Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 27 February 2023 – Tuesday 28 February 2023
Monday, 7 August 2023 – Thursday, 10 August 2023

Virtual Hearing

Name of Registrant:	**Ludo Msinamwa**
NMC PIN	05H0198O
Part(s) of the register:	Adult Nursing – August 2005
Relevant Location:	Causeway Coast and Glens
Type of case:	Misconduct
Panel members:	Tracy Stephenson (Chair, Lay member) Suzanna Jacoby (Lay member) Frances Mary Clarke (Registrant member)
Legal Assessor:	Michael Hosford-Tanner
Hearings Coordinators:	Max Buadi (27– 28 February 2023); and Petra Bernard (7 – 10 August 2023)
Nursing and Midwifery Council:	Represented by Michael Smalley, Case Presenter (27 – 28 February 2023); and James Edenborough (7 – 10 August 2023)
Miss Msinamwa:	Present and not represented
Facts proved:	Charge 1 in part – Undertaking 9
Facts not proved:	Charge 1 in part – Undertaking 4
Fitness to practise:	Impaired
Sanction:	Conditions of practice order (12 months)
Interim order:	Interim conditions of practice order (18 months)

Details of charge

That you, a registered nurse:

1. Having agreed undertakings recommended in the light of a case to answer being found in respect of the regulatory concerns set out in Schedule 1, failed to remedy the issues identified in your practice in that you breached the undertakings listed in schedule 2.

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

Schedule 1

Medication administration
Concerns with falls management and escalating concerns
Poor record keeping
Failure to adhere to care plan – moving and handling

Schedule 2

Undertaking 4

You will tell your case officer, within seven days of your becoming aware of:

- Any clinical incident you are involved in.
- Any investigation started against you.
- Any disciplinary proceedings taken against you.

On 23 December 2020, you were involved in a clinical incident involving a patient who had fallen. On 5 January 2021, you emailed MAC and included a document explaining that you had been involved in an incident in December 2020.

Although you informed MAC about the incident, you did not do so within the timeframe set by the undertakings.

Undertaking 9

You will work with your workplace manager, supervisor or mentor to create a personal development plan (PDP). Your PDP will address the concerns about:

- Following care plans in relation to moving and handling after a person has fallen
- Your assessment and observations of people after they have fallen
- Your documentation in relation to falls.

You will:

- Send your case officer a copy of your PDP within 2 weeks of these undertakings becoming effective
- Meet with your workplace manager, supervisor or mentor at least every two weeks to discuss your progress towards achieving the aims set out in your PDP
- Send your case officer a report from your workplace manager, mentor or supervisor every month. This report will show your progress towards achieving the aims set out in your PDP and comment on the standard of your practice in relation to the specific areas detailed in this undertaking.

You did not admit any of the charges.

Background

You were referred to the NMC in 2016 and again in 2017. As a result of these referrals, you agreed to be governed by undertakings to address the regulatory concerns related to medication administration, concerns with falls management and escalating concerns, poor record keeping and a failure to adhere to care plan – moving and handling.

The undertakings covered both referrals. It was extended and varied on 22 December 2020. Undertakings 4 and 9 are relevant to this case.

Undertaking 4 stated:

You will tell your case officer, within seven days of your becoming aware of:

- *Any clinical incident you are involved in.*
- *Any investigation started against you.*
- *Any disciplinary proceedings taken against you.*

It is alleged that on 23 December 2020, the day after the undertakings came into effect, an incident occurred at work pertaining to an unwitnessed fall of a patient. It is alleged that you failed to inform your NMC case officer of this within the seven day period, specified in undertaking 4.

Undertaking 9 stated:

You will work with your workplace manager, supervisor or mentor to create a personal development plan (PDP). Your PDP will address the concerns about:

- *Following care plans in relation to moving and handling after a person has fallen*
- *Your assessment and observations of people after they have fallen*
- *Your documentation in relation to falls.*

You will:

- *Send your case officer a copy of your PDP within 2 weeks of these undertakings becoming effective*
- *Meet with your workplace manager, supervisor or mentor at least every two weeks to discuss your progress towards achieving the aims set out in your PDP*

It is alleged that the PDP was not forthcoming within two weeks, which would have been 5 January 2021. Time was informally extended by the NMC's Monitoring and Compliance team ("MAC") to 22 January 2021. A handwritten PDP was sent by you on 19 January 2021 but this was not signed by your workplace manager. In email correspondence between yourself and the NMC there appeared to be issues at the Home causing delays of the PDP being sent to the NMC notably because of covid-19. A more complete PDP was provided by your workplace manager to the NMC in early April 2021.

