Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 3 March – Monday, 10 March 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Cajetan Ironah Mazi**
NMC PIN	10I4591E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 17 April 2013
Relevant Location:	Cornwall
Type of case:	Misconduct
Panel members:	Rachel Childs (Chair, Lay Member) Ranvir Virk (Registrant Member) David Anderson (Lay Member)
Legal Assessor:	Jeremy Barnett
Hearings Coordinator:	Angela Nkansa-Dwamena
Nursing and Midwifery Council:	Represented by Tom Hamilton, Case Presenter
Mr Mazi:	Present but not represented
Facts proved:	Charges 1a, 1b (i and ii), 1c, 1d and 2
Facts not proved:	Charge 3
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge (as amended)

That you, a registered nurse

1. On or around 22 February 2018 in relation to Patient A

    a. on one or more occasions did not recognise and/or escalate Patient A's deteriorating condition to the medical team and/or the nurse in charge

    b. did not administer Patient A's intravenous infusion
        i. at the prescribed rate of 2 hours and/or
        ii. increase the frequency when hypotension was identified

    c. did not inform the charge nurse of Patient A's condition when you went on your break

    d. did not undertake and/or record observations on the electronic observations 'EOBS' chart

2. Recorded within the electronic observations 'EOBS' chart a respiratory rate of 20 for Patient A

3. Your conduct at charge 2 was dishonest in that you deliberately sought to represent that Patient A's respiratory rate was 20, when you knew that it was not.

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

Decision and reasons on application to amend the charge

Prior to closing the Nursing and Midwifery Council's (NMC) case, the panel heard an application made by Mr Hamilton, on behalf of the NMC, to amend the wording of

Charge 1b (ii), in accordance with Rule 28 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The proposed amendment was to replace the word 'hypertension' with the word 'hypotension'. Mr Hamilton submitted that the proposed amendment would provide clarity and more accurately reflect the evidence and that it would not cause any injustice to you at this stage.

Original Charge

That you, a registered nurse

1. On or around 22 February 2018 in relation to Patient A

    b. did not administer Patient A's intravenous infusion
        i. …
        ii. increase the frequency when hypertension was identified

Proposed Amendment

That you, a registered nurse:

1. On or around 22 February 2018 in relation to Patient A

    b. did not administer Patient A's intravenous infusion
        i. …
        ii. increase the frequency when ~~hypertension~~ **hypotension** was identified

You told the panel that you had no objections to the error being corrected.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by correcting the typographical error. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and more accurately reflect the evidence.

Background

On 16 January 2019, the NMC received a referral from Royal Cornwall Hospitals NHS Trust (the Trust), raising concerns about you, a registered nurse. The charges arose whilst you were working as an agency nurse at Royal Cornwall Hospital (the Hospital).

It is reported that on the 22 February 2018, you were allocated the care of Patient A during a day shift on Newlyn Unit (the Unit). It is said that a Student Nurse (STN), who was working with you on the day, had raised concerns about Patient A's deteriorating condition. It is alleged that you did not take into account the STN's concerns and that you had allegedly input different values on the electronic observation (e-obs) system to those reported by the STN. After you commenced your afternoon break, it is reported that the STN raised her concerns to another nurse on the Unit and Patient A's condition was subsequently escalated.

Patient A later died from biliary sepsis and there were allegedly several failures in the care that was provided including a failure to increase observations, a failure to escalate Patient A's deteriorating condition, a failure to follow policy and allegedly inputting incorrect data onto the hospital's e-obs system.

Decision and reasons on facts

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

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: Lead Surgical Care Practitioner and Investigator of the incident at the time.
- Witness 2: Second Year Student Nurse at the time of the incident.
- Witness 3: Registered Nurse working on the Unit at the time of the incident.
- Witness 4: Registered Nurse working on the Unit at the time of the incident.

The panel also heard evidence from you under oath.

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 you.

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

Charge 1a

1. On or around 22 February 2018 in relation to Patient A

    a. on one or more occasions did not recognise and/or escalate Patient A's deteriorating condition to the medical team and/or the nurse in charge

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 2 and Witness 4, your oral evidence and the medical records of Patient A.

The panel noted that within her NMC written witness statement dated 20 July 2021, Witness 2 had outlined that she had been concerned about Patient A's condition throughout the course of the shift:

> *'I checked Patient A's respiration rate. A normal respiratory rate is between 12 and 20. I can recall it was above 20. A change in respiration rate it's a sign that something is seriously wrong. Patient A's histolic* [sic] *blood pressure was 67, which is really low. It normally should be above 120. I reported that he had a catheter in situ and he hadn't passed urine all day. He was having fluids and I recall he was drinking cups of tea. He was a typical patient that was deteriorating. He had a grey look on his face and had an increased temperature. He hit every red flag for a septic patient that was deteriorating. I escalated to the nurse that it had increased and BP looked worrying…'*

This was consistent with her oral evidence in which she also stated that Patient A had reported feeling unwell. This is further supported by Witness 2's local witness statement of 5 July 2018 and Witness 4's oral evidence and her documentation within Patient A's medical notes.

