Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
5 – 6, 8 – 9, 12 – 16,
20 – 22 July 2021

Virtual Hearing

Name of registrant:	**Raissa Labeja**
NMC PIN:	97A0030O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – January 1997
Area of registered address:	London
Type of case:	Misconduct
Panel members:	William Nelson (Chair, Lay member) Kim Bezzant (Registrant member) Jocelyn Griffith (Lay member)
Legal Assessor:	Paul Hester
Panel Secretary:	Safa Musad (05 – 06, 08 – 09, 12 – 16 July 2021) Xenia Menzl (20 – 22 July 2021)
Nursing and Midwifery Council:	Represented by Leeann Mohamed, Case Presenter
Mrs Labeja:	Present and represented by Ben Rich, Counsel instructed by The Royal College of Nursing (RCN)
Facts proved:	Charges 2 and 3
Facts not proved:	Charge 1 no case to answer
Fitness to practise:	Impaired (on charge 3)
Sanction:	Suspension Order, 6 Months (with a review)
Interim order:	Interim Suspension Order, 18 Months

Decisions and reasons on an application to exclude the evidence of Ms 1

At the outset of the hearing, Mr Rich on your behalf, made an application to exclude the evidence of Ms 1. He submitted that the evidence of Ms 1 should be excluded on two grounds. Firstly, he submitted that it would be an abuse of process for the NMC to rely on the evidence of Ms 1 and, in the alternative, it would be unfair.

The panel were provided with written skeleton arguments by Mr Rich and, in response, by Ms Mohamed on behalf of the Nursing and Midwifery Council (NMC). The panel also heard submissions from both counsel. The panel gave careful consideration to the written and oral submissions from both parties.

The panel noted that the NMC made late disclosure to you on material in your case on 2 July 2021.

The disclosed material on 2 July 2021 did not relate to the regulatory concerns in relation to Ms 1 but to a witness statement from Ms 2 who was the matron in charge of the ward at the time of the alleged incidents. Ms 2 in her statement, said '*I am unclear why* [Ms 1] *did not accept the fact that* [the Registrant] *lacked confidence to care for the patient'.*

Following this initial disclosure by the NMC and having heard submissions from both counsel, the panel allowed a short adjournment so that the NMC could further review unused material.

Having further reviewed unused material, the NMC made disclosure of the Case Examiners report in Ms 1's case. This disclosure states that one of the areas of regulatory concern in relation to Ms 1's nursing practice was that she "*Allocated Patient A to an agency nurse without the necessary training to care for Patient A*".

The panel accepted the advice of the legal assessor. In advising the panel, the legal assessor referred to the case of *R v Maxwell* [2011] 4 All ER 941 [at 13], cited in *Warren v*

A-G for Jersey [2012] 1 AC 22 [at 22] and Rule 31(1) of the Nursing and Midwifery Council (NMC) Fitness to Practice Rules SI 2004/1761 (the Rules).

The panel noted that Mr Rich advanced your case in respect of abuse of process under the second limb in Maxwell namely where it would offend the court's sense of justice and propriety to be asked to try the [Registrant] in the particular circumstances of the case. Mr Rich submitted that the second limb of Maxwell is engaged as the NMC appears to be contemplating running mutually exclusive cases against two registrants. Further, he submitted that these mutually exclusive cases would be upon the same set of proceedings and largely the same alleged facts.

The panel when giving consideration to this application had careful regard to the requirements of relevance and fairness when considering Rule 31 of the Rules and whether to admit oral evidence in this hearing. The panel noted that there is no dispute between the parties that Ms 1's evidence is relevant but that fairness must be carefully scrutinised before admitting her evidence.

The panel gave careful consideration to the disclosed material and whether, if admitted, it would offend the court's sense of justice and propriety when being asked to hear your case in the particular circumstances of your case. The panel noted that the test under the second limb of Maxwell is case specific in that a panel must consider such application in the light of the particular circumstances of the case.

The panel firstly considered the passage from Ms 2's statement. Neither party sought to provide the panel with the full statement of Ms 2. The panel acknowledged that this passage is capable, on a prima facie basis, of being supportive of your case. However, the panel noted that there is nothing in this passage which states that Ms 2 was actually present during the alleged incidents, and therefore an eyewitness. Furthermore, the panel noted that Ms 2 gives an opinion in that she is "*unclear why* [Ms 1] *did not accept the fact that* [you] *lacked confidence to care for the patient*". In giving an opinion, Ms 2 appears not to be a witness as to the truth.

The panel next considered the further material that was disclosed to you yesterday. This material relates to the areas of regulatory concern in relation to Ms 1 and, in particular, five passages from that report.

In considering the passages from the Case Examiners' report, the panel noted that the NMC have not formulated charges in respect of Ms 1. The panel did note that the concerns appear to be broadly similar to this case. However, the panel read these passages in the light that the Case Examiners' report is no more than a provisional report and is based upon the opinion of the reviewing NMC legal team.

In relation to this further disclosed material, the panel noted the statements and exhibits within the hearing bundles. The panel noted that Ms 1 has provided a statement at the investigation stage of her case and that this statement is the same as is being relied upon in your case. Consequently, the panel could find no prejudice. Further, the panel noted that Ms 1's police statement is included within the exhibits bundle for this hearing. Again, the panel finds no prejudice to you. The panel decided that in these particular circumstances the court's sense of justice and propriety would not be offended. In coming to this conclusion, the panel determined that Ms 1 can be cross-examined, as a witness of truth, on all material including the further disclosed material.

The panel noted that Mr Rich's submissions did not seek to argue that there has not been full disclosure by the NMC rather that there is an abuse of process or unfairness. In these circumstances, the panel decided that Ms 1 can be fully cross-examined on all material which has been properly disclosed and that there would therefore be no unfairness. The panel noted that it is entirely within its province to determine who is a witness of truth. In coming to that determination, it will not put any weight on what appears to be the NMC's provisional view that in the case against you it is Ms 1 who is to be believed but in the potential case against Ms 1 it may be you who are to be believed. The panel will consider all the evidence and determine what it considers to be credible and reliable bearing in mind that the burden of proof is always upon the NMC.

For the above reasons, the panel decided to admit the evidence of Ms 1.

