Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 18 - Friday 22 & Monday 25 & Wednesday 27 - Friday 29 September & Monday 2 - Tuesday 3 October 2023

Virtual Hearing

Name of registrant:	**Nyakallo Putsoane**
NMC PIN:	04H0144O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – August 2004
Relevant Location:	Port Talbot
Type of case:	Misconduct
Panel members:	Rachel Onikosi (Chair, Lay member) Pamela Campbell (Registrant member) David Newsham (Lay member)
Legal Assessor:	Attracta Wilson
Hearings Coordinator:	Sherica Dosunmu
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Miss Putsoane:	Not present and unrepresented
Facts proved:	Charges 1b, 3, 4a, 4c
Facts not proved:	Charges 1a, 2, 4b
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (17 months) - with review**
Interim order:	**Interim conditions of practice order (12 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Putsoane was not in attendance and that the Notice of Hearing had been sent to Miss Putsoane's registered email address on 26 July 2023.

Mr Radley, 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', (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 means of joining the virtual hearing and, amongst other things, information about Miss Putsoane'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 Putsoane 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 Putsoane

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

Mr Radley referred the panel to various email attempts made by the NMC to contact Miss Putsoane, from March to September 2023. He stated that Miss Putsoane last responded to the NMC in 2022, when she acknowledged the regulatory proceedings, confirmed her

contact information and provided the NMC with an update that she was not working as a registered nurse at the time. He informed the panel that Miss Putsoane has not responded to any communication from the NMC regarding today's hearing.

Mr Radley submitted that there has been no application for an adjournment and, as a consequence, there was no reason to believe that an adjournment would secure Miss Putsoane's attendance on some future occasion. He submitted that the allegations are serious and there is clear public interest in the expeditious disposal of this case.

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 Putsoane. In reaching this decision, the panel has considered the submissions of Mr Radley 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 Putsoane;
- Miss Putsoane has not engaged with the NMC since 2022, and has not responded to any further correspondence from the NMC in relation to these proceedings;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- The charges relate to events that occurred in 2019;
- Witnesses are due to give live evidence;

- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Putsoane in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to her at her registered email address, she will not be able to challenge the evidence relied upon by the NMC 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 disadvantage to Miss Putsoane is the consequence of Miss Putsoane's decision 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 Putsoane. The panel will draw no adverse inference from Miss Putsoane's absence in its decision making.

Details of charge

That you, a registered nurse:

On 16 March 2019:

1. Stopped Patient A's oxygen:

    a) without clinical justification and; **[Not proved]**
    b) without seeking the authority of a GP. **[Proved]**

2. Failed to monitor Patient A's oxygen levels. **[Not proved]**

3. Did not escalate and or take appropriate action promptly, after Patient A had pulled out the syringe driver. **[Proved]**
4. Failed to make adequate records of your observations of Patient A, in that you:

    a) Did not record that you had removed Patient A's oxygen. **[Proved]**
    b) Did not record any observations following the removal of Patient A's oxygen. **[Not proved]**
    c) Did not record that Patient A had removed the syringe driver. **[Proved]**

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

Adjournment

On 19 September 2023, the panel of its own volition requested the following documents in relation to the matters charged:

- Medication Administration Record (MAR) chart for Patient A on 15 – 16 March 2019, detailing Patient A's oxygen requirements;
- Observation charts for Patient A on 15 – 16 March 2019, with details of Patient A's oxygen saturations;
- Information from the Home regarding required observations at the time;
- Nursing notes for Patient A on 15 – 16 March 2019;
- Patient A's Care Plan;
- Any procedures, policies or systems notes particularly around the escalation of failings, such as if a syringe driver is removed/falls out and the oxygen failings;
- End of Life policy in place at the relevant time;
- Palliative file, in which Miss Putsoane asserted that she made notes at the time; and
- Photograph of the syringe driver pulled out by Patient A.

The panel was of the view that this additional information would provide relevant evidence that would assist its considerations in this case.

