Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 17 – Friday 28 July 2023

Virtual Hearing

Name of Registrant:	**Susan Tsolo**
NMC PIN	04A0920O
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – January 2004 Adult Nursing – July 2008
Relevant Location:	Leeds and York
Type of case:	Misconduct
Panel members:	Shaun Donnellan (Chair, Lay member) Pamela Campbell (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	Michael Hosford-Tanner
Hearings Coordinator:	Khadija Patwary
Nursing and Midwifery Council:	Represented by Matthew Kewley, Case Presenter
Mrs Tsolo:	Not present and unrepresented (17-18 July 2023) Present and unrepresented (20-28 July 2023)
Offer of no evidence:	Charges 1), 2), 3), 4), 5)b), 6)a), 7) and 8)
Facts proved:	Charges 5)a), 5)c), 6)c), 6)d), 9), 10), 11) and 12)
Facts not proved:	Charge 6)b)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Tsolo was not in attendance and that the Notice of Hearing letter had been sent to Mrs Tsolo's registered address by recorded delivery and by first class post on 16 June 2023.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mrs Tsolo's registered address on 17 June 2023. It had been signed for against the printed name of 'TSOLO'.

Mr Kewley, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Tsolo's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

The panel also noted that, following the notice, Mrs Tsolo had provided her response form on 27 June 2023, which further reassured the panel that Mrs Tsolo had received the notice.

In the light of all the information available, the panel was satisfied that Mrs Tsolo has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Tsolo

The panel next considered whether it should proceed in the absence of Mrs Tsolo. It had regard to Rule 21 and heard the submissions of Mr Kewley who invited the panel to continue in the absence of Mrs Tsolo.

Mr Kewley referred the panel to an email dated 8 July 2023 from Mrs Tsolo to her NMC case officer requesting a postponement of today's proceedings. Mrs Tsolo's stated that:

> *'*[PRIVATE] *I kindly request to postpone the hearing as also the representative from equality 4 black nurses told me very late that they won't be able to represent me and I'm seeking another representation and without a bundle from you which Im still waiting for from your side by post as you know I have problems with computers and I politely and humble myself to postpone the hearing.'*

Mr Kewley submitted that there are three routes that the panel could take today in light of Mrs Tsolo's request. He submitted that the first option would that the panel allow the request for a postponement and that the hearing does not proceed. The NMC will then relist the case as soon as it can and take steps to secure witness attendance. The second option would be that the panel consider adjourning for a short period which could be until the end of this week. He further submitted that the third option would be to proceed with the hearing as planned today.

Mr Kewley submitted that this is the second listing of this case which had been listed for a final hearing in December 2022. The panel at the first listing decided that the hearing should not proceed and that a postponement was granted. He submitted that the postponement was granted primarily due [PRIVATE] but there were also issues about documentation. He informed the panel that on 25 January 2023 the dates for the second listing were identified and these were then shared with Mrs Tsolo. Mr Kewley submitted that on 27 June 2023, Mrs Tsolo responded to the notice of hearing and stated that she was planning to attend the hearing.

Mr Kewley referred the panel to Mrs Tsolo's email dated 8 July 2023 in which she stated three separate points as to why she has requested a postponement. [PRIVATE], the second matter relates to an issue of obtaining legal representation and the third being that she does not have the hearing bundles. [PRIVATE].

[PRIVATE].

Mr Kewley submitted that in relation to Mrs Tsolo's second point, she was receiving support from a group called NMC Watch in December 2022. However, it is not clear whether there was any ongoing assistance from them because Mrs Tsolo was unable to secure help from them in relation to this hearing. He referred the panel to an email dated 18 December 2022 from a qualified barrister who had been approached by Mrs Tsolo to assist her with her case. The barrister had stated in February 2023 that he was not available to represent Mrs Tsolo in July and that alternative counsel would make contact with the NMC. Mr Kewley submitted that there was no formal correspondence from the barrister that he was no longer representing Mrs Tsolo. He submitted that Mrs Tsolo then informed her NMC case officer on 9 March 2023 that she will now be represented by an organisation called Equality 4 Black Nurses. He referred the panel to emails dated 10 and 27 March 2023 from the NMC case officer to the organisation asking for asking for a response as to whether they will be representing Mrs Tsolo. Mr Kewley submitted that Mrs Tsolo knew that she would not have a representative as she ticked "*no*" in her response as to whether she would be represented in the notice of hearing document on 27 June 2023.

Mr Kewley drew the panel's attention to the confirmation of delivery of the hearing bundles on 12 December 2022 which Mrs Tsolo had signed as received. He submitted that the NMC then again sent hard copies of the bundles in advance of this hearing with a covering letter dated 7 July 2023. He submitted that these were the same bundles from December 2022 and in effect were duplicates. The bundles were also sent electronically to Mrs Tsolo on 7 July 2023. Mr Kewley submitted that this is the second listing of this case, the referral itself goes back to April 2019 and half of the allegations go as far back as the 8 and 9 April 2019. He submitted that there are a number of witnesses who have made themselves available over the

course of this case to assist the panel and there would be an inconvenience to these witnesses if the case were to be postponed. He submitted that some of these witnesses had also made themselves available in December 2022. Mr Kewley stated that there were no public protection issues if a postponement were to be granted as there is currently an interim order in place. The current interim order had been extended by the High Court to September 2023. Some of the charges relate to breaches of interim orders.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Tsolo. In reaching this decision, the panel has considered the submissions of Mr Kewley, the email correspondence from Mrs Tsolo, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties, and the particular regard was to be had to fairness to Mrs Tsolo and her right to a reasonable opportunity to attend her hearing.

The panel had regard to the: *'When we postpone or adjourn hearings: CMT/11'*

> *'If a nurse, midwife or nursing associate is unable to attend the hearing for medical reasons, they'll need to provide evidence that they're unfit to participate in the hearing. That evidence should:*
>
> - *be an independent opinion following a proper examination of the nurse, midwife or nursing associate*

- *identify what exactly is wrong with the nurse, midwife or nursing associate, and why their health condition prevents them from participating in a hearing*
- *identify the practitioner making this assessment, and how familiar they are with the nurse, midwife or nursing associate's health condition*
- *include a view on the outlook of the health condition*

Where consideration is being given to granting an adjournment, the panel should only make the decision to adjourn if no injustice is caused to the parties, and after hearing representations from us and the nurse, midwife or nursing associate, or their representative (where present) and after taking advice from the legal assessor'

Mrs Tsolo was reminded of these requirements in an email dated 10 July 2023 from her NMC case officer in which she was asked to:

- *'Identify the doctor (name, GMC pin, etc) and give details of their familiarity with your medical condition(s), including detailing all recent consultations.*
- *Identify with proper particularity your medical condition and explain to what extent your condition(s) affects your participation in the hearing.*
- *Provide a reasoned prognosis and give the panel some confidence that what is being expressed is an independent opinion after a proper examination.'*

The panel also noted that:

- There is a strong public interest in the expeditious disposal of the case;
- Mrs Tsolo provided a response to the Notice of Hearing bundle on 27 June 2023 stating that she did not have any legal representation for his hearing;

- There has been good service of the Notice of Hearing bundle from the first time this matter was listed on December 2022;
- The panel acknowledge Mrs Tsolo had always indicated that she would like to be present at the hearing. However, it noted Mrs Tsolo's email dated 8 July 2023 in which she states her reasoning for the postponement;
- A number of witnesses are scheduled to give oral evidence and that this is the second time that some of them have been asked to give oral evidence/be on standby for this case;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The panel accept that Mrs Tsolo has had difficulties obtaining legal representation at this hearing;
- [PRIVATE];
- [PRIVATE];
- The charges relate to events that occurred in April 2019 and further delay may have an adverse effect on the ability of witnesses accurately to recall events and Mrs Tsolo made representations to the NMC to that effect in December 2022.

[PRIVATE].

There may be some disadvantage to Mrs Tsolo in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Mrs Tsolo's at her registered address, Mrs Tsolo will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give oral evidence on her own behalf, although she has submitted written responses and reflections which the panel will consider. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Tsolo's decisions to absent herself from the hearing without

adequate explanation, waive her rights to attend and thereby to not provide oral evidence or make oral submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Tsolo. The panel will draw no adverse inference from Mrs Tsolo's absence in its findings of fact.

On 17 July 2023 at about 11:50 the panel announced its decision that the case would proceed, and the evidence would commence on 18 July 2023 at 09:00 and Mrs Tsolo was informed of this decision at approximately 12:40 and that full reasons would follow.

18 July 2023

The panel had regard to further correspondence from Mrs Tsolo in relation to proceeding in her absence. The panel was of the view that the information it had been provided with was information which it had already known. [PRIVATE].

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

Mr Kewley, on behalf of the NMC, made a request that parts of this hearing be held in private on the basis that proper exploration of Mrs Tsolo's postponement request involves references to her health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Having heard that there would be references to Mrs Tsolo's health, the panel determined to hold parts of the hearing where her health is referred to in private in order to preserve the confidential nature of those matters. The panel was satisfied

that these considerations justified that course, and that this would outweigh any prejudice to the general principle of hearings being in public.

