, the panel placed most weight on the evidence of witnesses who were present at the time and/or observed personally the condition of Patient A. This being Witnesses 3, 5, 6 and 7. It also took into account Witness 4's evidence.

In their evidence, Witness 6 explains that on the night of the incident with Patient A, they called Ms Sluszniak, as the registered nurse on duty, on the emergency bell for both seizures. Witness 6 stated that Ms Sluszniak responded to the call bell in '*a matter of seconds.*' They stated that following the second call, Ms Sluszniak said that '*she was going to call an ambulance*.' The panel placed significant weight on Witness 6's evidence and concluded that Ms Sluszniak intended to call the ambulance following Patient A's second seizure which self-terminated at around 07:00 on 14 December 2019.

Witness 6 had recalled that the care of Patient A was '*taken off*' Ms Sluszniak before she could call the ambulance. However, the panel, after reviewing the timeline, concluded that the day staff would not have been at the Home until about 07:40, well after Ms Sluszniak had indicated to Witness 6 that she thought Patient A required an ambulance.

The panel considered that in Witness 5's evidence, they stated that during handover Ms Sluszniak indicated that Patient A "*was doing okay after the seizures and that* [Patient A] *had been continually visually monitored following the two seizures*." Further, Witness 5 stated that Ms Sluszniak *"did not inform me to call an ambulance as when she had presented the handover, Patient A had been stable condition*." The panel concluded that Ms Sluszniak had either changed her mind about the need for an ambulance or had simply failed to call one. Following handover and undertaking an observation on Patient A, Witness 5 said in their oral evidence, that they immediately called an ambulance as Patient A was '*bubbling at the mouth*' and '*looked quite unwell*.' Their evidence was supported by Witness 7, who upon attending Patient A at around 08:15 that morning, immediately called for help from the registered nurse on duty. When questioned by the Panel, Witness 5 confirmed that calling the ambulance was part of what she understood to be the policy at the Home, which from her understanding, stated that if a patient experiencing seizures continued to have other seizures, an ambulance should be called.

The panel also had regard to the evidence of Witness 3, who was the paramedic who attended Patient A at the Home. Witness 3, in their statement, said that a call was received from the Home at 08:40 and that Witness 3 and their crewmate arrived at the Home at 08.51. Witness 3 stated:

> "*We were very quick on the scene as we quickly recognised how unwell Patient A was."*

Witness 3 further stated:

"*On reflection, I am also concerned about the length of time it took for the ambulance to be called. Patient A was extremely poorly when we arrived at the scene and the call was made only a matter of eleven minutes prior to this. It was likely that Patient A had been deteriorating since having his seizures and … an ambulance should have been called earlier."*

The panel considered that this is further evidence that Patient A was in need of emergency care and an ambulance should have been called before the day shift took over.

The panel also bore in mind the evidence of Witness 4. Witness 4, being the Home Manager at the time of the incident, stated that there were digital care plans in place for Patient A. They advised that although the history of Patient A's epilepsy was unclear at this time, the Home was following the NICE Guidelines for Patient A's care. Witness 4, in their oral evidence, said that the Home policies, including the NICE Guidelines, were accessible and available to all members of staff and that this is the procedure Ms Sluszniak followed.

Although Witness 4 indicated that there was an epilepsy policy in the Home, the evidence given to this panel by senior carers and nurses contradicted this and that the NICE Guidelines were not easily accessible and/or available in the Home to support clinical decision-making. Witness 2, the Deputy Home Manager, stated that they believed that it was a nurses responsibilities to look up such guidelines on the internet. The panel did not consider this to be reasonable, given the wealth of NICE Guidelines available online. Given the evidence of the nursing and care staff, the panel considered it unlikely that the Registrant had applied an understanding of the NICE Guidelines to her care of Patient A.

It considered that Ms Sluszniak had limited information relating to Patient A as their care plan had not been completed and there was no information about the management of his epilepsy contained within them. In fact, Patient A's last known seizure was some 12 years prior to the incident.

The panel concluded that in the absence of clear procedure with patients who have epilepsy, and with the limited information relating to Patient A's condition, Ms Sluszniak should have erred on the side of caution and called an ambulance. This was supported by the facts that:

- The paramedic (Witness 3) clearly stated that the ambulance should have been called earlier;
- The day nurse (Witness 5) who took over from Ms Sluszniak rapidly concluded that such a call was necessary; and
- Ms Sluszniak herself had stated after the second emergency call that she was going to call an ambulance.