On 21 September 2023, after the NMC's final live witness evidence, Mr Radley provided the panel with an update and stated that the NMC is in still in the process of making enquiries for the additional information requested. He explained that the NMC will require time to obtain the information, to compile it into a bundle for review, and to serve the bundle on Miss Putsoane. He requested a short adjournment until 22 September 2023, to afford the NMC the opportunity to finish its enquiries. He stated that it is anticipated that the NMC should be in a position to serve the additional evidence on Miss Putsoane by close of business on 22 September 2023.

The panel accepted the advice of the legal assessor.

The panel determined that it was in the interest of justice and fairness to both parties to allow a short adjournment. It was of the view that the NMC should be afforded the opportunity to obtain evidence relevant to the matters charged in this case, and Miss Putsoane should be given the opportunity to review any new material. The panel decided that it would resume proceedings on Monday 25 September 2023.

On 25 September 2023, Mr Radley provided a bundle with some of the additional information requested. This bundle included a photograph of the syringe driver pulled out by Patient A with time stamp, a summary of patient notes for Patient A, and a Protection of Vulnerable Adult Non-Criminal Investigation Report from Swansea Bay Health Board (the Health Board) and Neath Port Talbot County Borough Council (the Council). He explained that NMC was still making enquires to Plas Cwm Care Nursing Home (the Home) regarding the existence of the other information requested, however, the Home will need more time to ascertain whether this information can be located and shared.

The panel had regard to the fact that 26 September 2023 was scheduled as a non-sitting day for the hearing and the proceedings would resume on 27 September 2023 in any

case. Taking into account the one-day break which was scheduled prior to the start of the hearing, the panel decided to allow a further adjournment on the afternoon of 25 September 2023 to afford the NMC more time to obtain the requested information by 27 September 2023.

On 27 September 2023, Mr Radley provided a bundle of documents from the Home to the panel and a timeline (dated 8 December 2020 to 7 February 2022) demonstrating many prior attempts made by the NMC to obtain further documents for Patient A from the Home.

The hearing resumed on 28 September 2023, and Mr Radley informed the panel that the NMC made substantial efforts to obtain all of the documents requested, however, due to factors external to the NMC only some of the documents could be obtained. He confirmed that the additional documents had been served on Miss Putsoane.

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 Mr Radley on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Miss Putsoane.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Agency Staff Nurse at the Home, on day shift on 16 March 2019;

- Witness 2: Operational Lead for District Nursing at the Health Board;
- Witness 3: Patient A's relative who was present at the Home on 16 March 2019;
- Witness 4: Senior Carer at the Home, on night shift on 15 - 16 March 2019;
- Witness 5: Band 6 Case Holder at the Health Board, at the relevant time; and
- Witness 6: Deputy Manager at the Council, at the relevant time.

The panel also had sight of a written witness statement from the following NMC witness, which was read at the hearing and introduced into evidence the Protection of Vulnerable Adult Non-Criminal Investigation Report:

- Witness 7: Deputy Manager at the Council.

Background

The NMC received a referral regarding Miss Putsoane's fitness to practise on 8 July 2019 from the Adult Safeguarding Team at the Council. At the time of the concerns raised in the referral Miss Putsoane was working as a band 5 registered nurse at the Home via Hoop agency.

On 16 March 2019, Miss Putsoane was working on night shift duty as an agency nurse at the Home. On this shift, Miss Putsoane was working in the nursing unit responsible for the

care of Patient A and other residents. Patient A was a patient with [PRIVATE] who was admitted to the Home on or around 21 February 2019. On 14 March 2019, Patient A's family was informed that he would receive end of life care and as a result he would be placed on a syringe driver. Patient A was prescribed oxygen and subsequently placed on a syringe driver on 15 March 2019.

The referral alleges that on 16 March 2019, whist on shift, Miss Putsoane removed Patient A's oxygen supply at approximately 04:00 without clinical justification or advice from a GP. It is alleged that Miss Putsoane failed to follow Patient A's care plan, failed to carry out or record any observations to monitor his oxygen levels, and failed to hand over this information.

