Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
23 – 26 and 30 – 31 May 2023

Virtual Hearing

Name of registrant:	Sandra Maria Guita Do Vale
NMC PIN:	15F0850C
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 19 June 2015
Relevant Location:	Essex
Type of case:	Misconduct
Panel members:	Deborah Jones (Chair, Lay member) Denford Chifamba (Registrant member) Susan Laycock (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Jumu Ahmed
Nursing and Midwifery Council:	Represented by Georgina Jenkins, Case Presenter
Miss Guita Do Vale:	Not present and not represented
Facts proved:	Charges 1(a), 1(b), 2(a), 2(b), 3(a), 4(a), 4(c), 5(a), 5(b), 6, 7, 8(a), 8(b), 8(c), 9, 10(b)
Facts not proved:	Charges 3(b), 4(b), 10(a)
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 Miss Guita Do Vale was not in attendance and that the Notice of Hearing letter had been sent to Miss Guita Do Vale's registered email address on 18 April 2023.

Ms Jenkins, 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 allegation, the time, dates and venue of the hearing and, amongst other things, information about Miss Guita Do Vale's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Miss Guita Do Vale 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 Miss Guita Do Vale

The panel next considered whether it should proceed in the absence of Miss Guita Do Vale. It had regard to Rule 21 and heard the submissions of Ms Jenkins who invited the panel to continue in the absence of Miss Guita Do Vale. She submitted that Miss Guita Do Vale had voluntarily absented herself.

Ms Jenkins submitted that Miss Guita Do Vale had last corresponded with the NMC in 2019. However, there had been no engagement at all since by Miss Guita Do Vale in

relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

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 Miss Guita Do Vale. In reaching this decision, the panel has considered the submissions of Ms Jenkins 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. It noted that:

- No application for an adjournment has been made by Miss Guita Do Vale;
- Miss Guita Do Vale has not engaged with the NMC and has not responded to any of the emails sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses have attended today to give live evidence, others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Guita Do Vale in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. 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 Miss Guita Do Vale's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Miss Guita Do Vale. The panel will draw no adverse inference from Miss Guita Do Vale's absence in its findings of fact.

Details of charge

That you, a registered nurse:

1) On 01 January 2019 acted in an inappropriate manner towards Colleague A by:

    a) Refusing reasonable instructions to work on another ward; **[PROVED]**
    b) Having refused the instructions in charge 1)a) above, locked yourself in the toilet, crying and/or shouting. **[PROVED]**

2) On one or more occasion between January and April 2019:

    a) Provided inaccurate and/or irrelevant information at handovers; **[PROVED in part]**
    b) Inappropriately wore gloves during medication administration. **[PROVED]**

3) On a date unknown between January and April 2019:

   a) Prepared medication for a patient to take home which was not in a properly labelled TTA pack; **[PROVED]**
   b) Spoke rudely to a doctor during a telephone call. **[NOT PROVED]**

4) On 8 April 2019, in relation to Patient B:

   a) Refused to remove the patient's catheter until after you had taken your break; **[PROVED]**
   b) disconnected the patient's cannula, threw the tube on the patient's bed and walked away without communicating with the patient; **[NOT PROVED]**
   c) removed the patient's catheter without drawing the curtains to afford privacy to the patient. **[PROVED]**

5) On 9 April 2019 used abusive behaviour in that you:

   a) Stated to Colleague A 'your head is nothing' or words to that effect; **[PROVED]**
   b) Shouted at Colleague A whilst at the nurse's station. **[PROVED]**

6) On 9 April 2019 failed to administer medication on time to 6 patient's who's care you were responsible for. **[PROVED]**

7) On 9 April 2019 caused a delay in Patient D being taken for surgery by not obtaining the patient's notes timeously. **[PROVED]**

8) On 9 April 2019, in relation to Patient A:

   a) You unreasonably refused to administer pain relief to the patient; **[PROVED]**
   b) unreasonably refused or delayed the provision of a bedpan to the patient; **[PROVED]**

c) talked about the patient in a derogatory manner saying she ‘shouldn’t be such a baby’, ‘she’s not ill, she’s not dying’, ‘she could have got to the toilet, she is stupid. She doesn’t need to be here’ or words to that effect. **[PROVED]**

9) On 2 occasions on 24 April 2019, inappropriately pre-prepared intravenous medication for administration to multiple patients within unmarked syringes on the same tray. **[PROVED]**

10) On 28 April 2019:

a) inaccurately recorded details of medication administration to a patient in that you entered details for your administration under the name of Colleague B. **[NOT PROVED]**
b) Refused to attend to a patient who’s care you were responsible for and who required pain relief and anti-nausea medication. **[PROVED]**

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

Background

The NMC received a referral from The Princess Alexandra Hospital NHS Trust (‘the Trust’) on 4 July 2019 in relation to allegations which arose whilst Miss Guita Do Vale was employed as a Band 5 Staff Nurse, working within Surgery and Gynaecology departments.

Miss Guita Do Vale commenced employment at the Trust on 24 September 2018, until she voluntary resigned on 16 May 2019.

Concerns were raised about Miss Guita Do Vale’s attitude and communication, failure to treat patients with dignity and respect and also poor practice in relation to medication administration.

The allegations relate to:

Complaints from patients detailing poor care, namely:

- not maintaining patient privacy and dignity when removing a urinary catheter;
- poor communication leaving a patient complaining of feeling intimidated.

Failure to follow trust policy in regards to medicines and IV drug administration, meaning errors could happen despite being reminded of the process, namely:

- The preparation of multiple patients' IV medication at the same time which is outside of trust policy. When challenged by this Miss Guita Do Vale was allegedly rude to her colleague. During the same shift she repeated this process and was again challenged;
- Leaving a drug trolley unlocked in the middle of a patient bay for a long period on many occasions.

Communication with staff, senior staff and patients is poor and described as aggressive, shouting and rude, namely:

- Inaccurate handovers and poor communication regarding patient treatment on handover;
- Raised voices to senior colleagues;
- Inappropriately loud and animated conversation when meeting with matron regarding sickness and review of probationary period.

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 the NMC.

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

Ms Jenkins made a request that this case be held in partly private on the basis that proper exploration of Ms Guita's Do Vale's case included reference to third party interests and patients' private lives. 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 will be reference to third party interests and patients' private lives, the panel determined to hold the hearing partly in private as and when such issues are raised.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Ms Guita Do Vale.

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:

- Colleague A: Band 6 Ward Sister at the Trust;

- Witness 1: Surgical Matron at the Trust;
- Witness 2: Matron at the Trust;
- Colleague B: Agency Nurse at the Trust;
- Patient A: Patient;
- Witness 3: Matron at the Trust; and
- Witness 4: Ward Manager.

Decision and reasons on application to admit Ms 5's written statement as hearsay evidence

The panel heard an application made by Ms Jenkins under Rule 31 to allow the written statement dated 4 February 2021, and the exhibits of Ms 5 into evidence, namely the local statement written by Ms 5, the email and the Datix Form dated 28 April 2019.

Ms Jenkins submitted that the written evidence of Ms 5 was relevant as it directly deals with the charges, in particular for charge 3(b) as it is the sole evidence and charge 9. She told the panel that the witness statement was not long, so therefore it would not be prejudicial to Miss Guita Do Vale. Ms Jenkins told the panel that Ms 5's exhibits contained notes of the alleged incidents which were written close to the time and the Datix form. Therefore, these are clearly relevant.