You told the panel that you had recognised that Patient A's blood pressure was low when you had conducted observations in the morning, and you had escalated this to

a doctor who prescribed a bag of fluids as a corrective measure. This was supported by observations that were inputted by you at 10:21 hours on the e-obs system, the record of the prescribed fluid at 10:45 hours and your retrospective documentation within Patient A's notes at 12:00 hours. The panel accepted that you had escalated Patient A's condition in the morning. However, it noted that you had accepted that you did not escalate Patient A's condition in the afternoon as you felt his presentation was unchanged from the morning and you needed to 'give the fluids time' to correct his condition before escalating to a doctor again. The panel also heard that you had worked with other nurses, and you believed that they were aware of Patient A's condition.

The panel had regard to Patient A's e-obs chart for 22 February 2018. It confirmed that at 14:39 hours, Patient A's National Early Warning Score (NEWS) was 6 due to a low blood pressure reading of 70/41mmHg, a decreased pulse of 50 beats per minute (bpm) and an increased respiration rate of 24 respirations per minute (rpm). At 15:30 hours, Patient A's NEWS was 4 with a low blood pressure of 77/48mmHg and a low temperature of 36.0ºC. The panel noted that the Trust's guidance with respect to the management of sepsis indicated that any individual with a NEWS ≥ 5 (amber or red), should be considered for sepsis screening.

The panel considered the above evidence and decided to accept the accounts of Witness 2 and Witness 4. The panel noted that Witness 2's account was consistent and was supported by Witness 4's oral and documentary evidence. It considered that Patient A's observations demonstrated a clear deterioration in his condition which was sufficient enough to cause Witness 2 concern and resulted in her subsequent escalation to Witness 4. The panel also acknowledged that Patient A himself had reported feeling unwell and swift action was taken to treat him.

The panel considered that as Patient A's allocated nurse, you had a responsibility to recognise and escalate his condition which was clearly deteriorating, especially when numerous concerns had been raised to you by Witness 2. The panel noted that although you were not the person who had recorded Patient A's observations at 14:39 hours and you had asserted that all members of staff were helping you with the care of Patient A, you still had oversight of his care, and you were responsible for

recognising and escalating his deteriorating condition and you had missed several opportunities to do so.

In light of the above, the panel determined that on one or more occasions, you did not recognise and/or escalate Patient A's deteriorating condition to the medical team and/or the nurse in charge.

Accordingly, the panel found Charge 1a proved.

Charge 1b (i)

1. On or around 22 February 2018 in relation to Patient A

b. did not administer Patient A's intravenous infusion

i. at the prescribed rate of 2 hours and/or

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1, Witness 3 and Witness 4, your oral evidence and Patient A's medical notes.

The panel noted that within her NMC written witness statement dated 1 March 2022, Witness 1 had outlined the following:

> *'…the patient was prescribed IVI fluids at 10:21…Cajetan should have set the IV to be administered over 2 hours, but instead set it to be over 4 hours. As per sepsis 6 policy, IV fluids should have been given over the prescribed time, which they were not… Cajetan did not ensure that Patient A received the correct fluid frequency.'*

The panel had regard to Patient A's fluid balance chart and fluid prescription chart. It noted that following your escalation of Patient A's condition at 10:21 hours, the doctor prescribed 1 litre (1L) of normal saline to be given over two hours, which you had commenced at 10:45 hours. A second bag of fluids to be given over six hours was commenced by you at 14:10 hours. The panel noted that it appeared that it had taken three hours and 25 minutes for the first bag a fluid to be administered to Patient A.

You told the panel that you had used a pump machine to administer Patient A's fluids, and you had set it to administer 1000mls (1L) over a period of two hours. This is supported by your documentation on Patient A's fluid balance chart, in which you recorded that 1000mls had been set to administer at a rate of 500mls/hour.

You further told the panel that there were various factors that could affect the delivery of fluids into a patient, such as kinks in the tubing, the condition of the cannula and the position of the patient's arm. You stated that throughout the time of the intravenous infusion (IVI), there would be instances where the pump would alarm, and it would take time for you to reach Patient A to sort out whatever occlusion was present. You stated that you had no control over this.

When you put this to Witness 1, Witness 3 and Witness 4 during cross examination, all of them agreed that there were factors that, in theory, could affect the delivery of fluids to a patient. However, as a nurse, it would be your responsibility to ensure that fluids are administered to the patient within the timeframe it had been prescribed. Witness 1 elaborated on ways you can minimise the impact of these factors such as re-siting a cannula or asking a member of staff to sit with the patient to ensure the fluid goes in.