In light of the above, the panel concluded that despite Ms Sluszniak's initial intention to call an ambulance she did not do so, and that she did not indicate to Witness 5 that an ambulance should be called. It also gave significant weight to Witness 3's evidence who considered that an ambulance should have been called earlier to assist with Patient A. Therefore, the panel found this charge proved.

Charge 1b) and 1c)

"That you, a registered nurse,

1. On 14 December 2019, in relation to Patient A,
    b. Left him in urine-soaked clothing and bed sheets.
    c. Left him in an unwashed state."

These charges are found NOT proved.

In reaching this decision, the panel took into account the evidence of Witnesses 1, 3, 5, 6 and 7.

Witness 1, in their oral evidence, stated that they had never experienced Patient A being reluctant to undertake personal care as that this was something Patient A would do themselves. Witness 1 emphasised that Patient A did not normally present themselves in an unkempt manner.

The panel considered Witness 3's account of Patient A when they arrived on scene at the Home. In their Witness Statement, Witness 3 said:

> "*A major concern was in relation to the condition which I found Patient A in. I was concerned that Patient A was unkempt; he was unclean and was in urine sodden clothing and bed sheet.* […] *I could not believe that Patient A's clothes and bed sheets had not been changed*."

The panel next considered Witness 6's account of Patient A. Witness 6 said that when they went to change Patient A's pad at about 06:30, Patient A had their first seizure. Witness 6 stated that at the time they did not change the pad considering the emergency that was presented. She did not state that Patient A was wet or soiled at that point.

Witness 7, who was on the day shift on 14 December 2019, said that they did not recall any urine smell in Patient A's room or that Patient A had been unwashed.

The panel concluded that although Witness 3 gave clear evidence that Patient A was left in urine clothing and bed sheets, it could not find that this was a failure by Ms Sluszniak. Whilst Witness 3 had found Patient A soaked in urine and in an unwashed state, there was no evidence before the panel as to when this had occurred. Ms Sluszniak had last seen the patient at 07:50 and Witness 3 did not arrive in his room until 08:55. In the absence of evidence as to the state of Patient A's clothing and bed sheets at 07:50, the panel was unwilling to speculate and therefore could not conclude that the Registrant had left him in urine soaked bedsheets and in an unwashed state.

Therefore, on the balance of probabilities, the panel found charges 1b) and 1c) not proved.

Charge 1d)

That you, a registered nurse,

1. On 14 December 2019, in relation to Patient A,
    d. Did not document the record of events in enough detail.

This charge is found PROVED.

The panel took into account Patient A's vital signs observation charts. The charts were completed by Ms Sluszniak on 14 December 2019 at 07:00. It outlines Patient A's position, pulse rate, respiratory rate, oxygen saturation and included a note of *'[a]fter seizures'*. However, the panel considered that there was no written narrative to accompany the vital sign observations of Patient A.

The panel next considered the Daily Notes of Patient A, completed by Ms Sluszniak. On 14 December 2019 09:19, the recorded entry is as follows:

> "*At 0615 am Patient A had clonic seizures lasting 3 minutes twice, with a break of about 10 min. Convulsion concerned the face and left hand. The regeneration time took about 40 min when* [Patient A] *start be fully responsive. After seizures* [Patient A] *was very exhausted and complained of nausea but* [Patient A] *did not vomit."*

The panel found that the above documentation in relation to Patient A was insufficient in detail. It considered that there was no narrative relating to the clinical decision making Ms Sluszniak made in relation to the care provided. There was no rationale to explain as to why the on-call doctor was not consulted, or that NHS 111 or 999 were not called following the two seizures.

It noted that the written Daily Notes were completed at 09:19 and the ambulance crew left with Patient A at 09:30. The panel had no evidence to demonstrate that the Daily Notes were provided to the ambulance or that Ms Sluszniak had provided a handover to the ambulance crew. Indeed Witness 3 commented in her evidence that she was not provided with sufficient and appropriate documentation.

Further, the panel noted that Witness 4 on 20 December 2019 directed Ms Sluszniak to make a retrospective entry on Patient A's records regarding the night of 13 December 2019/morning of 14 December 2019, as her initial entry into the Daily Notes was insufficient and the detail included in this retrospective entry was comprehensive and what the panel would have expected to have seen for the 14 December 2019.

