Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday 20 – Friday 28 January 2022

Virtual Hearing

Name of registrant:	Eric Richard Pushpadas Rajaratnam
NMC PIN:	85F0799E
Part(s) of the register:	Registered Nurse Mental Health – June 1994
Area of registered address:	Kent
Type of case:	Misconduct
Panel members:	Greg Hammond (Chair, lay member) Jonathan Coombes (Registrant member) Chris Thornton (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Catherine Acevedo
Nursing and Midwifery Council:	Represented by Jessica Bass, Case Presenter
Mr Rajaratnam:	Present and unrepresented
Facts proved:	Charges 1a, 1b, 1c, 1d, 2, 3
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Suspension order - 12 months
Interim order:	Interim suspension order - 18 months

Details of charge (as amended)

That you, a registered nurse:

1. On 22 January 2017 failed to adequately manage an emergency situation in that:

    a) You failed to provide CPR to Resident A.
    b) You failed to adequately direct health care staff to assist with the management of the emergency situation.
    c) You failed to provide the attending paramedics an adequate history of treatment you had provided to Resident A.
    d) You failed to ensure Resident A's notes and DNR (Do Not Resuscitate) were immediately available to paramedics on their arrival.

2. On 22 January 2017, failed to remain with Resident A throughout an emergency situation when you knew or ought to have known Resident A was suffering breathing difficulty.

3. Your actions and omissions in charges 1 and 2 above contributed to the death of Resident A.

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 Bass, on behalf of the NMC, to amend the wording of charge 1a.

The proposed amendment was to change 'basic life support' to 'CPR'. It was submitted by Ms Bass that the proposed amendment would provide clarity and more accurately reflect the evidence.

Original charge

1. On 22 January 2017 failed to adequately manage an emergency situation in that:

    a) You failed to provide **basic life support** to Resident A.

Proposed charge

1. On 22 January 2017 failed to adequately manage an emergency situation in that:

    a) You failed to provide **CPR** to Resident A.

You told the panel that you do not oppose the application to amend charge 1a.

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

The panel decided that such an amendment was 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 amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application for hearing to be held in private

At the outset of the hearing, the panel considered whether the case should be held wholly or partly in private on the basis that proper exploration of your case involves reference to your health conditions. This was considered pursuant to Rule 19 of the Rules.

Ms Bass indicated that, while the NMC's position was neutral, she would agree that any reference to your health conditions should be heard in private.

You told the panel that you do not mind your health conditions being made public.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to rule on whether or not to go into private session in connection with your health conditions as and when such issues are raised in order to protect your privacy.

Decision and reasons on application to admit the evidence of Ms 1

The panel heard an application made by Ms Bass under Rule 31 to allow the following into evidence:

- Written statement of Ms 1 dated 25 October 2019.

Exhibits:

- Management Investigation report dated 21 February 2017.
- Priory Group Cardio-Pulmonary Resuscitation (CPR) Policy.
- Priory Group Incident Management, Reporting and Investigation Policy.

Ms Bass submitted that Ms 1 was the Home Manager and she gives evidence about your role and responsibilities. She submitted that Ms 1's evidence is relevant as it provides important contextual information about what it was like to work for the employer at the material time and gives background information to the criticisms of the other members of staff. Ms Bass submitted that it would be fair to admit Ms 1's statement because it is not the sole and decisive evidence relied upon in respect of any of the charges.

Ms Bass submitted that Ms 1 was not present at this hearing and, whilst the NMC had made multiple efforts to ensure that this witness was present, their last response was in July 2021 and no communication has been received by the NMC since.

You submitted that you did not oppose the application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, "subject only to the requirements of relevance and fairness" a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Ms 1 serious consideration. The panel was satisfied that the evidence was relevant to the context in which the events to which the charges relate took place. The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms 1 to that of a written statement and accompanying exhibits. The panel considered that the evidence is not the sole or decisive evidence in support of any of the charges and it took into account that you did not oppose the application. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel determined that it would be fair and relevant to admit Ms 1's evidence.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Bass on behalf of the NMC and by you.