Later that morning, Patient A removed his syringe driver as he was reportedly agitated by it. Miss Putsoane was still on duty at the time and was alerted to this by Patient A's daughter. It is alleged that after being made aware that Patient A had removed his syringe driver, Miss Putsoane failed to contact the District Nursing (DN) team to replace this, as was required, but instead handed this information over at the end of her shift to the incoming nurse (Witness 1). It is alleged that during handover Miss Putsoane informed Witness 1 that Patient A had removed his syringe driver at 07:00, but did not tell Witness 1 that she had stopped the patient's oxygen. Witness 1 was due to start day shift duty at 08:00. Witness 1 later contacted the DN team to notify them that Patient A's syringe driver had been removed.

On 20 June 2019, professional concerns were raised to the Council's Adult Safeguarding Team regarding the events that occurred on 16 March 2019 in relation to Patient A. A Protection of Vulnerable Adult Non-Criminal Investigation was conducted by the Council and the Health Board, whereby Miss Putsoane was identified as a nurse of concern in the investigation. Following this investigation, a multi-agency meeting took place on 5 July 2019, which included the Council, the Health Board and the South Wales Police (the Police). At this meeting, it was determined that no further action would be taken in respect of criminality, but Miss Putsoane's actions warranted a referral to the NMC.

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.

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

Charge 1a

1. Stopped Patient A's oxygen:
   a) without clinical justification and;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 3, Witness 6 and Witness 7. The panel also had regard to the documentary evidence exhibited, which included a statement provided by Miss Putsoane at the local investigation, dated 11 July 2019.

The panel found that Witness 3, Witness 6 and Witness 7 provided evidence which indicated that Miss Putsoane stopped Patient A's oxygen on 16 March 2019. It considered that this was supported by Miss Putsoane's written statement at the local investigation, in which she accepted that she stopped Patient A's oxygen:

> *'*[Patient A] *was having oxygen on and off and as required.* [Patient A] *was unsettled and was pulling everything off. It wasn't the first time that he had taken off his oxygen. I checked his stats and wrote down on the notes. I took the oxygen off as he was pulling at it – this was the only reason and had nothing to do with him having to dry out or being end of life. He was not keeping it on and so I took it off. I stopped 02 I can't remember if I wrote it down. Stats were maintained at 90 something. I kept eye on stats and it was all ok'*

The panel considered Miss Putsoane's written statement provided at the local investigation, it noted that she stopped Patient A's oxygen as he was pulling at it and he was not keeping it on, this was her clinical justification for stopping it. The panel was not provided with any clinical evidence supporting the details of how the oxygen was prescribed; whether as a continued supply or 'as required'. It considered that a specific direction of 'as required' might have given justification for Miss Putsoane to remove the oxygen under particular circumstances. In the absence of all of this evidence, and the lack of documentary evidence in the form of Patient A's observation charts detailing oxygen saturation levels between 15 – 16 March 2019, the panel did not have sufficient evidence to determine, on the balance of probabilities, whether Miss Putsoane had clinical justification to stop Patient A's oxygen on 16 March 2019.

In these circumstances, the panel found charge 1a not proved.

Charge 1b

1. Stopped Patient A's oxygen:
    b) without seeking the authority of a GP.

This charge is found proved.

In reaching this decision, the panel had regard to the documentary evidence exhibited, which included the Council's Protection of Vulnerable Adult Non-Criminal Investigation Report and a statement written by Miss Putsoane at the local investigation, dated 11 July 2019.

The panel noted that the Council's Protection of Vulnerable Adult Non-Criminal Investigation Report contained information indicating that Miss Putsoane did not seek authority from a GP before she stopped Patient A's oxygen, which it regards comes from a

reliable source. In the investigation report it is stated that the following instruction was provided in Patient A's care plan:

'Patient A is to remain on O2 unless further instruction is obtained from the GP.'

The panel had no clinical evidence to indicate whether Patient A was prescribed '*O2*' continuously or on an 'as required' basis but noted that Miss Putsoane stated in her written statement at the local investigation:

'Patient A was having oxygen on and off and as required'.

The panel also noted the following from Miss Putsoane's written statement at the local investigation:

'I did remove the oxygen and I should have consulted with GP from that care plan.'

