Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
18 – 20 May 2022

Virtual Meeting

Name of registrant:	Mrs Generosa Pagayon Antonio
NMC PIN:	03Y0301O
Part(s) of the register:	RN1 – Adult Nurse (Level 1) -19 August 2003
Relevant Location:	Leeds
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair, Lay member) Lisa Punter (Registrant member) David Hull (Lay member)
Legal Assessor:	Paul Hester
Hearings Coordinator:	Dilay Bekteshi
Facts proved:	1a), 1b), 4a)
Facts not proved:	2), 3), 4b), 5a), 5b), 6)
Fitness to practise:	Impaired
Sanction:	Suspension order (6 months)
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Meeting

In the proof of service bundle, the panel was informed by a statement from the Nursing and Midwifery Council (NMC) officer that the notice of this meeting was sent to Mrs Antonio's registered email address on 12 April 2022 notifying her of this meeting taking place on or after 17 May 2022.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations as well as the dates and other details for the substantive meeting.

In the light of all of the information available, the panel was satisfied that Mrs Antonio's has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a Registered Nurse:

1) On the 25th August 2018:

    a) failed to assist Resident A when Colleague A told Resident A the phone was broken in the office
    b) failed to allow Resident A access to a phone in the office

2) On or around the 25th August 2018 failed to report and / or escalate an allegation of sexual abuse made by Resident A to the Care Home Manager or Senior Designated Person.

3) On or around the 25th August 2018 failed to hand over to a Registered Nurse colleague an allegation of sexual abuse made by Resident A.

4) On one or more of the following dates told Colleague B that you had told Colleague C and / or Colleague D about the disclosure of sexual abuse made by Resident A:

    a) 30 August 2018
    b) 15 October 2018

5) Your actions in charge 4 were dishonest as:

    a) You knew you had not told Colleague C and / or Colleague D about the disclosure of sexual abuse made by Resident A;
    b) You intended to implicate Colleague C and / or Colleague D by creating the impression that you had discharged your responsibility in Charge 2 and / or 3 above when you had not.

6) On or before 30 August 2018 told Resident A's daughter that you did not believe Resident A, when she disclosed her allegation of sexual abuse.

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

Mrs Antonio's response to notice of meeting and charges

The panel was informed by the hearings coordinator that Mrs Antonio has not responded to the notice sent to her on 12 April 2022 nor has she responded to the allegations or the charges at any stage of the NMC proceedings.

Witnesses

The panel had regard to the written statements and the exhibits of the following witnesses on behalf of the NMC:

- Witness 1: Regional Support Manager at Meadbank Bupa Care Home (the Home)
- Witness 2: Clinical Services Manager at the Home
- Witness 3: Carer at the Home
- Colleague A: Carer at the Home
- Colleague B: Care Home Manager at the Home
- Colleague C: Registered Nurse at the Home
- Colleague D: Unit Manager / Registered Nurse at the Home

Background

On 5 February 2019, the NMC received a referral from Bupa Legal Referrals about Mrs Antonio's fitness to practise. At the time of the concerns raised, Mrs Antonio was working as a staff nurse at Meadbank Bupa Care Home (the Home) in Leeds. The concerns raised relate to Mrs Antonio's practice on 25 August 2018.

It is alleged that on 25 August 2018, Resident A, who had a diagnosis of dementia, told Mrs Antonio that she had been sexually assaulted by a member of staff. It is alleged that in Mrs Antonio's local interview she stated that Resident A came into the office and asked to phone her daughter. Another member of staff told the resident that "*the phone was broken and there was no maintenance for the weekend; but it wasn't broken*". It is alleged that Mrs Antonio further stated that she did not document what Resident A told her as she was on her own and "*had lots to do*" and she "*didn't believe*" the resident.

It is alleged that Colleague C stated that when they arrived for their shift and went to take handover, Mrs Antonio already had her coat on and told them that *"generally everyone was fine*". Colleague C also stated that there was nothing written in the notes and that Mrs Antonio did not mention anything to them about the incident involving Resident A.

It is alleged that Colleague D, Unit Manager, stated that on 26 August 2018 Mrs Antonio did not speak to them about Resident A's disclosure during her shift.

Witness 1, the Registered Manager who was previously the Home's Regional Support Manager, was tasked with investigating the concerns raised.