Details of charge

'That you, a registered nurse, working at Croydon University Hospital, on 24 September 2013;

1. *Did not appropriately escalate Patient A's condition following observations at approximately 1100.* **[No Case to Answer]**

2. *Did not assess / take Patient A's observations prior to her transfer to Purley Ward.* **[Proved]**

3. *Did not assess / take Patient A's observations when concerns about her condition were brought to your attention by Person A, during the transfer to Purley Ward.* **[Proved]**

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

Decision and reasons on application of no case to answer

At the close of the NMC case, Mr Rich made an application of no case to answer in respect of all charges.

In respect of charge 1, Mr Rich submitted that there was no case to answer under Rule 24(7) of the Rules and the second limb of R v Galbraith [1981] 1 WLR 1039. Further, he submitted that there was no case to answer on current impairment under Rule 24(8) of the Rules.

In respect of charges 2 and 3, he submitted that there was no case to answer on current impairment under Rule 24(8) of the Rules.

Mr Rich provided the panel with a written skeleton argument and made oral submissions. Ms Mohamed provided the panel with a written skeleton argument.

The panel gave careful consideration to the above written and oral submissions and accepted the advice of the legal assessor.

Charge 1

In reaching its decision, the panel carefully considered the witness statement and oral evidence of Ms 6 together with the Root Cause Analysis report (RCA). The panel reminded itself that it was solely considering, at this stage, whether sufficient evidence has been presented to find the facts proved.

The panel noted in Ms 6's statement that she stated '*no escalation as it did not deviate from what her condition had already been. Doctors were aware and already on the ward and dealing with the situation.'* In relation to this passage of Ms 6's statement, she in her oral evidence, when asked what the source of this information was, said that it was what '*the nurses told her about why it was not escalated.*' Ms 6 did not identify these nurses either in her statement, oral evidence or the RCA. The panel also noted her evidence that if the accounts given by the unidentified nurses were correct then it was a reasonable course for a nurse or healthcare assistant not to do a specific separate escalation.

The panel had regard to the observations at 11:00 which were noted in the RCA with the comment "(Doctors not informed)". The RCA also records that at 11:30 the Colorectal FY1 saw Patient A on a ward round. Ms 6 in her oral evidence, stated that this would be the consultant doing a ward round. From this evidence it appears that Patient A saw a doctor, and probably a consultant, around 10 minutes after the observations were completed. The panel also noted that Ms 6 in her oral evidence said that the doctors when doing a ward

round would have access to the observations which would have been put in the patient's notes.

The panel noted that Ms 6, in her oral evidence, said that the escalation could be straight to a doctor and need not be, in the first instance, to the nurse in charge. In this regard, the panel noted the oral evidence of Ms 1 when she said that escalation could be to the nurse in charge or the doctor. The panel also noted that Ms 1 was not present on the ward round or when the observations were taken at about 11:19 and therefore cannot give evidence as to what occurred.

The panel considered that the evidence, at this stage, indicates that Patient A was relatively stable at 11:00 and that there was a short period between the observations being made and the doctor attending. Further, the evidence suggests that the doctor had access to those observations. The panel noted that Ms 6's evidence was that the doctors were aware and already on the ward dealing with the situation. In these circumstances, the panel considered that there was no necessity to escalate Patient A's condition to a senior nurse.

The panel gave careful regard to the wording of charge 1 which is '*Did not appropriately escalate Patient A's condition following observations at approximately 11:00.*' The panel was of the view, that taking the NMC's case at its highest the evidence is tenuous in that it is inherently weak and vague. In coming to this conclusion, the panel had regard to the comment in the RCA that the "(Doctors not informed)". The panel found this to be entirely enigmatic as no explanation is provided in the RCA as to what this means. Neither does the RCA identify a source for this comment. Therefore, the panel found this evidence to be vague and of no probative value.

For the above reasons the panel decided that there is no case to answer in respect of charge 1 under Rule 24(7) of the Rules.

Charge 2 and 3

The panel noted that under Rule 24(8) of the Rules it must decide whether sufficient evidence has been presented to support a finding of impairment in respect charges 2 and 3 separately.

The panel reminded itself that when considering impairment or fitness to practise it has to adopt a two-stage process. Firstly, the panel has to determine if the facts found proved amount to misconduct and then determine if there is current impairment.

The panel noted that charges 2 and 3 have been admitted on the facts. Having carefully considered those facts and the evidence so far adduced in relation to their context, the panel considered, in its professional view, that they could be capable of supporting findings of misconduct and current impairment.

Stage of proceedings

The parties sought clarity as to what stage this hearing has reached and specifically in regard to Rule 24 of the Rules.

Ms Mohamed submitted that as charges 2 and 3 have been admitted the factual stage has concluded and the panel should proceed in the misconduct and impairment stage.

Mr Rich submitted that the admissions to charges 2 and 3 were on the basis of an acceptance of the bare facts within the charges and that the context of those factual admissions still requires factual exploration.

The panel accepted the advice of the legal assessor. The panel had careful regard to Rule 24 of the Rules and the submissions made by both parties.

The relevant parts of Rule 24 of the Rules state:

(1) Unless the Committee determines otherwise, the initial hearing of an allegation shall be conducted in the following stages:

(a) the preliminary stage (paragraphs (2)-(5));

(b) the factual stage (paragraphs (6)-(11));

(c) where the allegation is of a kind referred to in article 22(1)(a) of the Order, the impairment stage (paragraph (12));

(d) the sanction stage (paragraphs (13) and (14)

(2) The Chair shall:

(b) ask for the charge to be read out; and

(4) Once any objections to the charge have been considered, the Chair shall enquire whether the registrant wishes to make any admissions:

(a) as to the alleged facts; and

(b) where the allegation is of a kind referred to in article 22(1)(a) of the Order, as to whether her fitness to practise is impaired.

(5) Where facts have been admitted by the registrant, the Chair shall announce that such facts have been found proved.

(6) The presenter shall open the Council's case and may present evidence in support of any alleged facts in the allegation, including those admitted by the registrant.

(9) Unless the Committee has determined that there is no case to answer under paragraphs (7) or (8), the registrant may present her case to the Committee and present evidence in support of her case.

