Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 7 November 2022 – Monday, 14 November 2022
Monday 18 September 2023 – Wednesday 20 September 2023

Virtual Hearing

Name of registrant:	Matilda Aryee
NMC PIN:	03J0307O
Part(s) of the register:	Registered Nurse – Adult Nursing – 9 October 2003
Relevant Location:	Brighton and Hove
Type of case:	Misconduct
Panel members:	Richard Weydert-Jacquard (Chair, registrant member) Sandra Lamb (Registrant member) Nicola Strother Smith (Lay member)
Legal Assessor:	Graeme Henderson
Hearings Coordinator:	Opeyemi Lawal (7 – 14 November 2022) Alice Byron (18 – 20 September 2023)
Nursing and Midwifery Council:	Represented by Sally Denholm, Case Presenter (7 – 14 November 2022) Represented by Mary Kyriacou (18 – 20 September 2023)
Mrs Aryee:	Present and represented by Dr Abbey Akinoshun, Erras Legal Services
No Case to Answer:	Charge 1c
Facts proved:	Charges 1a, 1b, 2a, 2b, 2c, 3b, 3c, 4a, 4b, 4c, 4d
Facts not proved:	Charges 1d, 3a, 5, 6
Fitness to practise:	**Impaired**

Sanction:	**Conditions of Practice Order (12 Months)**
Interim order:	**Interim Conditions of Practice Order (18 Months)**

Details of charge

That you, a Registered Nurse:

1) On 18 October 2018 in relation to an unwitnessed fall by Resident A:

    a) Inappropriately moved the resident from the floor onto the bed before a full examination had been carried out; **[Proved]**
    b) Failed to inform the resident's family or next of kin of the fall; **[Proved]**
    c) Failed to hand over details of the fall to the oncoming shift; **[No Case To Answer]**
    d) Failed to follow up your recommendation for a sensor mat for the resident. **[Not Proved]**

2) On 5 April 2019 in relation to an unwitnessed fall by Resident B:

    a) Failed to respond in a timely manner to the emergency call bell; **[Proved]**
    b) Failed to attend immediately when requested to do so by a colleague; **[Proved]**
    c) Failed to carry out post fall observations. **[Proved]**

3) On 9 April 2019 in relation to an unwitnessed fall by Resident C:

    a) Failed to respond in a timely manner to the emergency call bell; **[Not Proved]**
    b) Failed to inform the patients family or next of kin of the fall; **[Proved]**
    c) Failed to complete:

        i) Moving and handling risk assessment **[Proved]**
        ii) Falls risk assessment **[Proved]**
        iii) Post falls observation tool **[Proved]**

4) On 11 April 2019 in relation to an unwitnessed fall by Resident D:

    a) Failed to take charge of the situation **[Proved]**

b) Failed to carry out a post fall assessment **[Proved]**
c) Failed to provide emergency care **[Proved]**
d) Failed to provide details and/or a handover to ambulance personnel. **[Proved]**

5) On an unknown date between 29 August 2017 and 12 April 2019 used racially offensive language calling Colleague A ‘rude little white girl’ or similar words to that effect. **[Not Proved]**

6) On one or more occasions during 2019 and 2020, failed to preserve the safety of residents by sleeping whilst on duty. **[Not Proved]**

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

Background

The charges arose whilst you were employed as a registered nurse by Hallmark Care Homes. The alleged incidents occurred whilst you were working ay Maycroft Manor.

18 October 2018 – Resident A had an unwitnessed fall. On attending to assist, it is alleged you failed to follow the correct procedure by moving the resident onto the bed before fully examining him. It is also alleged that you failed to handover details of the fall to the oncoming shift and failed to notify the next of kin. It is also alleged you made a recommendation for a sensor mat however failed to follow this up. The patient was later taken to hospital by ambulance, and it was discovered he had suffered a broken hip.

5 April 2019 – Resident B had an unwitnessed fall in the lounge area. Staff operated the emergency alarm. It is alleged you failed to respond to the alarm, you were found by a care assistant in a room dealing with a non-urgent matter with another Resident. When asked to assist, it is alleged you were rude to the care assistant telling them you were busy. Another nurse who had finished their shift but was still on site attended to the Resident. It is alleged you thereafter failed to carry out the required post falls observations.

9 April 2019 – A Care Assistant responded to the sensor mat in Resident C's room. On finding the resident to have suffered an unwitnessed fall, the emergency call bell was activated. You allegedly failed to attend and on the Care Assistant finding you, you were doing a medication round and told the Care Assistant you were busy.