It is the NMC's case that there are two breaches of the undertakings. To prove its case, the NMC propose to call Ms 1, who was your line manager at the time.

Decision and reasons on application to adjourn the hearing

Mr Smalley, on behalf of the Nursing and Midwifery Council ("NMC"), informed the panel that Ms 1 was not present to give live evidence. He referred the panel to email correspondence between the NMC and The Grange ("the Home"). On 1 February 2023, Ms 1 was informed of the date of the hearing and that she is required to give live evidence. After no response was received by Ms 1, the NMC followed this email with another dated 7 February 2023.

On 27 February 2023, the NMC received an email from the Home, which stated:

> *"…[Ms 1] is currently on maternity leave and is in the Philippines, hence why you have not received a response and why it would be difficult for her to attend the hearing..."*

Mr Smalley also informed the panel that the Hearings Coordinator had emailed Ms 1 this morning informing her that she will be giving evidence today and to join a pre-meeting. Further, the Hearings Coordinator spoke to Ms 1 on the phone and she confirmed that she had recently given birth and would not be able to give live evidence today. This phone call was made shortly before the email was received by the NMC from the Home. In the phone call, Ms 1 asked that matters be confirmed by email/text

and the Hearings Coordinator sent an email promptly asking Ms 1 whether she might be able to attend remotely later this week.

Mr Smalley submitted that further enquiries have been made regarding alternative days of attendance for Ms 1. He submitted that the NMC have spoken to the Manager of the Home who confirmed that Ms 1 has been on maternity leave from 14 December 2022 and will be away for 12 months. Mr Smalley submitted that this causes problems with the NMC in the presentation of its case.

Mr Smalley submitted that the panel have three options. He submitted that the panel could proceed in the absence of Ms 1 and he will apply to have her witness statement admitted as hearsay evidence. He submitted that the panel can proceed without considering Ms 1's witness statement. He also submitted that the panel can adjourn the hearing so enquiries can be made to see if the NMC can secure the attendance of Ms 1.

Mr Smalley reminded the panel that this is a five day case that has one witness. He invited the panel to consider adjourning today's proceedings until tomorrow morning so further enquiries can be made regarding the attendance of Ms 1. He submitted that given the five days allocated for this hearing, there is time for these enquires to be made.

You had no observations regarding this application.

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

The panel noted that you dispute the evidence of Ms 1 and considered that it would be wholly unfair to proceed with the hearing without hearing from her.

In the light of this, the panel was of the view that it would be reasonable to give the NMC time to find out if Ms 1 can participate in this hearing.

Therefore the panel decided to adjourn the hearing until 09:30 tomorrow.

Decision and reasons on NMC's application to admit written statement of Ms 1 as hearsay evidence and your application to adjourn the hearing

Mr Smalley informed the panel that Ms 1 had not responded to the NMC's enquires regarding her availability to give live evidence.

The panel then heard an application made by Mr Smalley under Rule 31 to allow the written statement of Ms 1 into evidence as hearsay. He referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)* which identified a number of factors for the panel to consider with this application.

(1) whether the statement was the sole or decisive evidence in support of the charge;

Mr Smalley submitted that there is other documentation the panel can consider. He referred the panel to email correspondence from the NMC Monitoring and Compliance Officer to yourself and Ms 1.

(2) the nature and extent of the challenges to the contents of the statement;

Mr Smalley submitted that there is significant challenge from you and therefore there is a clear dispute in the evidence.

(3) whether there was any suggestion that the witness had reason to fabricate their allegations;

Mr Smalley submitted there is no reason to suggest the witness statement of Ms 1 has been fabricated.

(4) the seriousness of the allegations, taking into account the impact that adverse findings might have on the Registrant's career;

Mr Smalley submitted the charges are serious but the NMC will invite the panel to impose a conditions of practice order should the panel reach that stage.

