Name of registrant: Bogdan Mutu
NMC PIN: 15B0434C
Part(s) of the register: Registered Nurse - Adult
Nursing
Area of Registered Address: England
Type of Case: Lack of Competence and Misconduct
Panel Members: Martin Parker (Chair, Lay member)
Helen Hoult (Registrant member)
Anne Booth (Lay member)
Legal Assessor: Lucia Whittle-Martin
Panel Secretary: Lucy Eames (December 2017)
Anita Abell (March 2018)
Registrant: Not present and not represented
Nursing and Midwifery Council: Represented by Jeremy Loran, NMC case presenter
Facts proved: All
Facts not proved: None
Fitness to practise: Impaired
Sanction: Striking off order
Interim Order: Interim suspension order for 18 months
Details of charge as amended:

That you, a registered nurse, while employed by Royal United Hospitals Bath NHS Foundation Trust, and while undergoing periods of supervised practise and/or competence assessments between March 2015 and June 2016, failed to demonstrate the standards of knowledge, skill and judgment required to practise as a Band 5 Staff Nurse, in that you, whilst working in the ACE OPU and Midford Wards:

1. Did not consistently demonstrate an ability to communicate accurately and/or effectively, in that you:

   1.1. On or around 27 April 2015 told a colleague that a patient who was nil-by-mouth could have food and drink;

   1.2. On or before 21 May 2015 told a patient and/or the patient’s family that the patient was going to St Martin’s Hospital when there were no beds available at St Martin’s Hospital;

   1.3. On or before 21 May 2015:

       1.3.1. Failed to inform the person in charge that a patient had loose stools;

       1.3.2. Failed to handover without prompting that a patient had loose stools.

   1.4. On or before 22 May 2015:

       1.4.1. Told a doctor that the wrong patient needed a Sando K prescription reviewed;

       1.4.2. Did not know whether there was anything that you needed to handover to a doctor regarding a patient.

   1.5. On 25 May 2015:

       1.5.1. Did not hand over that a falls and/or Braden care plan needed to be completed for a patient;

       1.5.2. Were not aware that a patient had refused all medication despite this being handed over to you;

       1.5.3. Needed to be told to listen when the night nurse was handing over two insulin dependent patients.
1.6. On 3 June 2015, informed colleagues that a patient had been diagnosed with C Difficile when that was not correct;

1.7. On 12 June 2015, informed a porter that a patient did not require oxygen during his transfer when the patient did require oxygen;

1.8. On 13 July 2015:
   1.8.1. Relayed incorrect information about a patient requiring a side room;
   1.8.2. Informed the wrong relative about a patient’s condition and/or reason for moving.

1.9. On 12 September 2015, informed the family of a patient that the patient had dementia when there was not yet a formal diagnosis of dementia.

1.10. On 28 April 2016 inappropriately told a patient’s family that the patient had cancer;

1.11. On 30 May 2016:
   1.11.1. Were rude to a patient;
   1.11.2. Spoke about a patient’s personal information in a manner which could have been overheard.

**Charge 1 found proved in its entirety.**

2. **Did not consistently demonstrate an ability to effectively plan and prioritise patient care, in that you:**

   2.1. On or around 19 May 2015 did not complete comfort rounds for patients in your care without prompting;

   2.2. On or around 22 May 2015 did not promptly and without prompting complete comfort rounds for the patients in your care;

   2.3. On 25 May 2015, between approximately 06:00 hrs and 19:00 hrs, did not complete comfort rounds for a patient in your care;

   2.4. On 10 May 2016:
      2.4.1. Did not take observations for one or more of the patients in your care;
      2.4.2. Did not complete patient records for one or more of the patients in your care.
2.5. On 12 October 2015 failed to promptly take MRSA swabs having been asked to do so and without further prompting;

2.6. On 16 May 2016, after approximately 10:35 hrs, failed to record observations for a patient on a cardiac monitor;

2.7. On or around 22 June 2016 failed to check that insulin had been given to a patient with elevated blood glucose levels;

2.8. On 23 June 2015:
   2.8.1. Did not, without prompting, dress a wound appropriately;
   2.8.2. When asked what a drug was for replied with words to the effect of, “No idea and I don’t care.”

2.9. On 14 July 2015 attempted to apply an inappropriate dressing to a patient.

**Charge 2 found proved in its entirety.**

3. **Did not consistently demonstrate an ability to keep clear and accurate records relevant to your practice, in that you:**

3.1. On 12 October 2015, upon a patient’s discharge, did not:
   3.1.1. Complete the discharge summary;
   3.1.2. Make a district nurse referral;
   3.1.3. Supply the patient with dressings.

3.2. On 25 May 2015 did not complete a falls and/or a Braden care plan for a patient.

3.3. On 2 January 2016 did not complete a Post-Fall Assessment form and/or an incident form for a patient who had been on the floor.

3.4. On 8 September 2015 you did not complete:
   3.4.1. Cannula care plans for the patients in beds 10 and 12;
   3.4.2. The patient profile for the patient in Bed 11;
   3.4.3. The falls care plan for the patient in Bed 12;
   3.4.4. The falls, catheter and Braden and cannula care plans for the patient in Bed 15.
3.5. On 27 September 2015 did not include enough information in a Transfer of Care.

3.6. On 8 June 2016 required prompting to complete comfort rounds and hydration charts.

3.7. On 22 June 2016 failed to document care given to one or more patients;

3.8. On 24 June 2016:
   3.8.1. Failed to complete all care plans and comfort rounds for a patient on priorities of care;
   3.8.2. Failed to hand over one or more of your patients;
   3.8.3. Did not complete documentation for one or more of your patients.

3.9. On an unknown date, did not document the fluid charts.

**Charge 3 found proved in its entirety.**

4. **Did not consistently demonstrate the required standards in respect of drug knowledge and/or administration, in that you:**

   4.1.1 On or around 28 May 2015 when drawing up an inter-muscular injection started to withdraw the medication without a needle on the syringe;

   4.1.2 On or around 24 June 2015 attempted to guess the dosage of carbocysteine medication, rather than calculate it;

   4.1.3 On or around 8 September 2015 were unable to identify the uses for gabapentin and/or finasteride and/or Sodium Valproate and/or citalopram

   4.1.4 On or around 8 September 2015, gave glycerine suppositories to a patient when they were standing up;

   4.1.5 On or around 28 April 2015 gave a patient and/or advised a patient to take an additional 40 units of Insulin without authority to do so and/or when it was inappropriate to do so;
4.1.6 On one or more occasions in March 2016 required prompting in order to recognise when a medication(s) had been stopped and/or held;

4.1.7 On or around 2 May 2016 attempted to give calcium resonium when it was not appropriate and/or you did not have authority to do so;

4.2 At a meeting held on 2 September 2015, were not signed off as competent in respect of drug knowledge and/or administration, following 8 weeks performance management programme;

4.3 At a meeting held on 11 March 2016, were not signed off as competent in respect of drug knowledge and/or administration following a stage two performance management programme

4.4 At a meeting held on 21 July 2016, were not signed off as competent in respect of drug knowledge and/or drug administration following a 12 week performance management programme on Midford Ward;

Charge 4 found proved in its entirety.

5. On or around one or more of the following dates, you administered or dispensed medication unsupervised when you were not permitted to do so:

5.1 28 April 2015;
5.2 22 May 2015.
5.3 12 June 2015

Charge 5 found proved in its entirety.
6. On or around 29 June 2016 did not respect Patent A’s wishes in respect of taking her blood pressure, in that:

6.1 You insisted that you could/should take the blood pressure from her left arm; and/or
6.2 Acted in a rude and/or bullying manner

Charge 6 found proved in its entirety.

And, in light of the above, your fitness to practise is impaired by reason of your lack of competence and/or misconduct.

Decision on Service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Mutu was not in attendance and that written notice of this hearing had been sent to his registered address by recorded delivery and by first class post on 2 November 2017. Notice of this hearing was returned to sender on 9 November 2017.

The panel took into account that the notice letter provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mr Mutu’s right to attend, be represented and call evidence, as well as the panel’s power to proceed in his absence.

Mr Loran submitted the NMC 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.
In the light of all of the information available, the panel was satisfied that Mr Mutu had been served with notice of this hearing in accordance with the requirements of Rules 11 and 34. It noted that the rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision on proceeding in the absence of the Registrant

The panel next considered whether it should proceed in the absence of Mr Mutu. The panel had regard to Rule 21 (2) states:

(2) Where the registrant fails to attend and is not represented at the hearing, the Committee—

(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;

(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or

(c) may adjourn the hearing and issue directions.

Mr Loran invited the panel to continue in the absence of Mr Mutu on the basis that he had voluntarily absented himself. He submitted that there had been no engagement at all by Mr Mutu with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion. Mr Loran referred the panel to the case of General Medical Council v Adeogba [2016] EWCA Civ 162.

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 Mr Mutu. In reaching this decision, the panel has considered the submissions of the case presenter, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of Jones. It has 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 Mr Mutu;
- Mr Mutu has not engaged with the NMC and has not responded to any of the letters sent to him about this hearing;
- Mr Mutu has not provided the NMC with details of how he may be contacted other than his registered address;
- there is no reason to suppose that adjourning would secure his attendance at some future date;
- witnesses have attended today to give live evidence, others are due to attend;
- not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the patients who need their professional services;
- the charges relate to events that occurred in 2015;
- further delay may have an adverse effect on the ability of witnesses to accurately recall events;
- there is a strong public interest in the expeditious disposal of the case.

There may be some disadvantage to Mr Mutu in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he has made no response to the allegations. He will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his own behalf. However, in the panel’s judgment, 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, any disadvantage is the consequence of Mr Mutu’s decision to absent himself from the hearing, waive his rights to attend and/or be represented and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Mutu. The panel will draw no adverse inference from Mr Mutu’s absence in its findings of fact.

**Decision and reasons on application to amend the charge**

The panel heard an application made by Mr Loran, on behalf of the NMC, to amend the wording of charges 2.4, 2.7 and 3.3 and to add some additional charges.

It was submitted by Mr Loran that the proposed wording amendments would provide clarity and more accurately reflect the evidence. He further submitted that the proposed additional charges outline areas of practice in which Mr Mutu was allegedly not signed off as competent and also more allegations of the same behaviour set out in existing charges. Mr Loran invited the panel to consider that adding the further charges would be a clearer and fairer way to deal with the case. He submitted that the panel the Mr Mutu is unlikely to engage with these proceedings.

The original charges read as follows:

2.4. On 10 May 2015:

2.4.1. Did not take observations for the patients in your care;
2.4.2. Did not complete patient records for the patients in your care.
2.7. On 27 May 2016 failed to check that insulin had been given to a patient with elevated blood glucose levels;

3.3. On 2 January 2016 did not complete a Post-Fall Assessment form for a patient who had been on the floor.

The proposed amended charges would read as follows:

2.4. On 10 May 2016:
2.4.1. Did not take observations for one or more of the patients in your care;
2.4.2. Did not complete patient records for one or more of the patients in your care.

