Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing (Split event)
Monday 10 - Thursday 13 and Monday 17 – Wednesday 19 January 2022

Nursing and Midwifery Council
Virtual Hearing

Name of registrant:	**Fungai Thabani Munyaradzi**
NMC PIN:	07B2203E
Part(s) of the register:	Registered Nurse Mental Health Nursing – July 2007
Area of registered address:	Midlands
Type of case:	Misconduct
Panel members:	Gregory Hammond (Chair, Lay member) Yousuf Rossi (Lay member) Lorna Taylor (Registrant member)
Legal Assessor:	Lee Davies
Hearings Coordinator:	Elena Nicolaou
Nursing and Midwifery Council:	Represented by Alys Williams, Case Presenter
Ms Munyaradzi:	Present and represented by Wafa Shah, Counsel
Facts proved by admission:	Charges 3.1 and 3.2
Facts proved:	Charges 1.1, 1.2, 1.3, 1.5, 1.8, 2.1, 2.2, 2.3, 2.4, 2.5, 3.3, 3.4, 3.5, 4, 5.1, 5.2 and 5.3
Facts not proved:	Charges 1.4, 1.6 and 1.7
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months) with a review**
Interim order:	**Interim suspension order (18 months)**

Details of charge (as amended)

That you, a registered nurse, on 19 June 2018, you;

1. Acted in an uncaring manner towards Patient A in that you:

1.1. Turned away from Patient A; **[PROVED]**
1.2. Made a facial expression that conveyed dislike and/or uncaring and/or disinterest; **[PROVED]**
1.3. Held your nose; **[PROVED]**
1.4. Lifted your hand to assess your nails or alternatively your hand; **[NOT PROVED]**
1.5. Spoke to Patient A with an uncaring tone of voice; **[PROVED]**
1.6. Said "*he stinks doesn't he*" or words to that effect, in front of and/or to Patient A; **[NOT PROVED]**
1.7. Said "*why have you not gone to your mum's? Oh yes, because your mum does not want you, she kicked you out*" or words to that effect, in front of and/or to Patient A; **[NOT PROVED]**
1.8. Said "*what do you want me to do*" or words to that effect, in front of and/or to Patient A; **[PROVED]**

2. Failed to provide appropriate care and treatment to Patient A in that you:

2.1. Did not carry out a risk assessment; **[PROVED]**
2.2. Did not consider the risk that Patient A posed to himself and/or to others; **[PROVED]**
2.3. Did not ensure Patient A was conveyed to the Hospital; **[PROVED]**
2.4. Did not stay with Patient A but left the scene; **[PROVED]**
2.5. Did not make a Safeguarding referral in a timely manner; **[PROVED]**

3. You did not act professionally in that you:

3.1. Removed your identity badge; **[PROVED by admission]**

3.2. Did not identify yourself as a registered nurse and/or that Patient A had been allocated to you to the emergency call handler; **[PROVED by admission]**

3.3. Told the emergency call handler that you did not know Patient A, or words to that effect, when you did; **[PROVED]**

3.4. Told the emergency call handler that you were "*just passing*", or words to that effect, when you had been deployed to attend; **[PROVED]**

3.5. Asked Person A to lie to or alternatively to not disclose to the emergency call handler about how you knew Patient A; **[PROVED]**

4. Your conduct at charges 3.1 and 3.2 above lacked integrity in that you attempted to conceal that you were a registered nurse and/or that Patient A had been allocated to you; **[PROVED]**

5. Your conduct at charges 3.3, 3.4 and 3.5 above were dishonest in that:

5.1. Patient A was known to you already and was allocated to you; **[PROVED]**

5.2. You knew you had been deployed to attend the incident; **[PROVED]**

5.3. Did so with the intention to conceal that Patient A was known to you and/or that Patient A was allocated to you. **[PROVED]**

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Williams, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charges 3.2, 4, 5.1 and 5.3.

The proposed amendment was to amend the wording of charges 3.2, 4, 5.1 and 5.3 to instead say:

'3.2. Did not identify yourself as a registered nurse and/or ~~Patient A's Care Co-Ordinator~~ ***that Patient A had been allocated to you*** *to the emergency call handler;*

….

4. Your conduct at charges 3.1 and 3.2 above lacked integrity in that you attempted to conceal that you were a registered nurse and/or ~~Patient A's Co-Ordinator~~ ***that patient A had been allocated to you;***

5. Your conduct at charges 3.3, 3.4 and 3.5 above were dishonest in that:

5.1. Patient A was known to you already ~~as you were his Care Co-Ordinator~~ ***and was allocated to you;***

…

5.3. Did so with the intention to conceal that Patient A was known to you and/or that ~~you were his Care Co-Ordinator and/or that you had been deployed to attend the incident~~ ***Patient A was allocated to you****.'*

Ms Williams submitted that these amended charges would more accurately reflect the facts and bring the charges in line with the evidence that has been heard from some of the previous NMC witnesses. In light of the evidence heard from these witnesses, it would be in the interests of justice that the proposed amendments are made to provide clarity.

Ms Shah, on your behalf, indicated that she did not oppose these proposed amendments to the charges.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel decided that such amendments, as applied for, were in the interests of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It considered that the amendments are minor and would provide further clarity in light of the evidence that has been heard so far from the previous NMC witnesses. It considered that there has been no opposition from Ms Shah. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Shah, who informed the panel that you made a partial admission to charge 3.2.

In light of the allowed application to amend the charges, Ms Shah informed the panel that you made full admissions to charges 3.1 and 3.2 as amended.

The panel therefore finds charges 3.1 and 3.2 proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral, documentary and audio evidence in this case together with the submissions made by Ms Williams and by Ms Shah.

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 Witnesses 1, 2 and 3 called on behalf of the NMC and from Witness 4 called on your behalf at the sanction stage:

- Witness 1: Member of the public who found Patient A on 19 June 2018
- Witness 2: Former Team Leader within the Community Mental Health team, Isle of Wight NHS Trust St Mary's Hospital
- Witness 3: Service Manager for Acute Mental Health Services, Isle of Wight NHS Trust St Mary's Hospital
- Witness 4: Agency Nurse, character witness at the sanction stage.

The panel also heard evidence from you under affirmation.

Background

The NMC received a referral on 16 October 2018 from Isle of Wight NHS Trust St Mary's Hospital (the Trust).

At the time the concerns had been raised, you were working as an Agency Mental Health Nurse Practitioner within the Community Mental Health Team.

It is alleged you were on duty on 19 June 2018, and that a member of the public called Chantry House Mental Health Community Services (the Unit) to report that they had found Patient A in a field near their home. They said that they were concerned about the patient due to his unkempt appearance and disorientated state.