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

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

- Ms 2: Deputy Home Manager - Oaks Care Home
- Ms 3: Band 6 Paramedic – London Ambulance Service NHS Trust
- Ms 4: Staff Nurse – Oaks Care Home
- Ms 5: Senior Quality Assurance Manager - London Ambulance Service NHS Trust

The panel also heard evidence from you under affirmation.

Background

The charges arose when you were employed as a registered nurse at The Oaks Care Home ('the Home') where you had worked since January 2016.

The Home is a 93 bedded home for residents with dementia and mental health needs who require nursing care. The Home has six units over two floors. The ground floor has three units called Joydens, Bursted and Oxleas.

You were the nurse in charge of both Bursted and Joydens Units on the night shift of 22 January 2017. You were assisted by a number of Healthcare Assistants (HCAs). Another nurse, also an NMC witness, was the nurse in charge of Oxleas.

Resident A was a resident of Bursted unit and required 1:1 care because they had a history of becoming agitated and aggressive towards other residents particularly at night, and should not have been unattended at any time. They also required a soft diet.

At some point in the evening of 22 January 2017 the HCA assigned to Resident A for 1:1 care was making a cup of tea in the kitchen when she noticed that Resident A was gurgling and went to get help from you. You were preparing the medication on the adjoining unit. The HCA reported to you that something was wrong with Resident A and asked you to attend. The HCAs said that they thought Resident A was choking. You administered first aid but could see no evidence of choking. An ambulance was called by you at 20:50 by calling 999. An ambulance crew attended, arriving at the Home at 21:02 and were with the patient at 21:08 (having experienced some trouble gaining entry) and identified immediately that Resident A was in cardiac arrest. The ambulance crew removed some bits of a dough like substance lodged in Resident A's airway and, following a significant period of CPR and advanced life support, Resident A was transferred to hospital. Resident A later died in hospital.

There are a number of criticisms of the role that you played in the handling of the situation which are set out in the charges. You dispute these charges.

A coroner's inquest concluded that Resident A's death was caused by 'accidental death contributed to by neglect'.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and by you.

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

Charge 1a

On 22 January 2017 failed to adequately manage an emergency situation in that:

a) You failed to provide CPR to Resident A.

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Ms 3 and Ms 4.

In your evidence you accepted that you did not provide CPR for Resident A because you said they were breathing and alert and CPR was not necessary. The evidence of Ms 4 is also that Resident A was breathing and it was not necessary to provide CPR at the time you had been with her.

The evidence of ambulance paramedic Ms 3 is that Resident A was in cardiac arrest when they arrived and you were not with Resident A. You accepted that you were not with Resident A when the ambulance crew arrived inside at approximately 21:08. The ambulance crew followed their cardiac arrest protocol and commenced CPR.

The panel determined that if you had been aware that Resident A was in cardiac arrest it would have been your duty as a registered nurse to provide CPR. There is no information about precisely when Resident A went into cardiac arrest other than it was between the time you left for Joydens Unit and before the ambulance crew arrived. The panel found that you did not provide CPR to Resident A when it was needed and it determined that, as the registered nurse in charge at the time, you had a duty either to remain with the patient in case they required any assistance from you or to ensure that someone adequately qualified would do so in your absence. You did neither. The panel therefore found charge 1a proved.

Charge 1b

On 22 January 2017 failed to adequately manage an emergency situation in that:

b) You failed to adequately direct health care staff to assist with the management of the emergency situation.

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Ms 3 and Ms 4.

Your evidence is that you directed the HCAs to assist you on two occasions in standing Resident A up in order for you to carry out first aid and asking them to retrieve notes.

Ms 3's said in her witness statement that *"A number of care staff were behind [Resident A], not in direct eye line and they were sat or stood around a table, all very casual."*

Ms 4 was consistent in her evidence that, when she arrived in Bursted Unit, Resident A *"had her eyes closed and the three care assistants were standing around her, not really doing anything, they weren't even talking to her".*

The panel considered that the directions you said you gave to the HCAs were not adequate direction for them to assist with the management of the emergency situation. You could have directed the HCAs to provide close monitoring of Resident A's breathing. You could have directed one of them to make the 999 call. One could have been tasked with waiting at the door for the ambulance crew and one could have been directed to get Resident A's notes ready for the ambulance crew on arrival. You could have directed one of the HCAs to check on Joydens Unit instead of going yourself. You could have asked one of the HCAs to press the emergency bell.