Details of charge

That you, a registered nurse:

On the nightshift of 8-9 April 2019 at Fulford Nursing Home (the “Home”);

1) Failed to carry a pager, contrary to the Home’s policy on pagers; **(offer of no evidence)**

2) Failed to carry out all of the necessary checks of the residents under your care; **(offer of no evidence)**

3) Entered onto the digital system (Cura) that you had conducted the checks on said residents; **(offer of no evidence)**

4) Your conduct at charge 3 was dishonest, in that you intended for anyone reading the digital system to believe that you had carried out the checks on said residents when you had not; **(offer of no evidence)**

5) Failed to carry out appropriate medication administration, in that you;
    a) Failed to introduce yourself to residents prior to administering medication to them; **(proved)**
    b) Tried to administer medication to Resident A by putting the medication into their mouth whilst they were sleeping; **(offer of no evidence)**
    c) Tried to administer medication to Resident B by putting the medication into their mouth whilst they were sleeping; **(proved)**

6) Failed to follow correct procedure on or around the occasion of the death of Resident C, in that you failed to;
    a) Respond promptly to the news that Resident C was not breathing; (**offer of no evidence)**
    b) Call 999 for an ambulance; **(not proved)**
    c) Document the death; **(proved)**
    d) Provide the necessary details to the 111 operator; **(proved)**

7) Failed to act in a professional manner, in that you; **(offer of no evidence in its entirety)**
    a) Questioned colleagues in a confrontational manner in front of residents;
    b) Told colleagues that "*homosexuality is a mental illness*", or words to that effect;
    c) When told by Colleague 1 (IN) that they had a gay friend, responded by saying "*Oh I had a cousin who is gay and he died of AIDS*", or words to that effect;

8) Your comments at charges 7b and 7c were homophobic; **(offer of no evidence)**

Whilst working at Benedicts Nursing Home;

9) On 28 July 2019, whilst your registration was subject to an interim suspension order, worked as a registered nurse; **(proved)**

10) Between 5 December 2019 and 12 April 2020, whilst your registration was subject to an interim conditions of practice order, breached the conditions of said order, in that you; **(proved in its entirety)**
    a) Worked as the only registered nurse on duty, and so were;
        i) The Designated Nurse in Charge, contrary to condition 1 of the order;
        ii) Not supervised by a registered nurse, contrary to condition 2 of the order;

iii) Not supervised when administering medication, contrary to condition 3 of the order;

b) Failed to create a personal development plan with your line manager, contrary to condition 4 of the order;

c) Failed to inform the NMC of your employment within 7 days, contrary to condition 5 of the order;

d) Failed to provide a copy of these conditions to an organisation or person you worked for an/or an agency with which you were registered for work, contrary to condition 7 of the order;

11) On 23 April 2020, informed an interim order panel of the NMC, that; **(proved in its entirety)**

a) There were always two nurses on shift when you were working, when you were the only nurse on duty;

b) You were always supervised when administering medication, when you were not;

12) Your conduct at charge 11a and/or 11b was dishonest, in that you intended for the panel to believe you were working in compliance with your conditions of practice order; **(proved)**

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kewley, on behalf of the NMC, to amend the wording of charges 10)a)i), 10)d) and 11)b).

The proposed amendment for charge 10)a)i) is the insertion of the word "*designated*" as this was the particular term that the Investigating Committee used when they imposed the interim conditions of practice order. Mr Kewley submitted that in relation to charge 10)d), the phrase "*your employer*" is to be replaced with the actual wording that mirrors the interim conditions. He further submitted that an amendment to

charge 11)b) would be to delete the word "*were*" and replace it with "*when*" as it was a typographical error. It was submitted by Mr Kewley that the proposed amendment would provide clarity and more accurately reflect the evidence.

10) 'Between 5 December 2019 and 12 April 2020, whilst your registration was subject to an interim conditions of practice order, breached the conditions of said order, in that you;

a) Worked as the only registered nurse on duty, and so were;

*i) The **Designated** Nurse in Charge, contrary to condition 1 of the order;*

*d) Failed to provide a copy of these conditions to ~~your employer~~ **an organisation or person you worked for an/or an agency with which you were registered for work**, contrary to condition 7 of the order;*

11) On 23 April 2020, informed an interim order panel of the NMC, that;

*b) You were always supervised when administering medication, **when** ~~were~~ you were not;'*

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 was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Tsolo 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 application to admit hearsay evidence of Colleague 1 and Colleague 2 and written statement of Resident B

The panel heard an application made by Mr Kewley under Rule 31 to allow the hearsay testimony of Colleague 1 and Colleague 2 into evidence. In regard to Colleague 1 she was a carer on duty during the night shift on 8 and 9 April 2029. He

submitted that the NMC did not contact her to give her a statement as they had approached Witness 2 who is due to give oral evidence on 18 July 2023. This submission was later corrected to inform the panel that Colleague 1 had been approached but declined to co-operate with the NMC. Mr Kewley submitted that there is an argument that it would be disproportionate to contact every single witness who could possibly say something about an issue that is before the panel. The relevance of Colleague 1's evidence is that she gives an account of events that unfolded on the particular night. He first submitted that Colleague 1's evidence is not the sole and decisive evidence in the case, because Witness 2 had made a signed statement for the NMC and was going to give oral evidence on the same matters essentially and could be questioned. However, the panel was later informed on 25 July 2023 by Mr Kewley that Colleague 1's evidence was the only and decisive evidence on the matters contained in her informal internal email, as Witness 2 had absented herself and would not be giving evidence, and it was invited to review its decision, which is set out below.

Mr Kewley made a hearsay application in respect of Colleague 2, an employee at the Home who came on shift the following morning, which was the morning of 9 April of 2019. Colleague 2 gave an account of what Witness 2 said to her when she arrived at the Home in relation to some of the events that allegedly occurred over the course of the night shift. He further submitted that Colleague 2's evidence is not the sole and decisive evidence in the case. Mr Kewley later submitted that the NMC can still prove its case even without the hearsay testimony of Colleague 1 and Colleague 2. However, he submitted it will give the panel some contextual information about the morning of 9 April 2019.

The panel heard an application made by Mr Kewley under Rule 31 to allow the written statement of Resident B into evidence. He submitted that she gave a statement to the NMC on 19 August 2022. He stated that Resident B's evidence is relevant to charge 5)c), which concerns the allegation of putting medication into the resident's mouth and also charge 5)a).

Mr Kewley referred the panel to the email dated 12 July 2023 which stated that "[Resident B] *said she doesn't feel well enough to do it. It is her 100th Birthday on*

Friday this week and does not want it spoiled by having this hanging over her and her worrying about it. I did explain the importance of the case and that it would be good if she could speak and reassured her that I would be with her but she said it has gone on long enough and she does not feel as though she is well enough to do it." He submitted that Resident B will not be present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she will not be able to attend.

In the preparation of this hearing, the NMC had indicated to Mrs Tsolo in the Case Management Form (CMF), that it was the NMC's intention for Resident B to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Resident B, Mrs Tsolo made the decision not to attend this hearing and therefore would be unable to cross-examine her. On this basis Mr Kewley advanced the argument that there was no lack of fairness to Mrs Tsolo in allowing Resident B's written statement into evidence.

The panel gave the application in regard to Colleague 1 serious consideration. It considered whether Mrs Tsolo would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Colleague 1 to that of allowing hearsay testimony into evidence. The panel was of the view that Colleague 1's evidence is not the sole and decisive evidence in the case. It noted that Witness 2 and Colleague 1 were on the same shift, and the panel is due to hear live evidence from Witness 2. It further noted that if there is any contradiction in the hearsay evidence of Colleague 1 this can be clarified by Witness 2 in her live evidence.

In these circumstances, the panel came to the view that the evidence was fair and relevant, and it would accept into evidence the hearsay evidence of Colleague 1. It would, however, give it such weight as it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

The panel gave the subsequent application in regard to receiving the NMC statement of Colleague 2 as hearsay consideration. It considered whether Mrs Tsolo would be disadvantaged by allowing hearsay testimony into evidence. The panel highlighted that Colleague 2's hearsay evidence is double hearsay. It was of the view that the

hearsay evidence is too far removed from the facts and that Colleague 1's hearsay evidence is just an email and not a signed statement. In these circumstances the panel refused the application.

The panel gave the application in regard to Resident B consideration. The panel noted that Resident B's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, "*This statement … is true to the best of my information, knowledge and belief*" and signed by her. The panel considered whether Mrs Tsolo would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Resident B to that of a written statement.

The panel considered that as Mrs Tsolo had been provided with a copy of Resident B's statement and, as the panel had already determined that Mrs Tsolo had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. The panel noted that the reason for Resident B's nonattendance was sufficient and reasonable. It further noted that Resident B's local statement on 11 April 2019 was supportive of her witness statement, which has a statement of truth, and that her evidence will be the sole and decisive evidence in relation to charge 5)c).

The panel determined that there was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Resident B and the opportunity of questioning and probing that testimony. There was also public interest in the issues which relate to public protection being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Resident B but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit the written statement of Witness 2

24 July 2023

The panel heard an application made by Mr Kewley under Rule 31 to allow the written statement of Witness 2 into evidence. Witness 2 was had been scheduled to attend at this hearing but had failed to appear despite the NMC making efforts to ensure this witness was present. He submitted that Witness 2 did initially engage with the NMC, and she agreed to be interviewed and give an account to an NMC investigator. Witness 2 signed her witness statement in October 2020 and verified the statement with the statement of truth. He submitted that she indicated in her statement that she was willing to participate in the proceedings. Mr Kewley informed the panel that Witness 2 was sent a witness notice of hearing on 5 July 2023, which told her the two dates that she was to make herself available to give evidence during the proceedings He further told the panel that on 13 July 2023 there was a successful phone call made to Witness 2 from the NMC case officer in which she confirmed that she would be attending the hearing, as she had indicated she would in December 2022.

Mr Kewley submitted that on 13 July 2023, Witness 2 stated that she was going to make inquiries about working from home on the two days that she was asked to give evidence to this panel so that she could give her evidence from home on 19 July 2023. The NMC having become aware that there were difficulties engaging with her, emailed to reiterate the importance of attending to give her evidence when the case started last week. He submitted that the Hearings Coordinator made five telephone calls to Witness 2, none of which were successful and that the Hearings Coordinator did not leave any voicemails for Witness 2. He submitted that there were also three emails sent to Witness 2 asking her to be available to join and then also to join at particular times. The NMC case officer has again made efforts the morning of 25 July 2023 to call her with no success, and a voicemail had been left.