Witness 1 had then contacted the Hospital and subsequently the Unit, who advised them to call the police. They understood a member of staff from the Unit would attend. Witness 1 had provided Patient A with food and refuge in their front garden, but was concerned as they were alone with a stranger whilst their children were in the house.

It is alleged that when you attended Patient A, you acted in an uncaring manner towards him, you failed to provide appropriate care and treatment to him and you failed to act professionally in a number of regards. Moreover, it is alleged that in removing your badge and failing to identify yourself as a nurse you lacked integrity, and you were dishonest in concealing your knowledge of Patient A and the fact that you had been deployed to the incident, and in asking Witness 1 to lie to the emergency call handler.

It is alleged that following Witness 1's departure from the scene, Patient A walked away and you cancelled the ambulance, left Patient A alone, and failed to ensure that he was conveyed to A&E.

On their return, Witness 1 found Patient A wandering close to their house, and took Patient A to the hospital in their own car. It is further alleged that you later failed to make a Safeguarding referral for Patient A in a timely manner. Following this incident, Witness 1 submitted an anonymous post on social media, which they later removed, then sent a handwritten complaint to the Trust, expressing their frustration at the situation they found Patient A and themself in.

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

Charge 1.1

1. Acted in an uncaring manner towards Patient A in that you:

1.1. Turned away from Patient A

This charge is found proved.

In reaching this decision, the panel took into account the evidence provided by Witness 1 and you. The panel considered Witness 1's statement, as well as their handwritten complaint to the Trust in which they refer to you as 'X'. The panel gave more weight to this due to its having been written nearer the time of the incident. The complaint stated:

'X is turning her face away in disgust'.

The panel found that, despite a few inconsistencies, Witness 1 was credible overall in their evidence and, although emotions may have been running high during and after the incident, they were a credible eyewitness with no personal feelings against you. The panel took into account your denial of this charge, but found there were a large number of inconsistencies in your evidence which led the panel to prefer Witness 1's account when this was corroborated by their near-contemporaneous note of complaint.

The panel concluded that it is more likely than not that you did act in an uncaring manner towards Patient A in that you turned away from Patient A.

Based on the evidence before it and on the balance of probabilities, the panel found charge 1.1 proved.

Charge 1.2

1. Acted in an uncaring manner towards Patient A in that you:

1.2. Made a facial expression that conveyed dislike and/or uncaring and/or disinterest

This charge is found proved.

In reaching this decision, the panel took into account the evidence provided by Witness 1 which is similar to that of charge 1.1. The panel considered Witness 1's handwritten note which stated:

'…turning her face away in disgust'.

The panel also considered the oral evidence given by Witness 1 in which they stated that you had a nonchalant attitude and did not 'seem very bothered'. It considered that Witness 1 contradicts what you said in your oral evidence.

The panel found that, despite a few inconsistencies, Witness 1 was credible overall in their evidence and, although emotions may have been running high during and after the incident, they were a credible eyewitness with no personal feelings against you. The panel took into account your denial of this charge, but found there were a large number of inconsistencies in your evidence which led the panel to prefer Witness 1's account when this was corroborated by their near-contemporaneous note of complaint. The panel was of the view that as an experienced mental health nurse, you would have been trained to conduct yourself appropriately and professionally in challenging situations.

The panel was satisfied that it is more likely than not that you acted in an uncaring manner towards Patient A by making a facial expression that conveyed dislike and/or uncaring and/or disinterest.

Based on the evidence before it and on the balance of probabilities, the panel found charge 1.2 proved.

Charge 1.3

1. Acted in an uncaring manner towards Patient A in that you:

1.3. Held your nose

This charge is found proved.

In reaching this decision, the panel took into account the evidence provided by Witness 1 where they demonstrated the action alleged, their statement and handwritten complaint which stated:

'X holds her nose'.

The panel considered that in your oral evidence, you were adamant that you did not hold your nose in a way that was uncaring towards Patient A. This contradicts what Witness 1 stated in their evidence and the motions they made to demonstrate this action. However, the panel found that, despite a few inconsistencies, Witness 1 was credible overall in their evidence and, although emotions may have been running high during and after the incident, they were a credible eyewitness with no personal feelings against you. The panel took into account your denial of this charge, but found there were a large number of inconsistencies in your evidence which led the panel to prefer Witness 1's account when this was corroborated by their near-contemporaneous note of complaint.

The panel was satisfied that it is more likely than not that you acted in an uncaring manner towards Patient A in that you held your nose.

Based on the evidence before it and on the balance of probabilities, the panel found charge 1.3 proved.

Charge 1.4

1. Acted in an uncaring manner towards Patient A in that you:

1.4. Lifted your hand to assess your nails or alternatively your hand

This charge is found NOT proved.

In reaching its decision, the panel took into account the oral and documentary evidence before it. Witness 1 stated in their oral evidence that you had lifted your hand to 'assess your pretty nails' and also asserted this in their NMC witness statement. However, this action was not mentioned in Witness 1's near-contemporaneous complaint. The panel considered that the witness statement holds less weight when uncorroborated by other evidence because it was written a significant amount of time after the incident had occurred.

You initially stated in your evidence that you did not do this, but then conceded that you may have subconsciously looked at your hands.

The panel determined that although you may have looked at your nails, on the balance of probabilities and due to the lack of consistent, contemporaneous evidence, this was not done in an uncaring manner towards Patient A.

The panel therefore finds charge 1.4 not proved.

Charge 1.5

1. Acted in an uncaring manner towards Patient A in that you:

1.5. Spoke to Patient A with an uncaring tone of voice

This charge is found proved.

In reaching this decision, the panel took into account the evidence provided by Witness 1. It considered Witness 1's handwritten complaint which stated:

'X then talks to Patient A in a way I may speak to a toddler'.

The panel considered Witness 1's NMC statement, which stated:

> *'she just rolled her eyes and continued to ask (Patient A) in a patronising, loud and slow manner..'*

You denied consciously speaking to Patient A with an uncaring tone of voice and told the panel you had introduced yourself, giving your first name, and checking Patient A's name to confirm he was your allocated patient.

The panel considered Witness 1's account of their interaction with Patient A and their impression of how scared and vulnerable he seemed during the incident. The panel found that, despite a few inconsistencies, Witness 1 was credible overall in their evidence and, although emotions may have been running high during and after the incident, they were a credible eyewitness with no personal feelings against you. The panel took into account your denial of this charge, but found there were a large number of inconsistencies in your evidence which led the panel to prefer Witness 1's account when this was corroborated by their near-contemporaneous note of complaint.