In light of the above, the panel found that there was insufficient detail relating to the seizure occurrences. Therefore, charge 1d) is found proved.

Charge 2)

2. On 20 December 2019, made a retrospective entry to the record of events from 14 December 2019 in Patient A's daily notes when you should not have done so**.**

This charge is found NOT proved.

The panel considered the retrospective entry made by Ms Sluszniak in relation to Patient A. The retrospective entry was completed on 20 December 2019 at 14:18. During their live evidence, Witness 4 stated that they gave Ms Sluszniak a direction to complete a retrospective entry. They said the direction was given as the initial entry was insufficient and did not comprise enough detail of her account of the incidents that occurred.

The panel found that the retrospective entry was made as per instruction of Ms Sluszniak's line manager and was not of Ms Sluszniak's own volition. As such, she could

not be criticised for having made the entry which indeed clarified and provided clinical reasoning in relation to events of 14 December 2019. Therefore, Charge 2 is found not proved.

Charge 3 (in its entirety)

3. On the nightshift from 17 July 2020 to 18 July 2020, in relation to Patient B, did not,
    a. Record in the nursing care notes, the reason for administering a sedative.
    b. Monitor blood sugars regularly throughout the night.
    c. Record why you took a sugar reading at 07.00 hours.
    d. Document his symptoms or your actions.
    e. Escalate high blood sugar levels to the on-call doctor or NHS 111.
    f. Carry out and/ or document, observations.

These charges are found proved.

The panel took into account that charge 3a) to 3f) are linked as they relate to the care, observations and documentation of the treatment of Patient B.

In relation to Charge 3a), the panel had regard to Witness 4's written statement. Witness 4 stated:

> *"There was no documentation that a sedative had been administered by the Registrant."*

The panel noted that there was also no evidence to demonstrate Ms Sluszniak's rationale for administering a sedative to Patient B. The panel therefore concluded that charge 3a) was proved.

In relation to Charge 3b), Witness 2 stated:

"*I told the Registrant my worry was that whilst she had done a visual assessment of Patient B, she had waited until 07:00 to record* [Patient B's] blood sugar.

[…]

The Registrant did not document what had happened to make her take Patient B's blood sugar reading at this point."

The panel acknowledged that Ms Sluszniak told Witness 2 that the blood sugar levels were taken throughout the night. However, it had no evidence to confirm Ms Sluszniak's account and therefore concluded that the likely explanation is that no measures were taken, given that she made no documentary record. The panel therefore found this charge proved.

In relation to Charge 3c), the panel noted it had not been provided with any evidence to demonstrate that Ms Sluszniak did record why she took the blood sugar levels at 07.00. It further noted that there is no explanation for this reading. It therefore concluded that it is likely that no rationale for this reading was given. It found the charge proved on this basis.

In relation to charge 3e), the panel took into account the investigation meeting notes from 31 July 2020, in which Ms Sluszniak was asked why she had not contacted the on-call doctor. Her response was that she had '*given him water and tried to record his sugar levels.'* The panel considered that her response did not address the question asked of her and indicated that she had not made an attempt to seek help from the doctor. Similarly, Witness 2 confirms in their witness statement that they told Ms Sluszniak that she '*should have called 111 for assistance.'* The panel concluded that Ms Sluszniak had made no attempt to escalate concerns to the on-call doctor or NHS 111 about Patient B's high blood sugar levels and found this charge proved.

In relation to charges 3d) and 3f), the panel noted that it had not been provided with any evidence to demonstrate that Ms Sluszniak documented Patient B's symptoms or her

actions or that she had carried out or documented observations on Patient B. Further, the panel considered the disciplinary meeting notes, in which Ms Sluszniak, in relation to the documentation she completed on the care of Patient B, said:

"*It is true I expect punishment because of notes* [sic]"

The panel inferred from this statement that the Registrant acknowledged not recording or documenting the symptoms, her actions or her observations.

In light of the above, the panel concluded that charges 3d) and 3f) were proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Sluszniak's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Ms Sluszniak'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 Ihuomah invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Ihuomah submitted that the actions of Ms Sluszniak fell significantly short of the standards of a registered nurse. She stated that Ms Sluszniak's actions were a '*serious departure*' from the fundamentals of nursing as the facts found proved relate to poor record keeping, failing to recognise and escalate a worsening condition, and that those actions placed patients at a real risk of harm. Ms Ihuomah stated that part 10 of the Code had been breached.