The home's Registered Manager at the time, Colleague B, stated that on 30 August 2018 Resident A's daughter approached him and informed him about the incident. Mrs Antonio had allegedly failed to escalate the concerns, despite being the initial person Resident A had made the disclosure to. Following this, Colleague B decided to phone the police and alert the safeguarding team.

As part of the Home's investigation, Mrs Antonio was interviewed by Witness 1 and Colleague B.

The police investigated Resident A's allegation of sexual assault. As part of that investigation the police took written statements from Mrs Antonio, Witness 3 and Colleague D. Having investigated the allegation of sexual assault, the police decided to take no further action.

Mrs Antonio was suspended from the Home, pending investigation on 19 October 2018. Consequently, on 7 December 2018, Mrs Antonio's employment was terminated.

Panel's decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all of the documentary evidence in this case including the representations made by the NMC in its Statement of Case and Mrs Antonio's accounts given during the Home's investigation and to the police.

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.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1

1) On the 25th August 2018:

    a) failed to assist Resident A when Colleague A told Resident A the phone was broken in the office
    b) failed to allow Resident A access to a phone in the office

This charge is found proved in its entirety.

Charge 1a)

In reaching this decision, the panel took into account the interview minutes of Colleague A dated 15 October 2018 with Witness 1, the statement of Witness 1, the two internal interviews of Mrs Antonio dated 30 August 2018 with Colleague B and 15 October 2018 with Witness 1, and Mrs Antonio's police statement dated 5 September 2018.

The panel considered the Home's interview minutes of Colleague A dated 15 October 2018 which states:

> *"Q: Did Resident A say she wanted to telephone her daughter? If so, what did you tell her?*
>
> *A: Resident A asked to use my phone and I said this one is mine so she couldn't use it. Resident A didn't mention why she wanted to use it."*

The panel further considered Mrs Antonio's statement to the police dated 5 September 2018 which states:

> *"Resident A asked if she could phone her daughter because she wanted to report it. I told her that she has her own phone in her room…I then explained what happened to [Colleague A]. Resident A came back and asked again she could call her daughter from the office. [Colleague A] told resident A that the telephone was broken to stop Resident A from asking to make calls. The phone was not broken."*

The panel decided in light of the above evidence that Mrs Antonio knew that Resident A wished to make a phone call to her daughter. Mrs Antonio acknowledges that Colleague A had told Resident A that the phone was broken, although the phone was not broken. Mrs Antonio knew that Resident A was given this false information.

The panel determined that based on the evidence before it, Mrs Antonio did nothing to challenge or correct this falsehood and assist Resident A. The panel decided that had the information been correct about the phone, Mrs Antonio should have still assisted Resident A to make a phone call using a different device.

The panel noted that charge 1 is drafted in terms of a failure. The panel was mindful that when there is an allegation of failure the NMC must firstly establish a clear duty or obligation upon a registered nurse to act in a given way in a certain situation. The panel was not presented with any policy or protocol within the hearing bundle concerning residents using a phone and in particular the Home's phone. Accordingly, the panel referred to the Code (2015) and the requirement that registered nurses prioritise people, in

particular, the panel decided that in the circumstances which faced Mrs Antonio there was a clear duty to treat Resident A with kindness. The panel noted that Resident A was in some state of distress and that Mrs Antonio's response could have been given compassionately by assisting her in making a phone call to her family.

In the above circumstances, the panel decided that charge 1a) was proved on the balance of probabilities.

Charge 1b)

For the same reasons given above in relation to charge 1a), the panel found charge 1b) proved on the balance of probabilities. However, the panel could not distinguish between charges 1a) and 1b) as the assistance that Mrs Antonio failed to provide in charge 1a) was in fact not allowing Resident A access to a phone in the office.

In these circumstances, whilst the panel found charge 1b) factually proved, it does not add any culpability beyond that in charge 1a).

Charge 2

2) On or around the 25th August 2018 failed to report and / or escalate an allegation of sexual abuse made by Resident A to the Care Home Manager or Senior Designated Person.

This charge is found NOT proved.

In reaching this decision, the panel took into account the BUPA Safeguarding Policy (the Policy), the Home's investigation interview with Witness 2 dated 23 October 2018, the interview minutes with Mrs Antonio and Witness 1 dated 15 October 2018 and Mrs Antonio's police statement dated 5 September 2018.