Further, Ms Jenkins submitted that it would be fair to admit Ms 5's written evidence. She told the panel that Ms 5 was not present at this hearing and, whilst the NMC had made sufficient efforts and taken reasonable steps to secure Ms 5's attendance to ensure that she was present, she was unable to attend the hearing. She submitted that the NMC had first contacted Ms 5 in August 2022, had corresponded with her in September 2022 and

notified Ms 5 of the hearing dates in December 2022, in which Ms 5 responded to the NMC saying that [PRIVATE] as to whether she was available or not. Ms Jenkins informed the panel that notice of Ms 5 attending as a witness for this hearing was sent in April 2023 and emails were sent out on 24 May 2023 to ensure that Ms 5 was in attendance. Since then, the NMC had been contacted Ms 5 through telephone, and the latest telephone call was on 23 May 2023.

Ms Jenkins submitted that even though the NMC had sent the notice of the hearing to Ms 5 in April 2023 to the correct email address, Ms 5 had not received it. The NMC Case Officer noted:

> *'I spoke with* [Ms 5] *over the phone and checked with her that is she okay as she never responded to my emails. She mentioned to me that she has been having issues with her email and email keeps going to the junk, so she never checked it. I informed that she was meant to give her evidence today at 02:00 pm before the panel. I asked her if she would give her evidence tomorrow or Friday, she responded to me that* [she does not] *work for NHS anymore and* [her] *manager doesn't support* [her] *taking any last-minute half day for hearing.* [PRIVATE]*. Call ended.'*

Ms Jenkins told the panel that Ms 5 had left the NHS, and therefore, there was less allowance given to her by her employer to attend the hearing to give evidence.

In relation to the test of prejudice, Ms Jenkins submitted that Miss Guita Do Vale was not in attendance nor represented. Therefore, she had voluntarily lost her opportunity to cross examine the witness. Despite knowledge of the nature of the evidence to be given by Ms 5, Miss Guita Do Vale made the decision not to attend this hearing. On this basis Ms Jenkins advanced the argument that there was no lack of fairness to Miss Guita Do Vale in allowing Ms 5's written statement into evidence.

Ms Jenkins further submitted that if Ms 5 was to attend, her witness statement would go into record as her examination in chief, without Miss Guita Do Vale challenging it.

Ms Jenkins told the panel that Miss Guita Do Vale had difficult working relationship with some of her colleagues. However, that this does not apply to Ms 5. Rather Ms 5's evidence is balanced as she stated that Miss Guita Do Vale is a competent nurse. Therefore, there is no motivation by Ms 5 to fabricate the evidence.

Moreover, Ms Jenkins referred the panel to Miss Guita Do Vale's response to charge 9. Ms Jenkins submitted that Miss Guita Do Vale does not deny charge 9 but stated that she was not given the policy. Therefore, it was a matter for the panel to consider on the balance of probabilities.

In relation to charge 3(b), Ms Jenkins submitted that Ms 5's evidence is the sole evidence in support of this charge. However, that in taking all of the charges together, charge 3(b) was not the most serious charge. She submitted that if Ms 5's evidence is admitted, then any unfairness to Miss Guita Do Vale can be mitigated by the panel exercising its discretion to attach the weight that it considers appropriate.

In light of this, Ms Jenkins submitted that it would be relevant and fair to admit Ms 5's evidence as hearsay evidence.

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 reference to Rule 31 which 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 is admissible in civil proceedings.

In making its decision, the panel noted that Ms 5's witness statement and exhibits had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement, consisting of 2 pages, is true to the best of my knowledge and*

belief. I confirm that I am willing to attend a hearing and give evidence before a Committee of the NMC if required to do so.' and signed by her on 4 February 2021.

The panel considered whether Miss Guita Do Vale would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms 5 to allowing hearsay testimony into evidence. The panel considered that as Miss Guita Do Vale had been provided with a copy of Ms 5's statement and, as the panel had already determined that Miss Guita Do Vale 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 accepted that the NMC had taken all the steps it could to secure this witness' attendance.

The panel next considered whether it would be relevant and fair to admit Ms 5's witness statement and exhibits as hearsay evidence. In relation to charge 9, the panel was of the view that Ms 5's evidence was relevant as she was a direct witness. Furthermore, Ms 5's evidence was not the sole and decisive evidence for charge 9 and the panel is due to hear other witnesses on this. In relation to charge 3(b), the panel noted that Ms 5's evidence was the sole and decisive evidence. However, Ms 5 provided the NMC with contemporaneous evidence such as an email, local statement and a Datix form at the time of the incidents. Further, the panel had no evidence before it which would suggest that Ms 5 would fabricate her evidence.

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 Ms 5 and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to admit Ms 5's witness statement and exhibits as hearsay evidence, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts continued

The panel noted that, although Miss Guita Do Vale had previously worked at another Trust, she was a Portuguese nurse, which may have meant that there were cultural challenges when she was practising as a registered nurse. The panel noted that her cultural approach towards her fellow nurses might have had an impact on the way that her colleagues perceive her. However, the witnesses had all confirmed that Miss Guita Do Vale's spoken English and her understanding of English were good, therefore the panel noted that there was no language barrier.

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

Charge 1(a) and (b)

1) On 1 January 2019 acted in an inappropriate manner towards Colleague A by:

a) Refusing reasonable instructions to work on another ward;
b) Having refused the instructions in charge 1)a) above, locked yourself in the toilet, crying and/or shouting.

These charges are found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Colleague A, Witness 2, Witness 3 and Witness 4.

All the witnesses who gave oral evidence accepted that being asked to move to work on another ward was a regular occurrence and that this was not taken positively by the nurses as they felt uncomfortable and anxious. Nevertheless, all of the witnesses considered that being asked to work on another ward should be accepted as they are

needed for patient care which goes above all and as they were employed by a trust and not by a ward.

The panel took into account Colleague A's witness statement:

> *'16. I asked Sandra to move but she refused to go and kicked off, she began shouting at us. She just kicked off and ended up in the toilets hysterical, crying and sobbing and it appeared to me that she was trying to make herself sick within the toilet cubical.'*

The panel also took into account Witness 2's witness statement:

> *'8. About 30 minutes after I had made the request, I was contacted by Harold ward to say the Nurse hadn't arrived yet. I made contact with the Nurse in Charge* […] *to establish what was happening and was told that the Nurse was refusing to move, was very upset and that they had locked themselves in the bathroom and were hysterical.*
>
> *9. I attended the ward and found the nurse (Sandra Do Vale) within the staff toilet, she was very upset, behaving erratically and crying hysterically.'*

The panel noted from Witness 2's local statement dated 1 January 2019:

> *'While on my Duty Matron on the 01/01/2019 I was doing the staffing for the late shift trying to ensure that all clinical areas are safely staffed for the afternoon shift nightingale ward had 3RN on the late shift and 2 CW I contacted the Nurse in charge, and asked them to move a RN to Harold ward for the late shift which she was happy to do.*
>
> *About 30 mins later I was contacted by Harold ward to say the nurse hard not arrived so again I contacted the NIC on the ward to follow up the move to Harold*

ward I was told that there was an issue on the ward and the member of staff who had been asked to move was very upset and refusing to move (Sandra Do vale). The NIC said that she was very worried about this member of staff as they had locked themselves in the bathroom and was very hysterical. [sic]

On arrival to the ward I was lead to the staff toilet to find a very upset nurse crying hysterical she had locked herself in the bathroom and refusing to talk to anyone I managed to get her to come out and sit down and talk to me, when I asked her why she hadn't moved to Harold ward she told me that she was always being moved to other wards I explained that my job to day what to ensure that all inpatient areas had been safely staffed to ensure patient safety throughout the hospital.'