2.7. On or around 22 June 2016 failed to check that insulin had been given to a patient with elevated blood glucose levels;

3.3. On 2 January 2016 did not complete a Post-Fall Assessment form and/or an incident form for a patient who had been on the floor.

4. Did not consistently demonstrate the required standards in respect of drug knowledge and/or administration, in that you:

4.1.1 On or around 28 May 2015 when drawing up an inter-muscular injection started to withdraw the medication without a needle on the syringe;

4.1.2 On or around 24 June 2015 attempted to guess the dosage of carbocysteine medication, rather than calculate it;

4.1.3 On or around 8 September 2015 were unable to identify the uses for gabapentin and/or finasteride and/or Sodium Valproate and/or citalopram

4.1.4 On or around 8 September 2015, gave glycerine suppositories to a patient when they were standing up;
4.1.5 On or around 28 April 2015 gave a patient and/or advised a patient to take an additional 40 units of Insulin without authority to do so and/or when it was inappropriate to do so;

4.1.6 On one or more occasions in March 2016 required prompting in order to recognise when a medication(s) had been stopped and/or held;

4.1.7 On or around 2 May 2016 attempted to give calcium resonium when it was not appropriate and/or you did not have authority to do so;

4.2 At a meeting held on 2 September 2015, were not signed off as competent in respect of drug knowledge and/or administration, following 8 weeks performance management programme;

4.3 At a meeting held on 11 March 2016, were not signed off as competent in respect of drug knowledge and/or administration following a stage two performance management programme

4.4 At a meeting held on 21 July 2016, were not signed off as competent in respect of drug knowledge and/or drug administration following a 12 week performance management programme on Midford Ward;

That you, a Registered Nurse, whilst employed by Royal United Hospitals Bath NHS Foundation Trust working in the ACE OPU Ward:

5. On or around one or more of the following dates, you administered or dispensed medication unsupervised when you were not permitted to do so:

5.1 28 April 2015;
5.2 22 May 2015.
5.3 12 June 2015
The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

28.— (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—

(a)  the charge set out in the notice of hearing; or

(b)  the facts set out in the charge, on which the allegation is based,

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

(2)  Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.

The panel was of the view that such amendments, as applied for in charges 2.4, 2.7 and 3.3, were in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Mutu and no injustice would be caused to either party by the proposed amendments being allowed.

The panel considered that the proposed additional charges set out what allegedly happened and provide clarity. From March 2015 until July 2016 Mr Mutu's practice was supervised by his employers. Weekly feedback meetings took place during which issues arising on his shifts were discussed and performance objectives set with his agreement. Mr Mutu is fully aware of all issues which are the subject of these amended charges.

The panel accepted that the application had been made late, and Mr Mutu had not been given notice of it. The panel therefore considered the option of adjourning to give Mr Mutu the opportunity of objecting to the application, or attending, but concluded that this
would prove fruitless in light of the complete lack of engagement with the NMC so far. Furthermore Mr Mutu was aware of the alleged issues with his practice. The panel determined it was therefore appropriate to allow all the amendments and additional charges, as applied for, not only to ensure clarity and accuracy but also to ensure that the charges properly reflect the concerns raised in this case.

The panel, on its own volition, decided to make minor amendments to charges 2.5 and 2.8.1 to correct spelling errors.

These original charges read as follows:

2.5. On 12 October 2015 failed to promptly take MSRA swabs having been asked to do so and without further prompting;

2.8. On 23 June 2015:
   2.8.1. Did not, without prompting, dress a wound appropriately

The amended charges read as follows:

2.5. On 12 October 2015 failed to promptly take MRSA swabs having been asked to do so and without further prompting;

2.8. On 23 June 2015:
   2.8.1. Did not, without prompting, dress a wound appropriately

During the course of witness evidence it became evident that an important matter relating to patient care had been omitted from the charges. Mr Mutu had been suspended by the Trust pending investigation as a result of a patient complaint. He was fully aware of this issue as the complaint had been investigated. In the circumstances Mr Loran applied for a further amendment in the form of an additional charge, charge 6, to reflect the evidence that formed that basis of this complaint.
Having taken legal advice the panel decided to apply the same reasoning as had been applied in relation to its earlier decision on amendment of the charges and determined that it was appropriate to allow the inclusion of an additional charge to reflect the concerns raised.

**Decision on the findings on facts and reasons**

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Mr Loran, on behalf of the NMC.

The panel heard and accepted the advice of the legal assessor.

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 the facts will be proved if the panel was satisfied that it was more likely than not that the incidents occurred as alleged.

The panel has drawn no adverse inference from the non-attendance of Mr Mutu.

**Background**

The charges arose whilst Mr Mutu was employed as a Registered Nurse at the Royal United Hospitals Bath NHS Foundation Trust (the Trust).

Mr Mutu commenced employment with the Trust on 1 December 2014. He initially worked as a Band 4 member of staff until he received his NMC PIN number in March 2015.
The registrant subsequently worked as a Band 5 nurse on the ACE OPU ward from March 2015 until March 2016. He was transferred to the Midford Ward in March 2016 where he worked until the end of June 2016.

From March 2015 until September 2015 Mr Mutu worked under informal supervision. This informal supervision was set up by Ms 1 alongside HR to try and help Mr Mutu meet the criteria for a Band 5 nurse. It required Mr Mutu to be supervised by an experienced, qualified nurse and for that nurse to complete a daily feedback sheet for every shift. The panel had sight of many of these daily feedback sheets which are contemporaneous notes written at the end of each shift detailing Mr Mutu’s performance on that day.

From September 2015 until he was dismissed from the Trust in July 2016 Mr Mutu was under a more formal supervision programme which included direct supervision of medication administration and indirect supervision of his other work. Daily feedback sheets continued to be used but there were also weekly feedback meetings between Mr Mutu and the relevant Senior Sister to reflect on his progress that week. The panel has also had sight of the notes taken at many of these weekly feedback meetings.

Mr Mutu was referred to the NMC for an alleged lack of competency to perform at the standard required of a Band 5 nurse, in particular in relation to communication, medication, record keeping, listening and observation skills and basic nursing practice. These concerns arose following a number of incidents as set out in the charges.

Following two patient complaints in June 2016 Mr Mutu was subject to disciplinary action by the Trust.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case. The panel heard oral evidence from seven witnesses called on behalf of the NMC:
Ms 2- Band 5 nurse at the Trust;
Ms 3 – Band 6 nurse (Junior Sister) at the Trust;
Ms 4– Band 6 nurse (Junior Sister) at the Trust;
Ms 5- Band 6 nurse (Junior Sister) at the Trust;
Ms 1- Acting Senior Sister at the Trust;
Ms 6- Band 6 nurse (Junior Sister) at the Trust;
Ms 7- Senior Sister and Ward Manager at the Trust.

The written statement of Ms 8, Junior Sister at the Trust was read into the record.

The panel considered each of the witnesses individually and found them each to be credible. It noted that there was documentary evidence to support what they said, they had a clear recollection of the events or told the panel if they could not remember. The panel noted that the witnesses were supportive of Mr Mutu during the time they worked together. Mr Mutu himself in July 2016, agreed that the Trust had done everything possible to help him and he had no criticism of the support put in place.

The panel considered each charge and made the following findings:

**Charge 1:**

1. Did not consistently demonstrate an ability to communicate accurately and/or effectively, in that you:

**Charge 1.1:**

1.1. On or around 27 April 2015 told a colleague that a patient who was nil-by-mouth could have food and drink;

This charge is found proved.
The panel accepted Ms 1’s oral evidence whereby she advised the panel that she had held a weekly feedback meeting with Mr Mutu on the 27 April 2015 to discuss communication, in particular his listening skills. She had been informed that Mr Mutu had told a colleague that a patient could now eat and drink when in fact the patient was nil by mouth. The panel had sight of the weekly feedback meeting notes dated 27 April 2015 and signed by Ms 1. Ms 1 recorded and told the panel that she had been told that the patient was at the time awaiting the result of a Speech and Language Therapy (SALT) assessment which would indicate the patient’s ability to swallow before the nil by mouth directive could be removed. The weekly feedback note clearly states that Mr Mutu apologised at the meeting for telling his colleague the patient could now have food and drink and that he had ‘misheard’ due to noise in the Multi-Disciplinary Team Meeting (MDT). The panel found that Mr Mutu’s apology amounted to an admission and on that basis found this charge proved.

**Charge 1.2:**

1.2. On or before 21 May 2015 told a patient and/or the patient’s family that the patient was going to St Martin’s Hospital when there were no beds available at St Martin’s Hospital;

This charge is found proved.

The panel had sight of Ms 2’s witness statement in which she said Mr Mutu had taken a phone call and informed her that there was a bed available for a patient at St Martin’s (Community) Hospital. Ms Wilson therefore took steps to discharge the patient. Ms 2 found out that this was not the case when the Trust’s discharge liaison nurse called regarding another matter and told Ms 2 that she did not tell Mr Mutu there was a bed available. The patient was by this time en route to St Martin’s hospital. Ms 2 managed to contact the hospital transport and the patient was returned to ACE ward. Ms 2 advised the panel that this event could have been more serious if, in the meantime, the patient’s bed had been allocated to someone else as this patient would have had to be
readmitted via A&E and thus any necessary treatment would have been delayed. Ms 2’s statement also says that Mr Mutu was ‘adamant this is what the nurse had said’. The panel took into account the daily feedback sheet, compiled by Ms 2 on 21 May 2015, supported by her written statement and her live evidence. The panel found this charge proved on the basis of the evidence supplied by Ms 2.

**Charge 1.3:**

1.3. On or before 21 May 2015:
1.3.1. Failed to inform the person in charge that a patient had loose stools;
1.3.2. Failed to handover without prompting that a patient had loose stools.

This charge is found proved.

The panel took into account the daily feedback sheet dated 21 May 2015 written by Ms 2 which stated Mr Mutu:

‘did not inform co-ordinator his patient had loose stools until reminded 3 hours later and did not handover to night staff until reminded’.

Ms 2 confirmed this account in her live evidence explaining that the ward had recently had a C Difficile infection and that the concern in this case was about a possible further infection and therefore about patient safety. The panel found this charge proved on the basis of Ms 2’s live evidence and the daily feedback sheet.

**Charge 1.4:**

1.4. On or before 22 May 2015:
1.4.1. Told a doctor that the wrong patient needed a Sando K prescription reviewed;
1.4.2. Did not know whether there was anything that you needed to handover to a doctor regarding a patient.
This charge is found proved.