The panel had regard to the Policy on safeguarding, in particular, Figure 7 – Flowchart for the Management of Safeguarding which states:

"Report the incident to the Care Home Manager or Senior Designated Person, unless they are implicated. If so report the incident to the Area Manager."

The panel also had regard to the policy under the heading of "Reporting abuse" which states:

- *"If a staff member witnesses or suspects abuse they should challenge and try to stop the abuser. The incident should then be reported to the Care Home Manager or person in charge at once using Bupa's Speak Up Policy…*

- *If a staff member suspects any abuse it is their duty to report it to their Manager…"*

The panel also had regard to Mrs Antonio's police statement dated 5 September 2018 which states:

"I spoke to [Colleague C] in the office on handing over at 7:45pm and told her what Resident A had said to me about a man having sex with her. [Colleague C] did not believe this. I went home as I had finished by day. I came back in the next day and nothing was mentioned by Resident A about the man having sex with her. I told the unit manager [Colleague D], what Resident A had told me the day before. I told her at about 8am on Sunday 30th August. [Colleague D] did not believe this either."

The panel took into account Witness 2's interview minutes dated 23 October 2018 which states:

"I was the Manager on call that particular weekend. I had a number of calls on Saturday but nothing relating to Resident A all stuff about staffing, general issues. I'd spoken with [Colleague D] both mornings but nothing was mentioned to me about Resident A"

The panel took into account the interview minutes of Mrs Antonio by Witness 1 dated 15 October 2018 which states:

"I should have rang the police and the Home Manager to get advice. Or [Witness 2] (on-call Manager). It's really my fault, I admit that."

The panel noted that charge 2) relates to an allegation that Mrs Antonio failed to report and / or escalate the allegation made by Resident A to the Care Home Manager or Senior Designated Person.

The panel could find no suggestion or evidence from any of the material before it that Mrs Antonio reported or escalated the matter to the Care Home Manager.

The panel therefore considered whether Mrs Antonio failed to report and / or escalate the allegation to the Senior Designated Person.

The panel examined the Policy document and was concerned to note that the document was not consistent as to who Mrs Antonio should have reported and / or escalated the matter to. Variously within the Policy document these are referred to as Senior Designated Person, person in charge or "their manager".

The panel was mindful that the burden of proof at the fact finding stage is with the NMC. The panel could find no evidence within the NMC's case to identify who the Senior Designated Person was on 25 August 2018. In these circumstances, the panel decided that the NMC has not discharged the burden of proof.

The panel therefore found Charge 2) not proved.

Charge 3

3) On or around the 25th August 2018 failed to hand over to a Registered Nurse colleague an allegation of sexual abuse made by Resident A.

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Colleague C, the Home interview notes with Colleague C by Witness 1 dated 15 October 2018, the

witness statement of Colleague D, Colleague D's police statement dated 6 September 2018, the Home interview notes with Colleague D by Witness 1 on 15 October 2018, Witness 3's police statement dated 6 September 2018, the Home's interview notes on 8 November 2018, the Home's shift handover sheets dated 25 / 26 and 26 / 27 August 2018, Mrs Antonio's interview notes with Colleague B on 30 August 2018, the Home's Disciplinary Hearing minutes with Mrs Antonio on 29 November 2018 and Mrs Antonio's police statement dated 5 September 2018.

The panel took into account the witness statement of Colleague C which states:

> *"When I arrived for my night shift and went to take handover, the registrant already had her coat on and a carrier bag. She told me that generally everyone was fine. I normally check the handover sheet and I don't recall there being anything unusual on there. She also didn't raise anything to me, verbally, about the allegations I later found out Resident A had made. I know there was nothing written in her notes or said to me because if there had been something I would have blown the whistle and told someone."*

The panel took into account the witness statement of Colleague D which states:

> *"On the morning of the 26 August…I came in around 8.40am. I did not attend handover that day… [Mrs Antonio] did not speak to me about Resident A disclosure at any time."*

The panel also took into account Mrs Antonio's police statement dated 5 September 2018 which states:

> *"I spoke to [Colleague C] in the office on handing over at about 7:45pm and told her what Resident A had said to me about a man having sex with her. [Colleague C] did not believe this. I went home as I had finished my day. I came back in the next day and nothing was mentioned by Resident A about the man having sex with her. I told the unit manager [Colleague D] what Resident A had told me the day before. I told her at about 8am on Sunday 30th August. [Colleague D] did not believe this either."*

The panel noted that there appears to be an error in Mrs Antonio's police statement, in relation to the date of *"Sunday 30th August"* which should have read Sunday 26 August which accords with the calendar for 2018.