The panel also took into account Witness 3's witness statement:

'14. In early 2019 I was made aware of an incident which had happened involving Sandra refusing to move wards to cover a short fall in staff. I was off duty at the time of the incident.

15. Regularly staff were asked to move location to backfill areas where we were short in numbers. Even though there was a rota in place to ensure that the split was even Sandra apparently didn't like this.

16. When [Witness 2] *had asked for a member of staff to move, Sandra had taken what could be described as a meltdown, refused to move, acting inappropriately and in a hysterical manner.'*

Witness 3, in her oral evidence, told the panel that Miss Guita Do Vale has never raised the issue of moving wards with her directly.

Witness 4, in her witness statement, wrote:

‘14. Although I can no longer recall the exact date, I remember I was notified by the weekend Duty Medical Matron, [Witness 2] *about Sandra. At that time the Duty Matron would move staff to other wards to provide cover where other wards were short staffed. My understanding from* [Witness 2] *was that Sandra had been asked to cover another ward that weekend, but had refused to move to a provide cover; I understand she had started screaming and locked herself in a toilet. I understand Sandra was extremely upset as she felt she was always being moved around different wards, but this was not a professional way of managing this.’*

The panel accepted that no nurses like being asked to move wards. However, it accepted that Miss Guita Do Vale’s behaviour and her refusal to move was not seen as an acceptable response by any other nurses.

The panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale had refused to work on another ward and had locked herself in the toilet, crying and/or shouting. The panel, therefore, finds charge 1 proved in its entirety.

Charge 2(a)

2) On one or more occasion between January and April 2019:

a) Provided inaccurate and/or irrelevant information at handovers;

This charge is found proved in relation to irrelevant information only.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Colleague A and Witness 4.

The panel took into account Colleague A’s witness statement:

‘49. She would pass over unnecessary information, details that weren’t required and was unable to prioritise what was important, this meant that on a regular basis we didn’t get away on time and the shift taking over were held up carrying out their tasks.’

The panel also took into account Witness 4’s witness statement:

‘23. The computerised equipment used to capture the information should only take about five to ten minutes to update, but it appeared that Sandra was slow in using this system and continually required assistance from others. Sandra would be putting additional info into handover that was not relevant, hence I had to give guidance that handover needed to be the plan of care and actions needed now for the patient, rather than a narrative about her whole day.’

Witness 4 told the panel that Miss Guita Do Vale has had support and training on what is necessary for handovers.

The panel was of the view that both Colleague A and Witness 4 were clear in their evidence that Miss Guita Do Vale was repeating the doctors’ notes within the handover. It noted that this was irrelevant as handovers were for nurses to prioritise the nursing care that was required for the patient.

The panel did not have any evidence before it as to the accuracy of Miss Guita Do Vale’s handovers.

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale had provided irrelevant information at handovers. The panel, therefore, finds charge 2(a) proved.

Charge 2(b)

2) On one or more occasion between January and April 2019:

b) Inappropriately wore gloves during medication administration.

This charge is found proved.

In reaching this decision, the panel took into the documentary, supplementary and the oral evidence of Colleague A.

The panel took into account Colleague A's witness statement:

> *'50. Whilst we worked together we had a CQC Inspection and whilst the inspectors were present I was sitting at the Nurses station and Sandra was carrying out the drugs round, I had already told her on three occasions not to do the medication with gloves on as it has the potential to cause cross contamination. Which could be serious for patients.*
>
> *51. I was horrified when during the inspection she walked up to me at the nurse's station with her gloves on, the CQC lady was sitting next to me and I had to discretely tell her again.'*

In Colleague A's email dated 14 April 2019 to Witness 4, she wrote:

> *'The 2nd day of the CQC inspection I had to tell S D x3 times not to do her medication round with gloves on, I was horrified as I was sitting behand the nurses station and DS walked up to the station with her gloves on. The CQC lady was sitting in a chair next to the nurses station I discretely had to tell her again.'*

Colleague A, in her oral evidence, told the panel that it is acceptable to wear gloves when treating patients, but that they should be disposed of when coming out of a bay; it is

unacceptable to use the same pair of gloves to treat more than one patient due to cross contamination issues.

The panel noted that Miss Guita Do Vale would have received training on cross-infection control. The panel further noted that Miss Guita Do Vale would also have had access to the policies on the Trust's intranet site.

The panel was of the view that Colleague A was a cogent and consistent witness.

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale inappropriately wore gloves during medication administration. The panel, therefore, finds charge 2(b) proved.

Charge 3(a)

3) On a date unknown between January and April 2019:

a) Prepared medication for a patient to take home which was not in a properly labelled TTA pack;

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Colleague A.

The panel took into account Colleague A's witness statement:

'58. Another incident I recall was when Sandra had what I would consider a medication incident, Sandra came to the nurses station and had what looked like TTA'S for a patient she was about to discharge home. TTA is like a pharmacy pack, the label on it will have detailed instructions for a patient on how to take their

medication, it's very important for the safety of the patient to ensure they are taking the medication at the correct time for example.

59. Sandra asked me can I send the patient home with stock lactulose I explained no we can only give TTA'S with labels on, I asked her could I check the box that was in her hand she pulled the box towards herself and changed the subject I said again please let me see the box you have she then showed me a stock box of flucloxacillin I said we can't give this to the patient and I advised her to phone around other wards for a TTA pack and send a HCA to collect.

60. She then sounded stressed at this and asked me in a very sharp tone have you done your writing? Have you done your i-pad hand over I said yes I had she said well I have no time to find a pack of TTA meds.'

In Colleague A's email dated 28 April 2019 to Witness 4, she wrote:

'On the 26th S D came to the nurses station and had what looked like TTA'S for a patient she was about to discharge home. She asked me can I send the patient home with stock lactulose I explained no we can only give TTA'S with labels on, I asked her could I check the box that was in her hand she pulled the box towards herself and changed the subject I said again please let me see the box you have she then showed me a stock box of flucloxacillin I said we can't give this to the patient and I advised her to phone around other wards for a TTA pack and send a HCA to collect. She then sounded stressed at this and asked me in a very sharp tone have you done your writing? Have you done your i-pad hand over I said yes I have she said well I have no time to find a pack of TTA meds this was appalling as the relative was at the nurses station and heard everything. She said I have not started my medication yet I said I haven't either. S D seems to be unable to carry out simple tasks then gets very rude when offered advice or support.'

All witnesses during their evidence confirmed to the panel that medication training covered the provision of TTA packs for patients.

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale prepared medication for a patient to take home which was not in a properly labelled TTA pack. The panel, therefore, finds charge 3(a) proved.

Charge 3(b)

3) On a date unknown between January and April 2019:

b) Spoke rudely to a doctor during a telephone call.

This charge is found NOT proved.