The panel was clear in its own mind that, at the stage when the charges were put to you, Mr Rich made admissions which were solely limited to the bare facts within charges 2 and

3 and no more. In doing so, it was clear that Mr Rich disputed the factual background and context of charges 2 and 3. Consequently, all NMC witnesses were called and have been extensively examined by the parties and questioned by the panel. During Mr Rich's cross-examination of NMC witnesses he has clearly put your case and your version of events forward. The panel's view is clear that the admissions to charges 2 and 3 were not announced in accordance with Rule 24(4) of the Rules and that the hearing to date has been conducted by both parties and the panel on the basis that the factual background and context requires full exploration.

The panel had particular regard to Rule 24(1) of the Rules. Rule 24(1) of the Rules states that "unless the committee determines otherwise, the initial hearing of an allegation shall be conducted in the following stages -". Those stages are the preliminary, factual, impairment and sanction stages.

As there was no announcement of the facts being proved as would normally be required under Rule 24(5) of the Rules, the panel proceeded on the implicit understanding that it had dis-applied Rule 24(5) of the Rules as allowed by Rule 24(1).

In reaching its decision to proceed with the factual stage, the panel could find no prejudice to the NMC in prosecuting its case and that it would be in the interest of justice to fully explore the factual background to this case.

For the above reasons, the panel determined to proceed with the hearing on the basis that the facts stage has not concluded and will not do so until the panel has announced its findings in relation to the context of charges 2 and 3.

Background

The charges arose whilst you were working as an agency nurse at Croydon NHS Trust ('the Trust'). The allegations relate to the inadequate care provided to Patient A on 24 September 2013.

Patient A arrived at the Accident and Emergency department (A&E) on 23 September 2013 following a two-day history of rectal bleeding and abnormal observations. Patient A was an 86 year old female patient who had been a resident at a High Dependency Nursing home and had a tracheostomy tube in place due to Motor Neurone Disease. She also required 24-hour ventilator support.

It is alleged that at approximately 07.30 on 24 September 2013, Patient A was transferred from A&E to Queens 3 Ward (Q3), a ward for orthosurgical patients and medical patients. It is alleged that whilst Patient A was on Q3 ward her condition was not escalated following her observations at approximately 11:00 and it was alleged that you should have escalated Patient A's condition. The panel determined that you had no case to answer in relation to that charge.

It was decided later that day that Patient A would be transferred to Purley Ward (P2). It is alleged that you did not assess Patient A or take her observations prior to her transfer to P2. It is further alleged that the patient's distressed condition during the transfer was brought to your attention by Person A, but you did not assess the patient or take her observations. Upon arrival at P2, the deputy manager of the ward found that Patient A appeared lifeless.

The death of Patient A was subject to an internal investigation, a police investigation and a coroner's inquest.

Decision and reasons on facts

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

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

- Person A: The daughter of Patient A.
- Ms 1: Junior Sister and the nurse in charge of Queens 3 Ward at the time of the incident.
- Mr 3: Person A's partner, present at the time of the transfer.
- Ms 4: The healthcare assistant caring for Patient A at the time of the incident.
- Ms 5: Band 6 Deputy Ward Manager of Purley 2 Ward at the time of the incident.
- Ms 6: Head of Nursing for Integrated Adult Care (Medical Wards) when she conducted a root cause analysis investigation into the incident.

The panel also received the hearsay statement from Mr 7, the porter who assisted with the transfer of Patient A.

On your behalf the panel was alerted to comments in a police report which indicated that a student nurse accompanying Ms 1, and the ward manager of Q3 had asserted that it had been recognised at an early stage that Q3 was not a suitable ward for the care of Patient A. However, the panel did not have access to any relevant statements or interview records and was not prepared to speculate as to the implications of such assertions.

The panel heard evidence from you under affirmation and was provided with documentary evidence by you.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered all the witness and documentary evidence as well as the submissions by Ms Mohamed, on behalf of the NMC, and Mr Rich, on your behalf.

At the fact finding stage the panel would normally decide which, if any, of the facts alleged in any outstanding charges have been proved on the balance of probabilities. However, in your case the two remaining charges, charges 2 and 3, are drafted in terms of bare facts. As merely simple facts both charges require a factual background. The panel therefore assessed all of the evidence to establish, on the balance of probabilities, the relevant contextual facts, the credibility and reliability of all witnesses and to decide any culpability.

In its assessment of the evidence, it was apparent to the panel that the very extensive passage of time since the events in question had undermined the ability of the witnesses to recall with any reliability any matters not already recorded in their statements or interviews created years earlier.

A very brief initial local investigation into the death of Patient A appears to have been superseded by a police enquiry which did not conclude until 2017 when the Trust commenced a “Root Cause Analysis” investigation and the NMC also started its

investigation. The panel had access to only two statements which could possibly be described as produced at any time close to the events in question. One of these was the "Local statement of [Ms 1]", a very brief account dated 27 September 2013 and addressed to the matron. The other was a short statement by you apparently provided to the agency for which you worked and compiled on 25 September 2013. All the other statements and records of interview available to the witnesses to refresh their memories had been created many months or years after the events when exact recall might be expected to have been lost, although perhaps to a variable extent, depending on the impact on the witness at the time.

It was also obvious to the panel that, in the circumstances of this case where after the briefest local investigation, there was a referral for a police enquiry, there would have been a motive for some of those involved to be cautious and therefore avoid any contributory blame for the death of Patient A. In these circumstances, even where it was clear that the witnesses were doing their best to give a true account, the panel looked very carefully for corroboration in assessing the reliability of any evidence.

In carefully considering all of the evidence, the panel sought, where able, to base its factual findings on inferences drawn from contemporaneous or near contemporaneous documentary evidence and known or probable facts and did not give undue weight to uncorroborated oral evidence or witness demeanour.

This approach to considering the facts was moreover cautiously applied by the panel as it acknowledges that the allegations relate to events almost eight years ago and where a number of witnesses have understandably expressed problems when trying to recall exactly what occurred.

