# Nursing and Midwifery Council
# Fitness to Practise Committee

## Substantive Hearing

**Wednesday, 25 October – Monday, 30 October 2023**

Virtual Hearing

| | |
|---|---|
| **Name of Registrant:** | **Ronaldo Golimlim** |
| **NMC PIN** | 01F1060O |
| **Part(s) of the register:** | RN1: Adult Nurse, Level 1 (29 May 2001) |
| **Relevant Location:** | Buckinghamshire |
| **Type of case:** | Misconduct |
| **Panel members:** | Shaun Donnellan (Chair, lay member)<br>Terry Shipperley (Registrant member)<br>Alice Robertson Rickard (Lay member) |
| **Legal Assessor:** | Fiona Moore |
| **Hearings Coordinator:** | Franchessca Nyame |
| **Nursing and Midwifery Council:** | Represented by Rebecca Butler, Case Presenter |
| **Mr Golimlim:** | Not present and unrepresented |
| **Facts proved:** | Charges 1a, 1b, 1c, 1d, 1e, 2a, 2b, 2c, 2d, 2e, 3a, 3b, 4a, 4b, 4d, 4e |
| **Facts not proved:** | Charge 4c |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Conditions of practice order (12 months)** |
| **Interim order:** | **Interim conditions of practice order (18 months)** |

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Mr Golimlim was not in attendance and that the Notice of Hearing letter had been sent to Mr Golimlim's registered email address by secure email on 25 September 2023.

Ms Butler, on behalf of the Nursing and Midwifery Council (NMC), referred the panel to the Proceeding in Absence Summary document which shows that, from 22 May 2023 to 20 October 2023, five unsuccessful attempts were made by telephone and email to contact Mr Golimlim regarding this case.

Ms Butler 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 heard and accepted the advice of the legal assessor.

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

In the light of all of the information available, the panel was satisfied that Mr Golimlim 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 Mr Golimlim**

The panel next considered whether it should proceed in the absence of Mr Golimlim. It had regard to Rule 21 and heard the submissions of Ms Butler.

Ms Butler submitted that, as the panel has found that all reasonable efforts have been made in accordance with the Rules to secure Mr Golimlim's attendance today, the panel should proceed in the absence of Mr Golimlim. She highlighted that there has been no application for an adjournment from Mr Golimlim, and submitted that he has deliberately chosen to absent himself from this hearing.

Ms Butler further submitted that two witnesses are due to give live evidence today, and that this case has been active since 2019. She submitted that it is in the overall interests of justice and fairness to all, including Mr Golimlim and the NMC, to proceed with the hearing.

The panel heard and 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 decided to proceed in the absence of Mr Golimlim. In reaching this decision, the panel considered the submissions of Ms Butler, the Proceeding in Absence Summary, and the advice of the legal assessor. It 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:

- All reasonable efforts have been made by the NMC to secure Mr Golimlim's engagement;

- Mr Golimlim has not responded to any of the emails sent or telephone calls made to him about this hearing;
- No application for an adjournment has been made by Mr Golimlim;
- There is no reason to suppose that adjourning would secure Mr Golimlim's attendance at some future date;
- Two witnesses have been warned for attendance today to give live evidence;
- Not proceeding may inconvenience the witnesses and their employer(s);
- The charges relate to events that occurred in 2019 so 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 Mr Golimlim in proceeding in his absence. Although the evidence upon which the NMC relies has been sent to him at his registered address, Mr Golimlim has made no response to the allegations. He will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his 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 Mr Golimlim's decisions to absent himself from the hearing, waive his rights to attend and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

**Details of charges**

That you, a registered nurse:

1) Between 23 and 24 March 2019 failed to keep proper records, in that you, made notes on Patient A's clinical notes which were not:

    a) Dated; **[PROVED]**
    b) Timed; **[PROVED]**
    c) Signed; **[PROVED]**
    d) Printed with your name; or **[PROVED]**
    e) Legible. **[PROVED]**

2) Between 24 and 25 March 2019 failed to keep proper records, in that you, made notes on Patient A's clinical notes which were not:

    a) Dated **[PROVED]**
    b) Timed **[PROVED]**
    c) Printed with your name; **[PROVED]**
    d) Legible; or **[PROVED]**
    e) In the correct chronological order. **[PROVED]**