The panel was satisfied that you acted in an uncaring manner towards Patient A in that you spoke to Patient A in an uncaring tone of voice.

Based on the evidence before it and on the balance of probabilities, the panel therefore finds charge 1.5 proved.

Charge 1.6

1. Acted in an uncaring manner towards Patient A in that you:

1.6. Said *"he stinks doesn't he"* or words to that effect, in front of and/or to Patient A

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it. The panel considered that this comment was not mentioned in Witness 1's initial handwritten complaint although it is stated within Witness 1's NMC statement and repeated in their oral evidence. However, the panel considered that these hold less weight than the handwritten note of complaint because the NMC statement was written a significant amount of time after the incident had occurred. The panel also considered your oral evidence in which you asserted that you did not say this. While the panel found that your evidence contained many inconsistencies, it had also found some inconsistencies in Witness 1's evidence, which made it impossible to rely on without corroboration. In their evidence Witness 1 could not recall the exact words they heard in relation to this charge.

The panel determined that on the balance of probabilities and due to the lack of consistent, contemporaneous evidence, you having used using the words "*he stinks doesn't he*" or words to that effect could not be found proved.

The panel therefore finds charge 1.6 not proved.

Charge 1.7

1. Acted in an uncaring manner towards Patient A in that you:

1.7. Said *"why have you not gone to your mum's? Oh yes, because your mum does not want you, she kicked you out"* or words to that effect, in front of and/or to Patient A

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence before it. Ms Williams submitted that nobody seemed to know of this information about Patient A apart

from you. The panel considered, however, that Patient A could have disclosed this information to Witness 1 whilst he was in their front garden prior to your arriving on the scene.

The panel considered that this comment was not mentioned in Witness 1's initial handwritten complaint although it is stated within Witness 1's NMC statement and repeated in their oral evidence. However, the panel considered that these hold less weight than the handwritten note of complaint because the NMC statement was written a significant amount of time after the incident had occurred. The panel also considered your oral evidence in which you asserted that you did not say this. You told the panel that

> '*with my experience of information governance and confidentiality, I would not say that'.*

While the panel found that your evidence contained many inconsistencies, it had also found some inconsistencies in Witness 1's evidence, which made it impossible to rely on without corroboration. It considered that in your oral evidence, you denied making this comment.

The panel determined that on the balance of probabilities and due to the lack of consistent, contemporaneous evidence, your using the words *"why have you not gone to your mum's? Oh yes, because your mum does not want you, she kicked you out"* or words to that effect and/or in front of Patient A could not be found proved.

The panel therefore finds charge 1.7 not proved.

Charge 1.8

1. Acted in an uncaring manner towards Patient A in that you:

1.8. Said *"what do you want me to do"* or words to that effect, in front of and/or to Patient A

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Witness 1 and from you.

The panel considered Witness 1's complaint and NMC statement, in both of which this comment is quoted. It considered that Witness 1 was adamant about this comment, and that it was said on more than one occasion. Witness 1's initial handwritten complaint stated:

'I (You) just didn't know what to do' and '*What do you expect me to do?'.*

The panel took into account that Witness 1's initial complaint holds more weight as it had been written close to the time of the incident. It considered that Witness 1 was credible overall in their evidence, despite a few inconsistencies. The panel took into account your denial of this charge, but found there were a large number of inconsistencies in your evidence which led the panel to prefer Witness 1's account when this was corroborated by their near-contemporaneous note of complaint.

The panel was satisfied that you did act in an uncaring manner towards Patient A in that you said "*what do you want me to do*" or words to that effect, in front of and/or to Patient A.

Based on the evidence before it and on the balance of probabilities, the panel therefore finds charge 1.8 proved.

Charge 2

2. Failed to provide appropriate care and treatment to Patient A in that you:

2.1. Did not carry out a risk assessment;
2.2. Did not consider the risk that Patient A posed to himself and/or to others;
2.3. Did not ensure Patient A was conveyed to the Hospital;
2.4. Did not stay with Patient A but left the scene; and
2.5. Did not make a Safeguarding referral in a timely manner;

This charge is found proved in full.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it, including the audio files and transcripts of the conversations with the emergency ambulance service.

In relation to charge 2.1, you stated that you made an initial assessment at the scene of the incident and assessed Patient A to be at low risk of harm. However, in the transcript and audio file you appeared to contradict yourself by telling the emergency call handler that Patient A was in danger. The panel consider this to be at odds with your attested risk assessment.

You spoke about your panic and of Witness 1 asking you many questions at the time. The panel considered that there was no evidence of any assessment or rationale for your actions given in your evidence or documented in Patient A's notes. In fact, you failed to document your presence at the scene at all in the notes you made with regards to your involvement with Patient A that afternoon.

The panel determined on the balance of probabilities that you failed to provide appropriate care and treatment to Patient A in that you did not carry out a risk assessment. The panel therefore finds charge 2.1 proved.

In relation to charge 2.2, the panel considered that in your oral evidence you asserted that Patient A was at low risk.

The panel considered the photograph exhibited by Witness 1 of Patient A, which shows significant evidence of self-neglect and within the complaint the description of Patient A as being '*filthy, he smells… riddled with visible lice… no bags, just the clothes he sits in… soiled… barely able to walk…shaking'.* Witness 1 describes how Patient A had laid down on their garden pathway in a foetal position prior to your arrival at the scene.

This was supported by the duty mental health practitioner's report made at 15:22 that day, which was exhibited by Witness 3. This stated that Patient A was assessed as being again '*a risk to himself'.* The panel was however mindful that it had no opportunity to test this assessment as the duty practitioner had not been called to give evidence. Therefore the panel attached the appropriate weight to this hearsay evidence. The panel took into account that Patient A had been discharged from hospital less than one week previously, following a lengthy admission.

The panel took into account your oral evidence in which you stated that if you saw Patient A from a distance *'you wouldn't even know* (that anything was wrong)', which is contradictory to your words to the emergency call handler. The panel further considered the absence of documentation by you of the incident.

The panel found on the balance of probabilities that you failed to provide appropriate care and treatment to Patient A in that you did not consider the risk that Patient A posed to himself and/or to others. The panel therefore finds charge 2.2 proved.

In relation to charge 2.3, the panel took into account the evidence provided by Witness 3 and by you. Following reviewing the audio and transcripts of your calls it was apparent that you had requested a 999 ambulance for Patient A, but after Witness 1 had left and Patient A had walked away, you called the emergency call handler again to state he was '*gone*' and cancelled the ambulance. You told the panel you had no power to stop Patient A

leaving and you were not insured to transport him in your car. You also told the panel that you tried to call and then that you called the police, but it was unclear what you had requested from them, and none of these events were documented by you.