Mr Kewley submitted that there has been a pattern of consistent non engagement since 13 July 2023, when she confirmed that she would make herself available to attend this hearing. He referred the panel to *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). Mr Kewley submitted that the NMC accepts that where Witness 2's evidence is the sole and decisive evidence, the panel may consider that it would be unfair to admit her evidence on the basis that there is no other way of testing it. He stated that we are now in a very different position, which is there is no more witness evidence to come in relation to the charges at the Home, and therefore no way of testing the evidence. In relation to charge 1), the panel has heard from no witnesses who were on shift in April 2019 and the only evidence in relation to the allegation of not carrying a pager comes from Witness 2. He submitted that her evidence is therefore sole and decisive. In respect of charges 2), 3) and 4), Witness 2 is the sole and decisive witness. Mr Kewley submitted that in relation to charge 5), Witness 2 gives evidence that she was told by Resident A that Mrs Tsolo did not introduce herself. He submitted that this is a hearsay account, and if the panel were minded to admit the statement of Witness 2 it would appear to amount to double hearsay. He further submitted that in relation to charge 6)a), it is stated in Witness 2's written statement in paragraph 15 that Mrs Tsolo carried on her task and showed no urgency.

Mr Kewley confirmed the position of the NMC not to seek to introduce Witness 2's evidence as hearsay, and accepted that the panel had the option to review their decision to admit the internal email of Colleague 1 as hearsay evidence.

Mr Kewley submitted that there are no other witnesses who can give evidence in relation to charge 7) and 8). He submitted that there are a number of other matters that the panel ought to consider. Firstly, the nature and extent of the challenge to the evidence of Witness 2 and secondly that her evidence is disputed by Mrs Tsolo. He referred the panel to Mrs Tsolo's written responses that there is a suggestion that these allegations may have been fabricated and so credibility is an issue in relation to Witness 2 which would be tested in oral evidence, and, further, the serious nature of the charges.

Mr Kewley submitted that as to the non-attendance of Witness 2, the NMC do not know why Witness 2 has ceased to engage. He submitted that in order to try and engage Witness 2, the only other step that could be open to the NMC would be to apply to the High Court to obtain a witness summons to compel the attendance of Witness 2. It would require the proceedings to be adjourned, an application made to a High Court judge, the application and summons then served to Witness 2. The NMC did not seek such a step to be required by the panel, but merely wished to point out the powers of the panel under Rule 22.5. Mr Kewley accepted that if such steps were taken to obtain the attendance of Witness 2 it would require an adjournment of the hearing and that there was no guarantee that it would secure her co-operation and attendance.

Mrs Tsolo did not oppose the application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is "*fair and relevant*", a panel may accept evidence in a range of forms and circumstances, whether or not it would be admissible in civil proceedings.

Prior to making their decision the panel requested the NMC to contact Witness 2 by telephone and email one last time and to leave a voicemail offering any special measures or support that she may require if she decides to attend the hearing.

25 July 2023

Mr Kewley informed the panel that a further attempt to email and call Witness 2 was made by the NMC case officer on 24 July 2023. The NMC case officer had not received a response to either correspondence.

The panel had regard to and applied to *Thorneycroft v NMC* in their decision making. The panel was of the view Witness 2 was served the witness notice of hearing on 5 July 2023 and had knowledge of the two dates that she was to be available for. The panel noted that on 11 July 2023, the NMC had sent Witness 2 her witness statement and exhibits and she had confirmed her attendance to the NMC case officer on 13 July 2023. The panel further noted that since the last communication with Witness 2 there had been five calls without voicemails made to Witness 2 and two three emails with no response. The panel had directed the NMC to make further contact with Witness 2, but this was also unanswered with a voicemail left to say that if she were to attend special measures could be in place. The panel accepted that it did not have good or cogent reason of Witness 2's non-attendance. It further noted that the NMC had explored every possibility in securing Witness 2's attendance at the hearing.

The panel determined that it was not possible for Mrs Tsolo or the panel to test the credibility of Witness 2's account. The panel decided that it would be unfair to Mrs Tsolo if this challenge could not take place. It noted that in respect of charges 1, 2, 3, 4, 5)a), 6)a), 7) and 8) Witness 2's account was the sole and decisive evidence. The panel considered an adjournment to take this matter to the High Court. However, it was of the view that this was not proportionate.

Taking those matters into account, the panel determined that it would not be fair to Mrs Tsolo to admit Witness 2's hearsay evidence, and in these circumstances the panel rejected the application.

Renewed consideration of application to admit hearsay evidence of Colleague 1

25 July 2023

The panel of its own volition revisited their decision in accepting into evidence the hearsay evidence of Colleague 1 and Mr Kewley accepted that the panel had the ability to do so in the light of the new evidence and the correction in the original submission, that is that Colleague 1 had in fact been approached by NMC and had

declined to co-operate. The panel noted that due to Witness 2's non-attendance and having rejected the NMC's application in accepting Witness 2's statement into evidence, it was unable to test Colleague 1's hearsay evidence as both Witness 2's and Colleague 1's evidence is inextricably linked and it was unable to cross reference it with Witness 2's written statement. The panel therefore revisited and subsequently rejected the application to admit hearsay evidence of Colleague 1.

Decision and reasons on application to offer no evidence

The panel considered an application from Mr Kewley to offer no evidence in respect of charges 1, 2, 3, 4, 5)b), 6)a), 7) and 8). Mr Kewley submitted that following the panel's decision on the hearsay application in rejecting Witness 2's written statement into evidence, the NMC have no evidence to offer in relation to charges 1, 2, 3, 4, 5)b), 6)a), 7) and 8).

Mr Kewley submitted that in relation to charge 5)a), Mrs Tsolo is representing herself. He said that she does not have the benefit of a barrister representing her, but the panel will be aware that at this stage, if she did have counsel, the panel would be likely to receive an application of no case to answer on Mrs Tsolo's behalf. Mr Kewley submitted that the reason that he has not made a submission of no evidence on charge 5)a) is because there is some evidence which is hearsay evidence. He submitted that the panel at this stage can consider whether sufficient evidence has been adduced, upon which it could find charge 5)a) proved. He submitted that if the panel were to hear live evidence from Witness 2 there would have been a way of testing residents' account to some extent as Witness 2 gave evidence of what was reported to her when she walked into the room of Resident A who made the complaint.

Mrs Tsolo did not object to the application.

The panel took account of the submissions made. It heard and accepted the advice of the legal assessor who made reference to the NMC's guidance on offering no evidence.

Having previously determined that the written statement of Witness 2 was the sole and decisive evidence in respect of charges 1), 2), 3), 4), 5)b), 6)a), 7) and 8). The panel having further determined that this evidence is not admissible, it accepted the application on behalf of the NMC that there is no evidence they could offer in respect of the above charges.

The panel had regard to *R v Galbraith* [1981] 1 WLR 1039 and *PSA v NMC and X* [2018] EWHC 70 [Admin].

The panel of its own volition, given that Mrs Tsolo is unrepresented, considered whether there was sufficient evidence upon which the facts could be found proved in respect of charges 5)a), 5)c) and 9). It heard submissions from Mr Kewley addressing this matter and it determined that there was sufficient evidence to continue this matter and address it at the facts stage.

Decisions and reasons on application to recall Witness 1 and Witness 3

[PRIVATE].

Mr Kewley invited the panel to refuse the application. He submitted that this case has been listed for quite a few months now, and Mrs Tsolo would have been aware of the dates of this hearing and would have known that witnesses were going to be giving evidence. He submitted that Mrs Tsolo was sent his written opening at the beginning of the week, which indicated at the back that Witness 1 and Witness 3 would be giving evidence. Mr Kewley submitted that Mrs Tsolo on 17 July 2023 was also told by email that the first witness would be giving evidence on Tuesday morning when the refusal of the postponement was communicated to her. He submitted that Mrs Tsolo had voluntarily absented herself from the first part of the hearing this week.

Mr Kewley submitted Witness 1 and Witness 3 are senior nurses at the Home and clearly asking them to come back and give evidence again would cause inconvenience not only to them, but to the Home as a whole. Witness 1 and Witness

3 would need to put in place measures to cover their absence from their clinical duties.

The panel heard and accepted the advice of the legal assessor. The legal assessor summarised to the panel the questions which Mrs Tsolo had said she wanted to put to the witnesses and Mrs Tsolo accepted that the summary was correct and complete. The point of recalling a witness is to put material to them that was not available when the witnesses first gave evidence. Matters that can be put to a witness must be relevant to charges which are contested, not to address mitigation. Proceedings must be fair to all parties, including witnesses, and must be weighed against the public interest in the expeditious disposal of this case.

The panel had particular regard to the nature of the questions that Mrs Tsolo wished to ask Witness 1 and Witness 3. The panel noted that the questions she was going to ask were not addressing the detail of the charges. The questions she hoped to pose in regard to the policy had already been asked of the witnesses during their evidence. It was of the view that the questions Mrs Tsolo had indicated that she will ask, the panel already had the answers to. The panel further noted that due to the nature of this case, it will be an inconvenience to recall Witness 1 and Witness 3 due to their clinical role. Their role meant that their absence would affect colleagues and patients requiring a clinician.

The panel determined that Mrs Tsolo had voluntarily absented herself and she was also aware that the witnesses would be giving evidence. [PRIVATE]. The panel noted that refusing this application will not be unfair to Mrs Tsolo. Therefore, the panel rejected the application to recall Witness 1 and Witness 3.

Background

071955/2019

Charges 1) to 8) arose whilst Mrs Tsolo was employed as an agency nurse at Fulford Nursing Home (the Home).