3) Between 24 and 25 March 2019, in relation to Patient A's clinical notes failed to:
    a) record their deteriorating condition. **[PROVED]**
    b) record that their care needed to be escalated and/or that their care was escalated. **[PROVED]**

4) Between 24 and 25 March 2019, in relation Patient A's observation NEWS charts, failed to:
    a) review the observations and/or record a review of the observations. **[PROVED]**
    b) correct the NEWS scoring. **[PROVED]**
    c) make and/or record a decision on observation frequency. **[NOT PROVED]**

d) record that their care needed to be escalated and/or that their care was escalated. **[PROVED]**
e) countersign the observational chart. **[PROVED]**

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

**Background**

Mr Golimlim was referred to the NMC on 4 June 2020 by Buckinghamshire Healthcare NHS Trust ('the Trust'). At the time of the referral, Mr Golimlim was working as a Band 5 Staff Nurse on the Acute Medical Unit ('the Unit'), at Stoke Mandeville Hospital ('the Hospital'), part of the Trust. Mr Golimlim commenced employment with the Trust in December 2014.

Mr Golimlim was the named nurse for Patient A on the night shifts of 23 March 2019 and 24 March 2019. Patient A deteriorated over the latter night shift and passed away on the morning of 25 March 2019 shortly after the handover. A coroner's inquest then took place prior to the Trust investigation.

The Trust investigation, conducted by Witness 1, started 10 months later. Due to the passage of time, all witnesses interviewed struggled to recollect the shift and any specific detail. During the investigation interview, Mr Golimlim told Witness 1 that he had asked the nurse in charge, Witness 2, for help and to call the outreach and medical team. As Patient A was due to be reviewed by the surgical team, Mr Golimlim told Witness 1 that he "*had the initiative*" to ring the surgical team, but he was unable to get through.

It is alleged that Mr Golimlim's entries in Patient A's clinical notes were illegible. During the local investigation interview, he was asked to read out his documentation in Patient A's medical notes as Witness 1 could not decipher it. In the notes for that shift, there is no mention of him escalating concerns about Patient A's condition.

It is further alleged that Mr Golimlim's notes were not dated, timed, signed, name printed or in chronological order. One entry was slotted in on page 2 of Patient A's notes out of chronological order. In the local investigation, Mr Golimlim said that he wrote the notes out "*immediately after the night shift*".

The notes Mr Golimlim had made for Patient A on the previous night were also reviewed. It is alleged that similar circumstances applied, and he only made one entry and it was inadequate and illegible.

It is further alleged that, between 24 March 2019 and 25 March 2019, Mr Golimlim failed to correctly review and complete Patient A's NEWS chart.

Mr Golimlim was dismissed following a disciplinary hearing held on 2 April 2020.

**Decision and reasons on application to admit hearsay evidence**

The panel heard an application made by Ms Butler under Rule 31 to allow the written statement of Witness 2 into evidence. There had been difficulties in contacting Witness 2 today and, when contact was eventually made, the NMC was informed that Witness 2 was unable to attend as they were abroad dealing with a family emergency.

In the preparation of this hearing, the NMC had indicated to Mr Golimlim in the Case Management Form (CMF) on 22 May 2023 that it was the NMC's intention for Witness 2 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 2, Mr Golimlim made the decision not to attend this hearing. On this basis Ms Butler advanced the argument that there was no lack of fairness to Mr Golimlim in allowing Witness 2's written statement into evidence.

Ms Butler made reference to the cases of *Thorneycroft V NMC* [2014] EWHC 1565 (Admin) and *El Karout V NMC* [2019] EWHC 28 (Admin), which give guidance as to the issues a panel should consider when deciding whether to admit hearsay evidence. She submitted that the written statement could fairly be admitted into 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 that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel took into account that attempts were made to secure Witness 2's attendance and that they have a good reason for their non-attendance. The panel noted that Witness 2's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and is signed by them. The panel also noted that there is no suggestion of fabrication. It was satisfied that this written

statement is not the sole and decisive evidence relating to the charges, as it also has the benefit of the written records.