Witness 3's statement asserts that it was up to a nurse in this situation to carry out a dynamic risk assessment and if they were uncertain, to contact a senior manager for advice. You told the panel that you did not call for advice as you thought no one would be available. The panel considered your actions in calling a 999 ambulance, then allowing Patient A to leave the scene without seeking advice were at odds with each other. It had no evidence before it that you had provided appropriate care and treatment to Patient A, or made any further enquiries to ascertain that Patient A had arrived safely at the Hospital. It considered that you had walked away, even when Witness 1 had also left, leaving Patient A on his own when you clearly knew that he needed further assessment.

The panel found on the balance of probabilities that you failed to provide appropriate care and treatment to Patient A in that you did not ensure Patient A was conveyed to the Hospital. The panel therefore finds charge 2.3 proved.

In relation to charge 2.4, the panel took into account the evidence provided by you, Witness 1 and Witness 3. You told the panel that you followed Patient A into the nearby alleyway, a short distance from A&E, told him to go there and returned to your car as you were concerned you would get a parking ticket. You provided more than one different account of what you did next which the panel found conflicting.

In Witness 1's complaint statement and evidence, they give a broadly consistent account of returning home to find Patient A standing in the street, close to their home. They stated that Patient A needed prompting to recall who Witness 1 was, and they decided to put Patient A in their own car and drive to the mental health department of the Hospital to seek help.

The panel considered Witness 3's evidence that you should have phoned the Unit for further advice and guidance if you were unsure of what to do, and you did not do so. It considered that by calling an emergency ambulance, this indicated that you judged that Patient A needed assistance.

The panel found on the balance of probabilities that you failed to provide appropriate care and treatment to Patient A in that you did not stay with Patient A but left the scene. The panel therefore finds charge 2.4 proved.

In relation to charge 2.5, the panel considered that you had been tasked to complete a safeguarding referral by the duty worker on the day of the incident. It considered that this referral would have provided some care for Patient A but there is no evidence or documentation to suggest that this Safeguarding referral was completed. It considered that your evidence that you had delegated the task of making the referral to the nurse who was in the process of taking over your duties, but that they did not do this. However, the panel considered that it was your responsibility to ensure that a task delegated to another nurse was completed in a timely manner, and you failed to do so, which you acknowledged in your oral evidence. The panel also considered your statement that, as an agency nurse, you did not have access to the online toolset to make the referral, but this was contradicted by the oral evidence of Witness 3. The panel noted that you did not document the referral in your nursing notes.

The panel found on the balance of probabilities that you failed to provide appropriate care and treatment to Patient A in that you did not make a Safeguarding referral in a timely manner. The panel therefore finds charge 2.5 proved.

Charge 3.3

3. You did not act professionally in that you:

3.3. Told the emergency call handler that you did not know Patient A, or words to that effect, when you did

This charge is found proved.

In reaching this decision, the panel took into account the audio files and the transcripts. The panel considered that it is clearly heard in the audio file that you told the emergency call handler you did not know Patient A. It considered your evidence in which you stated that you said this because you were worried you would not be able to give the emergency call handler enough information about Patient A, as you did not know his history very well. However he was under your caseload and the panel considered your oral evidence in which you confirmed you knew Patient A's name and that he had recently been discharged but you did not have his full case history. It considered that you should have told the call handler that you did know Patient A, albeit you do not know very much, and that you should have given them the information that you did know.

In the audio file, the panel heard Witness 1 being asked to take over the call. Witness 1 gave the call handler a clearer account than yours of Patient A's condition, and stated that you were Patient A's mental health worker. The panel considered the information you gave to the call handler to be garbled and at times evasive, and it confused the call handler. Whilst the panel acknowledged that you sometimes struggle to find the right words in spoken English, the panel considered that the information that needed passing on was basic observation of the patient's state that a registered nurse should have had no difficulty relaying.

The panel also acknowledges that you had between 35 and 40 patients on your caseload and, as such, may have found it difficult to remember all the details of any individual patient without prior review of their case notes. However, it further considered that you had documented a Mental State Examination (MSE) on 11 June 2018, eight days before the incident occurred, and this provided a detailed summary of Patient A, indicating that you did know information about him that might have been useful to the emergency services.

The panel found that you did not act professionally in that you told the emergency call handler that you did not know Patient A, or words to that effect, when you did.

The panel therefore finds charge 3.3 proved.

Charge 3.4

3.4. Told the emergency call handler that you were *"just passing",* or words to that effect, when you had been deployed to attend

This charge is found proved.

In reaching this decision, the panel took into account the audio files and the transcripts. The panel considered it is clearly heard in the audio files that you told the emergency call handler you were '*just passing'*. You said in your oral evidence that you had passed by in your car on the way to your next planned home visit and gave the panel differing accounts of what caused you to stop. These included that you saw the incident that was occurring in Witness 1's front garden and stopped to investigate, only recognising Patient A after you approached them. The panel considered that, whilst your account was possible, it was highly implausible in the context of the information you acknowledged that you had received at the Unit earlier that morning with regards to Patient A.

The panel next considered Witness 2's evidence in which they stated that you were deployed to attend the scene after you had contacted them, and sought guidance. The possible actions discussed included phoning the police and attending the scene yourself, which the panel would consider 'being deployed'. All of the possible actions involved your visiting the scene of the incident. Witness 2 stated that it was agreed that you would visit the scene, preferably with another member of staff. The panel considered that Witness 2's oral evidence was consistent with their statement, and both credible and reliable. Witness

2 strongly denied that they had told you to '*stay put'* and wait for Patient A to be brought to A&E when this was put to them by Ms Shah on your behalf.

The panel found on the balance of probabilities that you did not act professionally in that you told the emergency call handler that you were "*just passing*", or words to that effect, when you had been deployed to attend.

The panel therefore finds charge 3.4 proved.

Charge 3.5

3.5. Asked Person A to lie to or alternatively to not disclose to the emergency call handler about how you knew Patient A

This charge is found proved.

In reaching this decision, the panel took into account the audio files and the transcripts. The panel considered Witness 1's comment to the call handler within the transcript, which stated:

'She has told me to tell you nothing'.

The panel considered Witness 1's handwritten note which stated:

'X asks me to lie for her'.

The panel considered both of these statements from Witness 1 and considered that Witness 1 would have had no benefit in making an untrue comment to the emergency call handler, as they did not know who you were and had no personal feelings towards you. It considered that the quality of the conversation between yourself and the call handler was unprofessional in failing to set out all of the information you should have done. The panel

took into account your denial of the charge, but found many inconsistencies in your evidence overall, which made you a less reliable witness than Witness 1, whose evidence contained only minor inconsistencies. In respect of this charge, Witness 1's oral evidence was corroborated by the audio recording and the near-contemporaneous note of complaint. The panel considered that Witness 1's decision to go back into their house to speak to the call handler to reveal the problem out of your earshot was further corroboration that you had acted in the way alleged.