Submissions on impairment

Ms Ihuomah 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. She made reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Ihuomah submitted that Ms Sluzniak's current fitness to practise is impaired. She said that Ms Sluszniak's failures placed patients at an unwarranted risk of harm and that the reputation of the profession would be damaged if a finding of impairment was not found. She stated that due to this impairment, Ms Sluszniak is unable to practise kindly, safely or

professionally. She said that the conduct would be able to be remediated however it has not been. The conduct is also likely to be repeated and she pointed the panel to the oral and written evidence of Witnesses 2, 3 and 4.

Ms Ihuomah submitted that Ms Sluszniak's actions demonstrate deep-seated attitudinal issues. She said that when Ms Sluszniak was asked at the investigation/disciplinary meetings for a further reflection on the incidents and to provide an understanding of what she had learnt, she stated she had not had the opportunity to do so. Further, Ms Ihuomah stated that there was no evidence of training or remedial actions provided by Ms Sluszniak as the 23 pages of training certificates were not provided by the Registrant, but rather Witness 2.

When considering context, Ms Ihuomah submitted that there is no evidence that the staffing levels, potential bullying or [PRIVATE] on her ability to provide adequate care to Patient A and/or Patient B. Ms Ihuomah submitted that these were not relevant factors for the panel to consider as:

- [PRIVATE];
- Ms Sluszniak did not, on any occasion, raise an issue that she was unable to cope or deal with her role due to the staffing levels;
- Although Witness 6 indicated that other staff had treated Ms Sluszniak disrespectfully, this was contradicted by the evidence of other witnesses for example Witness 7.

It was therefore Ms Ihuomah's submission that the panel should find that the misconduct amounts to a finding of current impairment.

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), *Meadows v GMC* [2007] EWCA Civ 130, *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Calhaem, R (on the application of) v General Medical Council* [2007] EWHC

2606 (Admin), *Ahmedsowida v GMC* [2021] EWHC 3466 (Admin), *Schodlok v General Medical Council* [2015] EWCA Civ 769, *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin) and *Council for the Regulation of Health Care Professionals v General Medical Council and Biswas* [2006] EWHC 464 (Admin).

Decision and reasons on misconduct

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

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

> ***8 Work Co-operatively***
> *To achieve this, you must:*
> *8.2 maintain effective communication with colleagues*
> *8.5 work with colleagues to preserve the safety of those receiving care*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *This applied to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> *10.2 identify any risks of problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
>
> ***13 Recognise and work within the limits of your competence***
> *To achieve this, you must, as appropriate:*

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required

15 Always offer help if an emergency arises in your practice setting or anywhere else
To achieve this, you must:
15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

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

The panel considered that Ms Sluszniak's actions resulted in a significant risk of harm to Patient A. It found that the failure to call an ambulance allowed time for Patient A to deteriorate further and that this was evidenced by the account of Witness 3, the paramedic who attended Patient A. However, the panel noted that the safeguarding report commissioned by the local authority concluded that an earlier call for an ambulance would not have prevented Patient A's death.

In relation to record keeping for Patient A, the panel considered the evidence of Witness 3, who stated:

"*One of these concerns what that the documentation and information that the Home's staff could provide us with was very limited specifically in regards to the two seizures which had occurred in the night. Ideally, I would have been informed about Patient A's past medical history including his history of seizures. I would also have been expected to be given a detailed account of what had happened to Patient A and why medical intervention had not been actioned prior to the 999 call.* [sic]*"*

The panel concluded that Witness 3's account demonstrated that the record keeping was clearly inaccurate which impacted on the care provided to Patient A. The inadequacy of record keeping compromised the care available to Patient A. The panel found this to be very serious in nature.

In relation to Patient B, the panel considered that the failure to monitor Patient B's blood sugars to be significant as Patient B was being assessed for possible diabetes. The panel noted that the failure to escalate and adequately monitor Patient B's blood sugar levels fell significantly short of the standard of care expected of a registered nurse.

In relation to record keeping for Patient B, the panel noted that although it did not have the Medication Administration Record (MAR) Chart to confirm what was documented, the disciplinary meeting notes confirmed that Ms Sluszniak did not provide a written rationale or documentation of the reasons for providing a sedative, for monitoring/taking blood sugar levels at 07:00 or the rationale to not escalate to the on-call doctor or NHS 111.