The panel next considered the evidence of the witnesses and reached the following conclusions:

Person A: The panel found the evidence of Person A to be credible and noted that her oral evidence was consistent with her police statement, dated 2 May 2014, and her NMC statement, dated 24 October 2017. It noted Person A had been emotionally involved in a traumatic experience and she gave a graphic account of matters she felt she could remember clearly. She was also clear when she did not know something or was not sure. Person A was present and close to Patient A at the time of the transfer and had taken notice of her mother's condition. She was clear that she had overheard a conversation between you and the senior nurse at the desk near reception in relation to an experienced nurse being required to move Patient A. Person A was definite that during that conversation you did not say that you were not qualified to transfer Patient A. During cross examination and panel questions the panel noted that even when challenged, Person A was clear about her evidence and was confident in her answers. The majority of her evidence, particularly on material issues, was corroborated, principally by Mr 3, but also some by Ms 4.

Mr 3: The panel considered the evidence of Mr 3. Mr 3 had provided a police statement on 2 July 2015, and an NMC statement on 23 October 2020. Those statements were mutually consistent and were essentially consistent with the evidence of Person A in whose company he had been throughout the incidents. His written evidence had differed only in respect of whether any beeping could be heard from the ventilator during the transfer. It was the view of the panel that that difference enhanced the corroborative effect of his written evidence as it was clearly an independent account. However, during his oral testimony Mr 3 changed that aspect of his evidence so that it was consistent with Person A's evidence that she could not hear any beeping. To that limited extent the panel found that he had compromised his credibility, but nevertheless felt able to put some weight on that evidence which was consistent with his written statements.

Ms 4: The panel considered the evidence of Ms 4 and noted that she candidly admitted that she no longer had any real recollection of the events in question, but she confirmed the truth of the police interview on 29 April 2014 and her NMC statement of 14 July 2017. In these circumstances her evidence could not be properly tested by cross examination and accordingly the panel cautiously considered her oral evidence as akin to hearsay. Nevertheless, the panel was able to put weight on those aspects of her evidence which were either unchallenged or corroborated, such as her statement that you had told her you had done the 11.00 observations of Patient A which was corroborated by the computer record. Her description of Patient A being alive immediately prior to the transfer was corroborated by Person A and Mr 3 who were clear that Patient A was alive during the early part of the transfer.

Ms 5: The panel noted that the evidence of Ms 5 was consistent with her written statements to the police, dated 11 and 20 April 2014, and to the NMC, dated 19 September 2017. She gave her evidence confidently and was very clear about what she could and could not remember. She said she had been shocked by the incident and appeared to the panel to have a clear and graphic recollection of her feeling of frustration that you had brought an apparently lifeless patient into her ward and had not said anything.

Ms 6: The panel considered the evidence of Ms 6 to be credible. The panel noted that Ms 6 was able to interpret the patient records and explain the relevant Trust policies. Ms 6 explained and confirmed that Patient A's observations that were recorded could only be entered within the computer system by you alone as you had your own unique login. The panel notes that Ms 6 also provided context and a good recollection of what she found during her investigation of the incidents.

Ms 1: The panel considered the evidence of Ms 1 and noted that it was consistent with her police interview on the 29 April 2014 and her NMC statement of 6 September 2017. It was clear that Ms 1 was unaware that specialist knowledge and skills were needed to care for or transfer a patient with the special needs of Patient A. Accordingly, she did not check whether you had the necessary training to look after Patient A and she denied that you had raised any concern when she had allocated Patient A to your full care. Ms 1 was new to her role as a junior sister and made a number of assumptions, such as that as a porter and an A&E nurse had brought Patient A to the ward it did not occur to her that the transfer should have been conducted by the Critical Care Outreach Team. When challenged about these she explained why she had made the decisions she made, rightly or wrongly, and did not resile from them. The panel reminded itself of the comment attributed to Ms 2 to the effect that she was '*unclear why* [Ms 1] *did not accept the fact that* [you] *lacked confidence to care for the patient*' but did not consider, for the reasons explained on page two of this decision, that it materially undermines Ms 1's credibility or the reliability of her evidence in these proceedings.

Mr 7: The panel considered that it was able to attach some weight to the hearsay statement of Mr 7 to the extent that it was consistent with and corroborated by other reliable evidence.

The panel noted that the statement of Mr 7, the RCA, Ms 4 and the police investigation report contain hearsay evidence.

The panel was cautious when receiving and considering hearsay evidence. This evidence was not verified under oath (apart from that of Ms 4) nor tested in cross examination. The panel acknowledges that there is a potential risk of relying on a prima facie plausible statement or document by a person who it has not been able to assess and who has not been tested by cross examination.

The panel, in ascribing such weight as it thought fit to the hearsay evidence, scrutinised it carefully in the context of other evidence to examine any discrepancies between the statement or document and the oral evidence of those other witnesses.

You: The panel then considered your evidence and in doing so reminded itself that you are an experienced nurse of good character who has worked in the UK since 1991. The panel also noted that you had worked as an agency nurse at the Trust on a number of shifts over the previous year. However, in its examination of your evidence the panel noted that not only was there a complete absence of corroboration of your account in seeking to avoid responsibility for the care of Patient A, and much of it was inherently improbable. It also conflicted with the evidence of every other witness. Furthermore, there were major and irreconcilable inconsistencies between the statements you made on the day following the events, your later statement for the coroner, and your oral evidence.

The panel considered the following parts of your evidence to be examples which were inherently improbable:

- Your claim that you could not escalate your concerns about Patient A to a doctor, because you did not see a doctor on the ward until just before the transfer when a doctor gave you Patient A's notes.
- Your claim that, although Patient A was in a bed in the bay allocated to patients under your care for between seven and eight hours, you did not provide any care for her (apart from the 10.00 observations as instructed by Ms 1) and did not know if anyone else did.
- Your claim that you did not do the 11.00 observations, despite them being entered on the computer under your unique PIN.
- Your claim to have telephoned your agency soon after being allocated Patient A to express your concern that you were not trained or qualified to do so, but you did not mention that call in the statement you prepared the following day.

The panel noted also that there were significant inconsistencies between your evidence and that of every other witness:

- Ms 1 stated clearly and consistently that patient A was allocated to you and you raised no concerns.
- Ms 4 stated that you told her you had completed the 11.00 observations as corroborated by the computer record.
- Ms 4 also stated that immediately prior to the transfer Patient A was moving her mouth and finger, just before you and the porter took her out of the bay, contrary to the implication of your evidence that when you thought she was asleep she was already dead.
- Person A and Mr 3 stated that they overheard an exchange between you and a senior nurse who was telling you that an experiences nurse was required to move Patient A. They were both clear that you did not say you were unqualified to undertake the transfer.
- Person A and Mr 3 both stated that Patient A was clearly alive and in distress as the transfer commenced and that she was gasping for breath and her shoulders were going up and down.
- Ms 5 stated that on arrival at P2 she noticed that Patient A appeared lifeless but you had said nothing.
- Ms 6 stated that the 11.00 observations recorded on the computer must have been entered by you.