On the evening of 8 April 2019, an agency nurse failed to arrive at the Home for a shift commencing at 20:00. Witness 3 was working a day shift and she contacted an agency called Sense Care who provided Mrs Tsolo as a last-minute agency nurse for the night shift. Mrs Tsolo arrived at the Home at approximately 21:45 on 8 April 2019 according to Witness 3 and 22:22 according to Mrs Tsolo in her responses. Witness 3 provided Mrs Tsolo with a handover, and she then completed the night shift alongside two carers, Witness 2 and Colleague 1.

During the nightshift there were a number of alleged incidents that had occurred. Mrs Tsolo:

- Failed to carry a pager contrary to the Home's policy on pagers;
- Failed to carry out all of the necessary checks of the residents under her care;
- Entered onto the digital system (Cura) that she had conducted the checks on said residents;
- Failed to carry out appropriate medication administration in that she:
    a) Failed to introduce herself to residents prior to administering medication to them
    b) Tried to administer medication to Resident A by putting the medication into their mouth whilst they were sleeping
    c) Tried to administer medication to Resident B by putting the medication into their mouth whilst they were sleeping
- Failed to follow correct procedure on or around the occasion of the death of Resident C in that she failed to:
    a) Respond promptly to the news that Resident C was not breathing
    b) Call 999 for an ambulance
    c) Document the death
    d) Provide the necessary details to the 111 operator
- Failed to act in a professional manner in that she:
    a) Questioned colleagues in a confrontational manner in front of residents
    b) Told colleagues that "*homosexuality is a mental illness*" or words to that effect

c) when told by Colleague 1 that they had a gay friend, responded by saying "*Oh I had a cousin who is gay and he died of aids*" or words to that effect

The carers reported their concerns to Witness 3 the following morning who then reported the concerns to Witness 1.

On 28 July 2020, whilst Mrs Tsolo registration was subject to an interim suspension order it is alleged that Mrs Tsolo worked as a registered nurse.

078197/2020

It is alleged that between 5 December 2019 and 12 April 2020 whilst Mrs Tsolo's registration was subject to an interim conditions of practice order, she breached the conditions 1, 2, 3, 4, 5 and 7 of said order.

It is also alleged that on 23 April 2020, Mrs Tsolo informed an interim order panel of the NMC that there were always two nurses on shift when she was working and that she was always supervised when administering medication. However, Mrs Tsolo was on occasion the only nurse on duty and therefore was not always supervised when administering medication.

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 Kewley on behalf of the NMC and by Mrs Tsolo.

The panel had confined its consideration to the charges which remain and has not taken into account the charges which had been dismissed and/or not proceeded with by the NMC, or evidence relating to those allegations. The panel had also put out of its consideration statements which it had read initially and subsequently rejected.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This

means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Registered Manager at the Home at the time of the allegations;
- Witness 3: Deputy Manager at the Home at the time of the allegations;
- Witness 4: Registered Manager at Benedicts Nursing Home, Wetherby (Benedicts Home) at the time of the allegations;
- Witness 5: Registered Manager at TempCare Personnel Limited (TempCare) at the time of the allegations;
- Witness 6: Investigator within the Professional Regulation Directorate at the NMC;
- Witness 7: Agency nurse at Park Avenue Care Home (Park Avenue) at the time of the allegations;
- Witness 8: Managing Director of First Health Care Limited (First

Health Care) at the time of the allegations.

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 Mrs Tsolo.

The panel has also considered Mrs Tsolo's oral statement to the panel on 27 July 2023 that the matters contained in her responses are true to the best of her knowledge and belief. Mrs Tsolo also confirmed at the same time that she did not wish to be questioned in cross examination and had chosen not to give oral evidence.

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

Charge 5)a)

5) Failed to carry out appropriate medication administration, in that you;
   a) Failed to introduce yourself to residents prior to administering medication to them;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's and Resident B's witness statements and Resident B's local statement dated 11 April 2019. It also took into account Mrs Tsolo's email of her response to the allegations dated 21 July 2023, internal response in April 2019 and her other written responses to the NMC.

At the outset, the panel established that Mrs Tsolo had a duty to carry out appropriate medication administration as a registered nurse and that this would include introducing herself to a resident before administering medication to the resident. The panel was of the view that Mrs Tsolo failed to carry this out.

The panel considered Resident B's witness statement in which she stated that "*I wasn't able to see the ID on the individual as I was still half asleep. However the person was wearing dark clothing - I couldn't tell if it was a uniform*." The panel recognised that there are discrepancies relating to the time that this incident occurred in Resident B's witness statement and her local statement which was provided to Witness 1 shortly after the incident had occurred. However, it noted that both the witness statement and local statement are reliable as Resident B was not consistent with regards to what had occurred. The panel further noted that Mrs Tsolo was on shift and was the only nurse on duty that night who could administer medication. Carers were not authorised to administer medication.

The panel considered Mrs Tsolo's email of her response to the allegations dated 21 July 2023 in which she stated that "*I dent* [sic] *this allegation. It is notable that the statement from* [Resident B] *started that she was upset at have been woken. This is not the same as attempting to give a patient tablets when asleep. It is also notable that the statement is unsigned typed statement. The fact that it has been typed makes it very unlikely that it was written by the resident but instead by the nurse taking the statement. There is no evidence that the nurse taking the statement has undertaken any training in statement taking particularly in vulnerable people. The fact that it is unsigned means limited weight should be afforded to its contents.*" The panel do not share the same view and note that this is not relevant. The panel recognise that witness statements are normally written up by another individual and not the person giving their account of the matters. It further noted that Resident B had subsequently signed a statement of truth. Witness 1 in her oral evidence confirmed to the panel that there was no history of Resident B making false allegations against staff.

The panel accepted the evidence of Resident B and decided it could attach significant weight to it although it could not be tested in cross examination.

On that basis, the panel was satisfied on the balance of probabilities that Mrs Tsolo, failed to introduce herself to residents prior to administering medication to them.

In light of the above, the panel therefore finds charge 5)a) proved.

Charge 5)c)

5) Failed to carry out appropriate medication administration, in that you;
   c) Tried to administer medication to Resident B by putting the medication into their mouth whilst they were sleeping;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's and Resident B's witness statements and Resident B's local statement dated 11 April 2019. It also took into account Mrs Tsolo's email of her response to the allegations dated 21 July 2023, internal response in April 2019 and her other written responses to the NMC.

The panel considered Resident B's witness statement in which she stated that "*On the night of the incident, the Registrant woke me up by trying to put something in my mouth. I couldn't see what tablets they were but pushed her arm away from my mouth and said what do you think you are doing'. The Registrant didn't say anything to me afterwards, she just went away after I pushed her arm away*."

The panel further considered Witness 1's witness statement in which she stated that "*As part of my local investigation, I approached and spoke with both the residents who had been involved. Each of the residents told me that they had awoken to find tablets being put into their mouths. I took statements from each, which I asked them to sign*." Witness 1 in her oral evidence confirmed to the panel that there was no history of Resident B making false allegations against staff.

The panel also considered Mrs Tsolo's email dated 21 July 2023 in which she stated that "*I have started my shift at 22:30 pm and all night medication was already given by day nurse.* [Resident B] *said it was 11 pm when she was woken up someone putting tablets in her mouth. I had not given night tablets. I have also worked in 2015 as bank nurse and 2016 and 2017 and I had given* [Resident B] *tablets and I knew her. because I worked day and nights. There were no concerns why in 2019 would I force tablets.*"

The panel had not had the opportunity to hear cross examination or ask any questions of Mrs Tsolo's in relation to her email dated 21 July 2023 under oath/affirmation and whilst the panel do not hold this against her it is impossible to test this evidence. The panel therefore gave this very limited weight. The panel preferred the evidence of Witness 1 and Resident B, which was considered credible and reliable, and broadly consistent. The panel has taken account of the evidence of Witness 1 concerning Resident B's shocked demeanour when Witness 1 spoke to her on the morning after the night shift.

On that basis, the panel was satisfied on the balance of probabilities that Mrs Tsolo, tried to administer medication to Resident B by putting the medication into her mouth whilst she was sleeping.

In light of the above, the panel therefore finds charge 5)c) proved.

Charge 6)b)

6) Failed to follow correct procedure on or around the occasion of the death of Resident C, in that you failed to;
   b) Call 999 for an ambulance;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 3's witness statement and oral evidence. It also took into account Resident C's daily care notes dated 9 April 2019.

The panel noted that whilst Mrs Tsolo was on the phone to the 111 operator they had informed her that they would arrange an ambulance to come to the Home, but also asked her to call 999. However, the panel was of the view that Mrs Tsolo may have misunderstood as to why she had to call 999 when she was on the phone to the 111 operator and the 111 operator was organising an ambulance which would verify the death of the resident.

The panel further noted that it was not established whether there was a duty for Mrs Tsolo to call 999 because no policy was adduced and although Witness 3 said that she expected Mrs Tsolo to abide by the law, the panel was unclear which law she referred to. The panel was also not satisfied that it was generally expected procedure for all nurses, such that she ought to have known to call 999 rather than 111.

For the reasons set out above and the lack of supporting evidence, the panel was not satisfied on the balance of probabilities that Mrs Tsolo failed to call 999 for an ambulance.

In light of the above, the panel therefore finds that the NMC has not discharged its burden of proof and finds charge 6)a) not proved.

Charge 6)c)

6) Failed to follow correct procedure on or around the occasion of the death of Resident C, in that you failed to;
   c) Document the death;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement and oral evidence. It also took into account Resident C's daily care notes dated 9 April 2019.

The panel considered Witness 1's witness statement in which she stated that "*Susan should then have documented in* [Resident C] *notes the time she was alerted to his death and by whom. I'd also expect her to fully and clearly document what was said by the staff member who alerted her to the death, any instruction Susan gave to the Carer(s) at that time and whether they followed her instructions. All Nurses should be aware of the procedure to follow in the event of an unexpected death.*

This is something that a nurse with the amount of experience Susan had should know. She should then have telephoned NHS 111 and advised them of the fact that the resident's death was unexpected so that they could inform the Coroner's team."