It is documented that Patient B was '*very agitated*' and at 02:00 it is reported that Ms Sluszniak administered a sedative without any evidence that she investigated an alternative cause for his presentation, which given his history and ongoing assessment was a critical consideration. This placed Patient B at risk of serious harm.

Therefore, in light of all of the above, the panel found that Ms Sluszniak's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct in relation to all the charges found proved.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Sluzniak'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. To justify that trust, nurses must be honest and open and act with integrity. 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;'*

The panel finds that patients were put at risk, that they were caused potential physical harm and Patient A's relatives experienced emotional distress as a result of Ms Sluszniak's misconduct. Her misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel acknowledged the evidence it had heard in relation to the circumstances surrounding the incidents. It considered the working environment to be very busy and that the staffing levels may have made it more difficult for Ms Sluszniak to practise safely. Having only one registered nurse (albeit supported by Health Care Assistants) to 68 patients in a specialised home caring for patients suffering from chronic and debilitating neurological, cognitive disabilities and challenging behaviours on a night shift was, the panel considered, a challenging proposition. Further, the panel heard evidence from Witnesses 6 and 7 that there were difficulties in the working relationships between the day and night staff which may have made communication more difficult and impacted on patient care. The panel was also concerned by the absence of a well-understood policy in the Home to manage patients with epilepsy.

However, the panel noted that it must make a decision on the individual actions of Ms Sluszniak during the incidents in question. It took into account the Code and the responsibility of a nurse to raise concerns about the levels of staff or support in a working environment. The panel noted that it had no evidence from Ms Sluszniak so any conclusions that it might have been tempted to draw about the challenges of the working environment were ultimately speculative. It would have been beneficial to have heard from Ms Sluszniak herself to provide further context regarding the incidents in question and what the night shift looked like from her perspective. The panel concluded that there was not enough evidence to connect the circumstances of the Home working environment to the failings of Ms Sluszniak identified at the facts stage, and therefore, that the circumstances, while possibly not optimal, do not prevent a finding of impairment.

The panel noted that it had not been provided with any reflective accounts from Ms Sluszniak. It noted the disciplinary meeting notes dated 22 July 2020, 31 July 2020 and 19 May 2021, where Ms Sluszniak provides her account of the incidents. Her accounts do not outline an understanding of the risk of harm to the patients or the potential damage to the reputation of the profession, however Ms Sluszniak details stressful personal circumstances; she stated she was '*very nervous, I think I forget important things I want to say, everything is in chaos after the situation in July*'. Further, Ms Sluszniak appears to accept that she failed to keep adequate records in relation to Patient B. The panel found that this demonstrates some reflection on the incidents but in its view this is not sufficient to reassure it in relation to future risk of repetition and demonstrated very limited insight into her failings and the reasons for them.

The panel was satisfied that the misconduct in this case is in theory capable of being addressed. It considered that record keeping, escalating concerns and clinical decision making could be strengthened with targeted specific training and supervision. However, it did not consider that the generic training courses undertaken by Ms Sluszniak as comprised in the "Registrant's Bundle" (in fact provided by Witness 2) demonstrated such targeted specific training.

The panel had no further evidence to demonstrate that Ms Sluszniak has undertaken any additional training to strengthen her practice.

In light of the above, the panel therefore found that Ms Sluszniak has not demonstrated steps to strengthen her practice.

The panel considered the submission of Ms Ihuomah that Ms Sluszniak demonstrates deep-seated attitudinal issues. It noted that the two incidents in question, although serious, were isolated occurrences. Further, it considered that while the investigation and disciplinary meetings notes demonstrated that Ms Sluszniak had very limited insight into the misconduct, this was not enough to conclude that she would be incapable of developing this over time with the right support and commitment on her part. The panel acknowledged that Witness 4 found Ms Sluszniak to be '*defensive'* and '*evasive'* in her answers during the investigation meeting, but on the basis of the written record alone, the panel was unable to reach the same conclusion. It took into account that such meetings are stressful and that [PRIVATE]. The panel considered that what may have come across as defensive to Witness 4 may simply have been nervousness about the situation in which she found herself. It took into account the positive comments from Witness 6, who worked regularly with Ms Sluszniak and described her as a '*good nurse*' who would listen to and be supportive of her colleagues. The panel was therefore did not conclude that Ms Sluszniak had deep-seated attitudinal issues.

However, Ms Sluszniak has not engaged with the NMC since 2020 and the panel has no information before it to reassure itself that there is little or no risk of repetition. The panel has already concluded that patients were placed at unwarranted risk of harm and therefore, it is necessary to make a finding of impairment on the ground of public protection.