The panel considered the above evidence and determined that you had not administered Patient A's IVI at the prescribed rate of two hours. The panel decided that although there was some evidence to suggest that you had set Patient A's IVI to administer the fluids over two hours, you had not ensured that this delivery had occurred during the two-hour timeframe. The panel acknowledged that you stated that it was out of your control if there were factors impeding the delivery of the fluids

but, it noted the evidence of Witness 1, Witness 3 and Witness 4 and concluded that it was your responsibility to ensure that the fluids were administered in spite of any obstructions. The panel further considered that there was no evidence before it, such as documentation in Patient A's records, to suggest that Patient A's IVI had been impeded due to the positioning of his arm or that there had been any issues with his cannula or the tubing.

In light of the above, the panel determined that you did not administer Patient A's IVI at the prescribed rate of two hours.

Accordingly, the panel found Charge 1b (i) proved.

Charge 1b (ii)

1. On or around 22 February 2018 in relation to Patient A

    b. did not administer Patient A's intravenous infusion

        ii. increase the frequency when hypotension was identified

This charge is found proved.

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

During her oral evidence, Witness 1 stated that you should have increased the rate of Patient A's IVI when you identified that his hypotension was persisting.

You told the panel that you could not change the rate without the instruction of a doctor and that you did not escalate to the doctor as you had just done so and the fluids needed time to correct Patient A's hypotension. Witness 1 agreed that the rate of Patient A's IVI could not be increased without a doctor's instruction, but stated that

you could have called a doctor, and verbal authority could have been given which would allow you to increase the rate.

The panel considered the above evidence and accepted the evidence of Witness 1. It recognised that in order to increase the rate of Patient A's IVI, you would need to seek instruction from a doctor prior to doing this. However, it noted that there was no evidence to suggest that you had actioned this. The panel was of the view that Patient A was hypotensive and you had a responsibility to escalate this as you were his allocated nurse. The panel noted that after commencing the IVI at 10:45 hours, you had not taken any further action to increase the frequency of IVI until observations were undertaken by another member of staff at 14:39 hours.

In light of the above, the panel determined that you did not increase the frequency of Patient A's IVI when hypotension was identified.

Accordingly, the panel found Charge 1b (ii) proved

Charge 1c

1. On or around 22 February 2018 in relation to Patient A
    c. did not inform the charge nurse of Patient A's condition when you went on your break

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 2, the oral and documentary evidence of Witness 1 and Witness 3 and your oral evidence.

In her written witness statement, Witness 2 had stated:

> *'Not long after that, he went on break and he handed over to [Witness 3]. He told [Witness 3] that there was another patient that was being*

discharged, but he stated nothing about Patient A's condition and hourly observation…'

Witness 3 had stated the following within her NMC written witness statement dated 12 February 2025:

'The registrant went on a break around lunchtime, and I don't remember anything being handed over to me relating to Patient A.'

However, during her oral evidence, Witness 3 could not recall being the Nurse in Charge or being the one who had sent you for your break. She also stated that the first time she had been informed about Patient A had been when Witness 2 had contacted her with concerns for his wellbeing.

Witness 1, in her written witness statement, outlined what the expectation would have been:

'Cajetan failed to handover the deteriorating patient to his colleagues…If I was going on my break, I would give a brief handover. You would expect the nurse to say that this is what I'm doing, these were the last observations I have taken and I'll be back in half an hour. The nurse in charge should have been aware as she should have been receiving alerts to flag the patient was deteriorating, however he should have handed over any issues with his patients to the nurse in charge.'

During your oral evidence, you told the panel that you would not have gone on your break of your own volition and on being sent on your break, you updated the Nurse in Charge on the matters she was not aware of, namely, a patient being discharged. You said that you did not hand over information about Patient A or his condition as there was no new information to provide an update, as you had kept the Nurse in Charge updated on Patient A's condition throughout the shift. You also stated that you had worked closely with the Nurse in Charge and other nurses on the ward, especially in relation to Patient A and the Nurse in Charge had been the one to countersign both of the fluids you had given Patient A. You said that you did not feel

the need to provide a handover to the Nurse in Charge, as she and other members of staff were aware of Patient A's condition.

Witness 4 gave oral evidence that she had no recollection of speaking with you that morning or about later sending you on your break.

The panel considered the above evidence and determined that, by your own admission, you did not inform the Nurse in Charge of Patient A's condition when you went on your break. The panel was satisfied that you went on your break around 15:30 hours, as you were not present on the Unit when Witness 2 had escalated her concerns to Witness 4 between 15:30 hours and 16:00 hours. At this time, Patient A's observations highlighted his deteriorating condition, and he was clearly unwell when Witness 3 and Witness 4 had assessed him. The panel decided that Patient A's condition was gradually deteriorating, and it was your responsibility to ensure that the care of an unwell patient had been properly handed over to another nurse in your absence, which you had failed to do. In addition, the panel also considered that you also had a responsibility to ensure that Witness 2 was appropriately supervised whilst you were on your break.