It further considered that "*Susan's shift was due to end at 08:00 hrs so the time available for her to complete documentation, or even the documentation itself, might have been impacted by the fact she knew she was soon to go home. However, I would have expected her to have recorded in full of her actions…*"

The panel also considered Resident C's daily care notes dated 9 April 2019 in which Witness 3 stated that "*No entry made by nurse Susan Tsolu* [sic] *of events leading up to my Arrival….*" The daily care notes did, however, have a detailed account completed by Witness 3.

The panel was of the view that it is expected of any registered nurse that they document up to date information whilst on shift. In an email dated 21 July 2023 Mrs Tsolo stated that Witness 3 had told her that she [Witness 3] would document the death and she trusted her to do so. The panel were unable to test the assertion by Mrs Tsolo and so gave it appropriate weight. The panel considered that as the nurse in charge on shift Mrs Tsolo had a duty to document Resident C's death in full.

On that basis, the panel was satisfied on the balance of probabilities that Mrs Tsolo failed to document the death of Resident C.

In light of the above, the panel therefore finds charge 6)c) proved.

Charge 6)d)

6) Failed to follow correct procedure on or around the occasion of the death of Resident C, in that you failed to;
   d) Provide the necessary details to the 111 operator;

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's and Witness 3's witness statements and oral evidence. It also took into account Resident C's daily care notes dated 9 April 2019 and Mrs Tsolo's email of her response to the allegations dated 21 July 2023.

The panel considered Witness 3's witness statement in which she stated that "*Susan handed me the phone and I introduced myself to the gentleman at the other end of the line. The gentleman was quite abrupt and seemed quite frustrated. It transpired that Susan had called 111 to report the death of one of the residents but had been unable to provide the relevant information which the gentleman at 111 needed to be able to action the request. The gentleman at 111 wanted to know which resident had died and I recall one of the other staff members having to give me this information to pass on. He asked whetheRsdnt Cs* [sic] *death had been expected, whetherRsdnt C* [sic] *was a palliative care patient, and whether his death had been expected. I provided this information*." This was corroborated during Witness 3's oral evidence in which she told the panel that when she spoke to the 111 operator, he did not know the details of what had happened or even which resident it was. Witness 3 said in oral evidence that the telephone was *"thrust at her"* upon her arrival at work.

This was further supported by Resident C's daily care notes dated 9 April 2019 in which Witness 3 stated that *the gentleman at NHS 111 when I spoke to him seemed frustrated that no one knew if the gentleman was palliative care and that he had been on the call for more than 15 minutes...'* The panel was of the view that Witness 3's witness statement and oral evidence was credible in respect of this charge.

The panel considered Mrs Tsolo's email dated 21 July 2023 in which she stated that "*It was at around 7am and whilst I was busy finding more information on Cura electronic device which I was not familiar with…*" It determined that Mrs Tsolo did struggle to get the necessary details to the 111 operator and that it was not sufficient that she was not familiar with the Cura system. As a registered nurse Mrs Tsolo should have been capable of documenting this.

On that basis, the panel was satisfied on the balance of probabilities that Mrs Tsolo failed to provide the necessary details to the 111 operator.

In light of the above, the panel therefore finds charge 6)d) proved.

Charge 9)

9) On 28 July 2019, whilst your registration was subject to an interim suspension order, worked as a registered nurse;

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's and Witness 8's witness statements and oral evidence. It also took into account Witness 4's exhibits of a rota for week commencing Monday 22 July 2019 and a casual/relief staff checklist dated 28 July 2019. It further took into account Witness 8's screenshot of 28 July 2019, Mrs Tsolo's email of her response to the allegations dated 21 July 2023, internal response in April 2019 and her other written responses to the NMC.

The panel considered Witness 4's oral evidence in which she told the panel that Mrs Tsolo had worked a shift on 28 July 2019 as an agency nurse. She also told the panel that Ms 1 was present at Benedicts Home to give an induction to Mrs Tsolo on that day. The panel had regard to the rota for week commencing Monday 22 July 2019 which refers to Mrs Tsolo's position on 28 July 2019 as: "*S.Tsolo RGN*." During panel questioning, Witness 4 confirmed that if a nurse was to work at Benedicts Home as a carer, Benedicts Home would not have put the nurse's *'RGN'* qualification on the rota. Witness 4 confirmed that if there were changes to the rota these would be entered retrospectively on the rota records.

The panel also considered Witness 8's witness statement in which he stated that "*Around July 2019, we received a copy of a timesheet from Susan which indicated that she had been working at Benedicts. No-one at the agency was aware that Susan had been working for Benedicts and the shift hadn't been booked through First Health Care. I assume that the Care Home Manager had Susan's personal details and had contacted her directly to arrange the shift. When Susan's time sheet came in, I asked the staff to let me have a look at it so I could try to work out what*

was happening. I recall picking up a text message from Susan in which she told me that she had been booked directly to work as a Registered Nurse within the Home."

The panel noted that Witness 8 during his oral evidence provided the panel with a screenshot which confirms that Mrs Tsolo was booked to work as a support assistant on 28 July 2019.

However, the screenshot indicated that Mrs Tsolo was working as a support assistant for only four hours on that day. The panel was of the view that the rota from Benedicts Home suggests that this could have been true for part of the day as she could have been paid as a registered nurse from the morning till 16:00. This was corroborated by the casual/relief staff checklist which indicates that Mrs Tsolo was shadowing Ms 1 who is a registered nurse.

Witness 8 in his oral evidence also told the panel that it was hard at times to understand Mrs Tsolo as to whether she was working shifts as a nurse or as a carer.

On that basis, the panel was satisfied on the balance of probabilities that Mrs Tsolo on 28 July 2019, whilst her registration was subject to an interim suspension order, worked as a registered nurse.

In light of the above, the panel therefore finds charge 9) proved.

Charge 10)a)i)

10) Between 5 December 2019 and 12 April 2020, whilst your registration was subject to an interim conditions of practice order, breached the conditions of said order, in that you;
    a) Worked as the only registered nurse on duty, and so were;
        i) The Designated Nurse in Charge, contrary to condition 1 of the order;

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement and oral evidence. It also took into account Mrs Tsolo's undated reflective piece, Witness 4's exhibits of a number of staff duty rotas, Witness 8's screenshot of 28 July 2019, Mrs Tsolo's written responses sent by email to the NMC.

The panel considered Witness 4's witness statement in which she referred to a number of shifts that Mrs Tsolo had worked from the week commencing Monday 2 December 2019 to 12 April 2020. The panel noted that Witness 4 stated "*Susan worked as a staff nurse. Her role involved the daily running of the shift, administration of medications and any clinical interventions which the clients required*."

The panel noted that during Mrs Tsolo's shifts in the weeks commencing 30 January 2020 and 6 April 2020, she was alone for most of the shift. The panel was of the view that there may have been some confusion from Mrs Tsolo that she was not the nurse in charge and that it was Witness 4. However, Witness 4 had confirmed to the panel that she did not work clinically and was not present at night, on Fridays or weekends and there were times that she would be working from home. The panel also noted that during night shifts Mrs Tsolo was the designated nurse in charge. Witness 4 confirmed in oral evidence that any registered nurse booked for a particular shift would be the designated nurse in charge.

The panel considered Mrs Tsolo's reflection in which she stated that "*I made an error by not complying with my conditions as I had misunderstood the conditions, my belief was that I had worked unpaid and had been supervised by two nurses…and* [Witness 7] *and signed off as competent I thought I was deemed competent to continue dispensing medication independently, I now fully understand that I should have informed Benedicts nursing home of my conditions of practice, I apologise for my error and have learnt that moving forward if I have any uncertainties I will clarify with the appropriate people. I will ensure that this will never happen again, I am responsible to ensure that I follow any conditions I will also ensure that my personal development plan is kept up to date*."

On that basis, the panel was satisfied on the balance of probabilities that Mrs Tsolo worked as the only registered nurse on duty, and so was the designated nurse in charge, contrary to condition 1 of the order.

In light of the above, the panel therefore finds charge 10)a)i) proved.

Charge 10)a)ii)

10) Subject to an interim conditions of practice order, breached the conditions of said order, in that you;
    a) Worked as the only registered nurse on duty, and so were;
        ii) Not supervised by a registered nurse, contrary to condition 2 of the order;

This charge is found proved.

In reaching this decision, the panel took into account Witness 4 witness statement and oral evidence. It also took into account Mrs Tsolo's undated reflective piece and Witness 4's exhibits of a number of staff duty rotas. It also took into account Mrs Tsolo's undated reflective piece and her written responses sent by email to the NMC.

The panel had regard to Mr Kewley's written closing submissions dated 25 July 2023 in which he summarised condition 2 as "*Condition 2 – The Registrant was to ensure that she was supervised by a line manager, supervisor or mentor at any time she was working, to consist of working at all times on the same shift as, but not always directly observed by, a registered nurse*." The panel was of the view that this indicates clearly that Mrs Tsolo was not permitted to be the only registered nurse on duty. It further noted that there were a number of occasions when Witness 4 was in the building and Mrs Tsolo said that Witness 4 was supervising her. The panel accept this to a certain point as Witness 4 had an open-door policy. However, this was not the case when Mrs Tsolo was on night shift duty and working during the weekends as Witness 4 did not work night shifts nor weekends. The panel was of the view that the rota's provided by Witness 4 indicate that even if two nurses sometime appear on duty they are not together for the whole of the shift.

The panel was satisfied on the balance of probabilities that Mrs Tsolo worked as the only registered nurse on duty on occasions, and so was not supervised by a registered nurse, contrary to condition 2 of the order.

In light of the above, the panel therefore finds charge 10)a)ii) proved.