In reaching this decision, the panel took into account the hearsay evidence of Ms 5:

‘19. On one particular occasion, she was so rude to a doctor on the telephone that they actually hung up on her.’

The panel did not have any evidence from the doctor or any evidence of what was said during a telephone call to a doctor. In the absence of any such evidence or any information regarding the context of the alleged conversation, the panel could not find this charge proved.

Charge 4(a)

4) On 8 April 2019, in relation to Patient B:

a) Refused to remove the patient’s catheter until after you had taken your break;

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Witness 4 and Patient B's incident complaint email to Ms 7 dated 15 April 2019.

The panel took into account Witness 4's witness statement:

> *'15. I also received three complaints from patients in April 2019 about Sandra. The first of these came from a patient in bed* [Patient B] *on 8 April 2019. This related to a patient request to remove a catheter.* [Patient B] *had to request this twice and was allegedly told by Sandra that she would do it, but only after she had taken her break. A catheter takes about 30 seconds to remove and if the patient is anxious, this should have been done almost then and there; it would not be acceptable to tell someone you're going on a break and you'll do it afterwards as this does not make them feel cared for. The emailed complaint was sent to* [Ms 7], *the Matron for Jon Snow at the time. In this case, it is unlikely the wait would have harmed* [Patient B], *but this was not person-centred care and this patient was anxious to have the catheter removed.'*

The panel was of the view that Witness 4 was a cogent and consistent witness.

The panel also took onto account Patient B's incident complaint email to Ms 7 dated 15 April 2019:

> *'It took 2 requests and 40 minutes for the other nurse to come and see me*. *I asked if I could have the catheter removed as I wanted to get up. It was now nearly midday. I was told 'I will do this but I am having a 30 break first and will do it afterwards.' The nurses' tone was not friendly and very direct (this nurse also had*

an accent, that I have reason to believe was Portuguese. I felt tears well up my eyes.'

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale refused to remove Patient B's catheter until after she had taken her break. The panel, therefore, finds charge 4(a) proved.

Charge 4(b)

4) On 8 April 2019, in relation to Patient B:

b) disconnected the patient's cannula, threw the tube on the patient's bed and walked away without communicating with the patient;

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient B's incident complaint email to Ms 7 dated 15 April 2019 and the oral evidence of Witness 4.

In Patient B's incident complaint email to Ms 7 dated 15 April 2019, Patient B wrote:

'A nurse in the light coloured uniform came in (she was also wearing a head dress) and asked about having my catheter removed. She said she would ask and asked me if I wanted by bedding changed, I said yes but I would need to get out of bed firs and then asked 'did I need the catheter removed? […]

[…]

After a while the nurse that I had spoken to about my catheter and bed changing (wearing a head dress) walked into the room. Grabbed the pipe connected to my

arm, disconnected it at the stand and basically threw the pipe in my direction onto the ed, then walked away without saying a word.'

There was no evidence before the panel to suggest that Miss Guita Do Vale was wearing a head dress. Further, Witness 4, during her oral evidence, confirmed to the panel that a nurse in a light coloured uniform was most likely a Healthcare Assistant. Witness 4 confirmed to the panel that it was likely that Patient B was talking about a Healthcare Assistant and not Miss Guita Do Vale.

The panel, therefore, did not find this charge proved.

Charge 4(c)

4) On 8 April 2019, in relation to Patient B:

c) removed the patient's catheter without drawing the curtains to afford privacy to the patient.

This charge is found proved.

In reaching this decision, the panel took into account Patient B's incident complaint email to Ms 7 dated 15 April 2019 and the oral evidence of Witness 4.

In Patient B's incident complaint email to Ms 7 dated 15 April 2019, Patient B wrote:

'Later on the nurse (Portuguese) returned and whilst I was sitting on a chair told me she was going to remove my catheter, it was rushed without any explanation as to what needed to be done. I was told to sit still and open my legs, which was a complete shock especially as she had not drawn the curtains and I had a window on my door.'

Witness 4, in her oral evidence, told the panel that she was told that Patient B was told to sit still and open her legs, which was unacceptable practice.

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale removed Patient B's catheter without drawing the curtains to afford privacy to the patient. The panel, therefore, finds charge 4(c) proved.

Charge 5(a)

5) On 9 April 2019 used abusive behaviour in that you:

a) Stated to Colleague A 'your head is nothing' or words to that effect;

This charge is found proved.

In reaching this decision, the panel took into account the documentary and the oral evidence of Colleague A. The panel also had regard to Colleague A's email on 14 April 2019 to Witness 4.

The panel took into account Colleague A's witness statement:

> '*20.* […] *I went back to the was treatment room and Sandra walked in she was talking so loud as if almost shouting I asked her to please lower her voice as I had pain my head which had hurt all morning, she looked at me and said 'your head is nothing.'*

In Colleague A's email to Witness 4 on 14 April 2019, she said:

> *'*[…] *I was in the treatment room and Nurse S D walked in she was talking so loud as if almost shouting I asked her to please lower her voice I also told her I was in pain my head had hurt all morning she looked at me and said your head is nothing.'*

Colleague A repeated this to the panel in her oral evidence.

All of the witnesses had confirmed to the panel that Miss Guita Do Vale spoke loudly and over other people.

Given the context provided by the witnesses, the panel was of the view that it would not be out of character of Miss Guita Do Vale to be speaking loudly. The panel was of the view that Colleague A was a cogent witness who was consistent with her evidence. [PRIVATE].

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale removed stated to Colleague A 'your head is nothing' or words to that effect. The panel, therefore, finds charge 5(a) proved.

Charge 5(b)

5) On 9 April 2019 used abusive behaviour in that you:

b) Shouted at Colleague A whilst at the nurse's station.

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Colleague A. This included Colleague A's email on 14 April 2019 to Witness 4.

The panel took into account Colleague A's witness statement:

'32.Sandra logged onto ICE and only a few patients showed on the list, she became stressed and flustered then started raising her voice at me, she then

continued to get louder and louder, I told her to calm down as this happens to me and I was trying to help her but she just had a go at me.

33.I told her when looking for blood results and she comes across a problem she should call pathology and seek help.

34. Sandra then suggested that this was all my fault and started shouting at me at the nurse's station. I called the doctor for her […] *were trying to help her but each time we were met with raised voice from Sandra.'*

In Colleague A's email to Witness 4 on 14 April 2019, she said:

'I went through with her how to obtain the level and got her access on ICE. S D went on ICE only a few patient showed on the list she became stressed and started raising her voice at me I told her to calm down as this happens to me. I told her when looking for blood results and she comes across a problem she should call pathology and seek help. S D then suggested that this was all my fault and started shouting at me at the nurses station. I called the doctor for her […] *but each time were met with raised voices from S D.'*

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale shouted at Colleague A whilst at the nurse's station. The panel, therefore, finds charge 5(b) proved.

Charge 6

6) On 9 April 2019 failed to administer medication on time to 6 patients whose care you were responsible for.

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Colleague A and Witness 1. This included Colleague A's email on 14 April 2019 to Witness 4.