The panel considered whether Mr Golimlim would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 2 to that of a written statement. It noted that Mr Golimlim had chosen voluntarily to absent himself from these proceedings and so would not be in a position to cross-examine this witness in any case. The panel also bore in mind the public interest in the issues being explored fully which supports the admission of this evidence into the proceedings.

In these circumstances, the panel determined that it would be fair and relevant to accept into evidence the written statement of Witness 2, 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**

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 Butler.

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 witness called on behalf of the NMC:

- Witness 1: Employed by Stoke Mandeville Hospital as a Matron for Integrated Medicine;

The panel admitted a written statement as hearsay evidence from the following witness called on behalf of the NMC:

- Witness 2: Employed by Stoke Mandeville Hospital as a Nurse in Charge on the Acute Medical Unit until November 2021.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. She cautioned the panel not to have regard in its deliberations to Exhibit PN/01 Appendix 12 (‘Guidance on Physiological Observations of Adult Non-Obstetric Inpatients’) as this guidance post-dates the events covered by the charges. Ms Butler had been alerted to this in advance by the legal assessor and indicated that it was not her intention to rely on the document. The panel accepted the legal

assessors advice and has not made reference to this document during its deliberations.

The legal assessor also referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code), and indicated that the panel could make reference to the Code when determining if there had been failings in Mr Golimlim's practice, as alleged in the wording of the charges.

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

**Charge 1**

> "That you, a registered nurse, between 23 and 24 March 2019, failed to keep proper records in that you made notes on Patient A's clinical notes which were not:
>
> a) Dated;
> b) Timed;
> c) Signed;
> d) Printed with Mr Golimlim's name; or
> e) Legible."

**This charge is found proved in its entirety.**

In reaching this decision, the panel took into account Mr Golimlim's entry into Patient A's clinical notes between 23 March 2019 and 24 March 2019, the Code, and Witness 1's live and written evidence.

In the clinical notes, the panel noted that the word '*NITE*' had been written in place of the date and time. It found that the relevant entry was not dated, timed, signed or printed with Mr Golimlim's name. This was supported by the live evidence and written statement of Witness 1 in which they stated that Mr Golimlim's explanation of the note was:

'*NITE means night time. Night of 23 March 2019, patient conscious and alert, no temperature, IV fluids infusing well, due meds administered, assisted to [their] needs, painkillers administered, patient had difficulty in opening bowel, stool softening Movicol administered, patient vomited once with 100ml, rested fairly handed over*'.

The panel further considered whether the note was objectively legible and determined that it was not.

The panel referred to Section 10 of the Code, particularly 10.4 which states registered nurses must '*keep clear and accurate records relevant to your practice*' by attributing '*any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*'. The panel was satisfied that Mr Golimlim had a duty to keep clear and accurate records and, on the face of the record itself, he failed to do so. Therefore, on the balance of probabilities, this charge was found proved.

**Charge 2**

"That you, a registered nurse, between 24 and 25 March 2019, failed to keep proper records in that you made notes on Patient A's clinical notes which were not:

a) Dated
b) Timed
c) Printed with Mr Golimlim's name;
d) Legible; or
e) In the correct chronological order.

**This charge is found proved in its entirety.**

The panel considered Mr Golimlim's entry into Patient A's clinical notes between 24 March 2019 and 25 March 2019, the Code, and Witness 1's live and written evidence.

In their written statement, Witness 1 stated that Mr Golimlim's explanation of the note was:

> '*Nite, patient assisted to* [their] *needs, obs are recorded, no temperature, patient due meds administered, given anti-emitate*[sic] *and patient pain killers, for continuity with treatment in care, IV fluid continue, patient uncomfortable, rested fairly, handed over and refused to use oxygen*.'

The panel heard Witness 1's live evidence and they explained that the '*NITE'* entry should have been recorded after the 19:15 entry on 24 March 2019 but was instead incorrectly recorded before the 13.30 entry on 24 March 2019 on a previous page.

The panel noted that, once again, the word '*NITE*' had been written in place of the date and time. It found that the entry for Patient A was not dated, timed, printed with Mr Golimlim's name, or in chronological order.

The panel considered whether the note was objectively legible and determined that it was not.