The panel noted that the account as between Colleague C and Mrs Antonio, and Colleague D and Mrs Antonio are at complete variance as to what occurred on 25 and 26 August 2018 and appear to be irreconcilable. Accordingly, the panel looked for other evidence to resolve these differing accounts.

The panel took into account the Home's interview notes with Witness 3 by Witness 1 dated 25 October 2018 which states:

> *"she didn't say anything about it but I told her to escalate it! I don't know if she had raised it. She was laughing and said the resident was lying. Yes, it was definitely the Night Nurse [Colleague C] and [Colleague A], the Carer who were there."*

The panel also took into account Witness 3's police statement dated 6 September 2018 which states:

> *"I started work at 8am on Saturday 25th August and finished at 8pm. At about 6:40pm we had just finished supper and I went into the nurses office to get my book to write my report. I noticed that [Mrs Antonio] was laughing and talking to another nurse in the office. [Mrs Antonio] said to me "[Witness 3], did you hear what Resident A said?" I asked what Resident A had said. [Mrs Antonio] said that Resident A had said…had come in her room and had sex with her."*

The panel noted that the above conversation took place in front of a nurse who was not identified in the police statement, but was identified in the Home's interview notes.

The panel closely examined the three accounts given by Mrs Antonio in relation to telling Colleague C and Colleague D about the allegation and could find no inconsistency between these accounts.

In these circumstances of there being irreconcilable accounts between Colleague A and Mrs Antonio, and Colleague D and Mrs Antonio the panel was helped by the independent evidence by Witness 3. In light of Witness 3's evidence, the panel decided, on the balance of probabilities, that Mrs Antonio did orally tell Colleague C about the allegation on 25 August 2018. In this respect, the panel took the professional view that handover can include written handover or oral handover.

The panel noted that charge 3) is drafted in terms of failing to handover to "a registered nurse" the charge does not specify which nurse just a registered nurse. Colleague C is a registered nurse.

Accordingly, the panel found this charge not proved.

Charge 4

4) On one or more of the following dates told Colleague B that you had told Colleague C and / or Colleague D about the disclosure of sexual abuse made by Resident A:

   a) 30 August 2018
   b) 15 October 2018

This charge is found proved only in relation to Charge 4a).

Charge 4a)

In reaching this decision, the panel took into account the interview notes with Mrs Antonio conducted by Colleague B dated 30 August 2018 which states:

> *"Resident A went to the lounge and staff done handover. I told [Colleague C] what Resident A told me. [Colleague C] said she does not believe Resident A.*
> *...*
> *I told the daughter that I told night nurse and [Colleague D], but they did not believe it"*

The panel determined, on the bare facts, that on 30 August 2018, Mrs Antonio told Colleague B that she had told Colleague C / or Colleague D about the disclosure of sexual abuse made by Resident A. The panel therefore found, on the bare facts, Charge 4a) proved.

Charge 4b)

The panel determined that there is no evidence to support this charge. There is no evidence to suggest that any form of communication occurred between Mrs Antonio and Colleague B on 15 October 2018. The only evidence of an interview being conducted does not relate to Colleague B as being the interviewer, but rather by Witness 1 and an identified employee of the Home. The NMC have not obtained a statement from Colleague B.

In these circumstances, the panel determined that the NMC has not discharged its burden of proof in respect of this charge. The panel therefore found charge 4b) not proved.

Charge 5

5) Your actions in charge 4 were dishonest as:

    a) You knew you had not told Colleague C and / or Colleague D about the disclosure of sexual abuse made by Resident A;
    b) You intended to implicate Colleague C and / or Colleague D by creating the impression that you had discharged your responsibility in Charge 2 and / or 3 above when you had not.

This charge is found NOT proved in its entirety.

Charge 5a)

The panel noted the wording of charge 5a) in respect of Colleague C and, in the light of its decision on charge 3), determined that charge 5a) in respect of Colleague C is not proved.