(5) whether there was a good reason for the non-attendance of the witness;

Mr Smalley informed the panel that Ms 1 said she had recently given birth. He referred the panel to the "Equal Treatment Bench Book" (February 2021 edition) (July 2022 revision). Under the heading "Adjustments for pregnant or breastfeeding women in courts and tribunals", it stated:

"…A woman who is heavily pregnant or has just given birth should not be expected to attend a court or tribunal unless she feels able to do so. Although every woman is different, this is likely to apply at least to the month before the birth and at least two months after the birth…"

(6) whether the NMC had taken reasonable steps to secure the attendance;

Mr Smalley submitted that attempts have been made to contact Ms 1 via email. He informed the panel that Ms 1's maternity leave and pregnancy were unknown to the NMC until 27 February 2023.

(7) the fact that the registrant did not have prior notice that the witness statement was to be read.

Mr Smalley submitted that you did not have prior notice to this application as the NMC was not aware of the circumstances of Ms 1 until 27 February 2023.

Mr Smalley referred the panel to the case of *El Karout v NMC [2019] EWHC 28 (Admin)* with regards to fairness. He submitted that the panel must first assess the admissibility of the evidence applying the NMC's rules of relevance and fairness. He submitted that if the panel consider the evidence to be fair, only then can it move onto what weight it wishes to give to such evidence.

Mr Smalley invited the panel to admit the statement of Ms 1 as hearsay.

You opposed the application and you said that admitting the statement of Ms 1 as hearsay would be unfair. You said that you have fundamental questions for Ms 1 and there is no opportunity to hear her answers. You said that allowing this application would not give you the opportunity to clear your name.

You said that Ms 1 should be present at this hearing to answer your questions or the statement should not be allowed to be admitted at all.

You said that your preference would be for the matter to be adjourned. You said that if the matter cannot be adjourned then you want the statement of Ms 1 to be dismissed entirely.

Mr Smalley reminded the panel of the "Equal Treatment Bench Book" and submitted that any adjournment would have to be from at least two months from today's date of 28 February 2023.

Mr Smalley submitted that if the panel refuse the hearsay application, then the NMC would not oppose your application to adjourn the hearing.

The panel heard and accepted the advice of the legal assessor. It considered the factors in the cases of *Thorneycroft* and *El Karout*.

Hearsay application

The panel was satisfied that the witness statement of Ms 1 was relevant to the sole charge of this case. It was also of the view that this witness statement could be considered to be the sole and decisive evidence because only Ms 1 is making comments regarding your performance as a nurse. The panel noted that it did not have information regarding this from any other source. In addition, Ms 1 asserts that the delay in the production in the PDP to the NMC was your fault, whereas you assert that the delay was by her.

The panel also noted that while it had no evidence that Ms 1 fabricated the contents of her witness statement, the central issue with the papers in relation to undertaking 9 is whether the delay in the production of the PDP was caused by Ms 1. The panel had taken account of the emails from Ms 1 to the NMC Case Officer indicating reasons on her part for the delay, which invite examination of Ms 1 in live evidence.

With regards to fairness, the panel bore in mind that you strongly contest the contents of Ms 1's witness statement. Additionally, the panel considered that, due to personal circumstances, it was not going to hear live evidence from Ms 1 and therefore her evidence cannot be challenged.

The panel was of the view that the only way the panel can fairly and properly make a decision as to the facts of this case, is if Ms 1 were to be present to be subject to cross examination, which can be achieved if the hearing does not proceed this week.

In light of the above, the panel decided to refuse the application. It concluded that it would not be fair to you or the NMC to admit the witness statement of Ms 1.

Adjournment application

The panel reminded itself that Ms 1 had recently given birth and as a result is not available to attend the hearing. It considered this to be reasonable grounds for non-attendance.

The panel bore in mind that the evidence of Ms 1 speaks to the sole charge of undertaking 9 and there is no live evidence being called by the NMC regarding undertaking 4. It also bore in mind that the NMC did not know the circumstances surrounding Ms 1's availability until 27 February 2023. Further, it considered that you strongly contest the evidence of Ms 1 and are willing to wait until she is able to give live evidence in order to clear your name.