The panel also took into account some of the major inconsistencies between your statements of 25 September 2015, 4 October 2018 and your oral evidence.

The panel noted that in your statement of 25 September 2015 you described your discovery that Patient A as occurring when she was with the '*Sister*' in P2. In your statement of 4 October 2018 you stated that you suspected that Patient A had already passed away before entering the lift and whilst entering the lift you thought Patient A had passed away some time ago.

Within the same statement of 25 September 2013 you stated that you entered Patient A's 10.00 observations on the computer. However, in your oral evidence you told the panel that your PIN to access the computer had expired and therefore you could not enter any data.

In view of these major concerns it has about the credibility and reliability of your evidence, the panel determined that where your evidence conflicted with that of any other witness it would prefer the evidence of the other witness unless there was some reliable corroboration of your account.

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

Charge 2

'That you, a registered nurse, working at Croydon University Hospital, on 24 September 2013;

2. Did not assess / take Patient A's observations prior to her transfer to Purley Ward.

This charge is found proved.

In reaching this decision, the panel noted that you admitted that you did not assess Patient A or take her observations prior to her transfer to P2 ward. You claimed that you had no duty to do so, as she was not your patient, even though Patient A was in a bed which was part of a bay allocated to you, and you had refused to take responsibility for her. However, the panel determined that based on all the information before it, it was clear that you were responsible for the care of Patient A and in this regard the panel accepted the evidence of

Ms 1 not only that you had not raised any objection when allocated Patient A but also that you raised no concern about your ability to care for her.

The Trust policy of which you should have been aware, was that any patient about to be transferred must be assessed to establish their fitness for transfer.

However, despite the fact that Patient A appears to have died during the transfer, the panel has seen no evidence to suggest that if observations had been taken the transfer would not then have taken place.

Accordingly this charge is proved in that you were responsible for Patient A and had a duty to assess her prior to transfer which you did not do.

Charge 3

3. Did not assess / take Patient A's observations when concerns about her condition were brought to your attention by Person A, during the transfer to Purley Ward.

This charge is found proved.

In reaching this decision, the panel took into account your initial admission to the bare fact of the charge but not to the context or factual background. Your evidence amounted to an assertion that Patient A was already dead when you started the transfer and that you nevertheless continued with the transfer because there was no one senior left on Q3 ward to deal with the situation and you did not know the doctors' telephone numbers. You claimed that you did not want to distress Person A and Mr 3 by informing them of Patient A's death. The panel does not accept your evidence on those matters and it prefers the mutually corroborative evidence of Ms 4, Person A and Mr 3 that Patient A was clearly alive when the transfer started. The panel also accepts the evidence of Person A and Mr 3

that Patient A was in visible and obvious distress once the transfer started and was struggling to breathe.

The panel further accepts the evidence of Person A and Mr 3, corroborated by the hearsay statement of Mr 7, that on a number of occasions you were alerted either directly or indirectly by the concerns about Patient A expressed by Person A and that you did not assess Patient A or provide any care for her. The panel noted your admission that you did not respond to the concerns expressed and that you did not look at Patient A's face.

The panel determined that the evidence showed, on the balance of probabilities, that Patient A was alive when the transfer started but was unresponsive by the time she arrived at P2 ward. The panel does not accept your evidence that during the transfer you touched Patient A's hand, felt it was cold, and found she had no pulse as it is likely that had you done so this would have been readily seen, in the circumstances, by Person A and or Mr 3. Likewise, the panel does not accept that on arrival on P2 ward you drew attention to Patient A's unresponsive condition. In that respect the panel prefers the evidence of Ms 5 who was frustrated that you appeared not to have noticed that Patient A was so pale.

Accordingly, this charge is proved in that Patient A was alive for at least part of the transfer, and was clearly in distress. You were alerted to her condition by the concerns of Person A but did not assess Patient A or take her observations.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Mohamed provided the panel with written submissions, these are as follows:

> *'1. The panel have found charges 2 and 3 proved.*
>
> *2. The panel must now consider whether the matters found proved*

a. *Amount to misconduct;*
b. *Amount to current impairment.*

MISCONDUCT

3. *Misconduct has been described in the case of Roylance v GMC (2000) 1 AC 311 as*

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

4. *It is submitted that charges 2 and 3 are sufficiently serious to justify a finding of misconduct. This is a matter for the panels own professional judgment and there is no burden of proof at this stage.*

5. *The incident is on one shift but it is a course of conduct over a period of time and involves the care of patient A.*

6. *It is submitted that Ms Labeja was responsible for patient A. It was her responsibility to ensure that she was cared for appropriately. The panel have found that*

   "However, the panel determined that based on all the information before it, it was clear that you were responsible for the care of patient A …."

7. *She did not take observations prior to the patient being transferred to Purley Ward. The panel have found that Ms Labeja*

"…had a duty to assess her prior to transfer which you did not do."

8. *The panel have also found that Ms Labeja was "alerted to patient A's condition by the concerns of Person A but did not assess Patient A or take her observations."*

9. *The panel have also accepted the evidence of person A and Mr 3 that patient A "was in visible and obvious distress once the transfer started and was struggling to breathe".*

10. *It is submitted that the following parts of "**The Code- Standards of conduct, performance and ethics for nurses and midwives**" are engaged and have been breached (2008 version).*

"The people in your care must be able to trust you with their health and well being

To justify that trust, you must

- *work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community*
- *provide a high standard of practice and care at all times.*

Make the care of people your first concern, treating the as individuals and respecting their dignity.