The panel next considered charge 5a) in relation to Colleague D.

The panel in relation to charge 3) has already noted that there is irreconcilable difference between the accounts given by Colleague D and Mrs Antonio. In this respect, the panel looked to other evidence and, in particular, the evidence relating to Witness 3.

Witness 3 in her interview with the Home stated that *"At handover on Sunday I asked [Colleague D] whether she heard about it and said "[Witness 3], I don't want to hear about it". And that's what I told the police."*

Witness 3 in her police statement dated 6 September 2018 said:

> *"When I went in the next morning at 8am my duty manager [named], was in and I told her what had happened yesterday, I started to tell her what Resident A had said to me and [named] cut me off and said "that Resident A". I left, she didn't want to listen to me."*

The panel noted that the name in the above passage does not appear to accord with the name of Colleague D. However, the panel noted that in her interview with the Home that Witness 3 names Colleague D and appears to be talking about the same incident when making her police statement. In this regard, the detail appears to be the same and Witness 3 stated in her Home interview "*And that's what I told the police."*

In the above circumstances, the panel placed significant weight upon the evidence of Witness 3 and accordingly found charge 5a) in respect of Colleague D not proved on the balance of probabilities.

Charge 5b)

As charges 2) and 3) have not been proved, it follows that Charge 5b) is therefore found not proved.

Charge 6

6) On or before 30 August 2018 told Resident A's daughter that you did not believe Resident A, when she disclosed her allegation of sexual abuse.

This charge is found NOT proved.

The panel noted that there is no statement from Resident A's daughter or from any person who may have been present during the discussion between Resident A's daughter and Mrs Antonio. Further, the NMC has not provided the panel with Resident A's medical notes so as to ascertain Resident A's state of health at the time of the sexual assault allegation being raised or any treatment that she was receiving.

The only evidence adduced by the NMC in support of this charge is the witness statement of Witness 1 which states:

> *"I also understood that the registrant, when Resident A's daughter confronted her about what Resident A had said, [Mrs Antonio] told her that she hadn't escalated it because she didn't believe Resident A."*

The panel carefully considered this passage. The information that Witness 1 relays does not come from an identified source and appears to be unidentified hearsay. In these circumstances, the panel decided that this passage is inadmissible evidence and therefore could not rely upon it.

In reaching its decision, the panel then turned to the Home's interview notes with Mrs Antonio conducted by Colleague B dated 30 August 2018 which states:

> *"…I told her daughter that Resident A could have had an infection and can be confused. Daughter said she believes her mum. I told her daughter that I told night nurse and [Colleague D], but they did not believe it."*

The panel also considered the Home's interview minutes with Mrs Antonio by Witness 1 dated 15 October 2018 which states:

> *"Q: Did you tell her that you didn't believe mum?*

A: I said she had been confused as was on [antibiotics] and that Colleague D hadn't believed her either"

The panel determined that within the investigation Mrs Antonio consistently stated that Resident A was confused as she had an infection and was on antibiotics. There is no evidence to suggest that Mrs Antonio told Resident A's daughter that she did not believe Resident A when she disclosed her allegation of sexual abuse.

The panel determined that the NMC has not discharged its burden of proof in respect of this charge. The panel therefore found charge 6) not 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 Mrs Antonio's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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, Mrs Antonio's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

The NMC 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. The NMC identified the specific, relevant standards where Mrs Antonio's actions amounted to misconduct.

The panel considered the relevant NMC submissions within its Statement of Case relating to the proved charges being 1a), 1b) and 4a). The panel disregarded any NMC submissions which related to the charges found not proved.

The panel received no submissions on misconduct and impairment from Mrs Antonio.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Meadow v General Medical Council* [2007] 1AllER, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin) and *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin)

When determining whether 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").