The panel took into account Colleague A's witness statement:

> *'26. I checked on JAC, which was our online medication system and Sandra had only completed one patient's medication. At this time she would have been in charge of seven patients, which would have consisted of a bay of six and one side room.*
>
> *27. The time now was 14.25 pm another patient* […] h*ad complained that she had not had her* [PRIVATE]*, I took this serious, as failure to give the medication at the correct time could lead to serious consequences such as an increased chance of the patient* [PRIVATE]*.*
>
> *28. Sandra just seemed to have no idea how serious this was and had not prioritised her patients.*
>
> *29. I had already earlier in the shift told Sandra how important the* [PRIVATE] *was for this patient and it should not have been delayed.*
>
> *30. I asked her, had she contacted the doctor? She hadn't* […]'

In Colleague A's email to Witness 4 on 14 April 2019, she said:

> *'It was around 13.00hrs and it was drug round time I went off and completed my drug round I was In E-bay whilst I was carrying out my drug round I noted that S D was sat on a chair for a long time I could hear HCA* […] *going through an admission pack with her it sounded like* [the HCA] *was giving S D teaching. I asked* [the HCA] *what was going on as I could hear a call bell and she confirmed she was teaching S*

D. I thought to myself how can S D be completing her drug round when she has been sat on the visitors chairs for so long? Then […] *the ward clerk came to me and said I have just had patient's come out of C-bay and let me know that they have not had any medication. I checked on JAC and S D had only completed ×1 patient's medication. The time now was 14.25pm. Another patient from C3 had complained that she had not had her* [PRIVATE] *I took this serious, I had already earlier told S D how important the* [PRIVATE]*was for this patient and should not be delayed any longer. I asked had you contacted the doctor? What is the APTR level and went through the* [PRIVATE] *prescription with her.'*

Witness 1 explained to the panel that it was imperative that patients had their medication on time, so that the subsequent nurse who is looking after them can safely give the prescribed medications on the next drugs round.

In light of the above, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale, on 9 April 2019, failed to administer medication on time to 6 patients whose care she was responsible for. The panel, therefore, finds charge 6 proved.

Charge 7

7) On 9 April 2019 caused a delay in Patient D being taken for surgery by not obtaining the patient's notes timeously.

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Witness 4. This included Witness 4's notes dated 9 April 2019 of Patient D's complaint.

The panel took into account Witness 4's notes dated 9 April 2019 of Patient D's complaint:

‘Patient complaint 09/04/19

Patient D asked to speak to me.

Nurse S.D had been looking after her the day before on the 08th.

She felt she should speak to me about the disorganisation and delay that S. D caused her. She was due for theatre and porter came. Nurse disappeared off with her notes and patient heard porter say she will miss her theatre slot if she didn't get her paperwork and get her round here.

The nurse was very abrupt to the porter. After approx. 25 minutes she was ready for theatre.

Patient reported they thought she was agency nurse who never worked on a ward before and she had no confidence in her ability to care to her. She also said that the nurse left a lady in pain and needing the commode. (Patient very upset and crying talking to ward manager)

She also said all the nurses when leaving the bay to do something lock the mobile trolleys with drugs in. Nurse S.D was gone for ages out of the bay and the trolley was open for anyone to get anything.’

The panel noted from Witness 4’s oral evidence that nurses were never given specific times for Porters to collect the patients to be taken to theatre. Therefore, it was normal practice to get patients ready for the theatre as soon as the shift started, as a matter of priority. Witness 4 told the panel that Miss Guita Do Vale would have known this and therefore she should have prioritised the patients who were due to go to theatre.

In light of the above, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale, on 9 April 2019, caused a delay in Patient D being taken for surgery by not obtaining the patient's notes timeously. The panel, therefore, finds charge 7 proved.

Charge 8(a)

8) On 9 April 2019, in relation to Patient A:

a) You unreasonably refused to administer pain relief to the patient;

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Patient A and Witness 4.

The panel took into account Patient A's witness statement:

'6. By about 07:00, I still needed the toilet and some more pain relief so I again asked and this was when I came across Sandra. I tried to explain that I am in so much pain and tried to explain that the nurse I had spoken to earlier had said I could maybe have more pain relief around 07:00ish. Instantly she said "no, it's not time". She never asked for my name, looked at my notes or informed me that she would check to see if it's possible or any other way to make me more comfortable.

[…]

18. During whole incident, I never did get pain relief from Sandra either – someone else took over and gave the meds, but this was delayed based on when the other nurse from the early morning said I could have had it. I was in real pain with my leg. 05:00, going on 10:00/10:30 is a long time to wait for pain relief, even longer given

my last dose was around 23:00-00:00 the previous night. It's a long time to wait for pain relief and I had been asleep before that, so I had gone a long time without pain relief.'

The panel was of the view that Patient A's evidence was compelling. [PRIVATE].

The panel also took into account Witness 4's witness statement:

'16. The second complaint I received was, from memory from [Patient A] *and this was relayed to 9 April 2019. I remember this patient as she was a young lady who had a* [PRIVATE] *which was the result of a particularly nasty rugby injury. I came in and was looking after her the shift after Sandra. When I arrived to see after handover, she was in tears.*

17. Sandra had been looking after her the day before and she had been in agony in the morning. She had apparently asked Sandra multiple times for pain relief and was in agony, she said Sandra had been ignoring her […]'

Witness 4 told the panel that if the pain medication was not to be given because it was not time, then there were alternative ways to relieve Patient A's pain, such as providing oxygen. She told the panel that other pain relief was available as and when it was needed.

In light of the above, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale unreasonably refused to administer pain relief to Patient A. The panel, therefore, finds charge 8(a) proved.

Charge 8(b)

8) On 9 April 2019, in relation to Patient A:

b) unreasonably refused or delayed the provision of a bedpan to the patient;

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Patient A and Witness 4. The panel also had regard to Patient A's complaint dated 9 April 2019.

The panel took into account Patient A's witness statement:

> *'13. As Sandra finished giving the first lady her medication, she moved to bed two on the left. This was* […] *who Sandra had just been ignoring regarding helping me.* [This patient] *refused her medications and said she will wait whilst she gets the commode for me. Sandra and this lady began to have a disagreement. At this point I couldn't hold anymore and started to try and get out of bed. Between* [this patient] *and* [another patient] *in the bed next to me grabbed a grey sick bowl each. They both tried to hold my body weight as I had no strength in my left leg to balance and hold. They placed the sick bowl underneath between my legs so I could toilet. These were only small bowls.'*
>
> *14. I believe both* [the patients] *were in for abdominal/stomach pain related issues and one of these ladies was in a lot of pain after her surgery – for them both to get up to help me go to the toilet was both embarrassing and humiliating. I wouldn't want to have to go to the toilet that way again with other patients holding me unnecessarily, I would rather just go home and suck it up.'*

The panel took into account Witness 4's notes dated 9 April 2019 of Patient A's complaint:

> *'Patient reported to ward manager the poor nursing care from the previous shift.*
>
> *Lady suffered* [PRIVATE] *and was unable to transfer self to bathroom. At 0800hrs she asked nurse S.D for analgesia as she was in pain.*

0900hrs asked again as by now pain unbearable and need the toilet nurse S.D still not given analgesia or commode.

At 0930hrs a friend who is a sister in A&E came to visit patient and she went and got patient sore analgesia still not given by S.D.

At 1000hrs patient became very upset with nurse S.D shouting as she desperately needed the commode that she had been waiting for reportedly for over 1 hr. Patient very distressed and was incontinent relying on patient next to her to put a small cardboard bowl under her.