1. *You must treat people kindly and considerately.*

Work effectively as part of a team

21. You must keep colleagues informed when you are sharing the care of others.

22. You must work with colleagues to monitor the quality of your work and maintain the safety of others in your care.

24. You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues.

26. You must consult and take advice from colleagues when appropriate.

28. You must make a referral to another practitioner when it is in the best interests of someone in your care.

Manage risk

32. You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.

33. You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards.

Uphold the reputation of your profession

61. You must uphold the reputation of your profession at all times.

11. *It is submitted that the conduct is so serious so as to amount to misconduct. Whilst the concerns are in relation to one shift, it is submitted that it is submitted that it is not an isolated event. It involves the care of patient A over the course of a shift.*

12. Given the findings of fact, the public would expect that the registrant to have taken some action in the circumstances.

13. It is submitted that given the findings of fact, this is not a negligent omission.'

Mr Rich disagreed with Ms Mohamed's submission that this was one incident on one shift but a course of conduct over a period of time. He submitted that these were two discrete charges on the omission of an action and not a course of conduct. Further, he submitted in reference to paragraphs 11, 12 and 13 of Ms Mohamed's submissions, that you have accepted that you had dismissed the concerns raised by Person A.

Mr Rich first addressed charge 2. He submitted that the panel found that observations should be done, however it also found that had these observations been done it would have had no impact on the transfer, which would have still gone ahead. He submitted that whilst this failing falls short of the expected conduct of a registered nurse, it is not serious enough to amount to misconduct.

With regard to charge 3 Mr Rich submitted that you accepted that you did not look at Patient A or assess her when Person A indicated that her mother was unwell. He submitted that you accept that this does amount to misconduct. You had just obtained the patient notes from the doctor and were looking at these during part of the transfer. You acknowledged that you did not pay attention to Patient A or her daughter, and were not aware that Patient A was struggling to breathe. Mr Rich acknowledged that this is not a trivial failing, however, he submitted that it is not the same as ignoring a patient who was struggling to breathe. You did not realise that Patient A was looking very pale and were not aware of anything serious being wrong. Mr Rich acknowledged that it is a registered nurse's duty to listen to concerns and react to them accordingly.

However, he reminded the panel that, whilst this is an emotional case as Patient A passed away and her daughter gave evidence in front of the panel, it needs to remain objective.

He submitted that there have been various inquiries into the passing of Person A, by the police and the coroner, which have not found that you caused or contributed to Patient A's death and there is no regulatory charge before this panel relating to causation or contribution. He therefore submitted that the panel needs to put the fact that Patient A passed away out of its mind when considering misconduct in this case.

Mr Rich invited the panel to put your misconduct against the context of your longstanding career as a registered nurse. He stated that this was a single patient, on a single day and that the whole incident happened over a period of a few hours.

Submissions on impairment

Ms Mohamed provided the panel with written submissions, which are as follows:

'***Impairment***

14. As with misconduct, there is no burden of proof at this stage and the panel is asked to exercise its own professional judgment. The panel must decide whether Ms Labeja is fit to practice without restriction.

15. The panel is directed to the case of ***CHRE v NMC and P Grant [2011] EWHC 927 (Admin)*** *which adopted the approach taken by Dame Janet Smith in the 5th Report to the Shipman Inquiry and the suggested questions to ask when looking at impairment.*

a. Has in the past acted and/or is liable to act so as to put a patient or patients at unwarranted risk of harm

16. *It is submitted that by not assessing Patient A, she put patient A at risk of harm as her condition was not monitored. Her deterioration was not assessed medically, and therefore appropriate action could not be taken.*

17. *It is therefore submitted that Ms Labeja has acted in a way that put patient A at risk of harm. She was the allocated nurse but does not seem to have accepted responsibility for this patient.*

b. *Has in the past brought and/or is liable in the future to bring the profession into disrepute.*

18. *The evidence of Person A and Vincent Clarke can assist with this. They set out clearly that they expected some action to be taken but that Ms Labeja was dismissive of them. She took no action. This, it is submitted has brought the profession into disrepute.*

19. *If a family member is raising a concern with a registered nurse and there is a dismissive response, it is submitted that this brought the profession into disrepute.*

20. *A member of the public would expect some action to be taken.*

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

21. *The following is a fundamental tenet of the profession:*

"The people in your care must be able to trust you with their health and well being

To justify that trust, you must

- *work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community*
- *provide a high standard of practice and care at all times.*

22. *It is submitted that Ms Labeja has breached this.*

CURRENT IMPAIRMENT

23. *The panel must ask themselves, is there a risk of repetition? The panel have been provided with a bundle of documents from the Ms Labeja.*

24. *Ms Labeja has not worked as a nurse for sometime. The reference at pg 1 of the 'Registrant's bundle' is dated 22 May 2018 and is signed Mr Ahmed Ismail. The reference categorically states*

    "I am happy for nurse Raissa to continue with her job fully supervised by myself or registered nurse colleagues."

25. *It is submitted that the professional reference that she has provided indicated that she requires supervision, therefore not free to practice unrestricted. The panel will be mindful that this reference is some 4 years old. It is submitted that there is no further information to suggest that she can practice without restriction.*

26. *In addition the Training certificates are also not recent. The latest date is June 2017. There is not any recent documentation as to remediation. It is therefore submitted that there is a risk of repetition.*

27. *It is submitted the panel cannot be satisfied that there is not a risk of repetition and it is therefore submitted that that a finding of current*

impairment is required to protect the public and to satisfy the wider public interest.

28. *In addition the panel is reminded at this stage that they are entitled to find current impairment of public interest grounds alone as is stated at paragraph 74 of Grant*

"I agree with the analysis and would add this. In determining whether a practitioners fitness to practice is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also the need to uphold professional standards an public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances".'

Firstly, Mr Rich addressed Mr Mohamed's submission with regard to paragraph 24. He submitted that the fact that the testimonial states that the doctor is '*happy for nurse Raissa to continue with her job fully supervised*' does not mean they wish for you to be formally supervised, but rather refers to any nurse on any shift being supervised by a senior. He invited the panel to disregard this submission.

During his submissions Mr Rich referred the panel to the following cases: *Professional Standards Authority for Health and Social Care v GMC and Parvan Kaur Uppall* [2015] EWHC 1304 (Admin), *Professional Standards Authority for Health and Social Care v NMC* [2017] CSIH 29 and *Vali v GOC* [2011] EWCH 310.