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

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

In reviewing the facts found proved and considering the public interest the panel concluded that a fully informed fellow practitioner would find Ms Sluszniak's failings to be unacceptable and by the same measure a member of the public would lose trust and confidence in the nursing profession and its regulator if Ms Sluszniak were found to not be impaired. Therefore, the panel also found Ms Sluszniak's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months, with a review. The effect of this order is that the NMC register will show that Ms Sluszniak'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

The panel noted that the NMC advised Ms Sluszniak, in the Notice of Hearing, dated 19 December 2024, that it would seek the imposition of a striking off order if the panel found her fitness to practise currently impaired.

Ms Ihuomah submitted that a striking off order should be imposed. She stated that there has been no evidence to demonstrate that the misconduct has been resolved. Further, the

only evidence of remediation is training certificates that are dated 2020, which is just shy of five years and there has been no further engagement from Ms Sluszniak.

Ms Ihuomah submitted that public confidence would be seriously diminished if Ms Sluszniak were able to continue to practise without restriction. She said that there are no conditions of practice that can be imposed that would maintain the public's confidence in the profession if Ms Sluszniak were to remain in practice.

Decision and reasons on sanction

Having found Ms Sluszniak'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;
- Conduct which put patients at risk of suffering harm; and
- Lack of engagement with the NMC process.

The panel also took into account the following mitigating features:

- [PRIVATE]; and
- Some evidence of a challenging work environment in which Ms Sluszniak was practising.

The panel bore in mind that it previously found that Ms Sluszniak's failings were not directly attributable to the mitigating circumstances and therefore that the aggravating features of this case outweigh the mitigating circumstances.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Sluszniak's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Sluszniak'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 Ms Sluszniak'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 factors in the SG which may point towards a conditions of practice order, in particular:

- No evidence of harmful deep-seated personality or attitudinal problems – the panel had found no such evidence;
- Identifiable areas of the nurse's practice in need of assessment and/or retraining – in this case, there were clearly specific issues relating to record keeping and escalation where Ms Sluszniak could benefit from training and supervision;
- No evidence of general incompetence;

The panel is of the view that there might potentially be practical or workable conditions that could be formulated, given the nature of the misconduct in this case, given that it relates to specific areas of practice that might respond well to retraining and supervision. However, the panel considered that as Ms Sluszniak has not engaged with the NMC or made any submissions it is not possible to formulate workable conditions and be assured that they would be complied with.

Furthermore, the panel concluded that the placing of conditions on Ms Sluszniak's registration would not adequately address the seriousness of this and would therefore not address 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; and
- No evidence of harmful deep-seated personality or attitudinal problems.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. The panel noted that Ms Sluszniak's misconduct consisted of two isolated incidents and did not present a pattern of incompetence. It considered that with the right level of training and support, and positive engagement on her part, Ms Sluszniak may be able to return to safe practice. The public would in the meantime be protected by the suspension order and the need for Ms Sluszniak to satisfy a review panel before she could return to practice.

It did go on to consider whether a striking-off order would be proportionate. The panel has previously found that there is no evidence of any deep-seated attitudinal issue that would lead it to conclude that Ms Sluszniak was fundamentally unsuited to nursing. It concluded that the public could be protected with a suspension order and the public interest in this

case would be met. The imposition of a striking off order would therefore be disproportionate at this time as it was not the only sanction that would be sufficient to protect patients, members of the public and maintain professional standards. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Ms Sluszniak'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 Ms Sluszniak. 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.

Any future panel reviewing this case would be assisted by:

- Engagement with the NMC and attendance at the review hearing;
- A detailed reflective account for both incidents;
- Evidence of any training completed since May 2020;
- Testimonials from a line manager or supervisor for paid and/or unpaid employment;
- An indication to the NMC regarding Ms Sluszniak's future intention to practise.

This will be confirmed to Ms Sluszniak 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 Ms Sluszniak'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 Ihuomah. She submitted that in light of the panel's decision for a 12 month suspension order, an 18 month interim suspension order should be imposed to cover the 28 day appeal period. She stated that if there is an appeal application by Ms Sluszniak, the 18 month period will cover the appeal application. Ms Ihuomah said that the interim order is necessary on grounds of public protection and is otherwise in the public interest.

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 protect the public and uphold the public interest.

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

That concludes this determination.