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

The panel was of the view that Mrs Antonio's actions fell significantly short of the standards expected of a registered nurse, and that her omission amounted to several breaches of the Code. The panel considered that the following sections of the Code were engaged in this case:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

***1.3** avoid making assumptions…*

***1.5** respect and uphold people's human rights*

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

***2.1** work in partnership with people to make sure you deliver care effectively*

***2.6** 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…support when they need it*

***3.4** act as an advocate for the vulnerable, challenging poor practice and discriminatory and behaviour relating to their care*

4 Act in the best interests of people at all times

To achieve this, you must:

***4.1** balance the need to act in the best interests of people at all times…*

5 Respect people's right to privacy and confidentiality

To achieve this, you must:

***5.5** share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand*

7 Communicate clearly

To achieve this, you must:

***7.2** take reasonable steps to meet people's language and communication needs, providing, whenever possible, assistance to those who need help to communicate their own or other people's needs*

16 Act…if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

***16.5** not obstruct…or in any way hinder a…person you care for…who wants to raise a concern*

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** …treating people fairly…*

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 recognised that a breach or breaches of the Code do not automatically result in a finding of misconduct. It went on to consider the charges 1a), 1b) and 4a) by determining whether Mrs Antonio's actions were sufficiently serious so as to amount to misconduct.

The panel noted that misconduct means misconduct of a sufficiently serious nature to be capable of calling into question Mrs Antonio's fitness to practise as a registered nurse. The panel took into account that a single omission is less likely to cross the threshold of misconduct than multiple omission. Nevertheless, and depending upon the circumstances, a single omission, if particularly grave, can be characterised as misconduct.

The panel determined that Mrs Antonio's omission in relation to charge 1a) was so serious as to amount to misconduct. The panel noted from its findings on facts that charge 1b) added no culpability. The panel did not consider charge 4a) to amount to misconduct as it was found proved on the bare facts and the panel therefore concluded there was no wrongdoing.

In determining that charge 1a) amounted to misconduct, the panel carefully considered the incident and its background.

The panel noted Resident A had dementia and was therefore a very vulnerable resident. Resident A made an allegation of sexual assault which is of the most grave kind. Mrs Antonio knew of the nature and extent of this allegation. Mrs Antonio, as a registered nurse should have known at the time that there was a clear duty upon her to assist Resident A by providing a phone so that she could call her family. In the panel's professional view, this was not the frequent situation of a patient or a resident wanting to make an ordinary social phone call, but one of the highest importance and urgency to Resident A and her family.

The panel in the above circumstances, found that Mrs Antonio’s failing in charge 1a) did fall seriously short of the conduct and standards expected of a registered nurse and amounts to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Antonio's 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 (council for healthcare regulatory excellence) v The Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin) 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 decided that when looking to the past that limbs a, b and c are engaged for the reasons above in relation to misconduct. It noted that, when looking to the past, the charge of dishonesty was not proved and that limb d of the Shipman test is therefore not engaged.

The panel next considered whether Mrs Antonio is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and / or bring the nursing profession into disrepute; and / or breach one of the fundamental tenets of the nursing profession.

In relation to this, the panel asked itself the questions posited in *Cohen.* Firstly, whether the misconduct is easily remediable. Secondly, whether the misconduct has been remediated. Thirdly, whether the misconduct is highly unlikely to be repeated.

The panel decided that in the circumstances of Mrs Antonio's misconduct, the behaviour behind the omission is remediable.

The panel went on to consider whether there is any evidence of remediation and Mrs Antonio strengthening her practice. Mrs Antonio has not engaged with the NMC and this hearing. Consequently, there is no material from Mrs Antonio in respect of remediation. There is no expression of remorse, no meaningful evidence of any insight into her shortcoming and no evidence of any training to address the deficiency in her practice. The only possible evidence of any insight appears in the Home's interview minutes conducted by Witness 1 on 15 October 2018. In that interview, she acknowledges that she would do things differently if confronted with a similar situation. In the panel's view, this does not amount to meaningful insight purely an acknowledgment of what went wrong.

In light of there being no steps in remediation, the panel concluded that there is a real risk of Mrs Antonio repeating similar misconduct. Accordingly, the panel determined that Mrs Antonio's fitness to practise is currently impaired.

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

The panel determined that a finding of impairment on public interest grounds was also required in view of the seriousness of the case, which involves serious breaches of the Code and breach of a fundamental tenet of the nursing profession. 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.

Sanction

The panel has considered this case 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 Mrs Antonio's 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

The panel considered the relevant NMC submissions within the Statement of Case relating to proved charges being 1a), 1b) and 4a). The panel disregarded any NMC submissions which related to the charges found not proved.

The panel received no submissions on sanction from Mrs Antonio.