The panel therefore granted the application for an adjournment. It was of the view that it would be fair to both you and the NMC for Ms 1 to be present and cross examined.

The panel direct that the NMC take the necessary steps to secure the attendance of Ms 1 before the hearing resumes. The panel wishes to make it plain that there appears to be no good reason why the attendance of Ms 1 at a virtual hearing cannot be achieved with the cooperation of Ms 1, provided there is an adequate adjournment. It expects that Ms 1 and the NMC can be in communication well in advance of the resuming hearing to achieve this.

On 28 February 2023, the hearing was adjourned part-heard pending availability of the sole witness to attend to give evidence at the resumed hearing.

The hearing resumed on 7 August 2023.

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 Mr Edenborough on behalf of the NMC and those made 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 evidence from the following witness called on behalf of the NMC:

- Ms 1 — Manager of the Home at the relevant time

The panel also heard evidence from you under affirmation.

Decision and reasons on application to amend the Charge 1 (Day two of the resumed hearing)

The panel heard an application made by Mr Edenborough on behalf of the NMC, to amend the wording of Undertaking 9 in Charge 1. He submitted that the proposed amendment would clarify the failing in the undertaking. He submitted that it was not specified in the papers and this amendment will provide clarity regarding the breach of the undertaking. In relation to the timing of the application, he acknowledged that it is late in the proceedings, however it has never been suggested that the charge was not clear or any concern raised as to what the allegation was. He submitted that the proposed amendment would provide clarity and more accurately reflect the evidence and the charge.

Original charge

Charge 1

That you, a registered nurse:

1. Having agreed undertakings recommended in the light of a case to answer being found in respect of the regulatory concerns set out in Schedule 1, failed to remedy the issues identified in your practice in that you breached the undertakings listed in schedule 2.

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

Schedule 1

Medication administration
Concerns with falls management and escalating concerns
Poor record keeping
Failure to adhere to care plan – moving and handling

Schedule 2

Undertaking 4

You will tell your case officer, within seven days of your becoming aware of:

- Any clinical incident you are involved in.
- Any investigation started against you.
- Any disciplinary proceedings taken against you.

On 23 December 2020, you were involved in a clinical incident involving a patient who had fallen. On 5 January 2021, you emailed MAC and included a document explaining that you had been involved in an incident in December 2020.

Although you informed MAC about the incident, you did not do so within the timeframe set by the undertakings.

Undertaking 9

You will work with your workplace manager, supervisor or mentor to create a personal development plan (PDP). Your PDP will address the concerns about:

- Following care plans in relation to moving and handling after a person has fallen
- Your assessment and observations of people after they have fallen
- Your documentation in relation to falls.

You will:

- Send your case officer a copy of your PDP within 2 weeks of these undertakings becoming effective
- Meet with your workplace manager, supervisor or mentor at least every two weeks to discuss your progress towards achieving the aims set out in your PDP

Send your case officer a report from your workplace manager, mentor or supervisor every month. This report will show your progress towards achieving the aims set out in your PDP and comment on the standard of your practice in relation to the specific areas detailed in this undertaking.

Amended charge

Charge 1

That you, a registered nurse:

2. Having agreed undertakings recommended in the light of a case to answer being found in respect of the regulatory concerns set out in Schedule 1, failed to remedy the issues identified in your practice in that you breached the undertakings listed in schedule 2.

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

Schedule 1

Medication administration
Concerns with falls management and escalating concerns
Poor record keeping
Failure to adhere to care plan – moving and handling

Schedule 2

Undertaking 4

You will tell your case officer, within seven days of your becoming aware of:

- Any clinical incident you are involved in.

- Any investigation started against you.
- Any disciplinary proceedings taken against you.

On 23 December 2020, you were involved in a clinical incident involving a patient who had fallen. On 5 January 2021, you emailed MAC and included a document explaining that you had been involved in an incident in December 2020.

Although you informed MAC about the incident, you did not do so within the timeframe set by the undertakings.

Undertaking 9

You will work with your workplace manager, supervisor or mentor to create a personal development plan (PDP). Your PDP will address the concerns about:

- Following care plans in relation to moving and handling after a person has fallen
- Your assessment and observations of people after they have fallen
- Your documentation in relation to falls.