The panel had sight of the daily feedback sheet dated 22 May 2015 written by Ms 2 which states:

‘At morning handover outside of bed 7 room I showed [Mr Mutu] the drug chart and said Sando K needs review. [Mr Mutu] said ok but later (around 10 mins) told the doctor that Bed 6 Sando K needs review. The doctor told me [Mr Mutu] told her the wrong patient. I asked [Mr Mutu] if [there was] anything to handover to doctor about Bed 10. [Mr Mutu] did not know. It was handed over to both of us from a night nurse a patient had a hypo’ (sic).

In her oral evidence Ms 2 confirmed her record. The panel concluded that Mr Mutu was confused as to the individual needs of each of the patients in his care on that particular day. The panel found this charge proved on the basis of Ms 2’s evidence supported by her signed feedback sheet.

Charge 1.5.1:

1.5. On 25 May 2015:
1.5.1. Did not hand over that a falls and/or Braden care plan needed to be completed for a patient;

This charge is found proved.

The panel had sight of the daily feedback sheet dated 25 May 2015 completed by Ms 2 and confirmed in her oral evidence. Ms 2 told the panel Mr Mutu only had five patients allocated to him, under her supervision, that day. He completed care plans for four patients but did not do the necessary falls and Braden care plan for the fifth patient, nor did he handover to the next shift that this hadn’t been done. Ms 5 confirmed in her
evidence that she subsequently discussed this with him at a weekly feedback meeting. On the basis of the evidence provided by Ms 2 and Ms 5 the panel was satisfied that Mr Mutu did not handover that a falls and/or Braden care plan needed to be completed and found this charge proved.

**Charge 1.5.2:**

1.5. On 25 May 2015:
1.5.2. Were not aware that a patient had refused all medication despite this being handed over to you;

**This charge is found proved.**

The panel had sight of the daily feedback sheet dated 25 May 2015 completed by Ms 2 and confirmed in her oral evidence. The feedback sheet recorded that a patient had refused all medication in the morning and that this was verbally handed over to Mr Mutu, that Mr Mutu said he did not know and that Ms 2 later gave the patient the medication otherwise it would be missed. In her oral evidence she further explained to the panel that in this situation she would normally wash the patient and re-try to administer medication when they were more awake. The panel concluded that Mr Mutu was not aware that a patient had refused all medication despite this fact being handed over to him. The panel found this charge proved on the basis of Ms 2’s evidence, supported by her daily feedback sheet.

**Charge 1.5.3:**

1.5. On 25 May 2015:
1.5.3. Needed to be told to listen when the night nurse was handing over two insulin dependent patients.

**This charge is found proved.**
The panel had sight of the daily feedback sheet dated 25 May 2015 completed by Ms 2. This recorded that:

‘Also needed to be told to listen when night nurse handing over re 2 patients insulin doses/administration. Relying on me to be on top of his patients’ medications. Though he needs me to administer I have told him he needs to know and then he can ask me to administer.’ (sic)

Ms 2 said in her live evidence that Mr Mutu had been chatting to staff rather than listening to the handover. She said that the Trust had been working towards Mr Mutu being responsible for his own patients but that he needed to listen at handovers so that he is aware of patient medication needs. The panel determined that Mr Mutu was not listening during the handover on 25 May 2015 so he needed to be told. The panel found this charge proved on the basis of Ms 2’s evidence, supported by her daily feedback sheet.

**Charge 1.6:**

1.6. On 3 June 2015, informed colleagues that a patient had been diagnosed with C Difficile when that was not correct;

**This charge is found proved.**

This charge was the first of a number of charges which relied upon an entry in the daily feedback sheet made by a registered nurse who had neither given evidence nor provided a formal witness statement.

Ms 1 exhibited the daily feedback sheet dated 3 June 2015, which had been completed by the Registered Nurse Supervisor who did not give evidence at this hearing. Ms 1 informed the panel that the daily feedback sheet was discussed with Mr Mutu at a weekly feedback meeting. The feedback sheet stated:
‘Except he said a patient had been diagnosed with C Diff when this was incorrect. He realised his mistake.’ (sic)

The panel understood that the evidence provided by this feedback sheet was hearsay evidence and attached less weight to it accordingly. However, the panel took account of the fact that the record had been compiled by a registered nurse in the course of his or her professional duty and could be presumed to be both honest, accurate and reliable. The panel was satisfied that it could rely on the daily feedback sheet exhibited by Ms 1, together with the notes of the weekly feedback meeting with Ms 1. It found this charge proved on this basis.

**Charge 1.7:**

1.7. On 12 June 2015, informed a porter that a patient did not require oxygen during his transfer when the patient did require oxygen;

**This charge is found proved.**

Ms 5 took the panel to the daily feedback sheet dated 12 June 2015 which included the following entry made by her:

‘Verbal feedback from Maevel, [Mr Mutu] was asked by a porter if a patient required oxygen during a transfer for investigation. [Mr Mutu] was unsure but said no. although nasal cannula was in place the doctor had turned it off. After prompting by Maevel, [Mr Mutu] checked oxygen sats prior to the patient leaving the ward.’

Ms 5, in her statement and in her oral evidence, told the panel that after prompting by a staff nurse [Mr Mutu] checked the patient’s oxygen requirements and confirmed that the patient needed oxygen during their transfer. [Mr Mutu] was unsure when the porter asked him about the oxygen requirements but instead of checking he just said the
patient did not require oxygen. In Ms 5’s opinion a potentially dangerous situation was only avoided by the intervention of another nurse.

The panel heard from Ms 1 that this matter was discussed with Mr Mutu at a weekly meeting. In her live evidence she told the panel that it appeared that Mr Mutu had just guessed that the patient did not require any oxygen when he was about to be transferred as he had not sought advice from a doctor, his supervising nurse or any other nurse colleagues.

The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6.

The panel was satisfied that this evidence, provided by a registered nurse, was both honest and reliable, and concluded on the balance of probability that this charge is proved.

**Charge 1.8:**

1.8. On 13 July 2015:
1.8.1. Relayed incorrect information about a patient requiring a side room;
1.8.2. Informed the wrong relative about a patient’s condition and/or reason for moving.

This charge is found proved.

The panel took into account the daily feedback sheet, exhibited by Ms 1, completed on 13 July 2015 by the supervising nurse. The daily feedback sheet states that Mr Mutu had ‘wrongly relayed information about a patient requiring a side room’ and that he ‘informed the wrong relative about patients status and why we were moving beds’. Ms 1 told the panel the implications of this, patients were often moved to a side room for end
of life care. The patient and their relatives might understandably be distressed if told the patient was being moved to a side room.

The daily feedback sheet also detailed that Mr Mutu realised his mistake and otherwise communicated well. The panel noted that the supervising nurse had been fair to Mr Mutu in her notes, identifying occasions when he had performed to a satisfactory standard.

The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6.

Based on this evidence, the panel found charges 1.8.1 and 1.8.2 proved.

**Charge 1.9:**

1.9. On 12 September 2015, informed the family of a patient that the patient had dementia when there was not yet a formal diagnosis of dementia.

**This charge is found proved.**

The panel took into account the daily feedback sheet, exhibited by Ms 1, completed on 12 September 2015 by the supervising nurse. The sheet detailed that Mr Mutu ‘wrongly said a patient had dementia to a family when there is no formal diagnosis as yet’. Ms 1 said in evidence that Mr Mutu should not have said this, there can be a variety of reasons why someone is acting confused, and that this inaccurate information could cause unnecessary stress.

The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was
accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6.

The panel therefore found this charge proved.

**Charge 1.10:**

1.10. On 28 April 2016 inappropriately told a patient’s family that the patient had cancer.

This charge is found proved.

The panel had sight of a note dated 28 April 2016 signed by Mr Mutu. It states ‘I have misled the patients family by telling them that she has bowel CA without a medical diagnosis present when family returns will make sure to apologise and explain my mistake’ (sic). On the basis of this note, the panel found this charge proved.

**Charge 1.11:**

1.11. On 30 May 2016:
1.11.1 Were rude to a patient;
1.11.2 Spoke about a patient’s personal information in a manner which could have been overheard.

This charge is found proved.

The panel took into account the daily feedback sheet, exhibited by Ms 7, completed on 30 May 2016 by the supervising nurse. The panel was satisfied that it could rely on this as this incident was discussed with Mr Mutu at a weekly review meeting. The daily feedback sheet states that a patient complained that Mr Mutu had been rude, talked too
loud and everyone could hear personal information. The patient was crying in the bay and asked not to be looked after by him again. Ms 8’s statement confirms this by saying ‘I remember an incident on 30 May 2016 when a patient’s son had complained as he felt [Mr Mutu] had been quite rude when talking to his mum and that everyone was able to hear her personal information’. Ms 8 escalated this to the Senior Sister. The panel gave less weight to Ms 8’s statement than evidence on oath but nevertheless the panel was satisfied that Mr Mutu was rude to the patient and had been talking loudly.

The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6, and was supported by the evidence of a meeting.

It therefore found this charge proved.

**Charge 1**

The panel concluded that the examples of poor communication in the 17 separate elements of charge 1 which occurred between 27 April 2015 and 30 May 2016 do prove that Mr Mutu did not consistently demonstrate an ability to communicate accurately and/or effectively.

**The panel found charge 1 proved in its entirety.**

**Charge 2:**

2. Did not consistently demonstrate an ability to effectively plan and prioritise patient care, in that you:

**Charge 2.1:**
2.1. On or around 19 May 2015 did not complete comfort rounds for patients in your care without prompting;

This charge is found proved.

The panel had sight of the daily feedback sheet dated 19 May 2015 exhibited by Ms 1. Ms 1 told the panel that, on this occasion, she was unsure which supervising nurse completed this sheet. However, as the panel was made aware of the process of the sheet being completed by the supervising nurse and the details of it being discussed with Mr Mutu, it had no reason to believe the sheet was incorrect. The entry on the sheet states that Mr Mutu had to be asked three times to complete comfort rounds for his patients and he replied each time with 'yes I know'. The panel also took into account the notes from the weekly meeting with Ms 5 on 22 May 2015 where these omissions were discussed with Mr Mutu.

The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6. and was supported by the evidence of the weekly review meeting.

The panel was satisfied that Mr Mutu needed prompting to complete his comfort rounds and therefore found this charge proved.

Charge 2.2:

2.2. On or around 22 May 2015 did not promptly and without prompting complete comfort rounds for the patients in your care;

This charge is found proved.
Ms 5’s notes from the weekly meeting with Mr Mutu on 22 May 2015 note that three hours after her meeting with Mr Mutu to discuss the issues in charge 2.1. above, Ms 5 found at least one patient where no comfort round was completed from 08.30 until 19.00 hours. Mr Mutu told Ms 5 that he had been too busy to complete the comfort rounds although the panel noted that he only had four patients to care for on that date. The panel was informed that the number of patients usually allocated to each registered nurse was ten.