The panel determined that, as the registered nurse in charge at the time, you had a duty to adequately manage the emergency situation and give the HCAs adequate direction, and you failed to do so. The panel therefore found charge 1b proved.

Charge 1c

On 22 January 2017 failed to adequately manage an emergency situation in that:

c) You failed to provide the attending paramedics an adequate history of treatment you had provided to Resident A.

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Ms 3.

Your evidence is that you accept that you were not present when the ambulance crew arrived at Resident A's location. You said that when you arrived you said nothing to the ambulance crew because they were busy with CPR.

Ms 3 said in her evidence that when you appeared, she asked you for Resident A's history. She also stated that *"He said he was told by other staff that Resident A had difficulty breathing and he said he came to assess her he had found she had been choking, so he took her blood pressure (which was apparently unreadable) then called 999. He made no mention of having performed chest thrusts or other first aid for choking to us".*

The panel considered the direct evidence of Ms 3 and, having found her evidence to be reliable and consistent, it accepted her account of the conversation. The panel was of the view that the history you provided to the ambulance crew was neither timely nor adequate in respect of the treatment you had provided to Resident A.

The panel determined that, as the registered nurse in charge at the time, you had a duty to adequately manage the emergency situation and to be present when the ambulance crew arrived to give them all the information they required, and you failed to do so. The panel therefore found charge 1c proved.

Charge 1d

On 22 January 2017 failed to adequately manage an emergency situation in that:

d) You failed to ensure Resident A's notes and DNR (Do Not Resuscitate) were immediately available to paramedics on their arrival.

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Ms 3.

Your evidence is that you were not present when the ambulance crew arrived but that you had got all the patient notes together in preparation and left them in the office.

Ms 3 stated in her evidence that *"Once the care staff realised we were doing CPR, they volunteered there was a DNR (Do Not Resuscitate order) in place for Resident A. We asked them to go and get it so we could check."*

The panel considered that, although you had prepared the information for the ambulance crew, your being absent when they arrived led to a delay in this information being immediately available to them.

The panel determined that, as the registered nurse in charge at the time, you had a duty to adequately manage the emergency situation and to be present when the ambulance crew

arrived to give them all the information they required, and you failed to do so. The panel therefore found charge 1d proved.

Charge 2

> *On 22 January 2017, failed to remain with Resident A throughout an emergency situation when you knew or ought to have known Resident A was suffering breathing difficulty.*

This charge is found proved.

In reaching this decision, the panel took into account your evidence.

You said in your evidence that Resident A had breathing problems when you called the ambulance and that when the ambulance crew arrived you were in Joydens Unit securing a medicine trolley and attending to another resident.

The panel considered that you did not remain with Resident A throughout the emergency situation and that you would have known it was an emergency situation because you called 999 for the emergency ambulance. The panel was of the view that you should have stayed on Bursted Unit and continued to manage the situation.

The panel determined that, as the registered nurse in charge at the time, you had a duty to remain with Resident A throughout the emergency situation when you knew or ought to have known that Resident A was suffering breathing difficulty and this situation should have been your priority at the time. The panel therefore found charge 2 proved.

Charge 3

Your actions and omissions in charges 1 and 2 above contributed to the death of Resident A.

This charge is found proved.

In reaching this decision, the panel took into account your evidence.

The panel took into account its earlier findings that you failed to remain with Resident A throughout the emergency situation; failed to provided CPR when it became necessary; failed to make sure the HCAs were directed adequately to assist in the management of the emergency situation; and failed to make sure that the ambulance crew had all the information required to best attend to Resident A, including care notes and the history of the treatment you had provided.

The panel also took into account the contextual issues which it considered to be wider contributing factors to the death of Resident A. These included the lack of documentation of Resident A's dietary requirements and the poor support you received from the Bursted HCAs, in particular the allocated 1:1 carer. The panel also noted the poor management of the Home and the fact that you were tasked with managing two Units on the night in question, a task which you had raised as being unsafe, but had nevertheless accepted. The panel also took into account that there were no reasonable adjustments in place regarding your health condition.

