Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday 13 May 2021

Virtual Hearing

Name of registrant:	Mafuno Constance Lapoza
NMC PIN:	15A0896E
Part(s) of the register:	Registered Nurse - Adult - March 2015
Area of registered address:	Cheshire
Type of case:	Misconduct
Panel members:	Christina McKenzie (Chair, Registrant member) Dr Natasha Duke (Registrant member) Linda Redford (Lay member)
Legal Assessor:	John Bromley-Davenport
Panel Secretary:	Holly Girven
Nursing and Midwifery Council:	Represented by Neil Jeffs, Case Presenter
Mrs Lapoza:	Present and represented by Karl Shadenbury, UNISON
Consensual Panel Determination:	Accepted with alternative sanction agreed
Facts proved:	Charges 1, 2a, 2b, 2dii, 3a, 3b, 3c, 3d, 3ei, 3eii and 4
Facts not proved:	Charges 2c and 2di
Fitness to practise:	Impaired
Sanction:	Caution order (3 years)
Interim order:	No order

Details of charge

That you, a Registered Band 5 nursing working on ward T5 at Royal Oldham Hospital on 10 July 2016, in relation to Patient A:

1) Failed to undertake observations within 8 hours of receiving handover for Patient A at 6am.

2) At, or around, 2.55:
    a. Incorrectly calculated / recorded an EWS a 1;
    b. Failed to carry out a further / repeat set of observations within 30 minutes to 1 hour of recording an EWS of 1 and / or at appropriate intervals thereafter;
    c. Having calculated / recorded Patient A's EWS as 1, failed to investigate and / or escalate Patient A's care;
    d. Failed to investigate and/or escalate Patient A's care as a result of:
        i. Low blood pressure;
        ii. Diminished urine output;

3) At, or around, 16:40:
    a. Incorrectly calculated / recorded an EWS score as 1;
    b. Failed to take and / or record a full set of observations;
    c. Failed to carry out a further / repeat set of observations within 30 minutes to 1 hour of recording an EWS of 1 and / or at appropriate intervals thereafter;
    d. Having calculated / recorded Patient A's EWS as 1, failed to investigate and / or escalate Patient A's care;
    e. Failed to investigate and/or escalate Patient A's care as a result of:
        i. Low blood pressure;
        ii. Diminished urine output

4) Your failures / conduct as set out at any and / or all above, contributed towards Patient A's loss of chance of survival

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

Consensual Panel Determination

At the outset of this hearing, Mr Jeffs informed the panel that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the Nursing and Midwifery Council (NMC) and you.

The agreement, which was put before the panel, sets out that the NMC intend to offer no evidence in relation to charges 2c and 2di, that you make full admissions to the facts alleged in charges 1, 2a, 2b, 2dii, 3a, 3b, 3c, 3d, 3ei, 3eii and 4, that your actions amounted to misconduct, and that your fitness to practise is currently impaired on the grounds of public interest by reason of that misconduct. It was further stated in the agreement that an appropriate sanction in this case would be a caution order for a period of five years.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

'The Nursing & Midwifery Council ('NMC') and Mafuno Constance Lapoza, PIN 15A0896E ("the Parties") agree as follows:

1. *Mafuna Constance Lapoza is aware of the CPD hearing. Mafuno Constance Lapoza does not intend to attend the hearing and is content for it to proceed in their and their representative's absence. Mafuno Constance Lapoza will endeavour to be available by telephone should any clarification on any point be required, or should the panel wish to make any amendment to the provisional agreement. Mafuno Constance Lapoza also agrees to waive the notice period for service of the Notice of Hearing. Mafuno Constance Lapoza understands that if the panel wishes to make amendments to the*

provisional agreement that they do not agree with, the panel will reject the CPD and refer the matter to a substantive hearing.

A. Preliminary issues

2. *The NMC intend to offer no evidence in relation to the facts of charges 2(c) and 2(d)(i) for the reasons set out in section D below.*

B. The charges

3. *Mafuno Constance Lapoza admits the following charges:*

That you, a Registered Band 5 nursing working on ward T5 at Royal Oldham Hospital on 10 July 2016, in relation to Patient A:

1) Failed to undertake observations within 8 hours of receiving handover for Patient A at 6am.

2) At, or around, 2.55:

a) Incorrectly calculated / recorded an EWS a 1;

b) Failed to carry out a further / repeat set of observations within 30 minutes to 1 hour of recording an EWS of 1 and / or at appropriate intervals thereafter;

d) Failed to investigate and/or escalate Patient A's care as a result of:

ii) Diminished urine output;

3) At, or around, 16:40:

a) Incorrectly calculated / recorded an EWS score as 1;

b) Failed to take and / or record a full set of observations;

c) Failed to carry out a further / repeat set of observations within 30 minutes to 1 hour of recording an EWS of 1 and / or at appropriate intervals thereafter;

d) Having calculated / recorded Patient A's EWS as 1, failed to investigate and / or escalate Patient A's care;

e) Failed to investigate and/or escalate Patient A's care as a result of:

i) Low blood pressure;

ii) Diminished urine output;

4) Your failures / conduct as set out at any and / or all above, contributed towards Patient A's loss of chance of survival

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

C. The facts

4. *Mafuno Constance Lapoza appears on the register of nurses, midwives and nursing associates maintained by the NMC as "Registered Nurse- Adult" and has been a registered nurse since 21 March 2015.*

<u>Introduction</u>

5. *In March 2017, HM Coroner's Office made a 'Regulation 28 report to Prevent Future Deaths' following an inquest touching upon the death of Patient A. The report was referred to the Department of Health and the Pennine Acute Hospitals NHS Trust ('the Trust'). The report sent to the NMC as an interested party, as well as other organisations including the CQC, GMC and local Clinical Commissioning Groups. The report described the following "Matters of Concern" relating to the Trust:*