The panel also had sight of the daily feedback sheet dated 22 May 2015 and completed by Ms 2. A note at the bottom of the sheet states Mr Mutu ‘helped his four patients with personal care. Comfort rounds for all 4 still not completed from night shift at 14.30’. Ms 2 confirmed this in her live evidence to the panel.

On the basis of this evidence the panel found this charge proved.

**Charge 2.3**

2.3. On 25 22 May 2015, between approximately 06:00 hrs and 19:00 hrs, did not complete comfort rounds for a patient in your care;

**This charge is found proved.**

The NMC’s evidence for this charge is the daily feedback sheet dated 25 May 2015 which includes a note which says ‘Update for 22 May 2015 19.00 Bogden [Mr Mutu] still had not completed comfort round for one of his patients since 06.00 hours”. In her witness statement Ms 2 states that this note was written on this sheet relating to 25 May 2015 as on that date she did not have access to the sheet which related to 22 May 2015. In the panel’s view it is clear that the charge should relate to 22 May 2015.
The panel has amended this charge to reflect the change in date from 25 May 2015 to 22 May 2015. The panel has done this of its volition in accordance with Rule 28. The panel concluded that no injustice would arise from this given that the underlying issues had been raised with Mr Mutu by the Trust.

From this evidence the panel determined that Mr Mutu had not completed a comfort round for a patient in his care.

On that basis the panel found this charge proved.

**Charge 2.4.1:**

2.4. On 10 May 2016:
2.4.1. Did not take observations for one or more of the patients in your care;

**This charge is found proved.**

The panel had sight of Ms 3’s handwritten report dated 10 May 2016 from her shift with Mr Mutu. In her live evidence she told the panel that she wrote this on the 12 May 2016 regarding the shift on the 10 May 2016. She confirmed she had a clear recollection when writing these notes. The panel was satisfied that it could rely on this evidence. In relation to one patient Ms 3 wrote ‘She had not had her observations taken since 06:00 with the night staff. It was now 2pm.’ Mr Mutu came on shift at 07.30. Ms 3 told the panel that this patient was particularly ill, was on oxygen, IV antibiotics and a nebuliser. Ms 3 told the panel that as a minimum Mr Mutu should have taken observations every four hours. The panel also noted that Ms 3’s handwritten report recorded that on being questioned about the above Mr Mutu became quite animated and raised his voice to the point that Ms 3 felt compelled to speak to her ward manager and matron about his attitude.
On the basis of this evidence the panel found this charge proved.

**Charge 2.4.2:**

2.4. On 10 May 2016:
2.4.2. Did not complete patient records for one or more of the patients in your care.

_This charge is found proved._

The panel had sight of Ms 3’s handwritten report dated 10 May 2016 from her shift with Mr Mutu. It stated that ‘throughout my shift there were many omissions in paperwork…comfort care plans not completed. Hydration charts not completed. End of bed patient profile and care plans not completed’. Ms 3 went on to say ‘It took me some time to correct and address his lack of work in these areas and put additional stress and pressure on an already taxing and stressful shift.’ The panel concluded that Ms 3 had a clear recollection of these events and was satisfied it could rely on her evidence and therefore found this charge proved.

**Charge 2.5:**

2.5. On 12 October 2015 failed to promptly take MRSA swabs having been asked to do so and without further prompting;

_This charge is found proved._

The panel took into account the daily feedback sheet dated 12 October 2015, completed by the supervising nurse, who had not been called to give evidence. An entry states that he had to remind Mr Mutu ‘to take MRSA swabs 2hrs after asking for them’. Ms 1 explained the risk that Mr Mutu’s lack of action could have caused.
The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6.

The panel determined that Mr Mutu failed to promptly take MRSA swabs having been asked to do so and without further prompting and therefore found this charge proved.

**Charge 2.6:**

2.6. On 16 May 2016, after approximately 10:35 hrs, failed to record observations for a patient on a cardiac monitor;

**This charge is found proved.**

The panel had sight of a note written by Ms 3 on 16 May 2016 which says ‘this patient was under the care of B Mutu. This patient was commenced on a cardiac monitor by [Mr Mutu] yet nil obs taken since 10:35am. [Mr Mutu] had 3 patients in the bay to look after’ (sic). The panel also took into account Ms 7’s witness statement which confirmed that Mr Mutu’s failure to take observations was discussed with him at a meeting. At the meeting Mr Mutu said the ward was busy. In fact he only had three patients to care for.

On the basis of this evidence the panel found this charge proved.

**Charge 2.7:**

2.7. On or around 22 June 2016 failed to check that insulin had been given to a patient with elevated blood glucose levels;

**This charge is found proved.**
The panel had sight of the daily feedback sheet dated 22 June 2016 completed by Ms 4. This recorded that:

‘[Mr Mutu] took handover from the night staff that a patient who is type 1 insulin diabetic was having morning blood glucose levels of 27.8mmol, failed to check insulin had been given and when I was informed by the doctor about the high BMs it was found that the night nurse had not given night insulin.’

Ms 4 informed the panel that the doctor had told her that Mr Mutu did not check insulin, or tell someone he had not, despite being told about the high blood glucose levels. Ms 4 said that this could have been serious as the patient could have had a hyper glycaemic episode. The panel was satisfied that this evidence was both honest and reliable and concluded that this charge is proved.

**Charge 2.8.1:**

2.8. On 23 June 2015:
2.8.1. Did not, without prompting, dress a wound appropriately;

**This charge is found proved.**

The panel had sight of the daily feedback sheet, exhibited by Ms 1, dated 23 June 2015 completed by the supervising nurse. This recorded that Mr Mutu ‘said he does not need teaching by me he is already a nurse although he was about to dress a wound inappropriately.’ This was discussed with Mr Mutu at a meeting with Ms 1 who said that Mr Mutu had appeared to take feedback on board regarding listening to advice. The panel also took into account Ms 1’s statement which said ‘Before dressing a wound you should look at the care plan. I believe [Mr Mutu] was trying to do his own thing and [the supervising nurse] had to tell him to look at the care plan as different wounds needed different dressings.’
The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6.

The panel concluded that on the balance of probability this charge is proved on the basis of the daily feedback sheet exhibited by Ms 1, together with the note of her meeting with Mr Mutu on 23 June 2015, and her statement.

**Charge 2.8.2:**

2.8. On 23 June 2015:
2.8.2. When asked what a drug was for replied with words to the effect of, “No idea and I don’t care.”

**This charge is found proved.**

This charge relied on the same daily feedback sheet as charge 2.8.1, exhibited by Ms 1, dated 23 June 2015 completed by the supervising nurse. This recorded that ‘when asked what a drug was for he replied “no idea and I don’t care”’.

The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6.

The panel was satisfied that it could rely on the daily feedback sheet exhibited by Ms 1, together with the note of her meeting with Mr Mutu on 23 June 2015, and her statement, and found this charge proved on this basis.
Charge 2.9:

2.9. On 14 July 2015 attempted to apply an inappropriate dressing to a patient.

This charge is found proved.

The panel had sight of the daily feedback sheet, exhibited by Ms 1, dated 14 July 2015 completed by the supervising nurse. This recorded that Mr Mutu:

‘was about to redress some leg ulcers as I came back from lunch and apply a dressing (inappropriate) without referring to the care plan. Reminded [Mr Mutu] to read wound care plans beforehand and follow advice given rather than guessing what to use and/or using honey tube for every wound. He seemed to take this on board.’

The panel noted that Mr Mutu had also received some positive feedback from the supervising nurse and considered this fair.

The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel's decision in charge 1.6.

The panel was satisfied that it could rely on the daily feedback sheet exhibited by Ms 1, and her statement, and found this charge proved on this basis.
Charge 2

The panel concluded that the examples of poor communication in the 11 separate elements of charge 2 which occurred between 19 May 2015 and 23 June 2016 do prove that Mr Mutu did not consistently demonstrate an ability to effectively plan and prioritise patient care. It noted the repeated incidences of Mr Mutu failing to complete essential care plans and comfort rounds despite being prompted. It further noted that Mr Mutu would go on breaks before completing tasks and there were multiple wound dressing errors 3 weeks apart. The panel found charge 2 proved in its entirety.

Charge 3:

3. Did not consistently demonstrate an ability to keep clear and accurate records relevant to your practice, in that you:

Charge 3.1:

3.1. On 12 October 2015, upon a patient’s discharge, did not:
3.1.1. Complete the discharge summary;
3.1.2. Make a district nurse referral;
3.1.3. Supply the patient with dressings.

This charge is found proved.

The panel had sight of the daily feedback sheet exhibited by Ms 1 dated 12 October 2015 completed by the supervising nurse which records ‘Also on this day [Mr Mutu] failed to complete a patient’s discharge summary or make a district nurse referral.’ In her live evidence, Ms 1 told the panel about the importance of making a district nurse referral and ensuring that patients are given a supply of dressings to take home on discharge.
The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6.

The panel was satisfied that it could rely on the daily feedback sheet exhibited by Ms 1 and her own evidence and found this charge proved.

**Charge 3.2:**

3.2. On 25 May 2015 did not complete a falls and/or a Braden care plan for a patient.

**This charge is found proved.**

The panel had sight of the daily feedback sheet, dated 25 May 2015 completed by Ms 2. This recorded that Mr Mutu ‘did 4 patients care plans. 1 patient had no care plans but needed Falls and Braden- not done or handed over.’

The panel was satisfied that it could rely on the daily feedback sheet produced by Ms 2 and found this charge proved on this basis.

**Charge 3.3:**

3.3. On 2 January 2016 did not complete a Post-Fall Assessment form and/or an incident form for a patient who had been on the floor.

**This charge is found proved.**

The panel had sight of Ms 5’s witness statement which said the following:
'On 2 January 2016, a patient fell over in a side room. I was on duty and saw a hoist going into the side room. [Mr Mutu] tried to hoist the patient himself and became very agitated with the care assistant who was trying to help. When I discussed the paperwork about this incident with [Mr Mutu] he became quite agitated with me and said it was not necessary to complete an incident form regarding the fall. I had another discussion with [Mr Mutu] when he was a little calmer. He said he wanted to complete the incident form the next day. I said this was not acceptable and completed the incident form myself. [Mr Mutu] said that the patient had not fallen so he did not think it was necessary to complete an incident form. I explained that as the patient was on the floor it had become an incident.'

The panel also had sight of the notes Ms 5 made on 2 January 2016, exhibited by Ms 1 which supported Ms 5’s statement. The panel was satisfied it could rely on this evidence and therefore found this charge proved.