The panel was satisfied that, on the balance of probabilities, Mr Golimlim failed in his duty to keep clear and accurate records in all of the particulars alleged.

**Charge 3**

> "That you, a registered nurse, between 24 and 25 March 2019, in relation to Patient A's clinical notes failed to:
>
> a) record their deteriorating condition.

b) record that their care needed to be escalated and/or that their care was escalated."

**This charge is found proved in its entirety.**

The panel had regard to Mr Golimlim's entry into Patient A's clinical notes between 24 March 2019 and 25 March 2019, the Code, and the Adult NEWS2 Chart.

The panel determined that, from the NEWS scores recorded, it could be inferred that Patient A was deteriorating as the scores increased from '*4*' to '*6*'. The panel noted that the relevant entry by Mr Golimlim in Patient A's clinical notes made no reference to their deteriorating condition being escalated or the need for it to be escalated:

> '*Nite, patient assisted to [their] needs, obs are recorded, no temperature, patient due meds administered, given anti-emitate and patient pain killers, for continuity with treatment in care, IV fluid continue, patient uncomfortable, rested fairly, handed over and refused to use oxygen*.'

The panel was satisfied that Mr Golimlim had a duty to record Patient A's deterioration and/or escalate it under 10.2 of the Code: '*…you must… 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*'. The panel found that it is clear, on the face of the record, that Mr Golimlim had failed to do so. As such, on the balance of probabilities, the panel found this charge proved.

**Charge 4a**

> "That you, a registered nurse, between 24 and 25 March 2019, in relation Patient A's observation NEWS charts, failed to:
>
> a) review the observations and/or record a review of the observations.

**This charge is found proved.**

In reaching this decision, the panel took into consideration the Adult NEWS2 Chart.

On the NEWS chart, the panel noted that there is a column which requires a countersignature for a NEWS score of three or more. There were six occasions during the night shift where Mr Golimlim was required to review the observations and to countersign to indicate that he had done so. He had only countersigned the chart on one occasion.

On the evidence before it, the panel were unable to determine whether or not Mr Golimlim had reviewed the observations. However, the panel was satisfied that, on five out of six occasions, Mr Golimlim had failed to record a review of the observations. Accordingly, on the balance of probabilities, the panel found this charge proved.

**Charge 4b**

> "That you, a registered nurse, between 24 and 25 March 2019, in relation Patient A's observation NEWS charts, failed to:
>
> b) correct the NEWS scoring.

**This charge is found proved.**

The panel took into account the Adult NEWS2 Chart and Witness 1's supplementary statement.

In their statement, Witness 1 highlighted the errors in the NEWS scores recorded:

> '*At 22:10 there was a score of 2 for Respiratory Rate, score of 2 for Oxygen Saturations, and a score of 2 for Heart Rate which equals 6 instead of 4 as documented…*

*At 00:15 there was a score of 2 for Respiratory Rate, a score of 2 for Oxygen Saturations and a score of 2 for Heart Rate which equals 6 instead of 4 as initially documented and altered…*

*At 01:35 there was a score of 2 for Respiratory Rate, a score of 1 for Oxygen Saturations and a score of 2 for Oxygen therapy, which equals 5 instead of 4 as documented…*

*At 05:30 there was a score of 2 for Respiratory Rate, a score of 1 for Oxygen Saturations, a score of 2 for Oxygen therapy and a score of 1 for Heart Rate, which equals 6 instead of 5 as documented…*'

The panel noted that out of the four incorrect NEWS scores, only one was corrected which Mr Golimlim appears to have countersigned. Given that there was an expectation for the observations to be reviewed and countersigned, the panel was satisfied that there was also a duty on the nurse reviewing the observations to ensure that the NEWS scores were correct. Mr Golimlim failed to correct the erroneous scores on three occasions. On the balance of probabilities, the panel therefore found this charge proved.

**Charge 4c**

"That you, a registered nurse, between 24 and 25 March 2019, in relation Patient A's observation NEWS charts, failed to:

c) make and/or record a decision on observation frequency.

**This charge is found NOT proved.**

In reaching this decision, the panel had regard to the Adult NEWS Chart.