Charge 10)a)iii)

10) Subject to an interim conditions of practice order, breached the conditions of said order, in that you;
    a) Worked as the only registered nurse on duty, and so were;
        iii) Not supervised when administering medication, contrary to condition 3 of the order;

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement and oral evidence. It also took into accounts Medication Administration Records (MAR) Sheets of Resident's W, Y, Z, Mrs Tsolo's undated reflective piece and her written responses sent by email to the NMC.

The panel considered Witness 4's witness statement in which she stated that *"At Benedicts, it is always the nurse who carries out the medication round and administers the medication to the residents. We do not have any Carers who are trained in medication administration. We have a medication trolley which is kept locked away in our medication room when not in use. Our pharmacy has reverted from a blister pack system to the traditional system of dispensing medications individually, so we're back to a traditional medication round whereby the nurse must check and dispense all the medications from individual bottles or packages. This means that the medication round does take a bit of time to complete. It is standard practise for the nurse on duty to take the medication trolley around the Home with them when they complete the medication round. Whilst Susan was working for us, I did see her out and about with the drugs trolley. I complete weekly and monthly medication audits and never picked up any issues with Susan's medication rounds. I*

have reviewed and extracted a number of MAR sheets which indicate that Susan administered medication whilst she was working at Benedicts."

The panel also considered the MAR Sheets of Resident's W, Y, Z which confirms that Mrs Tsolo administered medication to the above residents.

The panel further noted Mrs Tsolo's in her reflection confirmed that "*I thought I was deemed competent to continue dispensing medication independently, I now fully understand that I should have informed Benedicts nursing home of my conditions of practice, I apologise for my error and have learnt that moving forward if I have any uncertainties I will clarify with the appropriate people. I will ensure that this will never happen again*."

The panel therefore was satisfied on the balance of probabilities that Mrs Tsolo worked as the only registered nurse on duty, and so was not supervised when administering medication, contrary to condition 3 of the order.

In light of the above, the panel therefore finds charge 10)a)iii) proved.

Charge 10)b)

10) Subject to an interim conditions of practice order, breached the conditions of said order, in that you;
    b) Failed to create a personal development plan with your line manager, contrary to condition 4 of the order;

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's witness statement and oral evidence. It also took into account Witness 8's oral evidence, Mrs Tsolo's undated reflective piece, two unsigned Personal Development Plans (PDP) of hers and her written responses sent by email to the NMC.

The panel considered Witness 4's witness statement in which she stated that "*Whilst she worked at Benedicts, I was Susan's line manager - I was the only manager at the Nursing Home. The agency wouldn't be able to line manage someone. However, I didn't directly supervise Susan - there is an expectation that agency nurses are able to get on with the work, especially because they're only asked to do the basics. Following this incident, I started up a new process whereby I could undertake performance and development reviews with agency staff members who worked with us regularly, but I wouldn't have done anything specific with Susan, and I certainly wasn't supervising her. I was never approached and asked to create and/or administer a personal development plan. I would have expected Susan's agency to complete their own performance monitoring reviews and hold supervisory meetings with Susan*."

The panel also considered Witness 8's oral evidence in which he told the panel that he had no recollection of completing a PDP for Mrs Tsolo even if he was her line manager. The panel noted thar Mrs Tsolo was working at Benedicts Home on a regular basis from 5 December 2019.

The panel further considered Mrs Tsolo's undated reflective piece in which she stated, "*I had misunderstood that it was my responsibility to keep my personal development plan up to date, I had wrongly believed it was the agencies responsibility, on reflection I now realise that it is my responsibility to keep abreast of new knowledge and learnings and to keep this updated in a timely manner*." The panel acknowledged that Mrs Tsolo had produced two examples of a PDP. However, these were inadequate as they did not show a signature from a line manager. One of the PDP's post-dated this charge. It was of the view that Mrs Tsolo had failed to authenticate the PDP's by providing this to her employer or to the NMC.

The panel therefore was satisfied on the balance of probabilities that Mrs Tsolo failed to create a personal development plan with her line manager, contrary to condition 4 of the order.

In light of the above, the panel therefore finds charge 10)b) proved.

Charge 10)c)

10) Subject to an interim conditions of practice order, breached the conditions of said order, in that you;
    c) Failed to inform the NMC of your employment within 7 days, contrary to condition 5 of the order;

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's witness statement and oral evidence and her exhibit including a communications log for a telephone call with Mrs Tsolo, dated 23 April 2020 at 11:00. It also took into Mrs Tsolo's undated reflective piece, and her written responses sent by email to the NMC.

The panel considered Witness 6's communication log with Mrs Tsolo in which she stated that "*I asked Susan if she was currently working and she confirmed yes, she was. She advised that she has been working as a Nurse via TempCare (Agency) since January 2020. She has been working at Benedict Nursing Home and has been carrying out dayshift hours only. Susan advised that the reason for her working dayshift was because this allowed her to be supervised when on duty because there was another RN present. Susan advised that her duties were all the same as you would expect of an RN at a nursing home and included caring for the residents and medication rounds. She advised that she had completed her medication competency course and asked if we had received this. I confirmed we had received competencies from the RCN in January*." Witness 6 in her oral evidence told the panel that this was the first she knew of Mrs Tsolo's employment and that if correspondence had come in regarding Mrs Tsolo's employment it would have been seen by her whether sent by email or a letter. The panel noted that Mrs Tsolo was working at Benedicts Home from 5 December 2019 but Witness 6 was not aware of this until 23 April 2020.

The panel also considered Mrs Tsolo's undated reflective piece in which she stated that *"Going forward I will ensure that I will keep the NMC notified of all areas of work within seven days and that I will seek to find permanent employment and be open and transparent with the employer regards any conditions of practice that I placed on*

me. I will ensure that I will follow these conditions and follow the NMC guidelines to ensure I work within my scope of practice."

The panel therefore was satisfied on the balance of probabilities that Mrs Tsolo failed to inform the NMC of her employment within 7 days, contrary to condition 5 of the order.

In light of the above, the panel therefore finds charge 10)c) proved.

Charge 10)d)

10) Subject to an interim conditions of practice order, breached the conditions of said order, in that you;
    d) Failed to provide a copy of these conditions an organisation or person you worked for an/or an agency with which you were registered for work, contrary to condition 7 of the order;

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's and Witness 8's witness statements and oral evidence. It also took into account the Royal College of Nursing (RCN)'s email dated 13 November 2019.

The panel considered Witness 4's witness statement in which she stated that "*On Thursday 23 April 2020, I received a telephone call from Susan. Due to the passage of time, I can no longer recall exactly what Susan said to me but I do remember her saying that someone from the MC would be ringing me and she wanted me to say that I had been present in the Home during the shifts she had been working. I remember thinking that this was a bit odd and, at that point, I checked the MC website and discovered that Susan was subject to an Interim Conditions of Practice Order (ICOPO"). At no point during the time Susan worked at Benedicts was I ever shown a copy of Susan's conditions or told of their existence, either by Susan herself or by either of the agencies she worked through. | found out about the conditions myself when I looked up Susan's name on the NMC website on 23 April 2020*."

The panel also considered Witness 8's witness statement in which he stated that *"I do remember Susan informing me that she had been referred to the NMC and that there was a fitness to practise investigation being undertaken. Unfortunately, due to the passage of time, I can't remember the precise date when Susan gave me this information. She didn't discuss with me the nature of the NMC concerns investigation but I found it very difficult to follow what Susan was saying about it and she didn't provide me with any additional information. At the time, I wasn't unduly concerns about the investigation because Susan was working as an HCA via First Health Care, and that didn't require her to hold a PIN. Midway through 2020, I found out that Susan had been working as a Registered Nurse at Benedict's and that she failed to disclose that she was subject to an Interim Conditions of Practice Order, imposed by the NMC."*

The panel considered the RCN's email dated 13 November 2019 in which Mrs Tsolo's then representative stated that "*It is extremely important that you comply with the conditions imposed. It is <u>your responsibility</u> to do this. Even if you have notified your employer of the conditions and your employer needs to take some form of action; it remains your responsibility to follow this up and ensure it is done*." The panel was of the view that Mrs Tsolo had not informed any of the agencies or Benedicts Home that she was subject to an interim conditions of practice order.

The panel therefore was satisfied on the balance of probabilities that Mrs Tsolo failed to provide a copy of these conditions to an organisation or person she worked for an/or an agency with which she was registered for work, contrary to condition 7 of the order.

In light of the above, the panel therefore finds charge 10)d) proved.

Charge 11)a)

11) On 23 April 2020, informed an interim order panel of the NMC, that;
    a) There were always two nurses on shift when you were working, when you were the only nurse on duty;

This charge is found proved.

In reaching this decision, the panel took into account the transcript from the Interim Order Review Hearing on 23 April 2020 and Witness 4's exhibits of a number of staff duty rotas. It also took into account Mrs Tsolo's statement to this panel on 27 July 2023 that the matters contained in her written responses to the NMC were true to the best of her knowledge and belief.

The panel noted that Mrs Tsolo at the hearing informed the Investigating Committee panel chair that:

> *"THE REGISTRANT: My role there is we are working (inaudible) nurse giving out medication and doing everything that need to be done, really, as a nurse.*
> *THE CHAIRMAN: When you are giving medications, are you the only nurse who is there?*
> *THE REGISTRANT: There are two nurses already (inaudible) time or one nurse on duty.*
> *THE CHAIRMAN: Right, so there are always two nurses. When you give ----*
> *THE REGISTRANT: Yes."*

The panel was of the view that the staff duty rota sheets indicate that Mrs Tsolo was the only nurse on duty. The panel therefore was satisfied on the balance of probabilities that Mrs Tsolo on 23 April 2020, informed an interim order panel of the NMC, that there were always two nurses on shift when she was working, when she was the only nurse on duty.