"The RCA and inquest process identified a significant number of errors, omissions and missed opportunities to treat the deceased- all of which, on the balance of probabilities, could and would have improved the deceased's chances of survival, despite her pre-existing co-morbidities. Most of the failings identified in this case have been recognised in previous RCAs conducted by the Trust over the last 6-12 months. Despite evidence as to 'lesson learned'/actions plans set etc. flowing therefrom, there appears to be little (if any) timely progress being made in terms of improving/driving up the standards of care and preventing futire (sic) deaths. My concerns relate to the following in particular:

- *Poor communication by/between clinicians and nurses*
- *Poor record keeping – medical and nursing*
- *Poor leadership/supervision of nurses- Ward/Matron level*
- *In adequate supervision by on-call consultants of junior colleagues*
- *Incorrectly calculated early warning scores*
- *Baseline observations not recorded/inaccurately record (sic) /missing vital parameters (impacting upon the calculation of early warning scores)- outwith Trust guidance/deviation from the same not clinically justified*
- *Inaccurate fluid balance charts (persistent basic arithmetical errors/lack of recording)*
- *The absence of clinical judgement as a result of over-reliance placed upon tools such as the early warning scores*
- *Failure to repeat tests such as bloods and act upon the results accordingly*

- *Failure to escalate (by doctors and nurses) when signs of deterioration/change in the patient's clinical condition became apparent*

- *Delays in arranging urgent/additional test and treatment (in this case radiological CT scanning, bloods and IV antibiotics)*

Split site commitment/reconfiguration and the impact this potentially has upon patient safety and clinical care …"

6. *The NMC treated the matter as a generic referral and identified Mafuno Constance Lapoza as one of a number of nurses who were involved in the care of Patient A before they died. On 28 April 2017, the NMC opened a case in relation to Mafuno Constance Lapoza's fitness to practise who, at the time relevant time, was working as a nurse on Ward T5 at Royal Oldham Hospital ('the Hospital'), part of the Trust. Details of the events are set out below.*

7. *On 27 June 2016, Patient A was admitted to the Hospital for an elective sigmoid colectomy. The operation took place on 28 June 2016 and went as planned. The post- operative period was relatively uneventful. However, by 5 July 2016, Patient A started to show subtle signs of deterioration. Over the course of the weekend of 8 -11 July 2016, Patient A's condition rapidly worsened. Patient A was taken back to theatre on the evening of 11 July 2016, but suffered an intra-operative cardiac arrest and sadly died.*

8. *The Trust completed a Comprehensive Incident Investigation Report which identified a number of errors, omissions and missed opportunities to treat Patient A. Such matters related to a number of clinical staff, not solely the Mafuno Constance Lapoza, including another registered nurse ('Nurse B') whose case is also the subject of ongoing fitness to practise proceedings and has been joined to be heard with the present case..*

9. *Mafuno Constance Lapoza was working a long day shift on 10 July 2016. Patient A was handed over to them that morning. It is specifically noted by the parties that there were a number of errors on the part of other medical staff (including Nurse B, who cared for Patient A on the nightshift of 10 July 2016) and other contextual factors which contributed to failures in the standard of care provided to Patient A. No nursing staff were suspended and they were given work whilst they continued working.*

10. *As recorded above, a Coroner's inquest was held on 1 March 2017. The medical cause of death was recorded to be: 1. (a) Acute intraoperative cardiac arrest due to myocardial ischaemia; (b) Sepsis due to faecal peritonitis; (c) Breakdown of colonic anastomosis following colectomy for diverticular stricture and diverticulitis and 2. Coronary artery disease and hypertensive heart disease.*

11. *The Coroner concluded that medical and nursing neglect more than minimally contributed to Patient A's death. The Regulation 28 report referred to above was produced. The Trust took no action against Mafuno Constance Lapoza, who left the Trust and subsequently began working at Stepping Hill Hospital, part of Stockport NHS Trust.*

12. *The NMC investigated the following regulatory concerns:*

    1. *Failed to complete and record observations as required, resulting in inaccurate assessment of early warning signs;*

    2. *Failed to escalate a continuing early warning score (EWS) of 1.*

13. *The Case Examiner's referred both of the regulatory concerns to the Fitness to Practise Committee for adjudication.*

14. *As part of the NMC's case preparation, witness statements were obtained from [Ms 1]- Lead Nurse (formerly Quality Matron) at the Trust and [Dr 2]-*

Consultant Surgeon at the Trust. Additionally, independent expert reports were commissioned from [Ms 3] - Nursing Expert.

Specific charges

15. *Mafuno Constance Lapoza assumed responsibility for Patient A's care following handover at 6am on 10 July 2016. At that time Patient A had an Early Warning Score ('EWS') of '0', which would have indicated no significant concerns and necessitated observations at least every 8 hours. The nurse on previous shift had incorrectly calculated the EWS as '0'. The EWS should have been recorded as '1' because Patient A's systolic blood pressure had dropped significantly from 130 to 100. This incorrect recording was no fault of Mafuno Constance Lapoza.*

16. *Had an EWS score of '1' been correctly calculated, it would have indicated to Mafuno Constance Lapoza that observations were to be repeated after 30 minutes to 1 hour and, thereafter, 4 hourly in accordance with Trust policy. Additionally, Mafuno Constance Lapoza may not have been aware of the drop in blood pressure and the need to monitor more frequently. Patient A was reviewed by the doctor at a ward round at 9:40, who also failed to note concerns about Patient A's blood pressure. Mafuno Constance Lapoza did not record observations until 2:55 pm. This was almost an hour late. Patient A was on 8 hourly observations (based upon the incorrect EWS of '0') and such observations were not completed within 8 hours of receiving the handover at 6am* ***[charge 1]****.*