The panel noted that the boxes for observation frequency were completed on all six occasions and that a decision was made and recorded at 01.45 on 25 March 2019 to increase the frequency of observations. This occurs after the entry on the NEWS chart countersigned by Mr Golimlim. Therefore, the panel determined that someone made the decision on the frequency of monitoring and documented it on the NEWS chart. While this may have been made by another member of staff, the panel was of the view that is it as likely that it was Mr Golimlim as anyone else. Therefore, the panel determined that, on the balance of probabilities, this charge is found not proved.

**Charge 4d**

> "That you, a registered nurse, between 24 and 25 March 2019, in relation Patient A's observation NEWS charts, failed to:
>
> d) record that their care needed to be escalated and/or that their care was escalated.

**This charge is found proved.**

In reaching this decision, the panel took into account the Adult NEWS2 Chart and Witness 1's supplementary statement.

The panel established that it could be inferred that Patient A's condition was deteriorating from the NEWS scores recorded even when recorded incorrectly. The panel noted that the escalation column was either empty (on one occasion) or marked as '*N*' (on five occasions) which it had been told by Witness 1 in their live evidence indicated that Patient A's deterioration was not escalated. Further, this is supported by Witness 1's statement where they outlined that '*[t]here is no evidence of escalation completed'* at any point between 22.10 and the last recorded observation at 05.30.

Therefore, on the balance of probabilities, the panel found this charge proved.

**Charge 4e**

> "That you, a registered nurse, between 24 and 25 March 2019, in relation Patient A's observation NEWS charts, failed to:
>
> e) countersign the observational chart."

**This charge is found proved.**

The panel considered the Adult NEWS2 Chart for Patient A.

The panel had sight of the NEWS chart and noted that Mr Golimlim failed to countersign on five occasions out of six.

The panel was satisfied that, on the balance of probabilities, this charge was found 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 Mr Golimlim'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, 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 therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. Firstly, 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, Mr Golimlim's fitness to practise is currently impaired as a result of that misconduct.

**Submissions on misconduct**

Ms Butler invited the panel to conclude that the facts found proved amount to misconduct.

In her submission, Ms Butler identified the specific, relevant standards where the NMC says Mr Golimlim's failings amounted to a breach of the four fundamental tenets of the nursing profession and the Code:

> ***'Prioritise people***
>
> ***1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, You must:*
>
> *1.2 make sure you deliver the fundamentals of care effectively.*
>
> *1.4 make sure that any treatment, assistance or care for which*

*you are responsible is delivered without undue delay.*

*…*

***3 Make sure that people's physical, social and psychological needs are assessed and responded to***

*To achieve this, You must:*

*3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life.'*

***'Practise effectively***

***7 Communicate clearly***

*To achieve this, You must:*

*7.5 be able to communicate clearly and effectively in English.*

*…*

***8 Work co-operatively***

*To achieve this, You must:*

*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.*

*8.6 share information to identify and reduce risk.*

*…*

***10 Keep clear and accurate records relevant to your practice***

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

*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.*

*10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.*

*10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.'*

*'**Preserve safety***

***13 Recognise and work within the limits of your competence***

*To achieve this, you must:*

*13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care.*

*13.2 make a timely referral to another practitioner when any action, care or treatment is required.*

*13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence.*

*…*

***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***

*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.'*

With regard to the fundamental tenet of promoting professionalism and trust, Ms Butler submitted that, apart from four references being supplied, there is no indication that Mr Golimlim has cooperated with the NMC, and he has not engaged with this important part of the investigation against him.

**Submissions on impairment**

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

Ms Butler highlighted that she had identified 17 potential breaches within the four fundamental tenets set out in the Code. She submitted that, under the NMC guidelines, a breach of one of the fundamental tenants entitles the panel to conclude that a finding of impairment is required. She added that the panel making a finding of impairment would mark the unacceptability of the behaviour, emphasise the importance of the fundamental tenets of the profession and reaffirm proper standards.

In her submissions, Ms Butler addressed the matter of context. She acknowledged that Mr Golimlim was working on an acute unit during both night shifts. She submitted that a nurse is entitled to raise any concerns about staffing levels on the unit, however Mr Golimlim did not and has not engaged to be able to answer any questions which would assist him in relation to context.