The panel found on the balance of probabilities that you did not act professionally in that you had asked Person A (Witness 1) to lie to or alternatively to not disclose to the emergency call handler about how you knew Patient A. The panel found it more likely than not that you had asked Witness 1 to lie.

The panel therefore finds charge 3.5 proved.

Charge 4

4. Your conduct at charges 3.1 and 3.2 above lacked integrity in that you attempted to conceal that you were a registered nurse and/or that Patient A had been allocated to you

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it, which included the Trust's uniform policy. It considered that you were unable to give a clear answer in your oral evidence to show that you understand why you should be wearing your badge. The panel was of the view that wearing a name badge promotes a sense of safety and professionalism, and by removing it and preventing identification at the scene of the incident indicated a lack of integrity.

The panel had also heard evidence from Witness 1 who said:

‘I felt there was something underhand by the CCO’s (you) removal of her badge’.

The panel considered that the motivation for removing your name badge was to conceal your identity.

The panel considered your oral evidence in which you stated that you saw Witness 1 trying to take photos, were concerned and removed your badge. The panel preferred the evidence of Witness 1 in relation to this.

The panel considered that you having not identifying yourself as a registered nurse to the emergency call handler was also unprofessional and lacked integrity. It was of the view that you should have identified yourself as a registered nurse to the call handler when you were asked the clear question of how you knew Patient A, but that instead you attempted to conceal both your profession and your professional relationship with Patient A.

The panel found that your conduct at charges 3.1 and 3.2 above lacked integrity in that you attempted to conceal that you were a registered nurse and/or that Patient A had been allocated to you.

The panel therefore finds charge 4 found proved.

Charge 5

5. Your conduct at charges 3.3, 3.4 and 3.5 above were dishonest in that:

5.1. Patient A was known to you already and was allocated to you;
5.2. You knew you had been deployed to attend the incident; and
5.3. Did so with the intention to conceal that Patient A was known to you and/or that Patient A was allocated to you;

This charge is found proved in full.

In reaching this decision, the panel took into account all of the evidence before it and Ms Shah's submissions on your behalf that your failures were due to shock, panic and you not thinking clearly and that you had no motive to behave in the way alleged in this charge.

In relation to charge 5.1, the panel considered that you did know Patient A and he had been allocated to you as part of your caseload. It considered your own evidence that you had seen Patient A briefly at a meeting and documented an MSE on 11 June 2018 without examining Patient A prior to the incident occurring. However, the panel considered it more likely than not, on the balance of probabilities, that you had conducted the MSE in person because of the way the record was written. The panel considered the evidence of Witness 2 and Witness 3 who were of the view that it would be unusual not to see a patient when carrying out an MSE. Either way, you knew Patient A by sight and you recognised him on arrival at the incident and remembered his first name. The panel also noted that you had tried to call Patient A as well as his family the day before the incident, and that you knew of his circumstances. It considered the audio and transcript evidence showing that you did not reveal how you knew Patient A to the emergency call handler. The panel determined that an ordinary member of the public would find this dishonest.

The panel decided that your conduct in 3.3, 3.4 and 3.5 was dishonest in that Patient A was known to you already and was allocated to you. The panel therefore finds charge 5.1 proved.

In relation to charge 5.2, the panel considered that Witness 2 had discussed the options available to you for the incident. It found that Witness 2 had believed you had been deployed to attend the scene, and the options discussed with you did involve attending the incident, despite there being some confusion about the terminology of your role as a Care Co-Ordinator or an allocated Mental Health Practitioner (MHP); either way, Patient A was on your caseload. The panel took into account your view that the duty team was responsible for the incident when it was reported, not you as the allocated MHP. However,

it preferred the evidence of Witness 2 on this point which was corroborated by Witness 3. It determined that an ordinary member of the public would consider your denial that you had been deployed to attend the scene as dishonest.

The panel decided that your conduct in 3.3, 3.4 and 3.5 was dishonest in that you knew you had been deployed to attend the incident. The panel therefore finds charge 5.2 proved.

In relation to charge 5.3, the panel determined that you had made a deliberate attempt to conceal who you were. It considered that there was no justification as to why you should have concealed your role as a registered nurse and Patient A's allocated MHP to the emergency call handler. It was of the view that you did not consider any other options available to you. Witness 1's evidence was that by not revealing who you were to the call handler, you thought the emergency ambulance would arrive quicker than if they knew a registered nurse was on scene. The panel preferred the evidence of Witness 1 and the audio file on this point. The panel determined that an ordinary member of the public would find this dishonest as you did not reveal your relationship with Patient A when you should have done.

The panel determined that your conduct in 3.3, 3.4 and 3.5 was dishonest in that you intended to conceal that Patient A was known to you and/or that Patient A was allocated to you. The panel therefore finds charge 5.3 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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 Williams invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

Ms Williams identified the specific, relevant standards where your actions amounted to misconduct. She submitted that at the outset of the case, three areas of regulatory concern had been identified by the NMC which included the uncaring manner you demonstrated towards Patient A, deficiency in the care and treatment provided to Patient A, and dishonesty. She submitted that although not all of the charges have been found proved, the majority have been, and the three broad regulatory concerns have been made out.

Ms Williams submitted that the seriousness of the charges and the conduct proven is such that a finding of misconduct must follow. She referred to charge 1 in which it has been

found that you demonstrated a significantly unpleasant attitude and manner towards Patient A, and that the conduct that is demonstrated within the sub charges of charge 1 can never be justified. She submitted that the panel have found repeated failings by you in relation to providing appropriate care to Patient A on 19 June 2018, which included leaving the scene having identified that Patient A needed a formal assessment. Ms Williams submitted that you failed to carry out the appropriate Safeguarding referral, and that this gives rise to the risk of harm to Patient A although no actual harm had been caused.

Ms Williams submitted that the panel has found a lack of integrity due to your concealing your status as a registered nurse, as well as dishonesty. She submitted that, given the seriousness of the charges, a finding of misconduct must follow. She submitted that sections 1.1,1.2, 1.4, 2.6, 3.3, 7.1, 8.1, 8.2, 8.6, 10.2, 10.3, 11.3, 13.1, 13.2, 13.4, 14.1, 14.2, 14.3, 15.2, 15.3, 16.4, 16.5, 17.1, 17.2 and all of section 20, apart from 20.4, 20.9 and 20.10, of the Code have been breached.