17. *At the time of taking observations at 2:55, Patient A's systolic blood pressure was 85. Mafuno Constance Lapoza recorded a EWS of '1'. The systolic blood pressure drop was significant, as the normal range for the patient was 166- 158, so should have raised concerns about bleeding and dehydration and required investigation. The Nursing Expert opined that at 2:55, the EWS was scored incorrectly as '1', whereas it should have been '3' due to*

hypotension, commenting that Patient A was persistently hypotensive ***[charge 2(a)]****.*

18. *Irrespective of whether the EWS should have been recorded as '3' at 2:55, Mafuno Constance Lapoza had recorded a EWS of '1'. As a result observations should have been repeated after 30 minutes to 1 hour, followed by hourly observations. Observations were not repeated and entered in the clinical notes until 4:40, outside of this timeframe* ***[charge 2(b)]****.*

19. *The local investigation noted that there were historical concerns relating to many clinical staff in relation to matters relating to "Fluid Balance/Urine Output". There was no documented cumulative fluid balance recorded on 10 July 2016. Patient A was reviewed by the Surgical Registrar at 09:40, who noted that Patient A had not passed any urine since the removal of their catheter the previous day. Patient A was re-catheterised. As Patient A had not passed urine overnight, as a matter of best practice, their fluid balance would have been monitored hourly. There is nothing to suggest that the doctor suggested that this action should be taken.*

20. *Patient A developed hypotension on the morning of 10 July 2016. Nursing staff, including Mafuno Constance Lapoza, did not alert the critical care outreach team or the night management team of any concerns regarding Patient A's diminished urine output. Nursing staff also continued to miscalculate the cumulative fluid balance on several occasions making it difficult to ascertain an accurate recording. As noted above, the systolic blood pressure drop was significant, this should have raised concerns about bleeding and dehydration and it would have been obvious that this would have required investigation. The instructed expert specifically refers to inadequate monitoring of vital signs and urine output. Patient A's diminished urine output was not specifically investigated or escalated* ***[charge 2(d)(ii)]****.*

21. *At 16:40, Mafuno Constance Lapoza made an entry in the medical notes, stating that they had re-catheterised Patient A, dressed their wound and*

administered IV. They recorded a systolic blood pressure of 90. This was a further significant drop. A EWS of '1' was recorded. However, a full set of observations were not taken/recorded to verify this was correct. The independent expert refers to Patient A as being persistently hypotensive, which should have resulted in and EWS of '3', which would have triggered hourly monitoring ***[charge 3(a)]****. A full set of observation should have been taken and recorded* ***[charge 3(b)]****. Additionally, in line with Trust policy, the recording of a EWS of '1' should have resulted in further/repeat observations being carried out within 30 minutes to 1 hour and at appropriate levels thereafter. However, the next entry was not made in Patient A's notes until the following shift had commenced after Mafuno Constance Lapoza handed over care before their shift ended at 20:00, again outside of the Trust timeframe* ***[charge 3(c)]****.*

22. *Despite recording Patient A's EWS as '1' and the above factors, Mafuno Constance Lapoza failed to investigate and/or escalate Patient A's care* ***[charge 3(d)]****. The Outreach Team go off duty at 14:00 on weekends and the Night Practitioner Team do not commence work until 20:00. Therefore, the concerns could only have only been escalated to the clinicians on duty. There is no evidence in Patient A's records that Mafuno Constance Lapoza spoke to a doctor or escalated the concerns relating to Patient A's blood pressure, which would have been expected upon identifying the same at 14:55 and 16:40* ***[charge 3(e)(i)]****. There was no documented cumulative fluid balance recorded on 10 July 2016. The same issue arises in relation to Patient A's diminished urine output at 14:55* ***[charge 2(d)(ii)]*** *and 16:40* ***[charge 3(e)(ii)]****.*

23. *The independent expert refers to the inaccurate EWS recording, and the lack of observations and escalation. The expert states that there was a failure to adequately monitor and escalate and that persistent hypotension in an otherwise normotensive patient would have been a red flag of a deteriorating patient and that there was a breach of duty of care when the care of Patient*

A had not been escalated to a senior nurse or clinician. The independent expert opines that the following shortcomings contributed to the adverse outcome for Patient A: (a) inaccurate calculation of EWS; (b) lack of follow up when the patient remained hypotensive; and (c) lack of proper escalation of care and that in their opinion, Patient A would have had a better chance of survival if they had been referred to doctors earlier. Such factors contributed towards the delay in treatment ***[charge 4]***

24. *[Dr 2] was one of the main investigators in the formal department investigation at the Trust. A 'Comprehensive Investigation Report', also known as a 'Root Cause Analysis' was produced. The contributions made by [Dr 2] looked at clinical failings from a doctors point of view. [Dr 2] used a scoring tool called the P-POSSUM model to calculate the predictive risk of mortality for Patient A. This used various metrics, for example age, blood pressure and type of surgery. The computer calculates the risk. [Dr 2] calculated that if surgery had been carried out on 8 July 2016, Patient A's predictive risk of mortality would have been around 47%, whereas by 11 July 2016, the predictive score would have exceeded 80%. This means the chances of survival were significantly reduced by the delay. [Dr 2] says that other statistical prediction tools/models do exist, however, it is common sense that operating earlier would have resulted in a better outcome for Patient A.*

25. *[Dr 2] also states that they believe that Patient A could have been diagnosed as early as 8 July 2016 and that there was a lack of clinicians on duty to identify that Patient A was failing to progress. [Dr 2] does not necessarily think that nursing care was central to Patient A's demise. There were issues with the nurses not calculating the EWS score accurately and because the EWS score was miscalculated as lower, there was a missed opportunity to escalate to an appropriate clinician. However, Patient A was reviewed by doctors on a daily basis and until Patient A had deteriorated considerably,*

the anastomotic leak was not identified. The 'Root Causes(s)' are described in the report in the following way:

> *"The anastomotic leak ultimately led to the patient's death. If the failure to progress had been appreciated sooner, a CT scan would have been requested and a diagnosis of an anastomotic leak potentially made earlier. This would then have allowed the patient to undergo surgery in a timelier manner as opposed to undertaking surgery in extremis.*
>
> *On the balance of probabilities had the anastomotic leak been detected earlier, the patient would have stood a better chance of surviving this complication. Unfortunately the patient's poorly condition was only appreciated when they exhibited significant decompensation in their clinical condition on 11/07/16. At this point in time the patient had significant kidney injury, a gross disturbance in their blood biochemistry and was no longer stable in terms of cardiovascular parameters. At this point in time, the mortality would easily exceed 80% as opposed to a mortality risk of 47% had surgery been performed on 08/07/16.*
>
> *Ultimately there has been a failure to rescue this patient in the face of a developing complication. Whilst a complication such as an anastomotic leak carries a high risk of mortality even when recognised promptly, it is the failure to recognise and act in a timely manner by clinicians that has raised concern in this RCA."*

26. *Mafuno Constance Lapoza admits that the failures and conduct set out in the admitted preceding charges, contributed towards Patient A's loss of chance of survival* ***[charge 4]****.*

<u>Contextual/other factors</u>

27. *The parties acknowledge that there were a number of contextual and other factors which are relevant to the events in question and in respect of the events underpinning the charges.*

28. *Mafuno Constance Lapoza was a newly appointed staff nurse on Ward T5. There were a number of concerns relating to, and failures made by, wide-ranging clinical staff (both doctors and nurses) in relation to the care provided to Patient A. Those concerns both pre-dated and post-dated, the care provided by Mafuno Constance Lapoza. By way of illustration, on the day of the events, Patient A was handed over to Mafuno Constance Lapoza with an incorrect EWS of '0' and was also reviewed by a doctor at 09:40 who also failed to act on concerns relating to the patient's blood pressure.*

29. *Both doctors and nursing staff failed to recognise the signs of sepsis during Patient A's deterioration. Although Patient A's blood pressure dropped, their pain must have been well managed as the patient would have been expected to present with increasing pain, nausea and vomiting.*

30. *Nursing staff also continued to miscalculate the cumulative fluid balance on several occasions, making it difficult to ascertain an accurate reading. There had been Trust wide problems with monitoring urine output, which was subsequently picked up when the Trust started a deteriorating patient collaborative in December 2016. The concerns and contextual factors are also apparent from the issues raised in the local investigation and HM Corner's*

31. *The wide- ranging concerns above provide context to the facts admitted by Mafuno Constance Lapoza, as do the matters referred to below.*

32. *The regulatory concerns were accepted in the response provided to the Case Examiner's. Mafuno Constance Lapoza acknowledged that they failed to complete and record observations as required, resulting in an inaccurate assessment and escalation of Patient A's EWS, including the score of '1'. At the same time they acknowledged the significant risk of harm to the public and the seriousness of the regulatory concerns.*

33. *Following the incident, Mafuno Constance Lapoza continued to be employed by the Trust until February 2017, when they took up a new position at Stepping Hill Hospital, working for the Stockport NHS Foundation Trust. During this time, Mafuno Constance Lapoza has worked in similar environments to the ward where the events in this case occurred and with patients of a similar profile. There have been no subsequent NMC referrals.*

D. Application to offer no evidence (charges 2(c) and 2(d)(i))

34. *The NMC intend to offer no evidence in relation to the facts of charges 2(c) and 2(d)(i). In accordance with the decision of* ***PSA v NMC & X*** *[2018] EWHC 70 Admin at* ***[57]*** *the facts are set out for the panel below.*

35. *Charge 2(c) as set out above, alleges that at, or around, 14:55 having calculated/ recorded Patient A's EWS as '1', Mafuno Constance Lapoza failed to investigate and/or escalate Patient A's care. Charge 2(d)(i) is to similar effect, insofar as it alleges that there was a failure to investigate and/or escalate Patient A's care as a result of low blood pressure. The charges are disputed.*

36. *The evidence in support of the charges is derived from the Trust witnesses referred to above. In particular, [Ms 1] following consideration of the medical records.*

37. *Mafuno Constance Lapoza denies that they failed to escalate as alleged in charges 2(c) and 2(d)(i) on the basis that they informed the on call doctor called "[Dr 4]" that Patient A's blood pressure was low. Mafuno Constance Lapoza accepts that they did not document this discussion and, consequently, believes that the individual is [Dr 4]. Reference is made to the fact that evidence was not obtained from [Dr 4] to confirm whether or Patient A's low blood pressure was escalated and, in addition, that [Dr 4] was not interviewed as part of the comprehensive investigation report.*

38. *As noted above, the Case Examiner's determined that there was a case to answer in respect of both regulatory concerns, the second of which is capable of encompassing the specific facts alleged in charges 2(c) and 2(d)(i). When referring the regulatory concern to the Fitness to Practise Committee, the material parts of the Case Examiner's decision states:*

    "You were working a day shift on 10 July 2016. Patient A was handed over to you that morning. On two occasions during your shift you recorded Patient A's systolic blood pressure as significantly low, but did nothing to investigate or escalate this…

    We have considered the statement of [Ms 1]. She is Lead Nurse at the Trust. She was not working on 11 July 2016, nor was she involved with the investigation of the events leading up to Patient A's death. She reviewed the nursing records to gain an overview of what each nurse had done and provided a witness statement for the Coroner's inquest, commenting on the nursing care provided.

    [Ms 1] explains that you were working the day shift on 10 July 2016. Patient A was handed over to you with an EWS of 0, which indicated no significant concerns, and observations at least every eight hours. This EWS had been incorrectly calculated by the nurse on the nightshift, and should have been 1. This is because Patient A's systolic blood pressure had dropped significantly from 130 to 100. As the EWS had been incorrectly calculated, you may not have been aware of the drop in blood pressure, and the need to monitor Patient A more frequently.