In light of the above, the panel determined that you did not sufficiently inform the charge nurse of Patient A's condition when you went on your break.

Accordingly, the panel found Charge 1c proved.

Charge 1d

1. On or around 22 February 2018 in relation to Patient A

    d. did not undertake and/or record observations on the electronic observations 'EOBS' chart

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1 and Witness 2, the oral evidence of Witness 3 and Witness 4 and your oral evidence. The panel also had regard to Patient A's medical records.

The panel had regard to Patient A's e-obs chart and noted that prior to the escalation of his condition around 16:00 hours, Patient A only had three recorded sets of observations during the day shift at 10:21 hours, 14:39 hours and 15:30 hours. The panel noted that there was also no documentation of any other observations taken during this time.

Witness 1 had stated within her written statement that:

> *'[Patient A] started to deteriorate at 02.44 as seen in the timeline of events. Cajetan was not looking after him at the point. However, Cajetan should have increased the frequency of the observations and missed opportunities to do so at 10.21 and 14.39.'*

Witness 2 told the panel that she had been recording Patient A's observations and had done so '15-20 times'. She stated that at the time, she did not have an e-obs login therefore, she could not input them on the system. Instead, she was writing them down on a piece of paper and handing it to you to record. In response to panel questions, Witness 2 had stated that she had not given you a written record of the observations on every occasion. However, the panel was satisfied that she had communicated them to you.

You told the panel that you had recorded Patient A's observations throughout the day however, for some reason they were not submitted onto the system. You stated that you believed that there must have been a system failure with e-obs as you were sure that you took observations and recorded them.

However, within her witness statement, Witness 1 stated:

> *'There was no observation system failings as reported by the EOB's team in there interview which was submitted with the investigation.'*

During her oral evidence, Witness 3 stated that on some occasions, there could be WiFi or reception issues on the Unit that would affect e-obs, but this would be clear if you were using the handheld device used for recording the observations. Witness 4 also stated in her oral evidence that there could be issues with logging into e-obs but once you are able to enter, she did not know of any issues that would occur. Both Witness 3 and Witness 4 confirmed that they had experienced no issues with e-obs on 22 February 2018.

The panel considered the above evidence and accepted the evidence of Witness 1, Witness 2, Witness 3 and Witness 4. Witness 2 had been clear in her account of undertaking observations on Patient A '15-20 times'. The panel found Witness 2 to be a credible and reliable witness who openly admitted her shortcomings as an inexperienced student nurse at the time and it saw no evidence of any motivation from any of the witnesses to conspire against you.

The panel acknowledged that you stated that you had carried out observations, but they did not seem to appear on the system however, it noted that there had been no issues with the e-obs system as you had been asserting.

The panel was of the view that if there was an issue with e-obs, it would have been apparent to all. There was no independent evidence of a system failure, so the panel concluded that the only proper inference from the evidence was that the e-obs system was functioning properly.

In any event, the panel concluded that had there been any issue with the e-obs system, this would have been apparent to you and the appropriate step would have been for you to record the numerous observations for Patient A by hand. Yet there were no other recordings in the longhand medical notes or on a paper based NEWS chart.

The panel therefore concluded that, bearing in mind the severity of his condition, the observations recorded for Patient A had not been carried out at an adequate frequency.

In light of the above, the panel was satisfied that you did not undertake and/or record observations on the e-obs chart for Patient A.

Accordingly, the panel found Charge 1d proved.

Charge 2

2. Recorded within the electronic observations 'EOBS' chart a respiratory rate of 20 for Patient A

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 2, your oral evidence and the medical records of Patient A.

The panel had regard to Patient A's e-obs chart, on which, at 15:30 hours Patient A's respiration rate had been recorded by you as 20 respirations per minute (rpm). The panel was satisfied that you had recorded this value.

However, the panel considered it necessary to determine whether this value was incorrect based on the evidence before it.

The panel noted that the record of Witness 2's local interview dated 5 July 2018 had outlined that Witness 2 had:

> *'Stn recalls writing down the observations and passing them to the agency nurse. Stn remembers recording the blood pressure and his respirations were high, she reported this to the agency nurse and was told that, 'no he didn't think his resps were high and entered the resp rate as 20 into the eobs.'*

The panel noted that this was a reasonably contemporaneous statement.

This was consistent with her oral evidence and her written statement which outlined:

> *‘I checked Patient A's respiration rate. A normal respiratory rate is between 12 and 20. I can recall it was above 20. A change in respiration rate it's a sign that something is seriously wrong… I escalated to the nurse that it had increased and BP looked worrying. The registrant stated "he looks fine to me." He put his observations into the Eobs system and recorded a normal rate for me.’*

Witness 2 explained during her oral evidence that you had looked briefly at Patient A from across the Unit and determined that her measurement of the respiratory rate was not correct as Patient A did not appear that unwell and that she was mortified when you had inputted a different number.