The panel noted the NMC submission for a striking off order, but in the circumstances of several charges being not proved, the panel clearly came to the question of sanction with an open mind.

Decision and reasons on sanction

Having found Mrs Antonio's 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:

- Resident A was very vulnerable and had dementia.
- Resident A was not treated with sensitively and care. She deserved to have her disclosure dealt with sensitively.
- Mrs Antonio was a senior member of staff at the time. She had the obligation to act.
- Risk of harm to Resident A.
- Lack of insight into failings.

The panel also took into account the following mitigating features:

- No evidence of actual physical or psychological harm caused to Resident A.
- Mrs Antonio's misconduct was a single instance.
- No previous fitness to practise history in 19 years of practice.

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

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 Mrs Antonio's 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 Mrs Antonio's

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 a conditions of practice order on Mrs Antonio's nursing 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 practical or workable conditions that could be formulated, given the nature of the misconduct in this case. The panel was not satisfied that a conditions of practice order was sufficient to address Mrs Antonio's misconduct at this stage, having regard to the public protection and public interest elements of this case. As Mrs Antonio has not engaged with the NMC since the referral, the panel had no evidence of insight, remorse or remediation. There is no evidence before it to suggest that Mrs Antonio appreciates the serious ramifications of her acts and/or omissions. The panel considered there to be an underlying attitudinal issue present in this case, which may prevent Mrs Antonio from reflecting upon her misconduct and how it impacted Resident A, her family, the nursing profession and the wider public.

In taking account of the above, the panel determined that placing a conditions of practice order on Mrs Antonio's nursing registration would not be practicable, nor would it adequately address the seriousness of this case, nor would it satisfy the public interest considerations.

The panel went on to consider whether to impose a suspension order. The panel had regard to the SG, and the factors set out in deciding whether this would be an appropriate sanction. The panel noted that this case involved a single instance of misconduct. Whilst there is no evidence of a repetition of the behaviour since the original incident, the panel was not satisfied that Mrs Antonio had demonstrated any meaningful insight. It considered that she did pose a real risk of repeating her behaviour.

The panel went on to consider whether to impose a striking-off order. The panel considered that this was not the only sanction sufficient to protect the public and satisfy the public interest in this case. It considered that public confidence in the nursing profession

could be maintained through the imposition of a lesser sanction. The panel also determined that a striking-off order would be disproportionate in the circumstances of this case.

The panel concluded that a suspension order would be the most appropriate and proportionate sanction in this case. The panel considered that such an order would protect the public, whilst also marking the importance of maintaining public confidence in the profession, and sending to the public and the profession a clear message about the standard of behaviour required of a registered nurse. The panel also considered that a suspension order would afford Mrs Antonio the opportunity to engage with these proceedings, to reflect on the misconduct as determined by the panel, and to demonstrate evidence of insight, remorse and that she sufficiently strengthened her practice to a future panel.

The panel noted that a suspension order may cause hardship to Mrs Antonio. However, it considered that this was outweighed by the public protection and public interest considerations in this case.

The panel determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct. The panel noted that Mrs Antonio has not engaged with the NMC nor has advised the NMC of where she is currently working, however the panel considered that a suspension order for this length of time would give Mrs Antonio adequate opportunity to reflect on the panel's findings and to demonstrate the required insight and evidence of strengthened practice.

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:

- Mrs Antonio's engagement with the NMC and attendance at any future review hearing.

- A meaningful reflective piece to the NMC prior to the review of this case. This reflective piece must discuss Mrs Antonio's misconduct, with particular regard to:
    - how Mrs Antonio's actions have damaged the reputation of the nursing profession and the Home;
    - how her omission has affected Resident A, her family and the public's perception of nurses;
    - and how she would act differently in the future, if placed in a similar situation.
- Evidence of training relevant to the panel's findings, in particular, in relation to safeguarding and caring for vulnerable people including those living with dementia.
- Any references or testimonials from paid or unpaid work.

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 Mrs Antonio's own interest until the suspension sanction takes effect.

Determination on Interim Order

Under Article 31 of the Nursing and Midwifery Order 2001 ("the Order"), the panel considered whether an interim order should be imposed in this case. A panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, and/or is otherwise in the public interest, and/or is in the registrant's own interests.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension 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. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

This will be confirmed to Mrs Antonio in writing.

That concludes this determination.