The panel bore in mind its findings in charge 1a, where it was not satisfied that the NMC had discharged its burden of proof in relation to whether Miss Putsoane acted without clinical justification when she stopped Patient A's oxygen. However, in relation to this charge, the panel was satisfied, on the balance of probabilities, that Miss Putsoane did not seek the authority of the GP before stopping Patient A's oxygen.

Accordingly, the panel found charge 1b proved.

Charge 2

2. Failed to monitor Patient A's oxygen levels.

This charge is found NOT proved.

In reaching this decision, the panel had regard to the documentary evidence exhibited, which included the Council's Protection of Vulnerable Adult Non-Criminal Investigation Report and a statement written by Miss Putsoane at the local investigation, dated 11 July 2019.

The panel noted that the Council's Protection of Vulnerable Adult Non-Criminal Investigation Report contained information indicating that Miss Putsoane failed to monitor Patient A's oxygen levels. However, it also noted that this was directly contradicted by Miss Putsoane's written statement at the local investigation, in which she stated that she continued to monitor Patient A:

> *'*[Patient A] *was having oxygen on and off and as required.* [Patient A] *was unsettled and was pulling everything off. It wasn't the first time that he had taken off his oxygen. I checked his stats and wrote down on the notes. I took the oxygen off as he was pulling at it – this was the only reason and had nothing to do with him having to dry out or being end of life. He was not keeping it on and so I took it off. I stopped 02 I can't remember if I wrote it down. Stats were maintained at 90 something. I kept eye on stats and it was all ok'*

The panel considered that it was presented with conflicting evidence between the investigation report and Miss Putsoane's local statement. In the absence of independent corroborative evidence, such as Patient A's observation charts for 15 – 16 March 2019, which were referred to in the investigation report, the panel cannot be satisfied that, on the balance of probabilities, Miss Putsoane failed to monitor Patient A's oxygen levels.

In these circumstances, the panel found charge 2 not proved.

Charge 3

3. Did not escalate and or take appropriate action promptly, after Patient A had pulled out the syringe driver.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 3 and Witness 4.

The panel noted that Witness 3 was present when Patient A removed the syringe driver and provided eyewitness account of what happened. It noted the following evidence from Witness 3's written witness statement, which stated:

> *'On the night of 15 March 2019, my father was restless at 3am and pulled the driver out just before 7am, the NHS nurses put this back in around 10am. At the time he pulled this out, the registrant said that she had phoned for someone to come and put this back in, but we found out that she just went out and actually hadn't notified anyone that the driver had come out...*
>
> *…I know the driver was pulled out just before 7am, me and mum were there when it happened. We didn't know what to do when the driver had been pulled out, so I went and told the registrant that my father had pulled this out and the alarms were going off. I am aware that the she didn't record that this had been pulled out. When I reported this to her (not sure of her name but she was a black nurse) she told me to leave the room and wait because she was carrying out a handover and she would deal with this after*
>
> *The registrant never came to the room to even check that it had actually come out, she just said she would deal with this. The driver, cannula and the machine was beeping for hours before anyone came to deal with it. My father was screaming in pain during this time, the alarm was beeping and in such a small room so you can imagine the noise. I went back and forth to ask the registrant what to do about this. I understand the importance of a handover, but I even went back and asked her before she left her shift if she had done it and she told me it was sorted with the next handover team.'*

The panel found that Witness 3's evidence was consistent, in which she maintained that Patient A' pulled the syringe driver out before the end of Miss Putsoane's shift and this was not escalated promptly by her.