    [Ms 1] says that you did not record observations until 14:55, which was nine hours from when they were last recorded. Patient A's systolic blood pressure was 85 and you calculated the EWS as 1. This drop of blood pressure was significant as the normal range for the patient was 166 -158. This should have raised concerns about

bleeding or dehydration and it would have been obvious to you that it required investigation. An EWS of 1 requires observations to be repeated after 30 minutes to an hour, and then four hourly observations to monitor the patient.

[Ms 1] explains that at 16:40 you recorded a systolic of 90 and an EWS as 1. You did not record a full set of observations so [Ms 1] is unable to say if this was correct. There is no evidence that you spoke to a doctor about Patient A's blood pressure. [Ms 1] would have expected you to do so in the circumstances.

You accept the regulatory concerns. On the basis if your admissions and the evidence of [Ms 1], we find the facts of the regulatory concerns are capable of proof…

We note that you have accepted the regulatory concerns. In your reflection dated 19 September 2017, you say:

"I failed to calculate the early warning score accurately, when rechecking the set of observations I only checked the blood pressure did not check the whole set of observations. ***I did not mention to the nurse in charge nor did I escalate to senior house officer, however I mentioned to the doctor on call."***

We have seen no evidence that you escalated the concerns to the doctor on call. This is an issue of fact which we cannot resolve. We also find that although you have shown some insight into your clinical failings, you do not adequately address why you did not investigate and escalate such an obvious deterioration in Patient A's condition*…*

We consider the evidence in this case suggests that your actions were very serious. In her statement, ***[Ms 1] says that when Patient A's systolic blood pressure was 85 at 14:55, it would have been obvious to you that this required investigation. So there is a case to answer that you deliberately chose to take an unreasonable risk with Patient A's safety. If this allegation was found proved, it could be said that you were responsible for recklessly exposing Patient A to harm. This would mean your alleged failings concern your attitude as well as your clinical skills. We consider that this would make them less easy for you to put right…****" (emphasis supplied).*

39. *The status of the evidence as it presently stands is that there is a factual dispute in relation to the escalation concern in the disputed charges. Whilst the panel may be able to draw inferences from, for example, the lack of documented events, the position is far from clear.*

40. *The parties acknowledge that is possible for either party to seek to obtain evidence from [Dr 4] who, if they were the doctor on call may be able to assist in clarifying the position in relation to the disputed charges. However, for the reasons referred to below, it is considered disproportionate and unnecessary to do so.*

41. *The position in relation to [Dr 4] is far from clear. Even if they were involved in the events and are able to recall the same having regard to the passage of time, it may not be expedient to readily obtain such a statement. During the NMC investigation it was noted that there are a lack of witnesses to the events who are able to participate in the NMC investigation and that a number of medical staff involved in Patient A's care during the period of 8 to 11 July 2016, would have been referred for investigation by their regulatory bodies. For the avoidance of any doubt, there is no suggestion that [Dr 4] would have been involved or referred to any regulatory body. The issue is*

referred to in order to illustrate the potential difficulty in obtaining probative evidence of this nature due to the passage of time and other circumstances.

42. *A separate issue with any such evidence is that [Dr 4] does not appear to feature in the Trust investigation. In the absence of written records, which Mafuno Constance Lapoza accepts they did not make and do not appear to have been discovered as part of the Trust investigation, any recollection of a discussion at or around the time referred to in the charge is likely to be, at best, limited.*

43. *A further factor is the additional delays that may be involved. The events referred to in the charges occurred almost 5 years ago. Any further delay, unless absolutely necessary, should be avoided for all concerned. This includes Nurse B whose case is currently linked to the present case and, in the event of a postponement of this matter, would almost inevitably be impacted upon and have their case further delayed.*

44. *The above considerations focus upon potential practical difficulties in obtaining additional evidence and whether such evidence (if available), is likely to be of probative value. However, the main reason that it is considered appropriate to offer no evidence in relation to the disputed charges is that it is unnecessary and disproportionate to proceed with those charges on the basis that the overarching regulatory concerns are covered by those charges which are admitted and the matters in dispute do not add to the overall seriousness of the regulatory concerns.*

45. *The relevant regulatory concern referred to the Fitness to Practise Committee is "Failed to escalate a continuing early warning score (EWS) of 1". It is the regulatory concerns which falls to be considered, not the specific allegations which may said to constitute the concern. There is a distinction between not proceeding with a specific allegation in support of a regulatory concern and not proceeding with an entire regulatory concern which has*

been referred for adjudication. Specific NMC guidance at CAS-1 confirms this:

> *"If our concerns about a nurse, midwife or nursing associate's fitness to practise are about more than one area of practice, or more than one incident or issue, case examiners will consider the information and evidence about each incident or issue separately. However, they won't always need to comment on each individual piece of evidence about each separate issue in their decision, because* ***the case to answer decision is about our concerns about the nurse, midwife and nursing associate's fitness to practise as a whole, rather than individual factual scenarios"*** *(emphasis supplied).*

46. *The regulatory concerns referred for adjudication are reflected in the other admitted charges. More particularly, charges 2(ii), 3(e)(i) and 3(e)(ii) all relate to failures to investigate and escalate concerns, with charge 3(d) specifically relating to the failure to investigate and/or escalate the EWS of '1'.*

47. *The parties acknowledge that the Fitness to Practise Committee, as disciplinary tribunal, should play a more proactive role than a judge presiding over a criminal trial in making sure that the case is properly presented and that the relevant evidence is placed before it. Additionally, the Committee also has the power to direct that further steps be taken in relation to the obtaining of evidence:* ***Professional Standards Authority v (1) Nursing and Midwifery Council and (2) Jozi [2015] EWHC 764*** *(Admin).*