You will:

- Send your case officer a copy of your PDP within 2 weeks of these undertakings becoming effective
- Meet with your workplace manager, supervisor or mentor at least every two weeks to discuss your progress towards achieving the aims set out in your PDP

Send your case officer a report from your workplace manager, mentor or supervisor every month. This report will show your progress towards achieving the aims set out in your PDP and comment on the standard of your practice in relation to the specific areas detailed in this undertaking.

You failed to send your case officer a copy of your PDP within 2 weeks of the undertakings becoming effective.

You raised no objections to the application.

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 determined that the amendments, as applied for, would provide more clarity and would more accurately reflect the evidence and the charge. 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 was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on facts

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 you.

The panel then considered the disputed charge and made the following findings.

'Charge 1

That you, a registered nurse:

3. Having agreed undertakings recommended in the light of a case to answer being found in respect of the regulatory concerns set out in Schedule 1, failed to remedy the issues identified in your practice in that you breached the undertakings listed in schedule 2.

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

Schedule 1

Medication administration
Concerns with falls management and escalating concerns
Poor record keeping
Failure to adhere to care plan – moving and handling

Schedule 2

Undertaking 4

You will tell your case officer, within seven days of your becoming aware of:

- Any clinical incident you are involved in.
- Any investigation started against you.
- Any disciplinary proceedings taken against you.

On 23 December 2020, you were involved in a clinical incident involving a patient who had fallen. On 5 January 2021, you emailed MAC and included a document explaining that you had been involved in an incident in December 2020.

Although you informed MAC about the incident, you did not do so within the timeframe set by the undertakings.'

This undertaking in the charge is found not proved.

The panel took account of the accident report, dated 23 December 2020. In this report the panel noted that the nurse coming on the day shift recorded:

'Checked [Resident]. She was comfortable in bed. She complained of light pain on the left leg but able to move both legs. Informed GP. To observe for the next hour'.

The panel was of the view that this placed the incident in context and was not considered to be a serious incident by the incoming nurse or the GP who simply ordered hourly observations. The panel noted that you completed an incident report at the time and that Ms 1 did not raise any concerns with you until 29 December 2020, after she said she had heard a negative comment from a carer regarding your assessment. It was difficult therefore for you to establish prior to 29 December 2020 that it was a reportable clinical incident. You said that similar incidents often occur and the panel accepted that this would be likely in a care home and further noted that there was no evidence to contradict your assertion. The panel was of the view that without the NMC defining what a clinical incident is, it could not categorically determine that it was a reportable incident. Mr Edenborough accepted that not all clinical incidents, for example, a missed medication administration subsequently remedied without patient harm, needed to be reported to the NMC.

The panel noted that you did report the incident to the NMC on 5 January 2021 following a meeting with Ms 1 on 29 December 2020, who brought it to your attention that the incident needed to be reported to the NMC. The panel accepted your evidence that up until the incident was pointed out to you, you did not consider it to be a reportable clinical incident and there was no evidence from the NMC to establish that this was an unreasonable view.

The panel determined that you reported the incident to the NMC with the 7-day timeframe as stipulated in the undertaking.

In light of this, the panel concluded, on the balance of probabilities, that the evidence adduced by the NMC was insufficient to find this part of Charge 1 proved.

'Undertaking 9

You will work with your workplace manager, supervisor or mentor to create a personal development plan (PDP). Your PDP will address the concerns about:

- *Following care plans in relation to moving and handling after a person has fallen*
- *Your assessment and observations of people after they have fallen*
- *Your documentation in relation to falls.*

You will:

- *Send your case officer a copy of your PDP within 2 weeks of these undertakings becoming effective*
- *Meet with your workplace manager, supervisor or mentor at least every two weeks to discuss your progress towards achieving the aims set out in your PDP*

Send your case officer a report from your workplace manager, mentor or supervisor every month. This report will show your progress towards achieving the aims set out in your PDP and comment on the standard of your practice in relation to the specific areas detailed in this undertaking.

You failed to send your case officer a copy of your PDP within 2 weeks of the undertakings becoming effective.'

This undertaking in the charge is found proved.