The panel also noted the following evidence from Witness 1's written witness statement, which stated:

> *'Nyakallo did mention during the handover that Patient A had pulled the syringe driver out. I don't remember whether this was written down or not, but I remember she said that she didn't have time to ring anyone and asked me to carry on with this. I think that it was a hard overnight shift the night before because a lot of the patients were unwell. Typically there is only one nurse on the night shift with two carers. In my opinion there should be at least two nurses on shift because there was as big floor to cover. If they had more patients that needed assistance on a shift there would be another nurse around to manage the patient's needs as well. Nyakallo said that the syringe driver was pulled out around 07:00 hours, she told me this during the handover. At 07:45 hours we were in the dining room for the handover so it couldn't have been pulled out by the patient at that time. I called the District Nurses around 09:30 hours to notify them that the driver had been pulled out. I gave them information about the patient and that he had pulled the syringe driver out overnight. I told them that we kept him comfortable with the sub-cut doses and asked them to come as soon as possible to put the driver back in. Patient A's family were there the whole time. The patient was given his PRN medication when it was needed, he was kept comfortable from a pain perspective and was settled whilst other residents were being attended to.'*

Further, the panel noted the following evidence from Witness 4's written witness statement, which stated:

‘The moment the patient pulled out the syringe driver she should’ve told the District Nurses straight away. I can’t remember specific times, but I do know that the time she reported the syringe driver as having been pulled out wasn’t the correct time. I gave them the correct time this happened in my statement at the time. The registrant came and told me that the patient had pulled it out and asked me what to do. I told her what she needed to do which was to call the District Nurses, she said she would hand over to day staff and I told her that she needed to go straight away. I assumed she would ring them right after I told her, I guess that wasn’t done but I told her that she needed to do that right away.’

The panel found that Witness 1, Witness 3 and Witness 4’s account of what happened generally corroborate one another’s account that Patient A pulled out his syringe driver before the end of Miss Putsoane’s shift. The panel was of the view that Witness 1, Witness 3 and Witness 4 provided consistent detailed accounts that Miss Putsoane did not take appropriate action promptly when she found out that Patient A had pulled the syringe driver out, which it regarded as compelling.

The panel had regard to Miss Putsoane’s written statement at the local investigation, in which she stated that she was informed at 08:00 that Patient A had pulled the syringe driver out when it was time for her to hand over her shift. However, the panel preferred the consistent and corroborative evidence of Witness 1, Witness 3 and Witness 4 who were all present at the time or had received information at the handover and all of whom gave oral evidence.

The panel was therefore satisfied that, on the balance of probabilities, Patient A removed the syringe driver before the end of Miss Putsoane’s shift and she did not take appropriate action promptly.

Accordingly, the panel found charge 3 proved.

Charge 4a

4. Failed to make adequate records of your observations of Patient A, in that you:
    a) Did not record that you had removed Patient A's oxygen.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2. The panel also had regard to the documentary evidence exhibited, which included Patient A's Daily Record of Care on 15 – 16 March 2019.

The panel noted the following evidence from Witness 2's written witness statement, in which she stated:

> *'I was tasked with looking through the documentation with another member of staff. We found no entries whatsoever from the registrant in Patient A's care documents.*
>
> *The care documents start on 15 March 2019, the registrant didn't make any records on that date so you can see the majority of the records are from 19 March 2019.'*

The panel noted that Witness 2's written witness statement was supported by Patient A's Daily Record of Care on 15 – 16 March 2019, which did not include any entry from Miss Putsoane regarding Patient A's oxygen. The panel accepted this corroborative evidence. It noted that in Miss Putsoane's local statement she stated the following:

> *'I definitely did record that the oxygen had been removed and I wrote this on the notes. I wrote this on the end of life paperwork that the DN kept.'*

The panel considered the evidence given by Witness 2 to the effect that she would not expect entries to be made on the Community Nursing Patient Record by nurses working in the Home. The panel also had sight of these records noting that there were no entries by Miss Putsoane consistent with the evidence provided by Witness 2.

The panel was therefore satisfied that, on the balance of probabilities, Miss Putsoane did not record that she removed Patient A's oxygen.

Accordingly, the panel found charge 4a proved.

Charge 4b

4. Failed to make adequate records of your observations of Patient A, in that you:
   b) Did not record any observations following the removal of Patient A's oxygen.

This charge is found NOT proved.

In reaching this decision, the panel had regard to the documentary evidence exhibited, noting that it had not been presented with Patient A's observation charts for 16 March 2019, which would provide evidence of oxygen observations that took place at the time.

The panel bore in mind its reasoning for charge 2 and determined that it was presented with insufficient evidence to demonstrate that Miss Putsoane failed to record observations following the removal of Patient A's oxygen.