Mr Rich submitted that you found yourself in a difficult position and that you would not have known what to do in the situation you found yourself in. He submitted that, whilst you admitted the bare facts of the charges, it is impossible for a registrant to show insight when charges, or parts of the charges, are denied. However, he submitted that you gave an explanation on why you did not do an assessment, and that you recognise what you

should have done in the situation. He submitted that your failure in this case was not due to a technical skill that you need to acquire. He reminded the panel that you had been working for about a year in 2014 – 2015 and for a period covering maternity leave in 2017/18 after the incident without any issues.

Mr Rich submitted that the risk of repetition in the case is very low. He stated that it is highly unlikely that similar misconduct would happen again as this was a very specific situation.

Mr Rich submitted that you faced a police enquiry as well as an hospital enquiry and submitted that this provides enough scrutiny to mark the seriousness of your misconduct and that a finding of impairment in this case is not necessary. He submitted that a fair minded member of the public would be satisfied by this matter being resolved by the finding of facts and a finding of misconduct on charge 3 alone. Mr Rich reminded the panel that it is in the public interest to return a capable and safe nurse back to nursing. He reminded the panel of your deep desire to return to nursing and to the career that you have devoted over 30 years of your life to. Whilst he acknowledged that due to you not having practiced in the best part of eight years and that you might need to update your nursing knowledge he invited the panel to find you not currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel considered each charge separately. Although both charges related to fallings in regard to the same patient, the panel considers them to be discrete failings and not to be part of a course of conduct nor over a period time.

First, the panel considered charge 2. It noted that there was no evidence that Patient A was deteriorating or that her condition on the ward was causing concern. There had been an intention to transfer her for some time and the evidence indicated that the arrangements had been made and the porter called for before you were told to effect the transfer. At this stage it appears there was something of a rush to get everything ready and your failure to take the required observations occurred in that context. The panel also noted that the ward was busy and you had a full complement of patients. In that context it is the panel's view that this discrete failure to take Patient A's observations was not so serious as to amount to misconduct.

Then the panel went on to consider charge 3. The panel was of the view that it is expected of a registered nurse to care for her patients at all times and also look after and respond to any concerns raised by their relatives. The panel noted your own admission that you never looked at Patient A nor did you react to being made aware of Patient A's deteriorating state. The panel was of the view that you significantly failed in your duty as a registered nurse to care for Patient A and the welfare of Person A and Mr 3. It noted that your failings had a detrimental impact on Person A and Mr 3. The panel was therefore of the view that your failings in respect of charge 3 fell seriously short of the conduct and standards expected of a nurse and amounted to the following breaches of the Code (2008 edition):

Treat people as individuals

1 You must treat people as individuals and respect their dignity.

Collaborate with those in your care

8 You must listen to the people in your care and respond to their concerns […].

Provide a high standard of practice and care at all times

35 You must deliver care based on the best available evidence or best practice.

Uphold the reputation of your profession

61 You must uphold the reputation of your profession at all times.

The panel appreciated that a breach or breaches of the Code do not automatically result in a finding of misconduct but your failures in relation to charge 3 are so serious that they do amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired.

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her fitness to practise is impaired in the sense that s/he:

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

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

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

d) […]*'*

The panel finds that as a result of your failure to monitor Patient A during the transfer she was put at an unwarranted risk of harm. Furthermore, your failure to care for Patient A, in the panel's professional view, breached a fundamental tenet of the nursing profession and brought its reputation into disrepute.

Having found the first three limbs of the Shipman test to be engaged when considering the past, the panel went on to consider the test in relation to the future. In this regard, the panel considered whether your shortcomings are easily remediable; whether they have been remediated and whether it is highly unlikely that they will be repeated. The panel, in looking to the future, considered your current position in relation to remorse, insight and remediation.

In relation to the issues of remorse, insight and remediation the panel noted the submission on your behalf that your denial of the charge should not be held against you. However, the panel also noted that you made a bare admission to charge 3. In this regard the panel was concerned that you have not developed any meaningful remorse or insight following that bare admission.

Before effective steps can be taken to remedy concerns, you must recognise the problem that needs to be addressed. Therefore insight on your part is crucially important. The panel, in considering your insight, took into account the following factors:

- your ability to step back from the situation and consider it objectively;
- your recognition of what went wrong;
- you accepting your role and responsibilities at the material time;
- your appreciation of what could and should have been done differently; and
- your understanding how to act differently in the future to avoid reoccurrence of similar problems.

The panel was of the view that you have not been able to provide it with any adequate or comprehendible explanation for your misconduct and have not shown that you understand your role and responsibilities when transferring Patient A. It noted that you admitted that you had not looked at Patient A once she was in transfer, however, you were not able to explain what you could and should have done differently in the situation. The panel was of the view that your answer to being asked what you could have done differently, that there was nothing you could have done, demonstrates a fundamental misunderstanding of your role and responsibilities. This is not only in relation to monitoring and assessing a patient, even one with a Do Not Attempt Resuscitation (DNAR) order in place, but also in relation to responding to repeated concerns voiced by others. Furthermore, the panel was of the view that you have not shown any insight into the impact your actions had on Patient A, her relatives, Person A and Mr 3, who were present, your colleagues and the nursing profession as a whole. The panel further noted that during the course of your oral evidence you did not show any understanding of how to act differently in the future to avoid the reoccurrence of similar problems. It was therefore of the view that you have little or no insight into your misconduct.

Whilst the panel is satisfied that the misconduct in this case is capable of remediation, your failure to demonstrate, during this hearing, that you have developed any meaningful insight since your misconduct almost eight years ago means that you have not remediated your shortcomings and there is therefore a real risk of repetition.

The panel therefore decided that a finding of current impairment is necessary on the grounds of public protection.

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

The panel was of the view that your misconduct was a significant failure that had a great impact on Patient A's relatives and your colleagues. It was of the view that you have brought the profession into disrepute and that an informed member of the public would be shocked by the facts of this case.

Therefore, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case carefully and has decided to make a suspension order for a period of six months with a review. The effect of this order is that the NMC register will show that your registration has been suspended.

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

The panel carefully considered the victim impact statement provided by Person A and took it into account when deciding on sanction.

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Mohamed informed the panel that the NMC sanction bid is for a suspension order for a period of six months with a review. She reminded the panel that it had found that due to the lack of insight there is a real risk of repetition.