Ms Williams also invited the panel to consider the NMC witness statements and the Trust's internal policies when making its decision.

Ms Shah submitted that the panel have had sight of your reflective piece and evidence that you have provided for your case. She submitted that the panel should consider all the surrounding circumstances and what it already knows about you in relation to this case. She submitted that, in the light of the circumstances, the conduct in this case can be remediated.

Ms Shah referred to your CV and submitted that you have been engaged in public service within the health sector for 17 years. She submitted that you have devoted your career to working with challenging and vulnerable people and despite this challenging work, there has not been a single previous complaint to the NMC about you.

Ms Shah referred to the positive testimonials and submitted that, although you were questioned on these regarding the similarity of some of them, the NMC have not raised

any issues in relation to these references. She submitted that they originated from email accounts from the various people who had written them, in addition to providing their contact details, so they could be contacted by the NMC if required. She submitted that although the references appear to be similarly written, it does not mean that the value of them decreases or is questionable. She submitted that the references speak highly of you as a registered nurse, your caring attitude towards service users and that you are highly respected by patients and colleagues alike.

Ms Shah submitted that all of the evidence provided indicates that this conduct is out of character. She submitted that the panel has had sight of the positive references that cover your career and that no other referrals have been made against you. She submitted that you have actively engaged with working in challenging environments and invited the panel to consider that this is a one-off incident in a long career. She submitted that although the conduct is serious, it is an isolated incident.

Ms Shah submitted that this not a sequence or pattern of behaviour that has arisen from different employers or over a period of time. She invited the panel to take into account the evidence from the NMC witnesses that this was an unusual circumstance. She referred to Witness 2's statement in which they stated that you were flustered and that you did not appear confident dealing with the situation. She submitted that you went to Witness 2 for advice on the day of the incident and that this was an unusual circumstance.

Ms Shah submitted that no patient harm had been caused and you did, at the end of the incident, attend to Patient A with a colleague to have a meeting with him. She submitted that, from the evidence provided, Patient A was not a patient who was high risk that had been left alone by you.

Submissions on impairment

Ms Williams moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need

to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Williams referred to the case of *Grant* and invited the panel to take the four questions into account when making its decision. She submitted that all four questions are engaged. In relation to question one, she submitted that this is engaged in this case: although no direct harm was caused to Patient A, there was a risk of harm. She submitted that you attended to Patient A and advised that you would need to formally assess him in A&E. She submitted that you lied to the emergency call handler which caused confusion and misunderstanding, and this made it difficult to get an ambulance to the scene of the incident. She submitted that you left the scene and left Patient A, expecting him to find his own way to the hospital when you deemed him to be vulnerable and at risk. She submitted that you failed to make a Safeguarding referral even though you identified a need to do so.

Ms Williams submitted that question two of *Grant* is engaged as there were a number of ways throughout the course of the conduct found proved that the profession had been brough into disrepute. She submitted that the elements of dishonesty were found proved, and that there are also elements of attitudinal concern. She submitted that the manner in which you approached Patient A was unacceptable and that the panel had heard from Witness 1 in relation to the effect your manner had on their view of the nursing profession.

Ms Williams submitted that question three of *Grant* is engaged as you have breached fundamental tenets of the profession, and question four of *Grant* is engaged as the dishonesty charge in this case has been made out. She submitted that dishonesty is difficult to remediate and that your conduct casts doubt on your trustworthiness and reliability. She submitted that there is a suggestion of attitudinal problems, in the way that you dealt with Patient A set out in charge 1. She submitted that none of these failings can easily be put right and that there is nothing to suggest that the conduct has been

remediated. She submitted that no steps have been taken by you to address these issues and you continued to deny the charges throughout.

In relation to the risk of repetition, Ms Williams submitted that there has been no insight from you throughout, although you had made limited admissions, mainly in relation to record keeping. However, she submitted that these were primarily an attempt to explain the inconsistencies of the written records and your oral accounts of the events of the incident. She submitted that you have not recognised how your care fell short on the day of the incident and that there is clearly a risk of repetition.

Ms Williams invited the panel to make a finding of impairment on public interest grounds. She submitted that public confidence in the profession will have been eroded by your conduct and that the panel has heard directly from Witness 1 as to how the incident affected their own confidence in the profession.

Ms Shah referred the panel to your short reflective piece and submitted that this does demonstrate remorse. She submitted that you have not sought to go behind the panel's findings, and providing justification would not be appropriate in the circumstances. She submitted that you are sorry for your conduct and as you have never acted in this way before, this is an event that is unlikely to occur again.

Ms Shah submitted that you are still working and that there have been no other complaints of such conduct, or complaints about you being uncaring towards service users. She submitted that there have been no other allegations of dishonesty or a lack of integrity. She submitted that although the incident was unusual, it was an isolated incident which was out of character for you. She submitted that the conduct has not since been repeated.

Ms Shah submitted that you have apologised to the NMC, and participated and engaged fully in this hearing. She submitted that the conduct is unlikely to be repeated.

Ms Shah did not wish to make further submissions on the risk of repetition or a finding of impairment on public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance, Towuaghantse v GMC [2021] EWHC 681 (Admin), Cheatle v GMC [2009] EWHC 645 (Admin) and Cohen v GMC [2008] EWHC 581 (Admin).*

Decision and reasons on misconduct

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

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

> **'1. Treat people as individuals and uphold their dignity**
> To achieve this, you must:
>
> **1.1** treat people with kindness, respect and compassion
>
> **1.2** make sure you deliver the fundamentals of care effectively
>
> **1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
>
> **2. Listen to people and respond to their preferences and concerns**
> To achieve this, you must

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

7 Communicate clearly

To achieve this, you must:

7.1 use terms that people in your care, colleagues and the public can understand

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

10.3 complete all records accurately…

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

13. Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

14. Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation… which had the potential for harm

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15. Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

15.3 take account of… the safety of others and the availability of other options for providing care

16. Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times
To achieve this, you must:

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

20.2 act with honesty and integrity at all times…

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that there were a wide number of failings in relation to your behaviour in practice. The panel considered that the concerns are not just related to your clinical practice but also involve elements of dishonesty and a lack of integrity. The panel considered that it had found the majority of the charges proved, which included an uncaring manner and attitude shown towards Patient A.

The panel found that the concerns are serious and relate to failings of fundamental nursing skills and conduct, and were carried out in front of Witness 1. It considered your behaviour towards both Patient A and Witness 1 were unacceptable. It considered that you failed to follow up the incident after it had occurred and that you did not record your notes accurately. It noted the deficiencies in the care and treatment provided to Patient A,

and that you had asked Witness 1, a member of the public, to be complicit in your dishonesty in asking them to lie to the emergency call handler. It also considered Witness 3's evidence in which they stated that, when they heard your verbal interaction with the ambulance service, their '*jaw had dropped'* and that they were horrified to hear your denying knowing Patient A.