In these circumstances, the panel found charge 4b not proved.

Charge 4c

4. Failed to make adequate records of your observations of Patient A, in that you:
   c) Did not record that Patient A had removed the syringe driver.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2. The panel also had regard to the documentary evidence exhibited, which included Patient A's Daily Record of Care on 15 – 16 March 2019.

The panel noted the following evidence from Witness 2's written statement, in which she stated:

> *'I was tasked with looking through the documentation with another member of staff. We found no entries whatsoever from the registrant in Patient A's care documents.*
>
> *The care documents start on 15 March 2019, the registrant didn't make any records on that date...'*

The panel noted that Witness 2's written witness statement was supported by Patient A's Daily Record of Care on 15 – 16 March 2019, which did not include any entry from Miss Putsoane regarding the removal of Patient A's syringe driver. The panel accepted this corroborative evidence.

The panel was therefore satisfied that, on the balance of probabilities, Miss Putsoane did not record that Patient A removed the syringe driver.

Accordingly, the panel found charge 4c 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 Putsoane'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 Putsoane's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Radley referred the panel 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.'* He also referred to the case of *Calhaem v GMC* [2007] EWHC 2606 (Admin) and *Nandi v GMC* [2004] EWHC2317 (Admin).

Mr Radley invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision. He identified the specific, relevant standards where Miss Putsoane's actions amounted to misconduct.

Mr Radley submitted that Miss Putsoane's actions found proved are failings directly related to her clinical practice. He submitted that Miss Putsoane's actions were not simply breaches of a local disciplinary policy or minor concerns, but breaches to matters at the heart of the nursing profession and fundamental to her professional practice.

Mr Radley submitted that the issues identified with Miss Putsoane's practice relate to the discontinuation of oxygen therapy, medicines management, and management of emergency escalations such as notifying DN of the syringe driver removal at the Home. He submitted that Miss Putsoane's behaviour amounts to serious misconduct and has the potential to impact public trust and confidence in all nurses.

Mr Radley submitted that the panel may consider that there are relevant contextual factors to take into account in this case. He stated that it is fair and right to accept that Miss Putsoane worked in a home that had serious failings. However, he submitted that this does not remove the need for appropriate decision making as a nurse.

Mr Radley submitted that there are several factors of concern relevant to this case, medicines management, escalation of concerns, and lack of professionalism. He submitted that these factors could have a serious effect on workplace culture and patient safety if not dealt with effectively.

Submissions on impairment

Mr Radley 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. It also included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Radley submitted that the first three limbs of the test set out by Dame Janet Smith in the fifth Shipman report and adopted in *Grant* were engaged in this case:

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 profession into disrepute;*
c) *Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession;*
d) *…*

Mr Radley submitted that the breaches of the Code in this case involves a breach of the fundamental tenets of the profession. He submitted that a finding of impairment is required to mark the unacceptability of Miss Putsoane's behaviour, to emphasise the importance of the fundamental tenets breached, and to reaffirm proper standards or behaviour. He referred the panel to the case of *Yeong v GMC* [2009] EWHC 1923 (Admin) Hamer paragraph 36.07.

Mr Radley stated that Miss Putsoane has provided limited engagement in the process and has not attended these proceedings to explain her case. Further, he submitted that there is no evidence that she has addressed or taken steps to address any concerns or risks identified in the case. He highlighted that Miss Putsoane has not provided evidence of further relevant training or supervision; information relating to reflection and understanding of the issues raised in the proven allegations; insight/acceptance (in part) regarding the proven allegations; details of steps taken to address the concerns raised by the proven allegations; and/or evidence from others as to current skills and fitness to practise. He submitted that, in these circumstances, the likelihood of repetition is a concern which will impact on Miss Putsoane's ability to practise kindly, safely, and professionally. He submitted that the consequences of Miss Putsoane's conduct affected patient care and could have been very serious, such as delay in referral, albeit that the patient was in end of life care, his final days appeared more traumatic than they should have been.