She felt embarrassed, mortified, upset and had no confidence in nurse caring for her.

Patient reports nurse spoke over her and did no listen, shouting at patient saying she is wrong and she didn't wait an hour. Showed no remorse after the event just closed curtains and left patient.

Patient reports nurse spoke to other members of staff in a disgusting manner.

Nurse was at the desk and all the patients in C bay could hear her complaining about them.

Patient finally had enough and asked to speak to the Manager. Nurse replied she didn't know who that was. One of the sisters […] *went and helped patient.'*

The panel was of the view that Patient A was consistent in her oral evidence.

The panel also took into account Witness 4's witness statement:

‘18. [Patient A] *could not transfer to a commode at this point, so needed a bedpan due to the state of her injury. She had asked Sandra for a bedpan and was left to wait for ages. The patient next to her got her a little cardboard sick bowl to help when got to the point where she had to pass urine, as no bedpan available. Following this, Was going to self-discharge as she was so angry about the situation. She started to argue with Sandra about ignoring her and I understand Sandra just walked away at that point with no apology.* [Patient A] *had asked to speak to the Ward Manager that day and I understand that Sandra said she didn’t know who that was (It was me).* […]. *The harm to this patient was that she was left in unmanaged pain and she was deprived of her dignity when she had to urinate. There was a lack of communication and empathy*.*’*

In light of the above, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale unreasonably refused or delayed the provision of a bedpan to Patient A. The panel, therefore, finds charge 8(b) proved.

Charge 8(c)

8) On 9 April 2019, in relation to Patient A:

c) talked about the patient in a derogatory manner saying she ‘shouldn’t be such a baby’, ‘she’s not ill, she’s not dying’, ‘she could have got to the toilet, she is stupid. She doesn’t need to be here’ or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Patient A and Witness 4. The panel also had regard to Patient A’s complaint dated 9 April 2019.

The panel took into account Patient A’s witness statement:

‘19. After the incident Sandra could be heard in the corridor making comment about all of us in the bay. In particular it was more about me. I heard her say I “shouldn’t be such a baby”, “she’s not ill, she’s not dying” and “she could have got to the toilet. She is stupid. She doesn’t need to be here”. Sandra was also having altercations with other staff very loudly in the corridor and was shouting and was extremely rude to her colleagues. Her accent was distinctive.

20. I believe they were in the corridor (although this could have been the nursing desk; I could not see where they went). I could hear her saying I had a bad attitude, that she didn’t need to help people like me, and “she can go to toilet herself”. Then she spoke badly about other patients and was rude to her colleagues. It was really uncomfortable to hear. She was shouting at one of her co-workers or her manager (I’m not sure who it was, but the way she spoke to them was very similar to the way she spoke to patients on that bay that day). We could hear the shouting and there was nothing nice about it. It only heightened the humiliation and shame and made me feel worthless and not good enough to receive basic care. [PRIVATE]. *All the staff were generally patient friendly and alright, but Sandra was not supportive of anything and lacked empathy towards everyone including her colleagues.’*

The panel also took into account Witness 4’s notes dated 9 April 2019 of Patient A’s complaint.

The panel was of the view that Patient A’s and Witness 4’s evidence was consistent.

In light of the above, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale talked about the patient in a derogatory manner saying she ‘shouldn’t be such a baby’, ‘she’s not ill, she’s not dying’, ‘she could have got to the toilet, she is stupid. She doesn’t need to be here’ or words to that effect. The panel, therefore, finds charge 8(c) proved.

Charge 9

9) On 2 occasions on 24 April 2019, inappropriately pre-prepared intravenous medication for administration to multiple patients within unmarked syringes on the same tray.

This charge is found proved.

In reaching this decision, the panel took into account the hearsay evidence of Ms 5. This included Ms 5's handwritten local 'statement for 24 April 2019' and the Datix Form dated 28 April 2019. The panel also took into account Witness 1's Probationary Extension Letter 24 April 2019, Witness 1's meeting notes dated 8 May 2019 and the Trust's policy on medication at the time of the incident.

The panel took into account Ms 5's witness statement:

'6. SDV approached me on this particular shift to ask me to counter sign her lunchtime IV medication. When I went into the clean utility to check her medication she had around 4 or 5 patients; medications all drawn up and placed in the same tray. I told her I would be unable to check as I cannot confirm what is in each syringe.

7. It then felt like she had an attitude with me and re-did all her IV medications as requested so I was able to sign for them.

8. SDV then approached me again later on in the evening to counter sign her IV medications and she had done the same thing again, as in, having 2-3 syringes of different medications for different patients in the same tray.

9. Again I explained that I could not counter sign as it was unsafe practise and she again got an attitude and started slamming down trays in the clean utility.

10. I reported the incident to the Nurse in Charge on that shift plus I also completed a Datix so it would have been reported to the appropriate people also.'

The panel had sight of Ms 5's handwritten local 'statement for 24 April 2019'.

The panel also took into account the Datix Form dated 28 April 2019:

'A registered nurse contracted to ward John Snow loaded a tray with syringes and filled with IV antibiotics unlabelled for x3 patients. After being told by another qualified nurse not to perform this unsafe practice she then proceeded again at teatime medication round to do the same again. The same nurse told her again that this is unsafe and she could not counter sign with her. The nurse became rude and pushed the tray on the side in the treatment room.'

The panel had regard to Witness 1's witness statement:

'18. Due to several incidents I advised Sandra that she was going to be placed on a supervised practise for a week and that was as a supportive measure.

19.We had decided to take this action after a number of complaints and an incident surrounding the administration of IV medication when Sandra had not followed the Trusts policy of administering IV medications and unsafe practice was witnessed.'

The panel took into account Witness 1's Probationary Extension Letter 24 April 2019.

The panel also took into account Witness 1's meeting notes dated 8 May 2019:

'Emma then advised Sandra that she was now on supervised practice for a week and that this was a supportive measure. This action had been taken after

considering a number of complaints, issues raised and a recent incident surrounding the administration of IV medications. She explained that

Sandra would not be able to administer medications, oral or IV, that she would not be able to perform patient care without the supervision of another registered member of staff.'

The panel had sight of the Trust's 'Administration of IV medicines policy':

'5.3 Registrants must only prepare and administer one patient intravenous medication at a time. Multiple patient intravenous medications and infusions must not be prepared and left unattended or placed on a trolley with other patient medication.'

Witnesses had confirmed to the panel that drug administration training was provided to all registered nurses. Further, all registered nurses had to pass a competency on drug administration and IV drug administration. The panel noted that policies on medication administration was available in hard copy and electronically. Therefore, the panel was of the view that Miss Guita Do Vale should have been aware how to correctly administer IV medication.

The panel accepted that Miss Guita Do Vale had repeated this conduct on two occasions on the same day.

In light of the above, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do Vale, on two occasions on 24 April 2019, inappropriately pre-prepared intravenous medication for administration to multiple patients within unmarked syringes on the same tray. The panel, therefore, finds charge 9 proved.

Charge 10(a)

10) On 28 April 2019:

a) inaccurately recorded details of medication administration to a patient in that you entered details for your administration under the name of Colleague B.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Colleague B and Witness 4. This included Colleague B's 'Management statement of case' and Witness 4's record of incident 28 April 2019.