The panel considered that there is a strong public interest in this case, in particular taking into account that you had asked Witness 1 to lie to the emergency call handler. It considered that you have not yet demonstrated that you understand that what you did was wrong and found that you have shown limited insight into your actions. It determined that you have not acknowledged the impact your actions could have had on the public, Patient A and the profession. It considered that you sought to blame others instead of acknowledging your own wrongdoings, despite limited admissions at the outset of the hearing.

The panel found that this was a one-off incident. However, your misconduct occurred over a number of days as you did not admit to your wrongdoings immediately following the incident, when you had the opportunity to do so. In fact, it took you three days to complete your notes on the events that occurred, and these omitted key details including your presence at the scene.

The panel found that your actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

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, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *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) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel finds that Patient A was put at risk as a result of your misconduct. Your misconduct caused you to breach fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It determined that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel considered the case of *Grant* and found that all four limbs were engaged in this case. In relation to question a), the panel considered that you felt the need to call an emergency ambulance and told the call handler that Patient A was '*in danger'*. The panel considered that there was a risk of harm, although no actual harm was caused to Patient A, and that you should have been aware of the risks when you left him unattended.

In relation to question b), the panel considered your behaviour towards Patient A and Witness 1. It found that Witness 1 gave a clear account in relation to how they felt about your actions and the effect it had on them. It determined that there would be an impact on the reputation of the profession in this case as your actions might discourage the public from accessing nursing care.

In relation to question c), the panel considered the multiple breaches of the Code. It considered the lack of kindness and compassion shown towards Patient A and Witness 1. It determined that the appropriate care was not provided to Patient A and that you did not act professionally at the scene of the incident. It found that there is a broad scope of failings across the Code that demonstrates the various breeches.

In relation to question d), the panel considered the dishonesty element of the case that has been found proved. It considered that you had asked Witness 1 to lie to the emergency call handler, that you did not give the information the call handler needed and

that you provided an inaccurate record/documentation of the incident. The panel determined that this demonstrated dishonesty and a lack of integrity.

The panel considered the case of *Cohen* in relation to remediation. It considered that misconduct is difficult to remediate in cases of dishonesty. It considered the lack of insight you have shown into your actions and the impact these could have had on the public, Patient A and the profession. It considered that your reflective piece does not sufficiently address these concerns. It considered that the failings in your clinical practice are remediable, but the attitudinal problems and issues of integrity are not as easily remediable.

The panel finds that you have begun to recognise that some of your actions were wrong, although this awareness is limited and there is insufficient evidence before the panel to suggest that you have strengthened your practice or remediated the concerns raised. It considered that your written statement was brief and generalised and did not address your failings appropriately or the dishonesty element at all. It considered that you have shown emerging insight although this is still at a very early stage. It considered that you have shown some remorse but no indication as to the impact your actions could have had on Patient A, your colleagues, the public, your regulator and the nursing profession as a whole.

The panel considered that some of the positive references provided do attest to your knowledge, skills and good character. However, one of the references appears to have been written as an employment reference, only two of them attest to knowledge of the charges, and five of them appear to partly follow an identical template. These features reduced the weight the panel gave to these otherwise positive references. The panel determined that there is little evidence to reassure it that these actions will not be repeated.

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

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

The panel determined that a finding of impairment on public interest grounds is required. It considered that a well-informed member of the public would be concerned to learn about your actions. It took into account Witness 1's evidence of the strength of their frustration and how upset it made them feel. In addition, 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 decided that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months. 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 accepted the advice of the legal assessor.

The panel heard evidence from Witness 4 under affirmation who was called on your behalf. Witness 4 told the panel that they had a purely professional, supervisory relationship with you. They said they have worked with you on average four shifts a week

between 2013 and 2014 whilst working as a Band 6 Agency Nurse. They stated that they did not work with you from 2014 onwards although you did maintain a professional relationship with them, and that you mainly communicated over the telephone.

Witness 4 said that your behaviour is professional, and they appreciated the support structure you provided for them. They said you were very supportive to junior staff and that you took time to answer any queries they may have had. They also stated that you have shown passion for your job.

Witness 4 stated that they have never come across any issues in relation to your communication with colleagues or patients previously, and that they have only encountered professionalism from you. When questioned on your manner with patients, they stated that you had been polite, built a good rapport with them and always tried to facilitate one to one contact with them.

Witness 4 told the panel that they have never witnessed you interacting with a member of the public, apart from your interactions with family members of patients. They told the panel that you are polite in doing so and family members would often request to speak to you. They told the panel that you maintain professionalism and the fact that they engage with you is a sign that they have confidence in you.

Witness 4 told the panel that you are proactive with record keeping and you handled this well as a Deputy Manager. They told the panel that they have never doubted your honesty, and that you have always been someone who communicates well with other people and update them on what is happening. They told the panel that you have worked as a nurse for a significant number of years in many different positions, and they have never heard of any concerns in relation to your practice. They stated that you are openminded, that you have a good heart, that you are compassionate and show team spirit.

Witness 4 told the panel that they had never experienced you dealing with the emergency services before whilst working with you. They stated that you have dealt with many challenging situations before, for example, patients that show aggression. They told the panel that they stand by what they wrote in their character reference.

Submissions on sanction

Ms Williams informed the panel that in the Notice of Hearing, dated 29 November 2021, the NMC had advised you that it would seek the imposition of a six-month suspension order with a review if it found your fitness to practise currently impaired.

Ms Williams submitted that the appropriate sanction is a matter for the panel and invited it to consider the SG for serious cases when making its decision. She submitted that your misconduct is a significant departure from the standards expected of a registered nurse, and this is misconduct that put at risk the health and wellbeing of a patient and damaged public confidence in the profession.

Ms Williams submitted that, whilst a sanction is not meant to be punitive and should be proportionate, it should mark the seriousness of the case, protect the public and uphold public confidence in the profession. Ms Williams submitted that the aggravating features of this case are: that patient A was an extremely vulnerable patient in a vulnerable position on the day of the incident; that you had left Patient A alone at the scene; the attitudinal problems in relation to your conduct; that you treated Patient A with a lack of dignity and respect; your significant lack of insight and your dishonesty.

Ms Williams submitted that you deliberately breached your duty of candour and asked Witness 1 to lie for you. She submitted that you also covered up what had gone wrong in Patient A’s care that day and you did not complete your notes until a few days later. She submitted that your dishonesty gave rise to a real risk of harm to Patient A.