Mr Radley submitted that for these reasons Miss Putsoane's fitness to practise is currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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 Putsoane's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Putsoane's actions amounted to a breach of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *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***
> *2.1 work in partnership with people to make sure you deliver care effectively*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life*
>
> ***8 Work co-operatively***
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> *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

20 Uphold the reputation of your profession at all times

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges found proved amounted to misconduct, the panel considered the charges individually whilst taking into full consideration the evidence before it and the circumstances found proved arose.

The panel found that in charge 1b, Miss Putsoane stopped Patient A's oxygen without seeking the authority of a GP. The panel bore in mind that due to lack of information regarding the details of how the oxygen was prescribed, it was not clear whether or not Miss Putsoane was required to seek the GP's authority when she stopped the oxygen. In view of this, the panel determined that her actions did not amount to misconduct.

The panel found that in charge 3, Miss Putsoane did not escalate and/or take appropriate action promptly after Patient A had pulled out the syringe driver as she failed to notify the DN team. It took into account that the syringe driver was being used to manage pain and comfort at the end of life. The panel considered that it was Miss Putsoane's duty to act promptly and appropriately to mitigate the risk of harm to Patient A and she did not. It determined that Miss Putsoane demonstrated an unacceptably low standard of professional practice in this area which amounted to misconduct.

The panel considered charge 4a and 4c separately. In respect of these charges the panel found that Miss Putsoane did not record that she had removed Patient A's oxygen, did not record that Patient A had removed the syringe driver, and therefore failed to record adequate records in the daily notes for Patient A. The panel was of the view that creating an accurate written account of events relating to a patient's condition and treatment is particularly important for the safety of patients and the follow up care patients receive from other professionals. It found that in respect of these charges Miss Putsoane demonstrated failings in fundamental aspects of nursing care and practise which amounted to misconduct. The panel determined that Miss Putsoane's actions in each charge would be considered unacceptable by fellow practitioners and damaging to the trust that the public places in the profession.

The panel therefore concluded that Miss Putsoane's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Putsoane'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) *…'*

The panel determined that limbs a, b and c in the above test were engaged both in the past and in the future.

Taking into account all of the evidence adduced in this matter, the panel finds that Patient A was put at risk of harm as a result of Miss Putsoane's misconduct. The panel determined that Miss Putsoane's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel noted that whilst Miss Putsoane had made some early admissions at the local level investigation, it was not presented with evidence of insight or remorse. The panel considered that it had not received any evidence to suggest that Miss Putsoane has demonstrated an understanding of how her actions put a patient at a risk of harm, an understanding of her wrongdoings, how this impacted negatively on the reputation of the nursing profession and how she would handle the situation differently in the future. The panel took into account that Miss Putsoane had disengaged with the NMC regulatory process and therefore it was not presented with any information regarding her current level of insight or remorse.

The panel was satisfied that the misconduct in this case is capable of being addressed. The panel carefully considered the evidence before it in determining whether or not Miss Putsoane has taken steps to strengthen her practice. However, the panel has not received any information to suggest that Miss Putsoane has taken steps to address the specific concerns raised about her practice, such as relevant training or reflection.

The panel was of the view that due to the lack of insight, remorse or evidence of strengthened practice, there remains a high risk of repetition. The panel considered that Miss Putsoane's actions set out in the charges found proved demonstrated behaviour that fails to acknowledge professional and clinical protocols, which inevitably led to unsafe practice. On the basis of all the information before it, the panel decided that there is a risk of harm to the public if a finding of impairment is not made. The panel therefore determined that a finding of current impairment on public protection grounds is necessary.

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

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

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 17 months. The effect of this order is that Miss Putsoane's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Radley informed the panel that in the Notice of Hearing, dated 26 July 2023, the NMC had advised Miss Putsoane that it would seek the imposition of a conditions of practice order for a period of 18 months if it found Miss Putsoane's fitness to practise currently impaired.

Mr Radley invited the panel to consider whether the least restrictive sanction would be proportionate, and if it was not, the panel should then consider escalation until it arrives at a sanction with the most appropriate outcome.