**Charge 3.4:**

3.4. On 8 September 2015 you did not complete:
3.4.1. Cannula care plans for the patients in beds 10 and 12;
3.4.2. The patient profile for the patient in Bed 11;
3.4.3. The falls care plan for the patient in Bed 12;
3.4.4. The falls, catheter and Braden and cannula care plans for the patient in Bed 15.

**This charge is found proved.**

The panel had sight of the daily feedback sheet for 8 September 2015, completed by Ms 2. This recorded that:
'I checked on 9/9/15 what care plans [Mr Mutu] had done for his 5 pts 8/9/15.
Omissions: Bed 10- cannula care plans early and late; Bed 11- dots ‘patient profile’, Bed 12- cannula care plan early and late, falls; Bed 15- falls, catheter (including one for
change of catheter), Braden and cannula (including new one for new catheter dr put in and [Mr Mutu] aware and old cannula which should have been removed 8/9/15’ (sic).

The panel noted that this entry on the daily feedback sheet is supported by both Ms 2’s and Ms 1’s witness statements. In her live evidence, Ms 1 told the panel that she discussed the omissions with Mr Mutu at a meeting. The panel was satisfied it would rely on Ms 2’s and Ms 1’s evidence and found this charge proved.

**Charge 3.5:**

3.5. On 27 September 2015 did not include enough information in a Transfer of Care.

This charge is found proved.

The panel had sight of a report dated 27 September 2015, completed by Ms 6. This recorded that there was a ‘patient going to community hospital…Wrote transfer of care-no information on that. Thought it was amusing that patient came back and showed no empathy toward distressed patient and concerned relatives.’ Ms 1 also told the panel that this was discussed at the weekly meeting with Mr Mutu where he did not apologise and denied finding it amusing. Based on this evidence the panel was satisfied that on 27 September 2015 Mr Mutu did not include enough information in a Transfer of Care.

**Charge 3.6:**

3.6. On 8 June 2016 required prompting to complete comfort rounds and hydration charts.

This charge is found proved.

The panel had sight of the daily feedback sheet dated 8 June 2016 completed by Ms 4. This recorded that Mr Mutu ‘did need reminding to check comfort rounds and ensure
hydration charts were completed which when checked later were completed.’ The panel also took into account Ms 4’s witness statement in which she confirmed this entry and said that Mr Mutu ‘needed a lot of reminding to complete comfort and skin checks’. The panel was satisfied it could rely on this evidence and therefore found this charge proved.

**Charge 3.7:**

3.7. On 22 June 2016 failed to document care given to one or more patients;

*This charge is found proved.*

The panel had sight of the daily feedback sheet dated 22 June 2016 completed by Ms 4. This recorded that Mr Mutu ‘failed to document in the medical notes for the care provided by himself for the shift and observations for the patients were missed’. This evidence is supported by Ms 4’s witness statement. The panel was satisfied it could rely on this evidence and therefore found this charge proved.

**Charge 3.8:**

3.8. On 24 June 2016:

3.8.1. Failed to complete all care plans and comfort rounds for a patient on priorities of care;

3.8.2. Failed to hand over one or more of your patients;

3.8.3. Did not complete documentation for one or more of your patients.

*This charge is found proved.*

The panel had sight of the daily feedback sheet dated 24 June 2016 completed by Ms 4. This recorded that Mr Mutu ‘did not complete some care plans including comfort round for a patient who was on priorities of care’, and that he ‘failed to handover all his
patients to relevant nursing staff’ and that he ‘did not complete all documentation for all of his patients during his shift’. The panel took into account Ms 4’s witness statement which mentioned that there was a recurring issue of Mr Mutu not completing documentation and needing prompting to do so. Her witness statement also said that ‘the number of patients assigned to him was reduced but there were still gaps in his paper work. When I discussed this with him he understood why it was important and said he would do it but unfortunately it was not always done.’ The panel was satisfied it could rely on this evidence and therefore found all three elements of this charge proved on this basis.

**Charge 3.9:**

3.9. On an unknown date, did not document the fluid charts.

**This charge is found proved.**

The panel took into account Ms 8’s witness statement which said:

‘There was another incident when I was supervising him when he did not monitor a patient’s urine output. He did not document the fluid charts and when we checked he just said that the patient had not drunk or had not passed urine. This patient would have needed assistance to drink and he should have been monitoring her urine output. Elderly patients are at high risk of developing acute kidney injuries and if she had not been passing urine he should have escalated it to the medical team. When I explained this he nodded and said he would do it next time. This was a recurring issue with [Mr Mutu]. He would either not document patient care promptly or not document it at all.’

The panel also had sight of notes from a meeting between Mr Mutu and Ms 7 in which it records that ‘the issues this shift were that [Mr Mutu] had not done any paperwork for the shift (care plans, Fluid charts)’. The panel gave less weight to Ms 8’s witness
statement than evidence on oath, but nevertheless the panel was satisfied that it had sufficient evidence from these two registered nurses and therefore found this charge proved.

**Charge 3**

The panel concluded that the examples in the 16 separate elements of charge 3 which occurred across 13 months between 25 May 2015 and 24 June 2016 do prove that Mr Mutu did not consistently demonstrate an ability to keep clear and accurate records relevant to his practice. It noted the fundamental importance of record keeping in nursing, to share information with other colleagues and to ensure continuity of patient care. The panel found charge 3 proved in its entirety.

**Charge 4:**

4. Did not consistently demonstrate the required standards in respect of drug knowledge and/or administration, in that you:

**Charge 4.1.1:**

4.1.1 On or around 28 May 2015 when drawing up an inter-muscular injection started to withdraw the medication without a needle on the syringe;

**This charge is found proved.**

The panel had sight of the daily feedback sheet dated 28 May 2015 completed by Ms 2. This recorded that Mr Mutu ‘started to withdraw med from glass vial without needle on syringe’ (sic). In her live evidence Ms 2 confirmed this entry and explained to the panel the risk of doing this as small glass fragments could be drawn into the syringe. The panel was satisfied it could rely on Ms 2’s evidence and therefore found this charge proved.
Charge 4.1.2:

4.1.2 On or around 24 June 2015 attempted to guess the dosage of carbocysteine medication, rather than calculate it;

This charge is found proved.

The panel had sight of the daily feedback sheet dated 24 June 2015 completed by Ms 2's. This recorded that Mr Mutu:

‘was going to give carbocysteine without knowing what for but also as dose was 15mls liquid he picked up paper waxed pot and said that is about 20mls and was going to guestimate the dose’ (sic). In a meeting with Ms 1, Mr Mutu was advised to use a syringe in future and of the dangers of overdose/underdose. Mr Mutu stated he had never done this before and agreed not to repeat this poor practice.

The panel accepted this evidence and noted that there was an underlying risk of harm with guessing medication doses. The panel found this charge proved.

Charge 4.1.3:

4.1.3 On or around 8 September 2015 were unable to identify the uses for gabapentin and/or finasteride and/or Sodium Valproate and/or citalopram

This charge is found proved.

The panel had sight of the daily feedback sheet dated 8 and 9 September 2015 completed by Ms 2. This recorded that Mr Mutu:
'has done one whole med round 8/9 and part 9/9. Medications- does not know gabapentin and finasteride (told him last week) sodium valproate (thought for respiratory) handed over to us a.m. It is timed med, not sure if nurse mentioned what for though. Did not know citalopram.'

The panel also took into account Ms 2’s witness statement which said ‘I had spoken to him the previous week about gabapentin, a neurological pain medication and finasteride a prostate medication. Both were fairly common but he had forgotten their uses. This is basic nursing knowledge despite being told the week before.’

The panel was satisfied it could rely on Ms 2’s evidence and therefore found this charge proved on this basis.

**Charge 4.1.4:**

4.1.4 On or around 8 September 2015, gave glycerine suppositories to a patient when they were standing up;

**This charge is found proved.**

The panel had sight of the daily feedback sheet dated 8 and 9 September 2015 completed by Ms 2. This recorded that Mr Mutu ‘administered glycerine suppositories to patient stood up. Did not know they had to be laid down or on their left side.’ The panel also took into account Ms 2’s witness statement which said Mr Mutu:

‘administered glycerine suppositories to a patient whilst they were standing up. I do not know why he administered this without me when he was not supposed to but suppositories need to be given laid down and on the left had side otherwise they may not work.’
The panel was satisfied it could rely on Ms 2’s evidence and therefore found this charge proved on this basis.

**Charge 4.1.5:**

4.1.5 On or around 28 April 2015 gave a patient and/or advised a patient to take an additional 40 units of Insulin without authority to do so and/or when it was inappropriate to do so;

This charge is found proved.

The panel took into account Ms 2’s witness statement which said:

'When I first started supervising [Mr Mutu] there was a major incident with an insulin dependent patient who was self-administering their insulin. I did not see the patient self-administer any insulin. It was [Mr Mutu] that supervised the patient self-administering the insulin. [Mr Mutu] told me that the insulin did not all go in so he had told the patient to put another 40 units of insulin in. The patient confirmed with me that [Mr Mutu] had told him to inject another 40 units. You never administer insulin again if it has not gone in you monitor the situation with the doctor. The patient was seen by a doctor and appropriate action was taken. What greatly concerned me was that [Mr Mutu] had advised the patient to administer more insulin and that he felt he could do this without any authority. He did not think of the consequences to the patient which could ultimately be that the patient could have died from an insulin overdose. I did not feel that [Mr Mutu] understood the severity of the situation.'

The panel also noted that Ms 1 discussed this incident in a meeting with Mr Mutu in which he 'shrugged his shoulders'. The panel was of the view that this corroborated Ms 2’s evidence regarding Mr Mutu not understanding the severity of the incident. The panel was satisfied that Mr Mutu did act in the way set out in the charge, based on this evidence, and therefore found it proved.
**Charge 4.1.6:**

4.1.6 On one or more occasions in March 2016 required prompting in order to recognise when a medication(s) had been stopped and/or held;

**This charge is found proved.**

The panel had sight of the daily feedback sheet dated 15 March 2016 completed by the supervising nurse. This recorded that Mr Mutu ‘did not notice that a drug had been crossed off the first time he looked at it. However when he was prompted he recognised this.’ The panel also had sight of the daily feedback sheet completed by another supervising nurse dated 21 March 2016. This recorded that ‘again [Mr Mutu] struggled again to recognise if a medication has been stopped if not crossed the whole way through.’

A further daily feedback sheet dated 29 March 2016 recorded that ‘one issue- he did not recognise when a medication had been ‘held’ by doctors- a x was present on chart but he had not noticed until I said.’ The panel took into account notes from the weekly meeting between Ms 7 and Mr Mutu on 22 March 2016. These stated that Mr Mutu ‘had rushed through the medication chart and misread some of the medications that had been crossed out and thought they still needed to be given.’

The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6.