You told the panel that when Witness 2 had approached you with the observations, you did not think that the respiration rate was correct as it did not fit with your visual assessment of Patient A.

The panel considered the above evidence and accepted the evidence of Witness 2. It considered that Witness 2’s recollection of the incident was consistent across her local investigation interview, NMC witness statement and oral evidence. It noted that her account of recording a higher respiratory value was also consistent with the concerns she had that led to her escalation to Witness 4. In addition, the respiration rate Witness 2 reports she escalated to you was also consistent with the other recordings made by Witness 3 and Witness 4 after Patient A’s condition had been escalated, showing a trend in his condition. The panel also noted that this event had stuck with Witness 2 as she felt ‘mortified’ that you had recorded a lower value.

In light of the above, the panel was satisfied that you had recorded within the e-obs chart a respiratory rate of 20 for Patient A.

Accordingly, the panel found Charge 2 proved.

Charge 3

3. Your conduct at charge 2 was dishonest in that you deliberately sought to represent that Patient A's respiratory rate was 20, when you knew that it was not.

This charge is found NOT proved.

The panel first considered its finding in relation to Charge 2. Having established this, the panel went on to consider whether your action in Charge 2 was dishonest. It had regard to the test set out in *Ivey v Genting Casinos* [2017] UKSC 67 which outlines the following*:*

- What was the defendant's actual state of knowledge or belief as to the facts; and
- Was the conduct dishonest by the standards of ordinary decent people?

The panel also had regard to the NMC guidance entitled *'Making decisions on dishonesty charges' (reference DMA-8)* dated 27 February 2024. Within this guidance, Fitness to Practise Committee (FtPC) panels are advised to decide whether the conduct indeed took place and if so, what was the registrant's state of mind at the time.

In reviewing the evidence, the panel was satisfied that you had input the value of 20 rpm for Patient A on the e-obs system at 15:30, which was not in line with what Witness 2 had stated she had reported to you.

The panel considered whether in doing this, you had deliberately misrepresented Patient A's respiration rate. The panel noted that Witness 2 had stated that after she had given you Patient A's observations on a piece of paper, you did not believe they

were correct, and you had considered his respiration rate to have been normal following a brief visual assessment. This resulted in you inputting a lower value to what Witness 2 had reported to you, on the e-obs system.

The panel decided that there was insufficient evidence to suggest that you had done this dishonestly. It noted your account that Witness 2 had been incorrect in her assessment of Patient A as you believed that he did not appear as unwell as Witness 2's observations had indicated. The panel was of the view that although you should have taken Witness 2's concerns into consideration, you had overridden Witness 2's assessment with your own clinical judgement. Although your judgement of Patient A's clinical condition was inaccurate and could be considered poor in this situation, the panel determined that you had not dishonestly recorded Patient A's respiratory rate as 20 on the e-obs chart.

The panel therefore found Charge 3 not 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 your 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Mr Hamilton submitted that at this stage, there is no burden or standard of proof and misconduct is a matter for the professional judgement of the panel to determine. He referred to NMC guidance (*reference FTP-2a*) and the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, which defines misconduct as:

> *'a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Hamilton submitted that a single negligent act or omission is less likely to cross the threshold of misconduct, as outlined within the case of *Ashton v General Medical Council* [2013] EWHC 943. He submitted that this is relevant for the panel in considering the multiple acts and omissions that took place on 22 February 2018.

Mr Hamilton submitted that it is also relevant for the panel to consider the risks that Patient A had been exposed to. He submitted that the authority of *Threlfall v General Optical Council* [2004] EWHC 2683 (Admin) refers to risk as a relevant factor for whether a registrant's actions are characterised as misconduct. He submitted that the findings of the panel are sufficient to amount to misconduct in this case.

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

Mr Hamilton outlined the NMC's definition of fitness to practise and referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). He outlined the summary of Dame Janet Smith's 'test' outlined within the 5th Shipman report. He submitted that limbs a, b and c are engaged in this case and the panel should use this as a basis for finding impairment.

Mr Hamilton submitted that the evidence demonstrates that you exposed Patient A to significant risks, demonstrated by your failure to escalate his deteriorating condition despite clear signs of severe sepsis, amongst other failures. He submitted that these failings represent serious departures from professional standards and demonstrate that Patient A was exposed to an unwarranted risk of harm.

In relation to bringing the reputation of the nursing profession into disrepute, Mr Hamilton submitted that your actions in themselves brought the reputation of the nursing profession into disrepute. He further submitted that the way you addressed the allegations during this hearing also contributed to undermining confidence in the nursing profession as you made unsubstantiated claims of there being a 'system failure' in relation to the missing e-obs records and also insisted repeatedly that the witnesses were lying. Mr Hamilton submitted that the misconduct identified in this case would undermine confidence in the nursing profession and has tarnished its reputation.