Mr Radley outlined the aggravating factors he identified in this case:

- Vulnerable end of life patient;
- Lack of insight into failings;
- Impact on the reputation of the profession; and
- There are fundamental questions about Miss Putsoane's professionalism and a risk of lack of public confidence in nursing.

Mr Radley also outlined the mitigating factors he identified in this case:

- Partial admissions made; and
- No previous findings against Miss Putsoane.

Mr Radley submitted that the following factors are relevant to this case:

- Failure to escalate in the case of the syringe driver being removed. Training could be given to address the concerns identified;
- Lack of insight or acceptance of the wrong (partial admissions). Further training may help to explain the wrong; and
- Serious medication failings causing concern and identifiable risk (removal of oxygen).

Mr Radley submitted that, in these circumstances, a conditions of practice order would protect patients, members of the public and maintain professional standards. He referred the panel to the case of *Bawa-Gaba v GMC* [1 WLR 942] paragraph 13, and submitted that a conditions of practice order would also meet the public interest.

Decision and reasons on sanction

Having found Miss Putsoane'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 factors:

- Vulnerable end of life patient;
- Lack of insight into failings;
- Impact on the reputation of the profession;
- Conduct which put patients at risk of suffering harm;
- Lack of engagement with the NMC regulatory process; and
- Fundamental questions about Miss Putsoane's professionalism and a risk of lack of public confidence in nursing.

The panel also took into account the following mitigating factors:

- Partial admissions made;
- Conduct which occurred on a single shift; and
- Conduct which occurred on a busy under resourced night shift at the Home.

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 not protect the public or satisfy public interest if no further action is taken.

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 Putsoane'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 Putsoane'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 Miss Putsoane'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;*
- *Potential… to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

Having determined that Miss Putsoane's misconduct is capable of being addressed, the panel considered whether it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel was of the view that a conditions of practice order would give Miss Putsoane the opportunity to demonstrate that she is capable of safe and effective practice, while at the same time protecting patients.

The panel had regard to the fact that other than the concerns raised in this case, Miss Putsoane has had a longstanding career of 19 years as a nurse with no previous NMC regulatory concerns. The panel was of the view that it was in the public interest that, with appropriate safeguards, Miss Putsoane should be able to return to practise as a nurse. Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be disproportionate and would not be a reasonable response in the circumstances of Miss Putsoane's case because it would be unduly punitive. The panel determined that a suspension order or a striking-off order would not allow Miss Putsoane the opportunity to address the issues identified with her practice.

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

The panel determined 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 not be the sole nurse on duty on any shift you are working.

2. You must ensure that whilst on duty you are indirectly supervised, but not always directly observed by a registered nurse any time you are working.

3. You must work with your line manager, mentor or supervisor who is also a registered nurse to create a personal development plan (PDP). Your PDP must address the concerns about medicines management, management of emergency escalations, record keeping, and end of life care. You must:

a) Send your NMC case officer a copy of your PDP within 14 days of commencing employment or the date of this order, whichever is sooner.
b) Meet with your line manager, mentor or supervisor, who is also a registered nurse at least every month to discuss your progress towards achieving the aims set out in your PDP.
c) Send your NMC case officer evidence that you have completed a course on end of life care prior to any review of the order.

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

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

6. 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 in your capacity as a registered nurse.

7. You must tell your NMC 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.

8. You must allow your NMC 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 for 17 months.

Before the order expires, a panel will hold a review hearing to see how well Miss Putsoane 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 for another order.

Any future panel reviewing this case would be assisted by:

- Engagement with the NMC and any proceedings including attendance at future review hearings;
- A reflective statement from Miss Putsoane demonstrating her insight, what she has learnt since this hearing and how this has strengthened her practice;
- References and testimonials for Miss Putsoane relating to clinical work from her colleagues who are aware of the regulatory concerns of this case; and
- Evidence of any completed training and associated assessments that relate to the regulatory concerns in this case.

This will be confirmed to Miss Putsoane in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Putsoane's own interest until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Radley. He submitted that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest. He invited the panel to impose an interim conditions of practice order for a period of 12 months.

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 12 months to allow for any possible appeal period.

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

That concludes this determination.