It noted that Mrs Tsolo informed Witness 6 and this panel and that she had asserted in her email of 18 July 2023, that she did not understand the questions of the chair of the Investigating Committee panel because she was on a bus at the time. However, the transcript of that hearing shows that Mrs Tsolo had confirmed to that panel that she was in her house and could hear at the time the questions were asked and did not seek an adjournment. Mrs Tsolo did not indicate to the Investigating Committee panel that she could not hear or did not understand the questions asked to her.

In light of the above, the panel therefore finds charge 11)a) proved.

Charge 11)b)

11) On 23 April 2020, informed an interim order panel of the NMC, that;
    b) You were always supervised when administering medication, when you were not;

This charge is found proved.

In reaching this decision, the panel took into account the transcript from the Interim Order Review Hearing on 23 April 2020.

The panel noted that Mrs Tsolo at the hearing informed the Investigating Committee panel Chair that:

"THE CHAIRMAN: Right. Can you just tell me a little, you are working now for St Benedicts? What does that role entail? What are you actually doing? What is your role there?
THE REGISTRANT: My role there is we are working (inaudible) nurse giving out medication and doing everything that need to be done, really, as a nurse.
THE CHAIRMAN: When you are giving medications, are you the only nurse who I there?
THE REGISTRANT: There are two nurses already (inaudible) time or one nurse on duty.
THE CHAIRMAN: Right, so there are always two nurses. When you give ----
THE REGISTRANT: Yes.
THE CHAIRMAN: -- out the medicines do the two nurses give it out together, then?
THE REGISTRANT: I was supervised and then whatever -- and then after I have given medication they normally check what I have done. They check the file, they go through.
THE CHAIRMAN: So when you are actually giving the medication to a patient who is there, or somebody in the care home, you would give it to them and

then afterwards a nurse would check that you have given the right medication, is that right?
THE REGISTRANT: No, they were supervising me before, but when I have been working for a long time, for some time now, they also continue to check.
THE CHAIRMAN: Right, I am sorry to ----
THE REGISTRANT: They supervise, yes.
THE CHAIRMAN: -- go back, there is never an occasion where you are giving medicines to a patient and the other nurse would not be with you?
THE REGISTRANT: Yes."

The panel was of the view that Mrs Tsolo was trying to create the impression that she was always supervised when administering medication when she was not. The panel therefore were satisfied on the balance of probabilities that Mrs Tsolo on 23 April 2020, informed an interim order panel of the NMC, she was always supervised when administering medication, when she was not.

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In light of the above, the panel therefore finds charge 11)b) proved.

Charge 12)

12) Your conduct at charge 11a and/or 11b was dishonest, in that you intended for the panel to believe you were working in compliance with your conditions of practice order;

This charge is found proved.

In reaching this decision, the panel took into account the case of *Ivey v Genting Casinos* [2017] UKSC 67.

The panel considered what Mrs Tsolo knew when answering questions before the panel at the Interim Order Review Hearing on 23 April 2020. This panel was of the view that Mrs Tsolo knew what she was being asked and the conditions that she was working under. The panel determined that she did not genuinely believe that at all times, during all shifts, there were two nurses working or that she was always

supervised when administering medication. On at least some of the occasions when she was working at Benedicts she was in breach of those conditions. It noted that Mrs Tsolo informed Witness 6 and this panel that she did not understand the questions concerning the interim conditions of practice order as she was on a bus. However, it further noted from the Investigating Committee transcripts Mrs Tsolo was asked for reassurance by the panel Chair of the Investigating Committee if she was at home. Mrs Tsolo did not indicate that she did not hear or understand the questions asked to her. The panel was of the view that Mrs Tsolo's response to the questions were to persuade the panel Chair that she was working within the interim conditions of practice order. The panel determined that to an ordinary decent person this would be dishonest.

The panel therefore was satisfied on the balance of probabilities that Mrs Tsolo's conduct at charge 11)a) and/or 11)b) was dishonest, in that she intended for the panel to believe she was working in compliance with her conditions of practice order.

In light of the above, the panel therefore finds charge 12) 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 Tsolo'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 Tsolo's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Kewley invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the NMC code and submitted that the panel may consider that Mrs Tsolo had breached fundamental tenets of the Code. He submitted that Mrs Tsolo had breached code 1.1, 2.5, 10.1, 20.1, 20.3 and 23.3.

Mr Kewley submitted that in relation to medication administration concerning Resident B, Mrs Tsolo did not introduce herself and tried to administer medication in an unsafe approach. He said that this could have led to a medication error, and as Witness 1 stated in her witness statement it could have led to something worse, such as a choking type incident. He further submitted that the panel could take the view that Mrs Tsolo's approach in giving medication was undignified and it failed to treat the resident with respect which again Witness 1 makes the point in her statement.

Mr Kewley submitted that in relation to Resident C, the panel will be aware that record keeping is a fundamental and basic aspect of nursing practice. He drew the panel's attention to the fact that that Resident C was not expected to pass in the immediate hours of this shift, and at the time that the resident had passed Mrs Tsolo was alerted to his death. He submitted that Mrs Tsolo knew that there could have been an investigation by the coroner and a subsequent inquest so the records could have been of real importance. Mr Kewley submitted that it was not simply a case that Mrs Tsolo did not document something; she actually had a key role because she was the most senior clinical person present.

Mr Kewley submitted that at the time Mrs Tsolo was on the phone to the 111 operator she was the nurse in charge at the Home. Mrs Tsolo was expected to know about the residents, or at least be able to access the information about the residents within her care. He submitted that the 111 operator needed to know the basic information in order to process the incident that Mrs Tsolo was reporting to him.

Mr Kewley drew the panel's attention to the interim order breaches. He submitted that the Investigating Committee is given powers under the order to impose restrictions on an interim basis where those are necessary to protect the public or is in the public interest. He submitted that Mrs Tsolo had an obligation to comply with the orders of the interim orders panel. Mr Kewley submitted that Mrs Tsolo must have known the terms of those orders and that she was represented at the interim orders hearings as she had representation from the RCN. Mrs Tsolo received the decisions and she must have known of the restrictions that had been placed on her nursing practise. As the panel have found that Mrs Tsolo was in breach of her then interim suspension order and subsequent interim conditions of practice order, Mr Kewley submitted that this amounts to a failure to comply with an order of her regulator and is a failure to comply with the measures that were put in place to protect the public.

Submissions on impairment

Mr Kewley moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kewley submitted that registrants are expected to be open and honest with the NMC and its panels. He submitted that it is clear that the Chair of the interim orders panel on that occasion was really trying to get to the bottom of what the position was in terms of Mrs Tsolo's current work. Mrs Tsolo deliberately misled the panel into thinking that she was working in compliance with the conditions when she was not, in

fact, doing so. He submitted that these facts do amount to a serious departure from the expected standards of conduct of a registered nurse.

Mr Kewley submitted that Mrs Tsolo has in the past put patients at risk of harm, acted dishonestly and has in the past breached a fundamental tenet of the nursing profession. This panel will be concerned to assess the likelihood of any future repetition. He submitted that Mrs Tsolo has shown some insight which is evidenced in her reflective piece. Mr Kewley submitted that notwithstanding any future risk, the public interest in this case would require a finding of current impairment to maintain public confidence in the profession. He submitted that Mrs Tsolo's deliberate breaches of the orders imposed by the Investigating Committee and the subsequent misleading the panel at the review hearing shows dishonesty. The NMC requires nurses to act with honesty and integrity at all times, and so, for those reasons, Mr Kewley invited the panel to make a finding of current impairment.

Mrs Tsolo submitted that her nursing practice is not impaired. She informed the panel that she has been doing some nursing training and is willing to develop herself with further training. Mrs Tsolo told the panel that she has been in the nursing profession for 34 years and has been helping people throughout. She said that this is the first incident where she was suspended. She told the panel that she has dedicated her life all to helping people.

Mrs Tsolo informed the panel that these errors will not happen again. She said that the manager at Benedicts had said that there were no discrepancies in her medication administration. Mrs Tsolo submitted that she is not practising as a nurse currently and she can assure the panel that this will never happen again. She said that there is no underlying concern and that she did not harm any of the residents so there is no risk present. Mrs Tsolo told the panel that in relation to the breaches of the interim order, she went to Benedicts with the idea that there are nurses working on shift during the day and so if she needed any help Witness 4 would be there to assist as her line manager. Mrs Tsolo said that Witness 4 had an open-door policy where everyone could access her. Mrs Tsolo said that she has not undermined her regulator for 30 years and that she has been complying.

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] and the cases of *Johnson and Maggs v NMC* [2013] EWHC 2140 Admin and *Remedy UK Limited v GMC* [2010] EWHC 1245 Admin.

Decision and reasons on misconduct

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

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

> *'**1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> *1.1 treat people with kindness, respect and compassion*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***2 Listen to people and respond to their preferences and concerns***
>
> *To achieve this, you must:*
>
> *2.5 respect, support and document a person's right to accept or refuse care and treatment*
>
> ***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 with the requirement to respect a person's right to accept or refuse treatment*
>
> *4.2 make sure that you get properly informed consent and document it before carrying out any action*

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

23 Cooperate with all investigations and audits This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register

To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the charges individually.

In relation to charge 5), the panel considered 5)c) in isolation amounted to misconduct. The panel considered 5)a) in isolation did not amount to misconduct but that it reinforced and added to the misconduct found in relation to charge 5)c). Mrs Tsolo's actions in relation to these charges amounted to serious departures from acceptable standards expected of a registered nurse.

In respect of charge 6)c), the panel was of the view that this was an unexpected death of a resident and it happened whilst Mrs Tsolo was the nurse on duty and in charge of the Home. The panel noted that Mrs Tsolo should have documented the death of Resident C before she left work to go home. In relation to charge 6)d), the panel was of the view that Mrs Tsolo failed to provide basic details to the 111 operator whilst she was the nurse in charge. Mrs Tsolo should have been able to provide details such as the date of birth and medical history of the resident as she should have access to the care notes and these should have been in front of her. Therefore, this amounts to misconduct. Mrs Tsolo's behaviour in each of the charges 6)c) and 6)d) amounted to serious departures from acceptable standards expected of a registered nurse.