48. *The NMC has had regard to its overarching statutory objectives of the protection of members of the public and upholding the public interest. The overall seriousness of the regulatory concern and conduct in question is not in any way diminished by offering now evidence in relation to two charges in question. Conversely, it would be contrary to the public interest to purse such matters in all the circumstances. The panel invited to agree to the application to offer no evidence in respect of charges 2(c) and 2(d)(i).*

E. Misconduct

49. The facts amount to misconduct.

*50. The parties have had regard to **Roylance v General Medical Council (No 2) [2000] 1 AC 311** in which the Privy Council held that "serious professional misconduct is not statutorily defined and is not capable of precise description……It must be linked to the practice of medicine or conduct that otherwise beings the profession into disrepute and it must be serious". It was further held that "misconduct is a word of general effect involving some act or omission that falls short of what would be proper in the circumstances".*

*51. One of the sources of standards for the nursing profession can be found in the professional codes in force at the material time. At the time of the events referred to in the charges, the relevant code in force was **The Code: Professional standards of practice and behaviour for nurses and midwives (2015)**. The parties agree that the following parts of Code were engaged, and breached, in this case:*

1 Treat people as individuals and uphold their dignity
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance and care for which you are responsible is delivered without undue delay
2 Listen to people and respond to their preferences and concerns
2.1 work in partnership with people who deliver care effectively
3 Make sure that people' physical, social and psychological needs are assessed and responded to
3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages
8 Work cooperatively

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.4 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
10 Keep clear and accurate records relevant to your practice
10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements ***[Note:*** *it is not suggested that any falsification took place****]***
13 Recognise and work within the limits of your competence
13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely and appropriate 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 professional to carry out any action or procedure that is beyond the limits of your competence
20 Uphold the reputation of your profession at all times

20.1 keep to and uphold the standards and values set out in the Code

52. *The conduct referred to in the charges fell far short of what would have been expected of a registered nurse and represented a serious departure from the standards contained in the Code as particularised above.*

53. *The conduct was serious in that in that it relates to failures in respect of basic, but important aspects of nursing which should have at all times been undertaken effectively and appropriately. Failure to undertake such tasks appropriately have the potential for serious, unwarranted, patient harm as is evident from the sad circumstances of the current case and the outcome for Patient A.*

54. *The conduct also fell short of the local Trust policy "Standard for Adult Patient Observation Practice" and, as the independent expert opined, the "Guidance in the National Early Warning Score (Royal College of Physicians, 2017)".*

55. *The parties acknowledge that there were a number of systemic failings at the Trust in relation to the care of Patient A, which contributed towards inadequate care being provided and the loss of chance of survival. Nonetheless, Mafuno Constance Lapoza acknowledges that they were responsible for their own conduct and actions as set out in the facts and charges.*

F. Impairment

56. *Mafuno Constance Lapoza's fitness to practise is currently impaired by reason of misconduct.*

57. *In relation to impairment, a general approach to what might lead to a finding of impairment was provided by Dame Janet Smith in her Fifth Shipman*

Report. A summary is set out in the case of ***CHRE v Nursing and Midwifery Council & Grant*** *[2011] EWHC 927 at paragraph 76 in the following terms:*

> *"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. has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

58. *The first 3 limbs, namely a- c inclusive, are engaged in this matter.*

59. *Patient A was placed at unwarranted risk of harm by the failures referred to in the charges. The admissions in relation to charge 4 relating to the contribution towards loss of chance of survival evidence such matters.*

60. *The actions and omissions as set out in the charges also brought the nursing profession into disrepute and had the potential to undermine trust and confidence in the nursing profession. Whilst at all times acknowledging that matters relating to fitness to practice are for the Fitness to Practise Committee alone, it is agreed that the matters raised by HM Coroner highlight the public nature of the concerns relating to various healthcare*

practitioners, including Mafuno Constance Lapoza, and demonstrate how the profession was brought into disrepute. The public rightly expect registered members of the profession to provide a high standard of care at all times. By failing to adhere to such high standards there was the potential for damage to the reputation of the profession.

61. *Providing a high standard of care is also a fundamental tenet of the nursing profession. Further, the provisions of the Code, as referred to above, constitute tenets of the nursing profession. By failing to provide a high standard of care at all times and comply with the core principles of the Code as set out above, Mafuno Constance Lapoza breached fundamental tenets of the profession.*

Remediation, insight and risk of repetition

62. *In considering the question of whether the Registrant's fitness to practise is currently impaired, the Parties have considered* ***Cohen v GMC*** ***[2007] EWHC 581 (Admin),*** *in which the court set out three matters which it described as being 'highly relevant' to the determination of the question of current impairment:*

    a. *Whether the conduct that led to the charge(s) is easily remediable;*

    b. *Whether it has been remedied;*

    c. *Whether it is highly unlikely to be repeated.*

63. *The parties agree that the conduct is capable of remediation. The failings relate to serious clinical incidents, but which occurred on a single shift. Notwithstanding the seriousness of the failings, the parties acknowledged that a number of contextual factors (as set out above) were engaged and that the conduct does not arise as a result of an underlying attitudinal concern.*

64. *In terms of remediation, before effective steps can be taken to remedy the concerns, the nurse must recognise that the problems that need to be addressed. This requires the nurse to demonstrate sufficient insight. The NMC has published guidance (at FTP-13b) to assist in assessing insight, which includes the following:*

    "A nurse, midwife or nursing associate who shows insight will usually be able to:

    - *step back from the situation and look at it objectively*
    - *recognise what went wrong*
    - *accept their role and responsibilities and how they are relevant to what happened*
    - *appreciate what could and should have been done differently*
    - *understand how to act differently in the future to avoid similar problems happening*

65. *There have been other issues in respect of Mafuno Constance Lapoza's fitness to practice that have come to the NMC's attention. In the interests of transparency, the following matters are drawn to the Panel's attention.*

66. *In February 2016, Mafuno Constance Lapoza was involved in an incident in which a medication trolley was left unattended. This was satisfactorily resolved at a local employer level.*

67. *In addition, a reference from Mafuno Constance Lapoza's current employer dated 2 August 2017, referred to the following matters:*

    "a. Observation and EWS; the ward manager does not have any concerns regarding her current practice.

b. Record keeping and MAR; No previous concerns have been noted although we are currently investigating an incident where Mafuno has been noted to have a lapse in her documentation. Further information is required from Mafuno before we can conclude this investigation and make a decision on actions if appropriate.

c. Recognising signs of deterioration and escalating concerns; No previous concerns have been noted although we are currently investigating an incident where Mafuno has been noted to have escalated concerns however further information is required from Mafuno before we can conclude this investigation and make a decision on actions if appropriate.