With respect to breaching the fundamental tenets of the nursing profession, Mr Hamilton highlighted certain aspects of *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2015) (the Code) and submitted the following:

- **Section 1.2- make sure you deliver the fundamentals of care effectively** – By failing to provide timely escalation or adequate fluid management for Patient A.
- **Section 7.4: Check people's understanding from time to time to keep misunderstanding or mistakes to a minimum** – Your communications with Witness 2 should be considered.
- **Section 8.1: Respect the skills, expertise, and contributions of your colleagues, referring matters to them when appropriate** – The panel previously found that you had not communicated effectively with Witness 2 especially in relation to when you thought her assessment of Patient A's respiratory rate was incorrect.

- **Section 8.3: Keep colleagues informed when you are sharing care, Section 8.5: Work with colleagues to preserve safety and Section 8.6: Share information to identify and reduce risk** – the panel may wish to consider these in relation to your communication with Witness 2 and your lack of communication with other members of staff by not handing over care or escalating concerns.
- **Section 13.1: Accurately identify, observe, and assess signs of normal or worsening physical health** – You failed to act on clear signs of deterioration in Patient A's condition.
- **Section 13.2: Make timely referrals when action is required**
- **Section 14: Be open and candid with all service users about all aspects of care** – Although dishonesty was not found proved, the way you reacted to concerns raised to you demonstrated a lack of candidness and transparency.
- **Section 16.1: Raise concerns about patient safety or care levels when necessary** – You failed to escalate concerns about Patient A's deteriorating condition.

With respect to insight, Mr Hamilton referred to the NMC's Remediation and Insight Guidance. Paragraph 11 of this guidance outlines that whilst current impairment must be considered and it is considered a forward-looking exercise, the panel can consider past events and behaviour. He submitted that throughout this hearing, there have been instances where you have demonstrated a lack of acknowledgment of your professional responsibilities or accountability for your actions. Rather than reflecting constructively on what went wrong, you focused on alternative implausible explanations such as a 'system failure' and you repeatedly accused all the witnesses of lying and sought to shift blame onto others.

Mr Hamilton submitted that it is recognised by the NMC that the denial of allegations does not automatically mean that insight cannot be demonstrated. He also submitted that in fairness to you, the incident occurred on a single day and there does not appear to have been any repetition since.

Mr Hamilton referred to Paragraph 37 of the guidance which outlines that:

‘Decision makers should be cautious before attaching weight to assertions of insight in cases where the nurse or midwife has, until recently, denied the allegations or failed to accept responsibility for their actions.’

Mr Hamilton submitted that you have shown a lack of insight and insufficient insight may suggest a risk of repetition. He submitted that the risks posed by your actions are not hypothetical; they materialised in this case. Although this case is not about Patient A’s death, it is submitted that this instance of misconduct had potentially life-threatening consequences for Patient A and given your limited insight, there is no evidence that you have taken steps to remediate your practice or address these concerns. Mr Hamilton submitted that allowing you to continue practising unrestricted would expose patients to further unwarranted risks of harm.

Mr Hamilton further submitted that the panel must also consider whether a finding of impairment is necessary to uphold public confidence in the profession. He submitted that members of the public expect nurses to act with professionalism, competence, and accountability at all times and that failing to find impairment would undermine public confidence in the nursing profession and send a message that such serious failings can go unaddressed. He invited the panel to find your fitness to practise impaired on public protection and public interest grounds.

You told the panel that on reflecting upon the concerns about the care you gave Patient A on 22 February 2018, you recognised that your communication was not up to standard. As a result, you completed an online course on ‘Communicating Effectively’. In addition, you recognised that you should have assessed the care of Patient A closely and you have subsequently completed a course in ‘Assessing Needs’ and ‘Patient Centred Care in Nursing’, as you understand that every patient is different.

You told the panel that since the incident, you have continued to work unrestricted and no patient safety concerns have been raised. You stated that you have remained

a safe practitioner. You provided the panel with a positive reference from your agency and the certificates from your training courses.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance,* Grant, *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Fatnani & Raschid v General Medical Council* [2007] EWCA Civ 46.

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your 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*
> ***…***
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> ***2.1** work in partnership with people to make sure you deliver care effectively*
> ***…***
> ***8 Work cooperatively***
> *To achieve this, you must:*
> ***8.1** respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> ***8.2** maintain effective communication with colleagues*

8.3 *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

…

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

8.6 *share information to identify and reduce risk*

…

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 *complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

10.2 *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

10.3 *complete all records accurately…*

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*

…

20 Uphold the reputation of your profession at all times

To achieve this, you must:

…

20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

…'

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

The panel considered that Patient A's vulnerability contributed to the seriousness of this case and as Patient A's nurse, you were allocated the responsibility of escalating any concerns you had identified or those that had been raised to you.