The panel took account of your handwritten PDP plan and the email chain between you and the NMC dated 31 December 2020 to 17 May 2021.

The panel noted that you sent the NMC a handwritten draft PDP copy on 19 January 2021 which appeared to be a direct copy of part of the previous PDP plan rather than the revised PDP as required by the varied undertakings that commenced 22 December 2020. It noted that there may have been confusion and misunderstandings by both you and Ms 1 as to whose responsibility it was to send a document to the NMC and what was required by the NMC. The panel noted that there were some additional possible difficulties in the intervening period due to Covid-19 and the absence of your manager

who was on leave overseas. It noted that in her evidence Ms 1 stated that she did everything she could to help you with your PDP however the panel noted that it may not have been done in a timely manner. These are matters on which the panel will need to reach final conclusions after hearing submissions concerning possible misconduct and / or impairment.

The panel determined that the PDP did not reach the NMC within two weeks of the undertaking and it was only received after several reminders from the NMC. The panel heard evidence from you that you accept that it was your responsibility to ensure that the PDP was sent within the specified time and that you did not do so.

In light of this, the panel concluded, on the balance of probabilities, that the evidence adduced by the NMC was sufficient to find this part of Charge 1.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the fact found proved amounts 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.

NMC submissions on misconduct and impairment

Mr Edenborough invited the panel to take the view that the fact found proved amounts to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Mr Edenborough submitted that your actions fell short of what would be expected of a registered nurse. He directed the panel through the specific paragraphs within the Code where in the NMC's view, your actions amounted to misconduct, as follows: 6; 19; 20; and 23.

Mr Edenborough submitted that your failure to comply with undertaking 9 leaves open the regulatory concern of public protection intended to be covered, not just by this undertaking, but by the undertakings as a whole. Turning to the seriousness of misconduct, Mr Edenborough submitted that it could be said that, although not intentionally, you failed to cooperate with your regulator. He submitted that the view put forward by you that you failed at this because of someone else indicates a lack of insight on your part rather than mitigation. He submitted that if you were not able to maintain the support of Ms 1, you would have been able to go back to the NMC and obtain their assistance with the difficulty you were experiencing with adhering to the undertaking.

Mr Edenborough submitted that the PDP had undergone various iterations so one would expect that it was a matter that would be clear in your mind, which he submitted goes to a greater concern. The impact on confidence in the profession relies on the effective administration of this undertaking being followed, which is a wholly neutral document that was submitted late. He submitted that the document in question was put in place to protect the public and it is a serious matter that it has not been provided as required.

Mr Edenborough 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. In relation to the underlying point of seriousness, he submitted that insight is an important factor. He submitted that you have said in evidence that you accept that it was your responsibility to create and send your PDP to your NMC case officer. Despite this he said that your failure to submit it within the timeframe highlights that your insight is not fully developed.

Mr Edenborough referred the panel to a letter in the master bundle dated 10 November 2020, which highlight five regulatory concerns, which includes:

> *'1. Concerns with falls management and escalating concerns*
> *2. Poor record keeping*
> *...*
> *5. Failure to adhere to care plan – moving and handling'*

He submitted that it is clear what the earlier concerns were in the prior undertakings and the remaining concerns addressed in the latest varied undertakings. He submitted that undertaking 9 covers care plans and noted that it is relevant that the other parts of the undertakings have not yet been completed.

He submitted that on this basis, the evidence is sufficient to make a decision on misconduct and impairment. He submitted that if misconduct is found it follows that the regulatory concerns remain to be addressed, which means there is impairment on the ground of public protection and also in the wider public interest. He invited the panel to look at insight and whether it has sufficiently developed in relation to the regulatory concerns; he submitted that the answer is no as the undertakings have not been completed. He submitted that public confidence in the profession and the NMC as its regulator would be undermined if this breach was not marked.

You asked Mr Edenborough whether now that the charge is proved relating to undertaking 9, does that mean it includes other undertakings such as undertakings 6 or 7. Mr Edenborough, in summary, responded that undertakings 6, 7 and 8 indicate

the level of concerns overall, requiring indirect supervision which the required PDP in undertaking 9 was designed to deal with which has not been addressed.