Ms Williams also referred to the mitigating factors of the case which include: an unblemished career before the incident occurred and no further issues since the incident, and that no actual harm had been caused to Patient A.

Ms Williams submitted that taking no further action would not be appropriate considering the seriousness of the charges. She submitted that a caution order would only be appropriate if there was no risk to patients or the public, and that this would also not be suitable considering the seriousness of the charges found proved, including dishonesty.

Ms Williams submitted that conditions of practice would not be appropriate because, given the nature and seriousness of dishonesty in this case, it is unlikely that conditions of practice could be formulated to protect the public and patients, and address the public interest. She submitted that the type of dishonesty in this case would be difficult to remediate by any type of assessment or retraining, and it would not mark its seriousness.

Ms Williams referred to the NMC's sanction bid and submitted that a six-month suspension order would be proportionate in this case. She submitted that such sanction would mark the seriousness of your misconduct and maintain public confidence in the profession. She submitted that a brief period of suspension would recognise the mitigating factors in this case, in that it was a single incident and no actual harm was caused. She submitted that since the incident, you have been working with no further concerns raised.

Ms Williams submitted that at this stage, a striking off order would be disproportionate.

Ms Shah submitted that this is a serious case and identified as such by the NMC. She submitted that during the impairment stage, a number of comments were made about your insight. She submitted that the panel also hinted at the possibly of some attitudinal issues. She submitted that the panel were not satisfied you had appreciated the impact of your conduct.

Ms Shah submitted that you have since then provided the panel with a further reflective document and, only after reading the panel's determination in full and further reflecting on the panel's reasoning, had you begun to develop real insight. She submitted that in your latest reflective piece, you have shown understanding of the impact of your behaviour on patients and the profession. She submitted that you are fully accepting your accountability and your failures.

Ms Shah submitted that the evidence provided demonstrates that you are showing some insight. She submitted that you acknowledged that there is still some way to go in relation to gaining full insight, as this takes time. She submitted that the panel can be satisfied that over time you will develop further insight.

Ms Shah referred to the aggravating features that the NMC identified accurately. She submitted that, although it was one isolated incident, the dishonesty continued for a period of time after the incident occurred, as you did not reveal what had happened. She submitted that this is the most aggravating feature in this case. Ms Shah also referred to the mitigating features of the case and submitted that you have shown good practice and that you have worked in public services for a significant amount of time within a challenging area of nursing.

Ms Shah submitted that the panel has heard from Witness 4, and although they have not worked with you recently, you have maintained a professional relationship with them in a supervisory capacity to discuss formal matters. She invited the panel to give considerable weight to this evidence as Witness 4 was open and honest, and assisted the panel where possible. She submitted that Witness 4 had stated that you are caring, compassionate and that you understand the complexity of working in mental health nursing.

Ms Shah invited the panel not to consider a striking-off order and instead allow you a period of time to further reflect on your actions, and to return to the NMC in the future with developed insight and further efforts of remediation and training. She submitted that this is so a further panel can review what the risk of repetition may be.

Ms Shah submitted that a sanction is not meant to be punitive and that a suspension order is not a light sanction. She submitted that a serious sanction will send a clear message to others in the profession of what is and is not acceptable by the NMC. She submitted that the panel could impose a future review and give you the opportunity to appear again before a reviewing panel to demonstrate your further insight and remorse.

Ms Shah invited the panel to consider a three month suspension order to allow you to reflect on your actions, which would also appropriately address the public interest.

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 and the NMC's guidance on serious cases, including those involving dishonesty. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- There was a risk of harm to Patient A and you treated him with a lack of dignity and respect.
- Dishonesty to the ambulance service, in which you also attempted to involve Witness 1, and your inaccurate documentation following the incident.
- Breaching your duty of candour in relation to what you failed to do following the incident.
- Although this was a one-off incident, it spanned a protracted period.

The panel also took into account the following mitigating features:

- You have shown emerging insight.
- You have shown remorse in your reflective piece that was submitted at the sanction stage.
- Evidence heard from Witness 4 as a character witness.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection and public interest 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 determined that there are no practicable or workable conditions that could be formulated that would address the issues or remedy your actions from a public protection and a public interest perspective, given the wide-ranging nature of your misconduct, which is not something that can be addressed through retraining. The panel considered that clinical conditions of practice could be formulated, but they would not address the public interest or cover the scope and breadth of the deficiencies in your practice, or suitably address your dishonesty.

Furthermore, 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, or address the public interest in this case.

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;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with your remaining on the register. This was a single instance of misconduct, albeit over a protracted period. While the panel had some concerns over your attitude, it did not find these to be harmful, deep-seated problems. There was no evidence of repetition of the misconduct since the incident, the panel further considered your reflective piece submitted for the sanction stage to demonstrate emerging insight and remorse.

The panel decided that a suspension order would be sufficient to protect the public and mark the public interest. It would also give you an opportunity to further develop your insight, remorse and reflection into your actions and the impact it could have had on Patient A, your colleagues, the public, your regulator and the profession as a whole.

The panel went on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel

concluded that it would be disproportionate, at this time. 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.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction. The panel found that this sanction would be the most appropriate course of action and it would suitably protect the public and address the high public interest in this case. It determined that a period of suspension would allow you the time to develop and consolidate your insight and subsequently strengthen your practice and remediate the concerns that have been raised. It determined that this period of suspension would send a message to the public and the nursing profession setting out the expected standards of conduct and behaviour and that misconduct of this nature needs to be marked. It would also uphold public confidence and the reputation of the NMC as regulator.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

In making this decision, the panel carefully considered the submissions of both Ms Williams and Ms Shah in relation to the sanction that the NMC was seeking in this case. The panel determined that a six-month suspension order would be appropriate and proportionate as this is the minimum time necessary to mark the public interest, and it affords you sufficient time to develop and consolidate your insight into your misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Your continued engagement and attendance.
- Evidence of reflection, having developed meaningful insight.
- Evidence of any further training or learning you have undertaken.
- Evidence of how you have kept yourself up to date with nursing practice.

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

Submissions on interim order

The panel took account of the submissions made by Ms Williams. She submitted that the substantive suspension order will not come into effect until the 28-day appeal period has ended, or potentially longer if you decide to appeal the decision. In the light of the public protection and public interest issues identified, she invited the panel to impose an interim suspension order for 18 months to cover the 28-day appeal period.

Ms Shah did not make any observations and submissions at this stage.

Decision and reasons on interim order

The panel decided 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 due to the public protection and public interest issues identified, as well as to cover the 28-day appeal period.

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 panel's decision in writing.

This will be confirmed to you in writing.

That concludes this determination.