The panel noted that you were familiar with working at the Trust as you had worked there for four years, and you had stated that you had experience of caring for unwell patients such as Patient A, therefore this was not outside of your knowledge or capability. The panel found that the charges found proved were all concerning and your failures had put Patient A at an unacceptable risk of unwarranted harm. As an experienced nurse you were also supposed to be a role model for other members of staff, particularly Witness 2.

The panel therefore concluded that your 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, your 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 concluded that limbs a, b and c of the *Grant* test are engaged in this case. The panel found that a vulnerable patient, namely Patient A, was put at an unwarranted risk of harm as a result of your actions. The panel considered that your misconduct had breached the fundamental tenets of the nursing profession, as demonstrated by the breaches of the Code, and had therefore brought its reputation into disrepute.

The panel was aware that this is a forward-looking exercise and first considered the issue of remorse. The panel recognised that you had a right to contest the allegations but concluded that, even though you accepted that the standard of care delivered to Patient A at times was unsatisfactory, throughout the hearing you sought to blame your colleagues, managers, or even the IT system, rather than accept any responsibility yourself for what had happened.

The panel went on to consider whether your misconduct was remediable and whether you have already remediated your misconduct. It considered your positive reference from your employer and your training certificates.

The panel considered that your misconduct could be remediated as there were failings in identifiable clinical areas and that this could be addressed through significant reflection, insight and training. However, the panel noted that although the training certificates you had provided addressed some of the concerns in this case, the course content listed appeared broad and untargeted to the specific identified weaknesses in your practice. It also noted that one of the certificates provided appeared to be a sample and was undated. The panel therefore concluded that the certificates were insufficient to demonstrate meaningful remediation of the concerns.

The panel further considered that the positive reference you provided from your employer was completed by someone in an administrative role and it was unclear if they were aware of the concerns in this case. Again, this reference was insufficient evidence that the concerns in this case had been remediated.

The panel noted that you have not provided further evidence, such as an in-depth reflective piece and you have not appeared to have expressed any remorse or evidenced sufficient reflection or insight, specifically into your actions, their impact on patients, your colleagues, the wider public and the reputation of the nursing profession. The panel considered your insight to be limited, as no further evidence has been provided to demonstrate your understanding of the reasons behind your misconduct or the steps you have taken to remediate the concerns. In addition, the panel was concerned that the attitude you displayed during this hearing, such as suggesting the lack of observations was due to a 'system failure' or accusing several registered nurses of lying, indicated a pattern of deflecting responsibility and apportioning blame to others and demonstrated a lack of insight.

Due to your limited reflection and insight and an absence of remorse from you, the panel concluded that there is a likelihood of repetition of your conduct, and that there remains a real risk of serious harm to the public. The panel therefore decided that a finding of impairment was necessary on the grounds of public protection.

The panel took into account the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is also required as this case involved an experienced nurse, who failed to recognise and escalate the care of a vulnerable and deteriorating patient. The panel was of the view that a well-informed and reasonable member of the public would be deeply concerned by the circumstances of this case and that public confidence in the nursing profession would be undermined if a finding of impairment was not made. The panel therefore finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel considered this case very carefully and decided to make a conditions of practice order for a period of 12 months, with a review. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Mr Hamilton informed the panel that in the Notice of Hearing, dated 30 January 2025, the NMC had initially advised you that it would seek the imposition of a 12-month suspension order, with a review, if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal in light of the panel's finding of no dishonesty.

Mr Hamilton invited the panel to impose a conditions of practice order, with a review, for a period of 12 months and submitted that this is the most appropriate and proportionate sanction in this case.

Mr Hamilton submitted that the NMC recognises the following mitigating features in this case:

- Your engagement with the investigations and these proceedings
- You have demonstrated some limited insight as identified by the panel in its findings
- Further training you have undertaken although the panel has identified that this is of limited relevance to the concerns in this case.
- Positive testimonial from your employer
- There does not appear to be any evidence of repetition of similar incidents

Mr Hamilton submitted that a conditions of practice order would ensure that the public are protected, whilst also allowing you to remediate your practice with structured oversight. He submitted that there may be a possible benefit of enquiring with your employer about whether it can support a conditions of practice order.

Mr Hamilton suggested ten conditions of practice which the panel might feel were appropriate, including supervision, reporting and retraining.

Mr Hamilton submitted that a substantive order needs to be proportionate and strike a fair balance between protection of the public, meeting the public interest and balancing a registrant's rights. The right amount of regulatory force is needed to deal with the risks, but not more than that.

Mr Hamilton submitted that a conditions of practice order is the most appropriate sanction and anything below that would not be appropriate. He submitted that taking no further action after a finding of impairment would not be appropriate and a caution order would also not be appropriate to address the public protection issues identified in this case. Lastly, he submitted that a suspension order would not be appropriate in this case in light of dishonesty not being found proved.