The panel was satisfied it could rely on this evidence and determined that Mr Mutu had required prompting, on at least three occasions, to recognise when a medication had been stopped in March 2016. It therefore found this charge proved.
**Charge 4.1.7:**

4.1.7 On or around 2 May 2016 attempted to give calcium resonium when it was not appropriate and/or you did not have authority to do so;

**This charge is found proved.**

The panel took into account Ms 3’s witness statement which said:

‘I worked a further shift with [Mr Mutu] on 2 May 2016. The patient in the side room had been on calcium resonium which alters potassium levels. Patients are generally on the medication for a short period of time until their potassium levels get back to a normal range. High potassium levels can have a detrimental effect on the patient and calcium resonium will help to bring potassium within its normal level. [Mr Mutu] said the patient's potassium was in range and [Mr Mutu] began to start to give calcium resonium. I advised him to wait until we had spoken to the doctor. [Mr Mutu] was allowed to give medication as long as he was supervised.’

The panel also had sight of Ms 3’s handwritten note dated 2 May 2016 which records the incident and noted that she intervened to tell Mr Mutu to wait until that day’s blood test results were received and reviewed by the doctor.

The panel was satisfied it could rely on this evidence given by Ms 3, a registered nurse, and therefore found this charge proved on this basis.

**Charge 4.2:**

4.2 At a meeting held on 2 September 2015, were not signed off as competent in respect of drug knowledge and/or administration, following 8 weeks performance management programme;
This charge is found proved.

The panel had sight of a letter dated 8 September 2015 entitled ‘Re: Managing Performance Formal Stage One Meeting’ from Ms 1 to Mr Mutu which confirmed that a meeting took place on 2 September 2015 with Mr Mutu. The letter stated ‘I do not feel that you are performing at the required standard for a Registered Nurse’. The panel was satisfied it could rely on this evidence and on that basis found this charge proved.

Charge 4.3:

4.3 At a meeting held on 11 March 2016, were not signed off as competent in respect of drug knowledge and/or administration following a stage two performance management programme

This charge is found proved.

The panel had sight of a letter dated 14 March 2016 entitled ‘Outcome of Formal Stage 2 Performance Management Meeting’ which confirmed that a meeting took place on 11 March 2016 with Mr Mutu. The letter stated Ms 1 ‘described your ability to carry out your role as a Registered Nurse as ‘inconsistent’ and as a result of the inconsistency in your ability to understand the purpose of and administer drugs safely to date, it has not been possible to sign-off your drug competency booklet.’ The panel was satisfied it could rely on this evidence and on that basis found this charge proved.

Charge 4.4:

4.4 At a meeting held on 21 July 2016, were not signed off as competent in respect of drug knowledge and/or drug administration following a 12 week performance management programme on Midford Ward;
This charge is found proved.

The panel had sight of a letter sent to Mr Mutu dated 25 July 2016 entitled ‘Outcome of Reconvened Formal Stage 2 Performance Management Meeting’ from the Head of Nursing at the Trust to Mr Mutu which confirmed that a meeting took place on 21 July 2016 with him. The letter stated that Ms 7 who was present at the meeting ‘confirmed she would not be comfortable to sign you off as a competent registered nurse based on her supervision of your practice of the last 12 weeks.’ The panel was satisfied it could rely on this evidence and on that basis found this charge proved.

Charge 4
The panel concluded that the examples in the 10 separate elements of charge 4 which occurred across 13 months between 28 April 2015 and 21 July 2016 do prove that Mr Mutu did not consistently demonstrate the required standards in respect of drug knowledge and/or administration. It noted the repetitive nature of the issues highlighted and that this period of time has been summed up in three letters referred to in charges 4.2, 4.3 and 4.4. The panel found charge 4 proved in its entirety.

Charge 5.1:

5. On or around one or more of the following dates, you administered or dispensed medication unsupervised when you were not permitted to do so:

5.1 28 April 2015;

This charge is found proved.

The panel took into account its reasons for charge 4.1.5. It noted that Mr Mutu did not inform his supervisor that he had dispensed medication until after the incident. For that reason together with the reasons set out in relation to charge 4.1.5 the panel found this charge proved.
Charge 5.2:

5. On or around one or more of the following dates, you administered or dispensed medication unsupervised when you were not permitted to do so:

5.2 22 May 2015.

This charge is found proved.

The panel took into account Ms 2’s notes dated 22 May 2015. These stated:

‘He told me he gave Bed 2 his amoxicillin and there was nothing for Bed 3. I asked if he had given Bed 2 his amoxicillin? He said ‘yes’, I said ‘you are not meant to give patients medication unsupervised. He replied ‘I know’ I said ‘why did you then?’ He said ‘because you were talking’ I told him ‘then you wait’ He said ‘but it is wasting time’ … I told him not to do it as it his pin on the line, He replied ‘I know’.’

The panel took into account the note of Ms 5’s meeting with Mr Mutu on 22 May 2015 Her notes of that meeting record that on 22 May 2015 Mr Mutu had ‘administered medication unsupervised – we discussed this – he is aware he shouldn’t as has been discussed before. I explained we need to trust him to follow our guidelines and policies and that as at present he is not”. The panel was satisfied that it could rely on Ms 2’s and Ms 5’s evidence and therefore found this charge proved.
Charge 5.3:

5. On or around one or more of the following dates, you administered or dispensed medication unsupervised when you were not permitted to do so:

5. 3 12 June 2015

This charge is found proved.

The panel took into account notes from a feedback meeting on 13 June 2015 between Mr Mutu and Ms 5. These notes stated:

‘Medicines delivered safely, however on one occasion [Mr Mutu] was attempting to administer drugs to a patient unsupervised. I stressed again that at this time until he has completed his medicines competency this is unacceptable.’

The panel noted that the incident on 12 June 2015 is documented in the daily feedback sheet written by the supervising nurse on duty at the time from that date as follows ‘dispensing drugs from trolley into medicine pots with no trained nurse observing’. In her witness statement Ms 5 clarified that this was the incident she was discussing in the feedback meeting of 13 June 2015.

The panel understood that the evidence provided in the daily feedback sheet was hearsay evidence. However, the panel concluded that the hearsay evidence was accurate and reliable, for the same reasons as set out in the panel’s decision in charge 1.6. The panel was satisfied it could rely on this evidence and therefore found this charge proved.
Charge 5

The panel concluded that the three examples in charge 5 demonstrate that Mr Mutu administered or dispensed medication unsupervised. The panel is satisfied that Mr Mutu was never signed off as competent to administer medication in his time at the Trust and is also satisfied that he understood this.

Charge 6:

6. On or around 29 June 2016 did not respect Patient A’s wishes in respect of taking her blood pressure, in that:

6.1 You insisted that you could/should take the blood pressure from her left arm; and/or

6.2 Acted in a rude and/or bullying manner

This charge is found proved in its entirety.

The panel took into account Ms 7’s witness statement in which she said:

‘A second incident happened on 29 June 2016. I had been off the ward for a meeting. When I came back an alarmed junior sister approached me about a patient who was very upset. I spoke to the patient. She was a very sensible elderly lady. She had had a mastectomy and had lymph nodes removed. She was aware that her blood pressure should not be taken from the side of her body where she had had the mastectomy. [Mr Mutu] had tried to take blood pressure from her arm on the side she had had a mastectomy. He had argued with her and had told her that he knew better. This lady had become very upset. She was very emotional and felt that [Mr Mutu] had bullied her’.

In her oral evidence Ms 7 told the panel that Patient A had full capacity and ‘knew what she could or couldn’t do’. She also said that Mr Mutu kept trying to take her blood
pressure on the left arm stating that he was the qualified nurse and ignoring her request that he contact the breast clinic for advice. Patient A felt that he was not listening to her.

The panel was satisfied it could rely on Ms 7’s account of this incident set out in both her witness statement and her oral evidence. The panel was therefore satisfied that Mr Mutu had insisted that he should take the blood pressure from her left arm. It noted that Mr Mutu had upset Patient A sufficiently to make her complain to another nurse. Ms 7 told the panel that she was concerned about how Mr Mutu may behave to a patient who did not have capacity.

Based on this evidence that panel determined that Mr Mutu had insisted that he could/should take the blood pressure from her left arm and he acted in a rude and/or bullying manner

The panel therefore found this charge proved in its entirety.

Summary

The panel took into account the catalogue of incidents of fundamental bad practice found proved over a sustained period of 15 months between March 2015 and June 2016. Further, the panel noted that all the witnesses in this case said that Mr Mutu was not competent as a registered nurse and his colleagues were not prepared to sign him off or say he was competent. In particular the panel noted the comments made by Ms 7 who had told the Head of Nursing when asked if she would be comfortable to sign Mr Mutu off in a lower banded clinical role that “she had concerns about your ability to show empathy and this would be important irrespective of the grade or the role.” The panel was satisfied that Mr Mutu had failed to demonstrate the standards of knowledge, skill and judgment required to practise as a Band 5 Staff Nurse at the time.
Resumed hearing 20 March 2018

Decision on Service of Notice of Hearing

The panel was informed at the start of this resumed hearing that Mr Mutu was not in attendance and that written notice of this hearing had been sent to his registered address by recorded delivery and by first class post on 19 January 2018. Although the Track and Trace record indicated that the registered letter was signed for, it was subsequently returned to the NMC.

The panel took into account that the notice letter conformed to the NMC Rules in that it provided details of the allegation, the time, dates and venue of the resumed hearing and, amongst other things, information about Mr Mutu’s right to attend, be represented and call evidence, as well as the panel’s power to proceed in his absence.

Mr Loran submitted the NMC had complied with the requirements of Rules 32(3) which related to service of notice for part-heard hearings.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr Mutu had been served with notice of this resumed hearing in accordance with the requirements of Rules 32 (3) and 34. It took into account that is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision on proceeding in the absence of the Registrant

The panel next considered whether it should proceed in the absence of Mr Mutu. The panel had regard to Rule 21 (2) which states:
(2) Where the registrant fails to attend and is not represented at the hearing, the Committee—

(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;

(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or

(c) may adjourn the hearing and issue directions.

Mr Loran informed the panel that Mr Mutu had been in contact with the NMC since the original hearing.

On 21 February 2018 Mr Mutu called the Registration department of the NMC and informed it of a new address. Mr Mutu stated that he had not received any correspondence from the NMC “within the last eight months”. Mr Mutu also telephoned his case officer on the same day to inform her of the address change, stating that he had moved to a new address “a year ago” and that he had missed some NMC post.

Mr Mutu’s case officer emailed him on 22 February 2018 via the Egress system and sent him the following documents:

a. Resuming hearing confirmation
b. Part-heard hearing decision letter
c. Exhibit Bundle
d. Witness statement bundle
e. Transcript 20171204
f. Transcript 20171205
g. Transcript 20171206
h. Transcript 20171207
i. Transcript 20171208
j. Consent form for disclosure to representative
k. Personal contact and employment details form
l. Response to charges form
m. Travel and accommodation request form

The case officer was able to establish Mr Mutu accessed the documents via Egress on 23 February 2018.