However, notwithstanding the context, the panel determined that your own actions and omissions as the nurse in charge did result in delay to Resident A receiving potentially lifesaving treatment and thereby, on the balance of probabilities, contributed to her death. The panel therefore finds charge 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 and impairment

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.'*

The panel first heard evidence from you under affirmation. In response to questions put to you in writing by the NMC you told the panel that you accepted that you could have done things differently and you said you have learned and reflected for many years on the events of 22 January 2017.

You said you should not have agreed to take on more than 1 unit and you know now that you must make sure that you communicate to your manager any concerns and make sure your concerns are heard. You said you understand now that on that day you should have stayed with Resident A and not gone to another unit. Resident A should have taken priority in this situation. You said you should have given the ambulance crew a proper handover when they arrived, and that at the time you did not understand the procedure of the 999 call. You thought the ambulance crew would have been given a brief history by the call handler. You did not understand then that another handover was necessary and thought you might be wasting time as the ambulance crew had already started CPR.

You said that in future you will raise with management when your colleagues are underperforming to prevent something like this happening again. You said you could have helped to prevent the incident if you had fully observed the situation.

You said you understand that the public would not be happy about nurses in general if they knew about the conduct described in the charges.

You said you would avoid the same thing happening again by letting your employer know about your health condition and making sure your colleagues are also made aware. You said you would update your knowledge through study and training on choking and ask managers to make sure colleagues are also up to date on their knowledge and training. You said you would make sure to also stay focussed in any emergency situation when you are in charge. You said you would always communicate with your manager if you felt that you were unable to fulfil your duty and make sure to read the nursing code of conduct to make sure you are complying.

You said you have not done any training as you have not worked since these events and you have not had the opportunity to do training. You said if you returned to nursing you would undertake training. You also said that you know that you would need to sort out your health condition in order to return to nursing. You said you have enjoyed nursing for over 30 years and would like to return.

You told the panel that you were sorry for the mistakes you have made and you feel responsible and have faced the charges.

Ms Bass invited the panel to take the view that the facts found proved amount to misconduct. She referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code).

Ms Bass identified the specific, relevant standards where she submitted that your actions amounted to misconduct. Firstly, Ms Bass submitted that you failed to properly manage the patient's needs during the emergency that unfolded, secondly you failed to prioritise staying with the patient until the ambulance crew arrived, and thirdly your actions and omissions contributed to the death of Resident A.

Ms Bass submitted that your conduct undermines public confidence in the profession and is at the more serious end of the fitness to practise spectrum because the conduct contributed to the death of a vulnerable patient. She submitted that you departed from good professional practice and the facts, as found proved, are sufficiently serious to constitute misconduct.

Ms Bass 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Bass submitted that, from your oral evidence, you are seeking to deflect blame onto others and have not taken responsibility for your failings. In the absence of your accepting responsibility, you are unable to demonstrate insight or explain how your practice has changed so as to prevent your making the same mistakes again. Ms Bass submitted that

a risk of repetition remains high and your actions are so serious that a finding of current impairment is required in order to protect the public and to maintain public confidence in the profession and to uphold proper professional standards.

You asked the panel to take into consideration all the information you gave in your oral evidence.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

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

> ***"1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***4 Act in the best interests of people at all times***
>
> ***7 Communicate clearly***
>
> *To achieve this, you must:*
> *7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum*

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

…

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

8.6 share information to identify and reduce risk

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

To achieve this, you must:

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

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

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

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that you failed to properly manage Resident A's needs during the emergency, you failed to prioritise staying with Resident A until the ambulance crew arrived, and your actions and omissions contributed to the death of Resident A.

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

Decision and reasons on impairment

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

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

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

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

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

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

d) *...'*

The panel found limbs a, b and c were engaged in the *Grant* test. The panel found that Resident A was caused actual harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that you have demonstrated a degree of insight into your misconduct. The panel considered that you recognised how your misconduct caused harm to Resident A. You have demonstrated some understanding of why what you did was wrong and how this impacted negatively on the reputation of the nursing profession in the eyes of the public. The panel also took into account that you demonstrated remorse and you explained how you would handle the situation differently in the future. However, the panel was concerned that your reflection focused more on the role that issues at the home had played, rather than your personal involvement in the incident. The panel therefore considered that your insight into your misconduct is still developing.