Your submissions on misconduct and impairment

In relation to whether the breach of undertaking 9 amounts to misconduct, you told the panel that it should not be viewed as serious misconduct. You said that it was ultimately your responsibility to ensure that it was done and submitted that on some level it was a shared responsibility with another professional. You said that even though the NMC regards the PDP as an important legal document, no one was injured because the new PDP was not submitted.

You asked the panel to consider your personal circumstances. You said that you awoke this morning at 5:00am and have not slept in weeks and had a sense of apprehension about this case, having lost everything and felt defeated. You said that working as a nurse with a pending case with the NMC feels like you are the star in a horror show. You said that when you were working at the Home, you knew within four weeks of working there that it was not the place for you but there was no way out. You said you had already paid £2,500 pounds for your visa, moved to a new place and to a new job which was already toxic.

You said that you sought assistance and advice from Unison who took months to call you back. You said that you told Unison that you had a contract, that you were supposed to be in a supervised role yet were getting paid less than the people you were supervising. You said that Unison told you that you signed the contract so there is nothing that they could do. You said that you were only with Unison for indemnity cover. You told the panel that it is proving really difficult to secure a job with enough support to get out of the undertakings.

You told the panel that you have not done any training and not provided anything but it was not because you do not care. You said that you do not know anything other than being a nurse.

You were asked by the panel when it was that you last worked as a nurse since leaving the Home in 2021. You said that you sought work as a nurse and received a job offer. However, when the potential employer asked for a reference from Ms 1, the employer told you it was a bad reference so they rescinded the job offer. You said that you then joined an agency in April / May 2022 who were willing to give support with the undertakings however the person in charge of giving supervision left so there was no work available for you so you left.

You were asked by the panel whether you had ever written a reflective piece in relation to the undertakings and the situation you had got into. You said that you did one last year for your revalidation however everything was lost in a fire.

You were asked by the panel what type of nursing you would like to do in the future. You told the panel that you would like to do endocrinology and respiratory nursing; also chronic illness nursing which is an area you have worked in previously.

The panel heard and 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:

> ***‘20 Uphold the reputation of your profession at all times***
>
> ***23 Cooperate with all investigations and audits***
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that undertaking 9 covers concerns in relation to your practice and have been put in place to protect the public. You had agreed to those undertakings and so had accepted that they were necessary. The panel were of the view that the public would be concerned that there is some level of risk by not having that PDP completed and submitted within the stipulated timeframe, which was designed to strengthen your practice and ensure that it was safe. This meant that the NMC was not able to have oversight as to whether the concerns in the PDP were being addressed and adhered to.

The panel had regard to number of emails that you received from the NMC. It considered that you had received numerous reminders that the PDP needed to be submitted. The panel determined that you were not proactive enough to ensure that it was done.

The panel acknowledged that you encountered some difficulty in obtaining assistance from Ms 1 on occasions, however it was your responsibility to follow through to ensure that the PDP was completed and submitted to the NMC or escalate to the NMC why it was not possible to do so. You knew that a PDP had to be submitted to the NMC by 5 January 2021, but you only submitted a PDP on 19 January 2021 and you have accepted that this was only a draft PDP. The draft was also based on the previous undertakings and not addressing the new undertaking 9, which you had agreed to and which was effective from 22 December 2020. You have said in evidence that you later completed a full PDP of several pages, got it signed and scanned and thought you had submitted it to the NMC some time after February 2021. However, you have accepted that the scanned copy was not sent effectively, and was clear it was not received by the NMC, who continued to send you reminders in March 2021. Your approach to compliance with undertaking 9 was unfocussed and not thorough, and showed a lack of insight into how it is a serious matter not to comply with an undertaking you had given to

your regulator. You have said that Ms 1 let you down, but the correspondence does not show you engaging sufficiently with the NMC to overcome any such problems until long after the time when the PDP was due.

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. To justify that trust, nurses 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 *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) 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 finds that your misconduct had put patients at risk of harm and had breached some of the fundamental tenets of the nursing profession and therefore had brought its reputation into disrepute.

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 determined that there is limited insight from you into why timely completion and submission of the PDP is so important; that was the first and essential step required to strengthen your practice.