On 6 March 2018 a further email was sent to Mr Mutu from the case officer attaching the notice of hearing letter. On 7 March 2018 Mr Mutu responded by email stating that he intended to attend the hearing. A further email was sent to Mr Mutu from his case officer on 12 March 2018. Mr Mutu has not responded to the email of 12 March 2018, nor has he returned his travel and accommodation request form sent to him in the email of 22 February 2018. Mr Loran informed the panel that the only telephone number that the NMC has for Mr Mutu appears to have been disconnected.

In the circumstances Mr Loran submitted that Mr Mutu was aware that a hearing was taking place this week, he has not made any further attempts to contact his case officer and he has not returned his travel and accommodation request form.

Mr Loran invited the panel to continue in the absence of Mr Mutu on the basis that he had voluntarily absented himself. He submitted that although there had been some recent engagement by Mr Mutu with the NMC in relation to these proceedings, Mr Mutu had not attended and had not requested an adjournment.

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 Mr Mutu. In reaching this decision, the panel has considered the submissions of the case presenter, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of Jones. It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mr Mutu is clearly aware that a hearing is scheduled for this week
- Mr Mutu has accessed the documents supplied to him by the NMC so will be aware of the nature of the proceedings and the charges being considered by the panel
- although Mr Mutu has been in contact with the NMC he has not engaged with the hearing process in that he has not supplied any information for the panel to consider despite being given the opportunity to do so and having been aware of these proceedings since 23 February 2018
- having indicated that he intended to attend the resumed hearing, Mr Mutu had not attended on day 1 of the resumed hearing (19 March 2018) or the morning of day 2 (20 March 2018); the panel considered the question of proceeding in absence at approximately 14.00 on day 2
- no application for an adjournment has been made by Mr Mutu
- there is no reason to suppose that adjourning this hearing would secure Mr Mutu’s attendance at some future date
- the charges relate to events that occurred in 2015
- there is a strong public interest in the expeditious disposal of the case.

The panel noted there may be some disadvantage to Mr Mutu in that he is not able to put his case to the panel. However, the panel concluded that any disadvantage is the consequence of Mr Mutu’s decision to voluntarily absent himself.
In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Mutu. The panel will draw no adverse inference from Mr Mutu’s absence.

**Determination on misconduct, lack of competence and impairment**

Having announced its finding on all the facts, the panel then moved on to consider, whether the facts found proved amount to misconduct and/or lack of competence, and if so, whether Mr Mutu’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 suitability to remain on the register unrestricted.

There was no further oral or written evidence submitted to the panel at this stage.

In relation to misconduct, Mr Loran referred the panel to the case of Roylance v GMC (No. 2) [2000] 1 AC 311 which defines misconduct as a ‘word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.’

In relation to lack of competence the panel’s attention was drawn to the case of Holton v General Medical Council [2006] EWHC 2960. Mr Loran informed the panel that the standard to be applied was that applicable to the post to which the registrant had been appointed and the work he was carrying out.

Mr Loran drew the panel’s attention to the NMC publication The Code: professional standards of practice and behaviour for nurses and midwives (the Code) applicable from 31 March 2015. He submitted that Mr Mutu’s actions breached a number of provisions of The Code.
The panel has accepted the advice of the legal assessor.

The panel adopted a two-stage process in its consideration, as advised. First, the panel must determine whether the facts found proved amount to misconduct and/or lack of competence. Secondly, only if the facts found proved amount to misconduct and/or lack of competence, the panel must decide whether, in all the circumstances, Mr Mutu’s fitness to practise is currently impaired as a result of that misconduct and/or lack of competence.

Decision on misconduct and/or lack of competence

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement. It considered each of the charges separately.

The panel was of the view that Mr Mutu’s actions did fall significantly short of the standards expected of a registered nurse, and that his actions amounted to a breach of the Code. Specifically:

1. **Treat people as individuals and uphold their dignity**
   
   To achieve this, you must:

   1.1. Treat people with kindness, respect and compassion
   
   1.2. Make sure you deliver the fundamentals of care effectively
   
   1.3. Avoid making assumptions and recognise diversity and individual choice

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

2.2. Recognise and respect the contribution that people can make to their own health and wellbeing

2.3. Encourage and empower people to share decision about their treatment and care

2.4. Respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5. Respect, support and document a person’s right to accept or refuse care and treatment, and

2.6. Recognise when people are anxious or in distress and respond compassionately and politely.

4. **Act in the best interests of people at all times**

To achieve this, you must:

4.1. Balance the need to act in the best interest of people at all times with the requirement to respect a person’s right to accept or refuse treatment

5. **Respect people’s right to privacy and confidentiality**

As a nurse or midwife, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.1. Respect a person’s right to privacy in all aspects of their care
6. Always practise in line with the best available evidence

To achieve this, you must:

6.1. Make sure that any information or advice given is evidence-based, …

6.2. Maintain the knowledge and skills you need for safe and effective practice.

8. Work cooperatively

To achieve this, you must:

8.1. Respect the skills, expertise and contributions of your colleagues, referring matter 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 healthcare professionals and staff

8.4. Work with colleagues to evaluate the quality of your work and that of the team

8.5. Work with colleagues to preserve the safety of those receiving care

8.6. Share information to identify and reduce risk,

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

To achieve this, you must:

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

9.3. Deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times,
10. **Keep clear and accurate records relevant to your practice**

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

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.

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

To achieve this, you must:

13.1. Accurately assess signs of normal or worsening physical and mental health in the person receiving care.

13.2. Make timely and appropriately referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment.

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

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

18. **Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations**
To achieve this, you must:

18.1. Prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person’s health and are satisfied that the medicines or treatment serve that person’s health needs.

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

To achieve this, you must:

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

20. Uphold the reputation of your profession at all times

To achieve this, you must:

20.1. Keep to and uphold the standards and values set out in the Code

20.2. Act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

20.5. Treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct and/or lack of competence.
When reaching its decisions on misconduct and/or lack of competence the panel took into account that at the relevant time Mr Mutu was subject to considerable support and supervision provided by the Trust. It had been identified at an early stage that there were issues of concern with Mr Mutu’s practice. He was originally subject to informal supervision, which was replaced with formal supervision as the informal supervision appeared to have little effect. Throughout the relevant period Mr Mutu’s practice was restricted both in terms of the care he provided and the number of patients allocated to him. Nonetheless, even with this support there was no discernible improvement in his practice over a period of 15 months. Further, the panel concluded that the evidence pointed to attitudinal issues in relation to the way Mr Mutu dealt with patients, their relatives, and colleagues, and in how he responded to feedback.

The NMC has defined a lack of competence as a lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice. Having considered each charge individually the panel conclude that the following charges could be attributed to a lack of competence on Mr Mutu’s behalf:

- Charges 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.8, 1.9, 1.10,
- 2.1, 2.2, 2.3, 2.4.2, 2.5, 2.6, 2.7, 2.8.1, 2.9,
- 3.1, 3.2, 3.4, 3.6, 3.7, 3.8, 3.9,
- 4.1.1, 4.1.3, 4.1.4, 4.1.6, 4.1.7, 4.2, 4.3 and 4.4.

In all these charges there were identifiable shortcomings which the panel concluded were instances where Mr Mutu had not exercised his knowledge, skill or judgment to make safe and effective decisions for the benefit of his patients. This poor practice specified in the charges related to a period of 15 months, on two different wards and with a number of different experienced registered nurses supervising him. The
evidence indicates that he was unable to learn from earlier mistakes and that he was unable to consistently demonstrate:

- an ability to communicate accurately and effectively
- an ability to effectively plan and prioritise patient care
- an ability to keep clear and accurate records relevant to his practice, and
- the required standards in respect of drug knowledge and/or administration.

These are the key nursing skills, essential in any nursing position, required for safe and effective practice. Even with support Mr Mutu was unable to maintain safe standards of practice consistently over time. The panel concluded that Mr Mutu's performance in relation to these charges was significantly below the standard expected of a band 5 registered nurse, which is the post he was working in, and both individually and collectively the charges found proved amount to a lack of competence.

The panel concluded that the following charges could be attributed to misconduct on Mutu's behalf:

Charges 1.7, 1.11, 2.4.1, 2.8.2, 3.3, 3.5, 4.1.2, 4.1.5, 5 and 6.

These charges related to attitudinal matters such as

- ignoring instructions from colleagues (charges 3.3, 4.1.5, and 5)
- being rude or bullying to patients (charges 1.11, 6.1 and 6.2)
- not making an effort to ensure correct information was passed on (charge 1.7, and 3.5)
- not carrying out observations when he knew he was expected to do so (charge 2.4.1)
- a disregard for the dose and purpose of medication (charge 2.8.2, and 4.1.2).

The panel also heard evidence that when offered constructive criticism Mr Mutu often became agitated, was defensive, over-reacted and did not act upon advice. In one case
this caused the registered nurse supervising him to immediately alert her senior managers. Further, his lack of empathy was such that staff did not have the confidence that he would even be able work safely as a band 4 health care assistant.

The panel concluded that Mr Mutu’s behaviour in relation to these charges, and in particular his attitude towards his colleagues and patients, was significantly below the standard expected of a registered nurse. The panel determined that both individually and collectively these charges found proved above were sufficiently serious to amount to misconduct.

**Decision on impairment**

The panel next went on to decide if as a result of Mr Mutu’s misconduct and lack of competence his fitness to practise is currently impaired. The panel was mindful that a registrant’s impairment should be judged by reference to his suitability to remain on the register without restriction.

In deciding this matter the panel has again exercised its own judgement. It took account of the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.

The panel reminded itself of the guidance of Dame Janet Smith in her Fifth Shipman Report as cited by Cox J., in *CHRE v NMC and Grant* [2011] EWHC 97, regarding the proper approach to be taken when considering impairment:

*Do our findings of fact in respect of the [nurse’s] misconduct ...show that his fitness to practise is impaired in the sense that 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;

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

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

d) ...

The panel concluded that Mr Mutu’s misconduct and lack of competence had the potential to put his patients at unwarranted risk of harm. The evidence indicates that in many cases it was only because he was supervised by another registered nurse that potentially harmful situations were averted. There were instances where Mr Mutu’s action had caused actual harm such as the upset and stress caused to Patient A as a result of Mr Mutu’s rude and bullying behaviour.

The panel considered that Mr Mutu’s misconduct and lack of competence brought the profession into disrepute. His actions put patients at risk of harm and his attitude towards patients, their relatives and colleagues was unprofessional. The panel concluded that the public would not expect registered nurses to behave in this manner.