You told the panel that you have been practising for the past seven years since the incident with no issues and no concerns have been raised about you in relation to patient safety or your clinical practice.

In relation to the panel's assessment of the positive reference from your employer, you said that due to the influx of foreign nurses, there have been limited agency shifts. Due to this, you often do not end up working in the same place with the same people, so it makes it difficult to get a reference from a clinical practitioner. You stated that your employer would be the first port of call if any concerns about your practice had ever been raised.

You told the panel that although you do not agree with the panel's decisions, you accept them and would be willing to work under a conditions of practice order. However, you explained that it would be difficult for you to comply with the conditions as proposed by Mr Hamilton as it would make you a burden to the NHS in a situation where, as an agency nurse, you would be working shifts to fill staff shortages.

You reiterated that you have continued to practise without any concerns and that you love what you do. You invited the panel to offer you an opportunity to continue doing so.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel bore 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:

- Conduct which put a vulnerable patient, namely Patient A, at risk of suffering significant harm.
- Lack of insight into failings
- Lack of reflection and remorse
- Attitudinal concerns in relation to lack of accountability and a pattern of deflecting blame

The panel also took into account the following mitigating features:

- Some limited training to address the concerns

- A positive testimonial from your employer
- No evidence of repetition since the incident

Whilst the panel accepted the mitigating features in this case, it noted that they were limited in their scope, and it was concerned about the attitudinal concerns in this case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of this 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 your 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 your 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 your registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*

- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. It noted that the conditions proposed by the NMC were fair and thorough and would protect the public.

The panel also accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that this incident happened seven years ago and that, other than these incidents, it appears that you have had an unblemished career of 13 years as a nurse. The panel took into account that you had concerns about the workability of a conditions of practice order however, its primary duty is to ensure the public is adequately protected. It was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel did give careful consideration to the imposition of a suspension order given the attitudinal concerns it had previously identified in this case. However, it did not believe that these attitudinal concerns were deep seated to the extent that they could not be remediated. Therefore, the panel was of the view that to impose a suspension order would be disproportionate at this time and would not be a reasonable response in the circumstances of your case. It acknowledged that the incident occurred on one single day with a single patient and that there does not appear to be any evidence of repetition. Additionally, it noted its finding that your misconduct is remediable and that the public would be adequately protected if your practice was restricted with a conditions of practice order.

The panel acknowledged that you may face challenges in securing employment that would allow you to work under these conditions but did not consider that it would be impossible for you to achieve. The panel was mindful in any event that its primary function was the protection of the public.

Having regard to the matters it has identified, the panel concluded that a conditions of practice order will mark the importance of maintaining public confidence in the nursing profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must restrict your practice to a single substantive employer, which must not be an agency.

2. At any time you are working, you must be supervised by another registered nurse of Band 6 and above. This supervision must consist of working at all times on the same shift as, but not always directly observed by, a registered nurse of Band 6 or above.

3. You must work with your mentor or supervisor, who must be a Band 6 nurse or above, to develop a reflective practice profile which addresses the following areas of concern:
    - Taking and recording of observations, accurately and on time
    - Escalation of unwell patients

- Timely administration of prescribed medication
- Effective communication with and handover to other colleagues delivering care with you.

4. You must send evidence to your NMC Case Officer of this completed profile every 3 months of your conditions of practice order coming into effect.

5. You must complete training in:
    - Recognizing and escalating a deteriorating patient
    - Administering IV fluids at the prescribed rate
    - Accurate record keeping

6. You must send evidence to your NMC Case Officer of this completed training within 6 months of your conditions of practice order coming into effect

7. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

8. You must keep the NMC informed about anywhere you are studying by:
    a. Telling your case officer within seven days of accepting any course of study.
    b. Giving your case officer the name and contact details of the organisation offering that course of study.

9. You must immediately give a copy of these conditions to:
    a. Any organisation or person you work for.

b. Any employers you apply to for work (at the time of application).
c. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

10. You must tell your NMC Case Officer, within seven days of your becoming aware of:
    a. Any clinical incident you are involved in.
    b. Any investigation started against you.
    c. Any disciplinary proceedings taken against you.

11. You must allow your NMC Case Officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a. Any current or future employer.
    b. Any educational establishment.
    c. Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel 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 your own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Hamilton. He invited the panel to impose an interim conditions of practice order for a period of 18 months on the grounds of public protection and otherwise in the public interest. He submitted that as the substantive conditions of practice order will not take effect until after the 28-day period, an interim order is necessary to cover this intervening period to protect the public and meet the public interest in light of the panel's findings.

You did not make any submissions on this application.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The panel therefore decided to impose an interim conditions of practice order for a period of 18 months to allow for the possibility of an appeal to be made and determined. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.