In respect of charge 9), the panel was of the view that this amounted to misconduct. The panel determined that this was extremely serious as the interim suspension order was in place to protect the public. This demonstrated a disregard for her regulator.

In respect of charges 10)a)i)-10)a)iii), the panel was of the view that Mrs Tsolo had breached her regulator's conditions. The panel noted that this is extremely serious and a total disregard for her regulator. It further noted that the interim conditions of practice order were in place for a reason whether Mrs Tsolo agreed with it or not. Mrs Tsolo's behaviour in these charges amounted to serious departures from acceptable standards expected of a registered nurse.

In respect of charges 10)b), the panel was of the view that Mrs Tsolo had breached and failed to follow a requirement which was imposed by her regulator. The panel noted that nurses are aware of the fact that they will be regulated and Mrs Tsolo failed to respect this. In relation to 10)c), the panel was of the view that the NMC need to be aware of where nurses are working so they can communicate with the employer. The panel noted that the conditions were clear and Mrs Tsolo had an email from the RCN dated 13 November 2019 which outlined exactly what she needed to do. The panel determined that it was not acceptable for Mrs Tsolo to claim that she did not understand the process. As a professional, it was incumbent upon her to ensure that she understood all the requirements of the order and to seek

clarification if required. In respect of charge 10)d) the panel was of the view that for the above reasons this also amounts to misconduct.

In respect of charges 11)a) and 11)b) the panel was of the view that on various occasions Mrs Tsolo was the nurse in charge and she was not supervised when administering medication. Mrs Tsolo was asked at the interim order hearing if she was complying with her conditions, she deliberately misled the interim orders panel. Mrs Tsolo's actions in charges 11)a) and 11)b) would by the standards of ordinary people, and fellow professional nurses, be judged to fall far below the expected standards of a registered nurse

In respect of charge 12), the panel was of the view that this amounts to misconduct as Mrs Tsolo deliberately gave false information to the interim orders panel and she knew that the information was false. The panel determined that a nurse is expected to be professional at all times and Mrs Tsolo's actions in charge 12) would by the standards of ordinary people, and fellow professional nurses, be judged to fall extremely far below the expected standards of a registered nurse.

The panel found that Mrs Tsolo's actions with respect to charges 5)a), 5)c), 6)c), 6)d), 9), 10), 11) and 12) 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, Mrs Tsolo'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. Residents and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that residents were put at risk and that there was the potential for harm as a result of Mrs Tsolo's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. It went on to consider whether there may be a risk of repetition and in doing so it assessed Mrs Tsolo's current insight, remorse and remediation.

Regarding insight, the panel determined that Mrs Tsolo's insight was extremely limited. The panel noted that Mrs Tsolo did not recognise how her conduct has impacted negatively on the reputation of the nursing profession or on residents and that she has not demonstrated an understanding of the serious nature of her failings.

In relation to remorse, the panel noted that Mrs Tsolo did not express an understanding of how what she did was wrong or how this impacted negatively on the reputation of the nursing profession. The panel noted Mrs Tsolo's further written responses dated 28 July 2023 in which she continues to deny the charges found proved and also failed to address whether she has gained any further insight into the misconduct found proved.

The panel was satisfied that the misconduct in relation to medication administration is capable of remediation. However, the panel considered that it is extremely difficult to remediate dishonesty and attitudinal behaviours. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Tsolo has strengthened her practice. The panel was of the view that Mrs Tsolo has not demonstrated her strengthened practice, nor has she undertaken any training at an appropriate level. The panel noted that the breaches of the interim orders which were deliberate showed a disregard to her regulator and represent a deep-seated attitudinal issue. Where the panel found dishonesty, it would expect Mrs Tsolo to demonstrate that she has gained clear insight and that there would be no repetition. The panel was of the view that Mrs Tsolo had not yet been able to demonstrate that she would know exactly where to turn to should she find herself in a similar situation, and she had not satisfied it that the risk of repetition was sufficiently reduced. It further noted that there has been a failure to follow simple instructions.

The panel was of the view that Mrs Tsolo has not yet been able to demonstrate that she has remedied her practice or demonstrated full insight. Mrs Tsolo did not satisfy the panel that the risk of repetition was sufficiently reduced. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel concluded that public confidence in the profession would be undermined if a finding of current impairment were not made in this case and therefore also finds Mrs Tsolo's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel determined that Mrs Tsolo's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Tsolo off the register. The effect of this order is that the NMC register will show that Mrs Tsolo has been struck-off the register.

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

Mr Kewley informed the panel that in the Notice of Hearing, dated 16 June 2023, the NMC had advised Mrs Tsolo that it would seek the imposition of a strike-off order if the panel found Mrs Tsolo's fitness to practise currently impaired.

Mr Kewley referred the panel to the SG. He submitted that the aggravating factors in Mrs Tsolo's case is that she has a lack of insight. He submitted that Mrs Tsolo has been aware of the nature of the charges and has had a significant amount of time to demonstrate her insight into the issues. Mr Kewley submitted that the charges relate to serious dishonesty which arose from her professional practice as a nurse. There has been a deliberate disregard shown to the regulator by breaching the interim suspension order and interim conditions of practice order. Mrs Tsolo also misled the panel in April 2020. Mr Kewley submitted that the conduct in this case has put patients at risk of harm both in breach of the order and also putting the tablet in Resident B's mouth.

Mr Kewley submitted that there is limited mitigation in this case. He submitted that whilst it is right to say that dishonesty will always be serious, that there is no general rule and no general assumption that dishonesty will always attract a striking-off order. The panel may approach it in exactly the same proportionate way that it would with any other type of misconduct. Mr Kewley submitted that Mrs Tsolo's dishonesty and disregard for the regulator, is fundamentally incompatible with her continued registration. He submitted that as Mrs Tsolo had deliberately misled the interim orders panel these are failings which are indicative of an attitudinal concern which has not been put right. He submitted that this fundamentally undermines public confidence in the nursing profession and the conduct that the public would expect of a nurse namely to act with honesty, integrity and professionalism.

Mr Kewley submitted that any lesser sanction than a striking-off order would be insufficient to protect the public and to meet the public interest.

The panel had regard to Mrs Tsolo's email dated 28 July 2023 in which she stated that:

> "*I respectfully request the panel to restore me back as I feel my practice is not impaired now as I have not been giving medication and there is no risk .and I have never had medication errors before so there is no underlying cause for concerns as I have reflected this by completing relevant training to the charges.and I have learnt from these charges that it is important to ask if*

something is not clarified I should have asked more regarding conditions of practice which I' did not understand as I was under impression that I was not allowed to work unsupervised in the nursing home at Benedict and understand that the line manager should be the person in charge of the shift and work alongside with them.I will adhere to NMC Conduct and continue training sessions to improve my practice.Nursing is my vocation and I will ensure that I maintain high standardsrd [sic] *and safety for my patternts* [sic] [PRIVATE].*I apologies for any Inconveniences caused due to my practice not adhering to conditions of practice as I have misunderstood and request panel to consider a lesser sanction by dropping all charges as there is no risk for patient harm.I thank the panel for the advices they gave me and I have learned a lot from mistakes and this will never happen again*."

Mrs Tsolo further submitted that she has been a nurse for many years and that she has not made any mistakes in her professional life. [PRIVATE] that her twins were currently in education. [PRIVATE].

Mrs Tsolo told the panel that she qualified as a nurse in 1987 and came to the UK in 2004 as a general nurse, community nurse and midwife.

Decision and reasons on sanction

Having found Mrs Tsolo'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:

- Deliberate disregard to the regulator when breaching two separate interim orders on a number of occasions

- Lack of real insight and meaningful reflection into her failings
- Conduct which put vulnerable residents at risk of harm
- Dishonesty to her regulator
- Deep-seated attitudinal issues
- Separate incidents of misconduct: these were not isolated incidents

The panel also took into account the following mitigating features:

- Mrs Tsolo engaged with the NMC
- Absence of actual harm to residents
- Personal mitigation including her financial hardship and supporting her children and grandchildren
- Some insight shown albeit extremely limited
- Worked for an agency where there is less support in regard to PDP's and peer support

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

The panel 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 Tsolo'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 Tsolo's misconduct was not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Tsolo's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Furthermore, the panel had concerns about the likelihood of Mrs Tsolo complying with any conditions of practice given her pass failure to do so. The misconduct in regard to the dishonesty and deep-seated and attitudinal issues identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mrs Tsolo's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction in particular when addressing the dishonesty and deep-seated and attitudinal issues as well as the fact that the misconduct was not isolated incidents. The panel was not satisfied that Mrs Tsolo has shown real insight or that she has strengthened her nursing practice, despite having a lengthy period for reflection. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Tsolo's actions is fundamentally incompatible with Mrs Tsolo remaining on the register.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Mrs Tsolo's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Tsolo's actions were extremely serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Tsolo's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

Interim order

As a striking-off 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 Tsolo's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel considered the submissions made by Mr Kewley that an interim suspension order should be made to cover the appeal period. He submitted that an interim order is necessary to protect the public interest. He invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

Mrs Tsolo submitted that she does not want an interim suspension order, she wants the order to be revoked.

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

Decision and reasons on interim order

The panel was satisfied that an interim suspension order is necessary to protect the public and otherwise in the public interest. The panel had regard to the seriousness of the misconduct and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It considered that to not impose an interim suspension order would be inconsistent with its earlier findings.

Therefore, the panel made an interim suspension order for a period of 18 months.

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

This will be confirmed to Mrs Tsolo in writing.

That concludes this determination.