The panel had regard to Colleague B's witness statement:

'8. There was a further incident on that night where Sandra signed for medication she had administered to one of her patients in my name. I can't recall clearly if she went in on my log in, but basically she was on the computer and I think this patient needed paracetamol signed for. If I was logged on, she could still have signed the record for the meds under her name without logging me off, but the record was entered as if I had administered the medication. This made it look like I had administered the medication, which was inaccurate.'

The panel had regard to Witness 4's witness statement:

'26. My recollection is that [Colleague B] *was really worried that she would get into trouble as Sandra had logged into the system under her log in details (her log in was open and Sandra had jumped onto the computer) and had not completed the handover notes in a satisfactory manner, by signing for a medication which showed in* [Colleague B's] *name, which was not accurate. With the login system for medications, everyone competent for meds has a login, so as soon as you're done, you should log out. I don't know what the circumstances were as to how* [Colleague

B] *login was left open and Sandra got in, but Sandra would have known she was not logged in as herself. I've no way in knowing who the patient was so cannot access the notes in question now.*

The panel had regard to Witness 4's 'record of incident' 28 April 2019:

'Reported to ward manager 28/04/19 by Night Nurse usually works on Penn.

Handover was completely wrong from S.D the previous night. Handing over patients not on PCA anymore and yet they were.

Wrong plans of care, not all notes had been documented in and took 35 minutes to handover 6 patients.

Night nurse called S.D to ask about a medication from that evening that had not been signed for by S.D. She wondered if it had been given or omitted. S.D reportedly looked at screen and signed it on the others nurses login. Night nurse very angry and told her that is against policy that was not her login and now it looks like she has given that medication and she had not. S.D laughed and said sorry sorry.'

The panel also took into account Witness 4's oral evidence in which she confirmed that the extract from her record of incident could not have referred to Colleague B as she did not routinely work on Penn ward. She accepted that this record of incident must have referred to a different nurse.

The panel was of the view that there was no evidence that it was Miss Guita Do Vale who had incorrectly recorded details of medicines administration. Colleague B told the panel in her oral evidence that she had not been aware of the incident until it was raised with her by Witness 4. Colleague B wrote in her witness statement *'I can't recall clearly if she went in on my log in* […]'.

As there was no evidence that Miss Guita Do Vale inaccurately recorded details of medication administration to a patient in that she entered details for her administration under the name of Colleague B, the panel could not find this charge proved.

Charge 10(b)

10) On 28 April 2019:

b) Refused to attend to a patient whose care you were responsible for and who required pain relief and anti-nausea medication.

This charge is found proved.

In reaching this decision, the panel took into account the documentary, supplementary and the oral evidence of Colleague B. This included Colleague B's email to the NMC on 19 May 2019.

The panel had regard to Colleague B's witness statement:

'4. I have been asked to comment on the events of a nightshift on 28 April 2019 where I worked alongside Sandra. Due to the passage of time, I can no longer recall the incidents in great detail. I can no longer recall any issues with the handover on that day. I do remember that Sandra was on computer, but don't know what she put on the handover sheet.

5. I remember that during the shift that night, I heard a patient shouting for assistance. This was one of the patients Sandra was allocated to. I can't remember much about this patient's condition other than that she was a female surgical patient I asked Sandra to deal with her patient but she ignored me and continued with typing up her handover on the computer. She was sitting down doing

handover, instead of dealing with the patient. She just refused to help the patient, so I said I'd do it.

6. I went to see the patient, who was in pain and vomiting. I gave the patient pain relief and anti-nausea medication (paracetamol, intravenous ondansetron and later buscopan). I had to escalate to a doctor to get some of the medication signed off. After I got the medication to the patient, she settled within about 15 minutes.'

The panel had regard to Colleague B's email to the NMC on 19 May 2019:

'I was working with nurse SDV on night shift 28th April 2019. Nurse SDV was on computer, her patient was screaming out in pain and vomiting. I gave the patient iv. Paracetamol and iv ondanstron the vomiting resolved but patient was still in pain. Doctor was sitting in office I asked if I could give buscopan iv as patient had same previously in A&E 7hrs previously Dr. ordered me to give same and stated he would prescribe on computer shortly. I gave the patient iv buscopan she settled straight away. Nurse SDV said she was going to report me to ward manager as I was causing a problem. I informed her that I was putting the patient first as she would not help her patient. The ward manager said I did the right thing by helping the other nurse.'

Witnesses told the panel that a nurse sitting at the nursing station would be able to hear a patient within the bay who was calling and shouting for assistance. The panel was of the view that Miss Guita Do Vale was able to hear this patient, and that, in not assisting this patient, she refused the responsibility she had for this patient.

In light of the above, the panel determined, that on the balance of probabilities, it is more likely than not that Miss Guita Do refused to attend to a patient care whom she was responsible for. The panel, therefore, finds charge 10(b) 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 Miss Guita Do Vale'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, Miss Guita Do Vale'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.'*

Ms Jenkins provided the panel with written submissions on misconduct.

Ms Jenkins invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of **'**The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Ms Jenkins identified the specific, relevant standards where she submitted Miss Guita Do Vale's actions amounted to misconduct.

Submissions on impairment

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

Ms Jenkins provided the panel with written submissions on impairment.

Ms Jenkins submitted that Miss Guita Do Vale's fitness to practise is currently impaired by way of misconduct as she placed patients at serious risk of harm and undermined public confidence in the profession. She further submitted that at this moment in time, in the absence of any insight into what happened and without any explanation which caused her to act that way, those errors are capable of being repeated. She submitted that the errors made by Miss Guita Do Vale are not easily remediable, as they are wide ranging, and she has not shown any willingness to accept her mistakes and learn from them. She submitted that this could be demonstrative of an attitudinal problem. In light of this, she submitted that due to Miss Guita Do Vale's lack of any insight, there is a risk that her behaviour will be repeated in the future. She therefore submitted that a finding of impairment is necessary on the grounds of public protection and otherwise in the wider public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *CRHPC v 1. GMC and 2. Biswas* [2006] EWHC 464*, Calhaem v GMC* [2007] EWHC 2606 (Admin), Spencer v GOC [2012] EWHC 3147 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Roylance v General*

Medical Council (No 2) [2000] 1 A.C. 311, C*heatle v General Medical Council* [2009] EWHC 645 (Admin), *Cohen v GMC* [2008] EWHC 581 (Admin) and *Grant.*

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 Miss Guita Do Vale's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Guita Do Vale'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*
>
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***2 - Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
>
> *2.1 work in partnership with people to make sure you deliver care effectively*
>
> *2.2 recognise and respect the contribution that people can make to their own health and wellbeing*

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

5 - Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.
To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

6 - Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

8 - Work co-operatively
To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues …

8.2 maintain effective communication with colleagues

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

9 - Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

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:

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

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

To achieve this, you must:

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

18 - Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

19 – Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

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

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It had regard to the case of *Roylance v General Medical Council* which

defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

The panel determined that Miss Guita Do Vale's actions in each of the individual charges did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct. The charges found proved involve multiple breaches of the fundamental tenets of the nursing profession contained within the Code. The panel was of the view that Miss Guita Do Vale was an experienced registered nurse who should have had the knowledge of what was required of her as a registered nurse. The panel determined that Miss Guita Do Vale's conduct failed to prioritise people and the safety of patients.