Ms Mohamed submitted that taking no further action or a caution order would not address the public protection issues identified by the panel, nor would these sanctions address the public interest. She submitted that neither would be appropriate nor proportionate in this case.

Ms Mohamed then submitted that, given the lack of insight, a conditions of practice order would also not be appropriate or proportionate in these circumstances. However, the panel found that the misconduct identified is remediable and Ms Mohamed therefore submitted that a six month suspension order would allow for enough time for you to

develop insight and demonstrate your reflection and provide any further evidence to satisfy a further panel that you have gained insight into your failings.

Ms Mohamed submitted that a striking off order would be disproportionate in this case given that the panel found that your misconduct is remediable.

Mr Rich firstly stated, on your behalf, that you want to apologise to the family for your role in the events on that day and that you understand the distress caused to the family by the mismanagement of Patient A in the hospital. He stated that you concede that you did not know what to do with Patient A. You have been dealing with this for the past eight years and felt '*hung out to dry*' by having to accept Patient A as your patient when the care of her was not your area of expertise.

Mr Rich acknowledged that you struggled to answer some simple questions asked by the panel and that part of the difficulty for you was to extract yourself from the case and talk about it in a more general way. He reminded the panel that you gave evidence in your second language and at times struggled to say what you wanted to say.

Mr Rich submitted that on the background of your previous unblemished career, you know your answers should have been better.

Mr Rich invited the panel to factor in your previous interim orders in its decision on sanction. He reminded the panel that you were subject to an interim suspension order for a period of 18 months and, following that, to an interim conditions of practice order for another two and a half years. You have not been working as a registered nurse since the interim order was lifted. Whilst not trying in any way to equate them to the impact on the family of Patient A, the effects on you have been considerable.

Mr Rich acknowledged that based on the panel's findings taking no action or a caution order would not be sufficient to protect the public nor would it address the public interest in this case. He also acknowledged that due to the lack of insight found a conditions of

practice order would not be suitable in your case. He reminded the panel that it found that your misconduct was remediable and therefore submitted that a striking off order would not be proportionate in this case.

Mr Rich submitted that this was a single occasion of misconduct, relating to a single patient, on one single day during a long and unblemished career as a registered nurse with no deep seated attitudinal or behavioural issues. He therefore invited the panel to impose a short period of suspension. He submitted that this would enable you to digest the outcome of the hearing, reflect on your misconduct and develop a perspective on the events. He acknowledged that you had about eight years since the events, however he reminded the panel that part of this was consumed by successive proceedings during which you were questioned by the police and the coroner. Mr Rich stated that the proceedings have now come to an end and that you have presented your case as you saw it, however, you can now step back and adjust to the new reality provided by the panel's findings.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- A lack of insight into your failings; and
- The impact of your failings on Person A and her family.

The panel also took into account the following mitigating features:

- This was a single, isolated incident in an otherwise longstanding and unblemished career.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- […]*;*
- *No evidence of general incompetence;*
- […]*;*
- […]*;*
- […]*;*
- *The conditions will protect patients during the period they are in force; and*

- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that, in the light of its findings about your lack of insight, there are no relevant, practicable or workable conditions which could be formulated to provide adequate public protection while you develop your insight to a level where any repetition of your failings is highly unlikely.

The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel acknowledges that although you have a significant lack of insight into your misconduct, you had barriers in the past that have prevented you from fully reflecting on the events. It was of the view that now that the police investigation and the coroner's inquest have concluded, you have the time and capacity to take the panel's objective view on the events and reflect on it accordingly. It also noted that you accept that you need some time to reflect on the events. The panel was satisfied that in this case, your misconduct, serious though it was, is not fundamentally incompatible with remaining on

the register. It was a solitary and exceptional aberration which, with the development of your insight, should not recur and is thus remediable.

The panel went on to consider whether a striking-off order would be appropriate. Taking account of all the information before it, the panel concluded that it would be disproportionate and unnecessary as a suspension order with a review means that you will not be able to return to practice until you have developed the insight necessary to preclude any real risk of repetition.

Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order and it would work against the public interest in that it would prevent the potential return to practice of an experienced and potentially safe nurse.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction. It will not only protect the public but is also sufficient to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

In determining a period of six months for the suspension order, the panel noted that regulatory sanctions are not like sentences in criminal courts. There is no principle that time spent on an interim order must be deducted from a substantive order: *Ujam v GMC* [2012] EWHC 683 (Admin) and *Abdul-Razzak v GPC* [2016] EWHC 1204. Common fairness dictates that panels must take into account any interim order and its effect on a registrant when deciding on whether a sanction is proportionate: *Kamberova v NMC* [2016] EWHC 2955. The panel noted that so long as it properly considers these issues it is entitled to conclude, in a given case, that the interim order does not affect the substantive order: *Akhtar v GDC* [2017] EWHC 1986 (Admin).

In respect of the above case law the panel noted that the protection of the public is the overarching concern and that it has made findings against you in respect of both public protection and the wider public interest.

Whilst the panel has decided that the contextual circumstances of this case are serious it notes that you have been subject to an interim suspension order between 4 December 2015 and 1 June 2017 and an interim conditions of practice order between 1 June 2017 and 17 February 2020. These interim orders have been in place for over four years and have impacted upon your right to practise as a registered nurse, and most probably upon your finances and your professional reputation.

The panel reminded itself that any substantive sanction imposed should not be unduly punitive and decided in the protracted circumstances of this case that common fairness dictates that the length of the suspension order should be proportionate. Accordingly, whilst the seriousness of the case may ordinarily merit a twelve month suspension order, the panel took into account that you have been subject to an interim order for over four years and therefore, in the interests of justice, imposes a six month suspension order with a review. It considers that six months should be enough time for you to develop full insight into your misconduct.

Any future panel reviewing this case may be assisted by:

- A comprehensive reflective piece, following a recognised model, which covers the following issues:
    - Your personal responsibility for what went wrong, why it went wrong, and how you will avoid any repetition of your failings;
    - The impact your actions had on Patient A, her family, your colleagues and the reputation of the nursing profession.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interest until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Mohamed. She submitted that an interim order is necessary to protect the public for the reasons identified by the panel earlier in its determination until the suspension order comes into effect. She therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

Mr Rich had no submissions with regard to an interim order.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim

suspension order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

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

That concludes this determination.