With regard to the likelihood of repetition, Ms Butler submitted that the charges found proved indicate attitudinal concerns which, coupled with Mr Golimlim's failure to engage and take steps to remediate his practice, demonstrates that there is a likelihood of repetition.

For the above reasons, Ms Butler submitted that Mr Golimlim's fitness to practise is impaired on public protection grounds.

Ms Butler conceded that Mr Golimlim supplied personal references which have described him as '*kind and compassionate*'. However, she submitted that this is not relevant to the panel's decision today. She submitted that the only personal

reference of relevance is from Mr Golimlim's previous line manager dated 20 March 2020. However, this reference does not address the concerns raised. Ms Butler further submitted that, given Mr Golimlim has not provided the panel with any information from the last three and a half years, has shown no remediation or strengthening of his practice, when considering the public interest, there is insufficient evidence to say that the concerns raised are easy to "*put right*".

Ms Butler also submitted that the attitudinal concerns affect patients, Mr Golimlim's colleagues and the nursing profession as a whole. She added that he has not informed the panel that these incidents were a one off, and he has not provided any reasons for them happening. She submitted that all Mr Golimlim has offered by way of a defence is a suggestion that he did escalate concerns regarding Patient A's deteriorating condition, but there is no other evidence to indicate that he did so.

Therefore, Ms Butler submitted that Mr Golimlim's fitness to practise is impaired on public interest grounds as the charges found proved are serious and numerous breaches have been identified.

The panel heard and accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

**Decision and reasons on misconduct**

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

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

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

> ***'8 Work co-operatively***
> *To achieve this, You must:*
> *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.*
> *8.6 share information to identify and reduce risk.*
>
> ***'10 Keep clear and accurate records relevant to your practice***
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event.*
> *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.*
> *10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.'*

***‘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.*’

The panel noted that the death of Patient A had led to a coroner’s inquest. It further noted that the verdict of the coroner was that Patient A’s death was due to natural causes. There is therefore no suggestion of causation of death in the allegations. The allegations brought by the NMC and found proved by the panel focus on Mr Golimlim’s record keeping across the two night shifts in which these concerns arose, rather than his clinical care. For these reasons, the panel was not satisfied that Mr Golimlim was in breach of all of the sections of the Code suggested by Ms Butler.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mr Golimlim had responsibilities and failed in those responsibilities in that he made numerous recording errors over the course of both night shifts. The panel determined that his poor record keeping put his patients at a real risk of harm. Further, there is no reliable evidence of any mitigating circumstances on the days of the incidents.

As such, the panel found that Mr Golimlim’s failings fell seriously short of the conduct and standards expected of a nurse and cumulatively amounted to misconduct.

**Decision and reasons on impairment**

The panel next went on to decide if, as a result of the misconduct, Mr Golimlim’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 make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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

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

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

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

The panel considered the Grant test and, given that there are no charges alleging dishonesty, was satisfied that the fourth limb is not relevant. However, it determined that the first three limbs of the test were engaged.

The panel found that patients were put at risk of harm as a result of Mr Golimlim's misconduct. The panel was of the view that accurate record keeping is important as it ensures that patient deterioration can be tracked, and that action can be taken accordingly. Mr Golimlim's misconduct breached the fundamental tenets of the nursing profession in that he failed to communicate effectively and keep accurate records, therefore bringing its reputation into disrepute.

Regarding insight, the panel considered that Mr Golimlim has not provided any evidence demonstrating an understanding of how his actions and/or omissions put the patients at a risk of harm, why what he did was wrong and how this impacted negatively on the reputation of the nursing profession. The panel also noted that Mr Golimlim has not expressed remorse for his misconduct, nor has he demonstrated how he would behave differently in the future.

The panel was satisfied that the misconduct in this case is capable of being addressed. However, the panel had no evidence before it which demonstrated that Mr Golimlim has taken steps to strengthen his practice or remediate his misconduct.

In light of the above, the panel determined that there is a risk of repetition, therefore it decided that a finding of impairment is necessary on the grounds of public protection.

The panel also decided that a finding of impairment on public interest grounds is required to promote and maintain public confidence in the nursing profession and the NMC as a regulatory body, and to uphold and declare proper professional standards for members of the profession.