The panel took account that there has been no reflective piece, training or testimonials put before it to address the regulatory concerns identified. The panel determined that there is a risk of repetition, given that there had been continuing undertakings since 2018, leading to the new undertakings effective from 22 December 2020 which showed

that there were still concerns about your ability to practise safely and without restriction after a long period of undertakings.

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/protect the wider public interest, which 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 was of the view that it was your responsibility to do the PDP and you had a duty to address the revised undertakings and cooperate with your regulator. The panel accept that there may have been some difficulty in achieving this, however extensions were given by the NMC and they were clear that it was supposed to be provided in a particular timeframe.

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.

Submissions on sanction

Mr Edenborough informed the panel that in the Notice of Hearing, dated 25 January 2023, the NMC had advised you that it would seek the imposition of a conditions of practice order for a proposed period of 24 months if it found your fitness to practise currently impaired.

Mr Edenborough submitted that it is clear that there are outstanding concerns that need to be addressed in relation to the practical clinical issues undertaking 9 was crafted to deal with. He submitted that conditions of practice that attempt to achieve the same as the undertakings is the minimum necessary for remediation in order to address the concerns at this stage. He submitted that some ancillary conditions may also be required and insight is a concern which may be addressed by a reflective piece.

Mr Edenborough submitted that the term of the conditions of practice order sought is 24 months with a review. He submitted that this matter has gone on for some time and there is a history behind the given undertakings. He submitted that the panel look to what is fair and reasonable for remediation to take place and that conditions of practice are not too onerous or too short for matters to take effect.

You told the panel that conditions of one year would be preferable although you were not sure whether two years would be more applicable if there would be a review. You also asked the panel to consider whether the number of conditions could be lessened or integrated, for example, from nine conditions to six conditions. You also said that you thought that meeting your line manager monthly would be sufficient and more workable.

You also told the panel that having conditions of practice is a restriction as it makes it difficult to get employment. You said, as an example, if you apply to ten employers, you will receive one or two call backs; then at interview when looking at what the NMC are looking for in terms of supervision, it leaves it up to the employer to say whether they can take it on or not. Further, you told the panel that being a visa-required candidate is an additional burden on potential employers.

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

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:

- Undertakings that have been in place since 2018
- Limited insight into failings

The panel also took into account the following mitigating features:

- Made an admission
- Difficulties at the time including the impact of Covid-19 and communicating with line manager who was abroad for lengthy periods

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.

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

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order. The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case .

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

2. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

3. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

4. You must keep us informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

5. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).

d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

6. You must not be the nurse in charge of a shift.

7. You must not be the sole nurse on a shift.

8. You will ensure that you are supervised by another registered nurse at any time you are working. Your supervision will consist of working with, but not always directly observed by a registered nurse nominated by your workplace manager.

9. You will work with your workplace manager, supervisor or mentor to create a personal development plan (PDP). Your PDP will address:
   - Falls prevention
   - Management of patients following a fall including:
     - Assessments
     - Observations
     - Moving and handling
     - Care planning and escalation

   You will:

   - Send your case officer a copy of your PDP within a month of starting your employment
   - Meet with your workplace manager, supervisor or mentor at least every month to discuss your progress towards achieving the aims set out in your PDP
   - Send your case officer a report from your workplace manager, mentor or supervisor every three months. This report will show your progress towards achieving the aims set out in your PDP and comment on the standard of your practice in relation to the specific areas detailed in this undertaking.

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

In addition to complying with the conditions a future reviewing panel would be assisted by:

- A reflective piece;
- Testimonials; and
- A progress report if this is not covered by reports already submitted under condition 9.

This will be confirmed to you in writing.

Interim order

As the conditions of practice 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 conditions of practice 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 Mr Edenborough. He submitted that it is necessary for the protection of the public and is otherwise in the public interest, in order to cover the period of any appeal made by you against the substantive order. He submitted that it would be in the interests of the public to ensure an interim order is in place prior to the substantive sanction coming into effect.

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 a suspension 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 conditions of practice order. In light of the panel's order, not to impose an interim conditions of practice order would be inconsistent with their earlier determination. The panel therefore imposed an interim conditions of practice order for a period of 18 months to allow sufficient time for any appeal period.

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