The panel also took into account the questions identified in *Cohen v General Medical Council* [2008] EWHC 581 (Admin), namely whether the conduct which led to the charges is easily remediable, whether it has been remedied and whether it is highly unlikely to be repeated.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account that you have not worked as a nurse for more than 4 years and have had limited opportunity to demonstrate safe practice or undertake any additional learning or training. The panel therefore concluded that your misconduct has not yet been fully remediated. Furthermore, the panel determined that there remains a risk of repetition based on the lack of full insight and the lack of any evidence of training or learning to address your misconduct. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

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

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 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.

Submissions on sanction

Ms Bass outlined what the NMC considered to be the mitigating and aggravating features of the case to the panel. She took the panel through the available sanctions in turn from the least restrictive and submitted why the NMC considered they would not be appropriate.

Ms Bass submitted that your lack of insight and lack of evidence of strengthened practice raises fundamental questions about your professionalism, and the only order which would

be sufficient to protect patients and maintain confidence in the profession is a striking-off order.

You thanked the panel for the reasonable adjustments made for you to be able to participate fully in the hearing. You submitted that you understand that you failed in your duties as a nurse and you have reflected on what happened and will do better in the future. You said you would like to have another chance to practise again and that, if that chance was afforded to you, you would undertake the necessary steps and find a solution for your health condition.

You said that you have been a nurse for 32 years without any issues being raised about your practice. You told the panel that you do not want to be struck-off and you wish to keep your NMC registration. You told the panel that you understand that patient's needs always come first and in future will provide patient safety and look forward to the opportunity to provide good patient care.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Your actions and omissions at the time of the incident contributed to the death of Resident A.

The panel also took into account the following mitigating features:

- Multiple other factors contributing to Resident A's death including:
    - The poor management of the Home and the failure to address concerns raised by you, in writing, prior to this incident.
    - Poor support from the HCAs on the night of the incident including the failure to alert you to the full facts of the incident prior to your arrival.
- Lack of reasonable adjustments for your health condition.
- You demonstrated remorse for your misconduct during the hearing.

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 not protect the public nor be in the public interest to take no further action.

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

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel is of the view that there are no practicable or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through conditions. 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 adequately mark the public interest.

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 considered that this was a single incident but acknowledged that it involved multiple aspects. The panel identified that you had developing insight into your misconduct and had no evidence that you had deep-seated attitudinal problems. The panel noted that you had not repeated the misconduct although it recognised you had not practised in over 4 years. The panel took into account your previous 32 years of practice without any concerns being raised. The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with your remaining on the register.

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

In making this decision, the panel carefully considered the submissions of Ms Bass in relation to the sanction that the NMC was seeking in this case. However, the panel considered a suspension order was appropriate in this case to mark the seriousness of the misconduct and give you the opportunity to reflect on your misconduct and provide evidence of steps you have taken to return to safe practice.

The panel was satisfied that a period of no less than 12 months' suspension was necessary in this case in order to mark the public interest in maintaining public confidence in the profession and in the NMC, and upholding proper professional standards. With this consideration in mind, the panel further decided to make an order under Article 29 (7) (b) of the Order specifying that an application to vary, replace or revoke the suspension order may not be made within the maximum period permitted, namely 10 months.

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.
- A written reflective statement into your specific failures during the incident using a recognised model of reflection such as Gibbs.
- Evidence of your future plans and efforts you have made to maintain your understanding of nursing practice.
- Evidence of work undertaken by you in a care setting, or elsewhere, either paid or unpaid.
- Testimonials or other evidence from employers.

This decision will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the substantive suspension order 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 Bass. She submitted that an interim order is necessary on the grounds of public protection and is in the wider public interest. She invited the panel to impose an interim suspension order for 18 months to cover the appeal period.

You submitted that you do not oppose the application.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 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 decision of this hearing in writing.

That concludes this determination.