Having regard to all of the above, the panel was satisfied that Mr Golimlim's fitness to practise is currently impaired.

**Sanction**

Having found Mr Golimlim's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case.

In reaching this decision, the panel 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 heard and accepted the advice of the legal assessor.

**Submissions on sanction**

Ms Butler submitted that the aggravating factors in this case are:

- Mr Golimlim's lack of engagement with the NMC in three and a half years
- Mr Golimlim has not demonstrated remediation or insight into his failings

Ms Butler further submitted that there are no mitigating factors in this case.

Ms Butler invited that the panel impose a conditions of practice order and proposed certain conditions which she submitted would address the risk and the public interest. She also submitted that the panel may alternatively take the view that a suspension would be appropriate given the lack of engagement by Mr Golimlim. She added that the lack of cooperation with the regulator does not reach the level of a striking off order.

**Decision and reasons on sanction**

The panel bore 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:

- Mr Golimlim not providing any evidence of insight into his failings
- Mr Golimlim not providing evidence of him taking steps to strengthen his practice
- Mr Golimlim's conduct put patients at risk of harm

In relation to mitigating features, the panel noted the four references. The panel bore in mind that one of the references dated 20 March 2020 was written by Mr Golimlim's line manager from 2014 - 2020. The panel also noted that no recent management references have been provided. The remaining testimonials from colleagues and a patient's relative were undated. However, all attested to Mr Golimlim's kindness and good professional skills. The panel further noted that there was no evidence of any previous Fitness to Practise history.

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 and determined that, due to the seriousness of the case and the public protection issues identified, an order that does not restrict Mr Golimlim'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 Mr Golimlim's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Golimlim's registration would be a sufficient and appropriate response. The panel is mindful that

any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case, protect the public, and address the wider public interest.

In light of the fact that Mr Golimlim has not recently engaged with these proceedings, the panel considered very carefully whether he would engage with a conditions of practice order, or whether a suspension order would be more appropriate. It concluded that, although a suspension order could also protect the public and meet the public interest, to impose a suspension order would be disproportionate at this time. A reviewing panel may take a different view if Mr Golimlim does not reengage with this process.

Balancing all of these factors, the panel concluded that a conditions of practice order is the appropriate and proportionate sanction to mark the importance of maintaining public confidence in the profession, and send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel decided to make the order for a period of 12 months. The effect of this order is that Mr Golimlim's name on the NMC register will show that he is subject to

a conditions of practice order and anyone who enquires about his registration will be informed of this order.

The panel decided that the following conditions are appropriate and proportionate in this case:

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

1. You must inform the NMC of your current employer and the type of work you are undertaking within one month of this decision being sent to you.

2. You must ensure that you are supervised any time you are working as a registered nurse. Your supervision must consist of working at all times on the same shift as, but not always directly observed by, a registered nurse.

3. You must meet with your supervisor every month to discuss:
   - Your record keeping
   - How and when to escalate concerns about a patient’s deteriorating condition

4. Prior to any NMC review hearing, you must obtain a report from your supervisor commenting on:
   - Your record keeping
   - Your decision making in relation to escalating concerns

5. You must send your NMC Case Officer evidence that you have successfully completed a course on the importance of clinical record keeping.

6. You must work with your supervisor to create a personal development plan (PDP). Your PDP must address the concerns about record keeping and communication with colleagues with regard to escalating concerns. You must:

    - Send your case officer a copy of your PDP and your progress towards achieving it prior to any NMC review hearing.

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

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

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

d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

10. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

11. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is 12 months.

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

Any future panel reviewing this case would be assisted by:

- Engagement with the NMC regarding the review hearing
- Recent testimonials

- A written reflective piece addressing the concerns identified in the charges found proved and the impact on the reputation of the profession

**Interim order**

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel 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 Mr Golimlim's own interests until the conditions of practice order takes effect.

**Submissions on interim order**

Ms Butler invited the panel to impose an interim order for a period of 18 months to cover the appeal period and any appeal if made. She requested that the interim order be expressed in the same terms as the conditions of practice order the panel decided was the appropriate sanction for the substantive order.

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

**Decision and reasons on interim order**

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months.

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

This will be confirmed to Mr Golimlim in writing.

That concludes this determination.