68. Consequent to the above, confirmation was received on 31 August 2017, that an investigation meeting had been held and the matter resolved. By way of further information, this was a serious incident involving a post-operative patient who was discharged and readmitted within 12 hours. The patient passed away shortly after readmission. Mafuno Constance Lapoza carried out the discharge, but had not made any decisions around discharging the patient. The patient's family raised concerns about monitoring and whether the patient was fit for discharge.

69. At the time the employer considered it was an inappropriate discharge but not the cause of death. Mafuno Constance Lapoza had received the handover for the patient with a EWS of '1' (on a scale of 1-7) that morning. Mafuno Constance Lapoza had not been carrying out the observations, which were done by another nurse during the shift and noted a change in respiratory rate, bringing the EWS up to '2'. This did not need to be escalated under the guidance in place at the time, but may have warranted a review. The colleague did not raise any concerns with Mafuno Constance Lapoza and the issue was that she carried out the discharge without

reviewing the observations and documenting what action she had taken. It was a busy day and errors were made by several persons.

70. *The employer decided to take no further action and supported Mafuno Constance Lapoza with training and reflection. The employer was, at the time, about to switch to the National EWS system, meaning all staff would have competency training. Mafuno Constance Lapoza would also be involved in a documentation audit. This information was before the Case Examiner's when considering whether there was a case to answer in respect of the regulatory concerns. There are no other known concerns. The events which occurred well in excess of 4 years ago were not factual matters relied upon when the Case Examiner's found a case to answer and do not undermine the effective remediation and reflection undertaken in relation to the matters before the Panel, which is referred to in greater detail below.*

71. *Mafuno Constance Lapoza has produced a reflective piece using the Gibb reflective cycle method which is produced at '**Appendix 1**' to this agreement. The reflective piece, together with the admissions made to the charges above, demonstrates insight into the misconduct. In addition, Mafuno Constance Lapoza has undertaken general and specifically targeted training. Copies of various training certificates are produced at '**Appendix 2**' to this agreement.*

72. *Mafuno Constance Lapoza has continued to work following the incident. Produced at '**Appendix 3**' are copies of 'Assessment Forms; relating to work undertaken. A number of positive references and testimonials have been produced and appear at '**Appendix 4**' to this agreement. Such matter also demonstrate practical remediation, taking into account that Mafuno Constance Lapoza has continued to work as a nurse since the matters referred to in the charges. Additionally, Mafuno Constance Lapoza has expressed remorse in relation to the issues.*

73. *It is agreed that having regard to the above factors that, that there is little risk of the misconduct being repeated.*

Public protection impairment

74. *A finding of impairment is not necessary on public protection grounds. Whilst acknowledging that the misconduct in this matter is extremely serious, with evidence of actual patient harm, the contextual and consequent factors as referred to above, together with the limited risk of repetition is such that a finding of impairment on pubic protection grounds as of today's date is not required.*

Public interest impairment

75. *A finding of impairment is necessary on public interest grounds*

76. *In* ***CHRE v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin****) Cox J commented as follows:*

> *"71. It is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations… namely, 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 .."*
>
> *74. 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."*

75. I regard that as an important consideration in cases involving fitness to practise proceedings before the NMC where, unlike such proceedings before the General Medical Council, there is no power under the rules to issue a warning, if the committee finds that fitness to practise is not impaired. As Ms McDonald observes, such a finding amounts to a complete acquittal, because there is no mechanism to mark cases where findings of misconduct have been made, even where that misconduct is serious and has persisted over a substantial period of time. In such circumstances the relevant panel should scrutinise the case with particular care before determining the issue of impairment."

77. Having regard to the serious nature of the conduct and the principles referred to above, a finding of impairment is necessary on public interest grounds. As also recognised above, an important consideration is that a finding of no impairment would lead to no record of the charges and conduct being marked, which would be contrary to the public interest.

78. The public would be concerned about the serious failings in this case. The concerns are of such a serious nature that the need to protect the wider public interest calls for a finding of impairment to uphold the standards of the profession, maintain trust and confidence in the profession and the NMC as its regulator. Without a finding of impairment, public confidence in the profession and the NMC would be seriously undermined.

79. Mafuno Constance Lapoza's fitness to practise is impaired on public interest grounds.

G. Sanction

*80. The appropriate sanction in this case is a **five year caution order**.*

81. The aggravating factors in this case are as follows:

a. *The conduct placed Patient A at unwarranted risk of harm and contributed towards their loss of chance of survival.*

82. *The mitigating factors in this case are:*

a. *The admissions to the charges and evidences of insight and expression of remorse.*

b. *The contextual factors involved at the time of the events, including wide ranging, systemic failures on the part of other clinicians, including doctors.*

c. *Consequent evidence of good practice, training and positive testimonials.*

83. *The parties acknowledge that the public interest must be at the forefront of any sanction. The public interest includes the protection of patients, maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.*

84. *The full range of sanctions have been considered by the parties in ascending order.*

85. *The parties first considered whether it is appropriate to take no action. It is agreed that taking no further action would be inappropriate in view of the seriousness of the conduct and the need to declare and uphold proper standards of conduct and behaviour. By taking no action, there would be no adequate mechanism to mark the seriousness of the concerns in the case.*

86. *The parties agree that a* ***five year caution order*** *is the appropriate sanction in this matter. Such a sanction takes into consideration the fact that the underlying concerns were serious, but also the various mitigating circumstances referred to above, including the important contextual factors involved in the case and the overall standards of care provided to Patient A. In particular, this sanction recognises the insight and remediation in this case and the low risk of repetition and absence of a finding of impairment on*

public protection grounds which would necessitate some form of restriction. The duration of the agreed sanction is the longest that may be imposed by way of a caution order and will be disclosed to anyone enquiring about Mafuno Constance Lapoza's fitness to practise.