The panel also considered that Mr Mutu’s misconduct and lack of competence breached fundamental tenets of the nursing profession in that he did not prioritise people, did not practise effectively, did not preserve safety and did not promote professionalism and trust.

The panel therefore concluded at the time of the events Mr Mutu’s fitness to practise was impaired.

The panel next considered whether Mr Mutu’s fitness to practise is currently impaired and considered his likely future behaviour. In doing so, it took into account the guidance in the case of Cohen v General Medical Council [2008] EWHC 581 (Admin):
“… It must be highly relevant in determining if a [nurse’s] fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated.”

The panel concluded that, theoretically, the lack of competence charges should be remediable. Although the registered nurses supervising Mr Mutu tried to steer him towards independent practice he was never able to consistently demonstrate that he could do this safely without supervision even with a significantly reduced caseload of patients. He continued to make the same or similar basic errors throughout the period of supervised practice. The panel concluded that as he had not been able to benefit from 15 months supervision it was unlikely that he would be able to remediate these shortcomings in his practice.

The panel has already concluded that many of the misconduct charges are attitudinal. It considers that it would be difficult to demonstrate remediation of an attitude.

The panel next considered whether Mr Mutu has demonstrated any remorse, remediation or insight. Mr Mutu has not supplied any information for this hearing, even after his recent engagement with his case officer. Given that the panel has no information about any attempt Mr Mutu has made to remediate his shortcomings, and there is no evidence of remorse or insight, the panel concluded that the risk of repetition of similar incidents is high. Given the risk of repetition the panel has concluded that Mr Mutu’s fitness to practise is currently impaired on the ground of public protection.

The panel also considered the public interest in upholding standards in the profession and in maintaining confidence in the NMC as regulator. The panel concluded that members of the public would consider that Mr Mutu’s lack of competence and misconduct was serious. The panel also concluded that fellow nurses would consider Mr Mutu’s conduct deplorable. In the panel’s judgement public confidence in the
profession would be undermined if a finding of impairment were not made in this case. For these reasons, the panel concluded that Mr Mutu’s fitness to practise is also currently impaired on the grounds of public interest.

**Determination on sanction**

Having determined that Mr Mutu’s fitness to practise is impaired, the panel went on to consider what sanction, if any, it should impose on his registration.

The panel took into account the submissions made by Mr Loran and all of the evidence before it.

The panel accepted the advice of the legal assessor.

Under Article 29 of the Nursing and Midwifery Council Order 2001, in relation to the misconduct charges, the panel can take no further action or impose one of the following sanctions: make a caution order for one to five years; make a conditions of practice order for no more than three years; make a suspension order for a maximum of one year; or make a striking off order. In relation to the lack of competence charges the panel cannot make a striking off order at this stage but all other sanctions are available. The panel has borne in mind that the purpose of a sanction is not to be punitive, though it may have a punitive effect. It took into account the NMC publication, *Sanctions Guidance (the SG).*

The panel considered the sanctions in ascending order of seriousness.

The panel has applied the principles of fairness, reasonableness and proportionality, weighing the interests of patients and the public with Mr Mutu’s own interests and taking into account the mitigating and aggravating factors in the case. The public interest
includes the protection of patients, the maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

The panel concluded that the aggravating features in this case include:

- the deficiencies in Mr Mutu’s practice were widespread and rendered his practice unsafe
- there was no improvement in his practice over a period of 15 months even with extensive support from the Trust
- many of the deficiencies relate to basic nursing skills
- many deficiencies were repeated despite extensive support and regular feedback and his acknowledgement that he needed to show consistency in his performance
- Mr Mutu frequently ignored instructions given to him by the registered nurse supervising him or other registered nurses and worked outside the parameters of his performance restrictions
- some of Mr Mutu’s actions caused patient harm and distress
- Mr Mutu’s repeated failure to carry out comfort rounds showed a reckless disregard for his vulnerable patients and, without supervision, could have led to patient neglect
- Mr Mutu’s response to legitimate constructive criticism of his practice was unprofessional and inappropriate, for example, he often became agitated, defensive and spoke loudly
- Mr Mutu has not demonstrated any insight into the deficiencies in his practice
- Mr Mutu has not demonstrated any remorse or remediation
• Mr Mutu exhibited harmful attitudinal issues, including a lack of empathy and compassion, and a rude and bullying approach to patients.

The panel considered the mitigating features suggested by Mr Loran, which were that Mr Mutu had made some attempts to improve his practice, and that there were times when his practice seemed to improve. The panel considered that this was what would be expected of a registered nurse whose practice was called into question and concluded that the suggested mitigation was not sufficiently out of the ordinary to be considered a mitigating factor.

Mr Mutu was never able to practise without supervision. His colleagues tried to encourage him to be able to practise independently and safely, for example, by transferring him to a quieter ward with less turnover of patients and allocating him a lower compliment of patients to care for. Despite these measures Mr Mutu was never able to maintain consistency in his practice for any length of time and fundamental nursing errors were frequently repeated.

The panel first considered taking no further action but determined that this would be inappropriate. It would not address the seriousness of the misconduct and lack of competence, which relate to widespread and fundamental nursing failures and render Mr Mutu’s practice unsafe. To take no further action would not provide sufficient public protection from a nurse who lacks basic competence and empathy. In those circumstances it would not be in the public interest to take no further action as it would be wholly insufficient to maintain public confidence in the profession nor would it uphold the standards of behaviour expected of a registered nurse.

The panel then went on to consider whether a caution order would be appropriate. The panel concluded that a caution order was not appropriate as the matters of concern were too serious and could not be described as being at the lower end of the spectrum of impaired fitness to practise. The panel has identified that the risk of repetition is high and a caution order would allow Mr Mutu to practise without restriction. Further, a
caution order would not be in the public interest as it would not maintain confidence in the profession, it would not provide sufficient public protection and it would not uphold the standards of behaviour expected of a registered nurse.

The panel next considered a conditions of practice order. The panel took into account that Mr Mutu had already received 15 months of supervised practice and was not able to demonstrate sustained improvement. His practice remained unsafe throughout the period. Further, the panel has identified attitudinal issues which cannot be addressed through a conditions of practice order. Finally the panel took into account that Mr Mutu has not engaged with the NMC hearing and so it cannot conclude that he has demonstrated a willingness to comply with any conditions of practice. Taking all of these factors into account the panel concluded that it would not be possible to formulate a workable and practical conditions of practice order in this case which would provide sufficient public protection. The panel also concluded that conditions of practice would not be appropriate given the seriousness of this case.

The panel considered whether a suspension order would be appropriate in this case. The panel reminded itself that in relation to the lack of competence charges, a suspension order is the most severe sanction a panel can impose. It may, however, impose a more severe sanction for the misconduct charges if it is necessary for the protection of the public or is otherwise in the public interest. The panel took into account the factors listed in the SG which suggest that a suspension order might be appropriate. However, the panel concluded that in Mr Mutu’s case

- this was not a single instance of misconduct but was repeated over a significant period of 15 months
- harmful attitudinal issues have been identified in the misconduct charges
- the panel has no information as to what has happened since
- the panel has no evidence of insight, and
- the panel identified that the risk of repetition is high.
These factors suggested to the panel that it needed to consider a striking off order in relation to the misconduct charges.

The panel then considered a striking-off order in relation to the misconduct charges only. The panel again worked through the SG.

The panel concluded that the misconduct charges were a serious departure from the relevant professional standards. In particular, in relation to Mr Mutu’s

- failure to check whether a patient required oxygen before transfer (charges 1.7),
- failure to carry out observations for a seriously ill patient (charge 2.4.1)
- refusal to complete a post-fall assessment when asked to do so by a senior colleague and his lack of understanding of the need to inform future colleagues caring for that patient (charge 3.3)
- inadequate completion of a Transfer of Care (charge 3.5)
- attempting to guess the dosage of medication (charge 4.1.2)
- advising a diabetic patient to administer additional insulin without carrying out blood sugar testing and seeking the advice of his supervising nurse or a doctor (charge 4.1.5), and
- administering medication unsupervised when he knew that he was not permitted to do so (charge 5).

The panel concluded that all of the above either caused patient harm or had the potential to do so.

Mr Mutu’s actions in relation to charge 6 violated his patient’s rights, ignored her express wishes and ignored her ability to make decisions on her own care. His actions
in relation to charges 1.11 and 2.8.2 were indicative of a harmful attitudinal issue which manifested itself in a lack of empathy and compassion for his patients. The panel concluded that Mr Mutu abused his position as a registered nurse and, at times, was rude and bullying in his approach to patients and relatives.

Finally the panel has concluded from Mr Mutu’s behaviour, particularly his constant disregard for the instructions given to him by the registered nurse supervising him or other registered nurses, that Mr Mutu had displayed a persistent lack of insight into the seriousness of his actions or their consequences.

In the circumstances of this case, the panel concluded that a striking off order was the only sanction which will be sufficient to protect the public.

The panel reflected on the wider public interest and considered whether the need to uphold the reputation of the profession and the need to declare and uphold proper standards of behaviour and conduct amongst nurses requires that Mr Mutu’s name is removed from the register. The panel concluded that the public would be greatly concerned if Mr Mutu was allowed to remain on the NMC register given the many serious issues identified. In addition the panel concluded that the reputation of the profession and the need to uphold proper standards of conduct and behaviour would be undermined if Mr Mutu were allowed to remain on the register. The issues raised in this case are so serious that they are incompatible with on-going registration.

**Determination on Interim Order**

Pursuant to Article 29 (11) of the Nursing and Midwifery Order 2001, this panel’s decision will not come into effect until after the 28 day appeal period, which begins on the date that notice of the striking off order has been served. Article 31 of the Nursing
and Midwifery Order 2001 outlines the criteria for the imposition of an interim order. The panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, or is otherwise in the public interest or in Mr Mutu's own interest. The panel may make an interim conditions of practice order or an interim suspension order for a maximum of 18 months.

Mr Loran, on behalf of the NMC, made an application that the panel impose an interim suspension order for an 18 months period to cover the appeal period and any possible appeal.

The panel has accepted the advice of the legal assessor. It has also had regard to the NMC's guidance to panels in considering whether to make an interim order. The panel has taken into account the principle of proportionality, bearing in mind the interests of the public and Mr Mutu's own interests.

The panel has taken into account its reasons for making a striking off order. For those same reasons, the panel concluded that an order is needed for the protection of the public and is otherwise in the public interest. The panel first considered whether an interim conditions of practice order would be appropriate and proportionate and determined that it would not be for the same reasons given in the substantive order. The panel therefore imposes an interim suspension order.

The period of this order is for 18 months to cover any potential appeal, but if at the end of a period of 28 days, Mr Mutu has not lodged an appeal the interim order will lapse and be replaced by the substantive order. On the other hand, if Mr Mutu does lodge an appeal, the interim order will continue until the appeal is concluded.

That concludes this determination.