The panel was of the view that Miss Guita Do Vale's actions were not mere negligence or a single act, but involved multiple failures and demonstrated a concerning lack of empathy and kindness towards her patients and colleagues. It also believed that her behaviour and actions could be indicative of attitudinal issues. The panel was also of the view that Miss Guita Do Vale's conduct would be considered as unacceptable by fellow practitioners.

On the basis of the above, the panel determined that Miss Guita Do Vale's conduct and behaviour fell significantly short of the standards expected of a registered nurse and was sufficiently serious so as to amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Guita Do Vale's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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 the NMC's latest guidance on

impairment, the NMC suggests that the panel asks itself *'can the nurse, midwife or nursing associate practise kindly, safely and professionally?*'

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

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

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

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

d) …'

The panel concluded that limbs a, b and c of this test were engaged.

Whilst there is no evidence to suggest that Miss Guita Do Vale's actions caused actual harm, there was a significant concern by the panel that her actions clinically compromised patient care and consequently placed them at a risk of harm. There was evidence before the panel that patients under her care were caused significant distress by her actions and behaviour. Furthermore, the panel determined that Miss Guita Do Vale's misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find Miss Guita Do Vale's fitness to practise to be impaired.

The panel did not have any documentation or other evidence before it addressing Miss Guita Do Vale's insight as to the impact her actions had on her patients, colleagues, the nursing profession and the wider public as a whole. Therefore, the panel in the absence of any evidence from Miss Guita Do Vale could find no significant evidence of any insight into her misconduct. Without any evidence from Miss Guita Do Vale the panel could not be satisfied that she understands and appreciates the seriousness of her failures to act appropriately.

In considering whether Miss Guita Do Vale had remediated her nursing practice, the panel noted that it did not have any relevant information before it. It was of the view that some of the charges, such as medication administration errors, are potentially remediable. However, it bore in mind that attitudinal concerns, such as those already identified, are often more difficult to remediate than clinical concerns.

Therefore, in having regard to the above, the panel considered there to be no evidence to demonstrate that Miss Guita Do Vale had either strengthened her practice or sought to

remediate her misconduct. The panel was of the view that Miss Guita Do Vale has not demonstrated that she has a level of insight into the concerns identified. The panel also did not have any evidence to allay its concerns that Miss Guita Do Vale may currently pose a risk to patient safety. In the absence of any evidence to the contrary, it considered there to be a risk of repetition of Miss Guita Do Vale's misconduct and a risk of unwarranted harm and distress to patients in her care, should adequate safeguards not be imposed on her nursing practice. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered there to be a public interest in the circumstances of this case. The panel found that the charges found proved are serious and included attitudinal concerns. It was of the view that a fully informed member of the public would be concerned by its findings on facts and misconduct. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Miss Guita Do Vale's fitness to practise as a registered nurse is currently impaired on the grounds of public protection and public interest.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Guita Do Vale off the register. The effect of this

order is that the NMC register will show that Miss Guita Do Vale 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

Ms Jenkins informed the panel that in the Notice of Hearing, dated 18 April 2023, the NMC had advised Miss Guita Do Vale that it would seek the imposition of a striking-off order if it found her fitness to practise currently impaired.

Ms Jenkins submitted that the aggravating features include: a pattern of misconduct over a period of time, Miss Guita Do Vale's lack of insight into her failings and conduct which put patients at risk of serious harm. She submitted that there are no relevant mitigating factors.

Ms Jenkins informed the panel that a reference had been sought from Miss Guita Do Vale's subsequent employer in respect of her conduct since the time of the charges now found proved. She read out the information that had been provided that Miss Guita Do Vale appeared to be repeating exactly the same behaviour that the panel has now found proved in her next place of employment. The panel heard that Miss Guita Do Vale left that employment after less than a month without giving any notice or appropriate communication and having allegedly antagonised her colleagues.

Ms Jenkins submitted that taking no further action or issuing a caution order would not be appropriate or proportionate as there is a high risk of harm to patients. She further submitted that a conditions of practice order would not be sufficient nor appropriate as this is a case where there is evidence of attitudinal concerns and no willingness to respond positively to training or retraining. Ms Jenkins submitted that some of Miss Guita Do Vale's

actions were verging towards abuse of patients as some patients were caused unnecessary discomfort, particularly Patient A as a consequence of the failure to address her needs. She submitted that the concerns before the panel are wide-ranging. Therefore, it would not be possible to impose a package of conditions that either would or could adequately protect the public.

With regards to suspension order, Ms Jenkins submitted that it would not be an appropriate or proportionate sanction as this was not a single instance of misconduct where a lesser sanction is not sufficient, and there is evidence of personality or attitudinal problems. She further submitted that this case contains multiple allegations over a period of time and is not a single instance of misconduct. Therefore, she submitted that a suspension order would not be the sufficient sanction.

Ms Jenkins submitted that the concerns raised fundamental questions about Miss Guita Do Vale's professionalism as a registered nurse and in particular her actions towards Patient A. Therefore, she submitted that a striking-off order is the proportionate order in the circumstances.

Decision and reasons on sanction

Having found Miss Guita Do Vale'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:

- Lack of insight into failings;
- A pattern of misconduct over a period of time;

- Conduct which put patients at risk of suffering harm.

The panel could not identify any mitigating features.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Guita Do Vale'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 Miss Guita Do Vale'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 Miss Guita Do Vale's registration would be a sufficient and appropriate response. The panel noted that Miss Guita Do Vale's registration has been subject to an interim conditions of practice order since 2019. It heard submissions from Ms Jenkins that Miss Guita Do Vale had only worked with these conditions for a short amount of time. Further, the panel noted that Miss Guita Do Vale is not practising in the U.K. as a registered nurse. In light of this, 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. It also determined that the misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Guita Do Vale'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 panel had regard to the SG which outlines the circumstances where a suspension order may be appropriate. The panel considered that this was not a single instance of misconduct as there was pattern of misconduct perpetrated over a period of time. It determined that Miss Guita Do Vale had demonstrated attitudinal problems and had not demonstrated any insight, remorse, nor any steps she has taken to strengthen her practice regarding her failings.

The panel was of the view that Miss Guita Do Vale's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. It determined that Miss Guita Do Vale had put her needs before the those of her patients and had demonstrated a complete lack of empathy for a number of her patients and colleagues. The panel considered that Miss Guita Do Vale's actions are so fundamentally incompatible with her remaining on the register that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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?*

The panel determined that Miss Guita Do Vale'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 Miss Guita Do Vale's misconduct was serious, had the potential to place patients at risk of harm and distress and to allow her to continue practising would

undermine public confidence in the profession and in the NMC as a regulatory body. The panel recognised the adverse effect that a striking off order may have on Miss Guita Do Vale but was mindful of case law and of the NMC's own guidance that the reputation of the nursing profession is more important than the fortunes of an individual nurse.

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 Miss Guita Do Vale'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.

This will be confirmed to Miss Guita Do Vale in writing.

Interim order

As the 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 Miss Guita Do Vale's own interest until the striking-off sanction takes effect.

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

Submissions on interim order

The panel took account of the submissions made by Ms Jenkins. She submitted that an interim suspension order for a period of 18 months is required for the same reasons as submitted previously and to allow sufficient time for any appeal to be heard.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. The panel was satisfied that not to impose an interim order will be incompatible with its previous decision.

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

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

That concludes this determination.