87. *A conditions of practice order would not be an appropriate sanction, having regard to the absence of a finding of impairment on public protection grounds and the due to no identifiable areas of retraining or supervision being identified and required at this stage.*

88. *The parties consider that a suspension order and striking off order would be inappropriate. The conduct, although serious for the reasons agreed above, is not such so as to require temporary or permanent removal from the register and is not incompatible with ongoing registration. Such sanctions would be disproportionate.*

89. *In approaching the question of sanction, the parties recognise that it is also in the public interest to permit a nurse to continue work safely and effectively following the completion of the fitness to practise process.*

H. Referrers comments

90. *The circumstances in which this matter was brought to the NMC's attention via HM Coroner is set out above. Consideration has been given to the NMC guidance at DMA-1b which includes the following in relation to the obtaining of referrers comments: "We do not ask for comments where the referrer is a police force referring a conviction or caution, and neither the force nor its personnel have had a significant and ongoing involvement in the case". Even if HM Coroner was to be considered to the "referrer" for the purpose of the case, by analogy the same principle applies and, as a consequence, comments have not been obtained.*

The parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.

Here ends the provisional CPD agreement between the NMC and you. The provisional CPD agreement was signed by you and the NMC on 12 May 2021.

Decision and reasons on the CPD

The panel decided to accept the CPD, subject to an agreed amendment to the sanction imposed.

The panel heard and accepted the legal assessor's advice. Mr Jeffs referred the panel to the 'NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. He reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and you. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel noted that the NMC intend to offer no evidence in relation to charges 2c and 2di. The panel accepted the NMC's application to offer no evidence for the reasons set out in the CPD at paragraphs 34 to 48. The panel therefore finds charges 2c and 2di not proved.

The panel further noted that you make full admissions to the facts alleged in charges 1, 2a, 2b, 2dii, 3a, 3b, 3c, 3d, 3ei, 3eii and 4. Accordingly the panel was satisfied that

charges 1, 2a, 2b, 2dii, 3a, 3b, 3c, 3d, 3ei, 3eii and 4 are found proved by way of your admissions, as set out in the signed provisional CPD agreement.

Decision and reasons on impairment

The panel then went on to consider whether your fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and you, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of misconduct, the panel determined that the facts found proved did amount to misconduct. The panel considered that your actions breached standards set out in the Code and did fall below the standard expected of a registered nurse.

In this respect, the panel endorsed paragraphs 49 to 55 of the provisional CPD agreement in respect of misconduct.

The panel then considered whether your fitness to practise is currently impaired by reason of misconduct. The panel determined that your fitness to practise is currently impaired solely on the grounds of public interest. The panel noted the training you have completed and the positive testimonials provided. The panel considered that you have shown insight into your actions and remediated the concerns, so that there is a now a low risk of repetition. The panel therefore concluded a finding of current impairment is not required to protect the public.

However, the panel considered that the charges are serious and public confidence in the nursing profession and the NMC as its regulator would be undermined should there not be a finding of current impairment. As such, the panel was satisfied that a finding of current impairment is required on public interest grounds.

In this respect the panel endorsed paragraphs 56 to 79 of the provisional CPD agreement.

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 feature:

- The conduct placed Patient A at unwarranted risk of harm and contributed towards their loss of chance of survival.

The panel also took into account the following mitigating features:

- The admissions to the charges and evidences of insight and expression of remorse.
- The contextual factors involved at the time of the events, including wide ranging, systemic failures on the part of other clinicians, including doctors.
- Consequent evidence of good practice, training, candour about your current practice and positive testimonials.

The panel also recognised that it is in the public interest to permit a nurse to continue to work safely and effectively following the completion of the fitness to practise process.

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

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 whilst the outcome for Patient A was tragic, it noted that your omission was part of a wider, systemic failure by the Trust and other clinicians.

The panel noted that you have shown insight into your conduct. The panel noted that you made admissions and have engaged with the NMC since referral. The panel has been told that there have been no adverse regulatory findings in relation to your practice either before or since this incident and you are a valued member of nursing staff at your current employer.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. The panel noted that it is agreed that a finding of impairment is only necessary on public interest grounds, and considered that through additional training and reflection you have remediated the misconduct found proved.

The panel concluded that no useful purpose would be served by a conditions of practice order. It is not necessary to protect the public and would not assist you in your nursing practice. The panel further considered that a suspension order would be wholly disproportionate in this case.

The panel agreed with the CPD that a caution order would adequately address the public interest.

However, the panel considered that the proposed length of five years was disproportionate due to the finding of impairment solely on public interest grounds. The panel considered that a caution order for three years would meet the public interest and would accurately reflect the serious nature of the misconduct, including charge 4.

The panel put this sanction to Mr Jeffs, on behalf of the NMC, and Mr Shadenbury. Both parties agreed that a caution order for three years would be appropriate and would meet the public interest.

For the next three years, your employer, or any prospective employer, will be on notice that your fitness to practise had been found to be impaired and that your practice is subject to a restriction. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of three years would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered nurse.

At the end of this period the note on your entry in the register will be removed. However, the NMC will keep a record of the panel's finding that your fitness to practise had been found impaired. If the NMC receives a further allegation that your fitness to practise is impaired, the record of this panel's finding and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to you in writing.

That concludes this determination.