It is alleged that you attended 20-25 minutes later and you failed to inform the Resident's next of kin, failed to complete the risk assessment or to document any observations and failed to hand over the fall to the next shift.

11 April 2019 – Resident D suffered an unwitnessed fall and upon a Senior Care Assistant arriving, noted the Resident to have a large open wound to their knee. This was a previous wound which had apparently re-opened as a result of the fall. The Care

Assistant called for an ambulance and carried out first aid, covering the wound. When you arrived, it is alleged that you were rude to the Senior Care Assistant, demanding to be able to take the cover off the wound. You allegedly failed to take control and assess the Resident, left and did not return when the ambulance arrived, therefore did not hand over details to the ambulance staff.

In the course of the investigation, the Senior Care Assistant Ms 3 also mentioned, when explaining how you had been rude to her, that she had previously had a disagreement with you about swapping staff. During this disagreement you allegedly had called her a ‘rude little white girl’.

Also, whilst investigating these matters, the NMC was told by witness Ms 4 that you often slept on duty and would sleep for 3-4 hours every shift.

Following a local level investigation, you were dismissed.

Response to charges

Following the reading of the charges, Dr Akinoshun on your behalf, indicated that you did not admit any of these charges.

Decision and reasons on application of no case to answer

The panel considered an application from Dr Akinoshun that there is no case to answer in respect of charges 1(c), 4 and 6. This application was made under Rule 24(7).

In relation to this application, Dr Akinoshun submitted that the evidence that has been provided to the panel in relation to the charges is insufficient and the panel can conclude that the facts of the charges cannot be found proved.

Dr Akinoshun took the charges in turn.

In relation to Charge 1(c), Dr Akinoshun submitted that the allegation stemmed from the sole and decisive evidence of Ms 1 but no direct oral or written evidence was given to the panel to substantiate the allegation. Therefore, there is no case to answer in respect of this charge.

In relation to Charge 4, Dr Akinoshun submitted that the charge in its entirety should fall away. He submitted that Ms 3 is the only witness that directly speaks to charge 4 and Mr 2 can only speak to what he was told during the investigation. As the evidence is contradictory from both witnesses, Dr Akinoshun submitted that there is no case to answer for the entirety of charge 4.

In relation to charge 6, Dr Akinoshun submitted that the evidence presented to the panel is vague, weak and inconsistent as the charge itself was misconceived.

In these circumstances, it was submitted that the charges should not be allowed to remain before the panel.

Ms Denholm agreed with the application and submissions made by Dr Akinoshun, in relation to charge 1(c). However, Ms Denholm submitted that the evidence in support of charges 4 and 6 is not weak and the evidence presented to the panel is sufficient to be considered. So, therefore Ms Denholm submitted that there is a case to answer in relation to charges 4 and 6.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charge 1(c) proved. The panel considered that the word ‘failure’ implied that there was a ‘duty to handover details of the fall’, which you failed to do. However, the panel noted that Ms 1’s witness statement did not detail the handover process and no handover document from that day has been provided. Following investigation there was no complaint about you handing over details of the fall. The outcome report noted that there was no formal handover ‘but you did mention a couple of things to the team’. The panel was not satisfied that you were under a duty to handover details of the fall.

In relation to charge 4, the panel considered that there was evidence from Mr 2, that you had a duty to carry out each of the elements but failed to do so, since you were the most senior person on shift. The panel noted that Ms 3’s evidence conflicts with the evidence of the policy makers and the evidence of Mr 2 but the panel took the view that it is not appropriate to dismiss the charge at this stage. The panel will have to assess at a later stage how to resolve the conflict in evidence between Ms 3 and Mr 2.

In relation to charge 6, the panel determined that there is evidence to support this charge from two sources, which includes the evidence from Ms 4, who allegedly saw you sleeping. The panel noted from the evidence of Mr 2 that he had carried out unannounced visits to the Home but saw no evidence of you sleeping. The panel will have to assess all of this evidence at a later stage.

Therefore, the panel was of the view that there had been sufficient evidence to support the charges 4 and 6 at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Amendment issues

During the course of Dr Akinoshun's submissions, he pointed out that charge 6 had a wide latitude of time. It was alleged that you slept on duty during 2019 and 2020. Since you have been dismissed from the Home in 2019 it made no sense for 2020 to be included.

It was accepted, on behalf of the NMC, that the timescale in the charge was wider than necessary. The panel was invited to consider amending the charge under Rule 28.

The panel noted that it did have the power to amend the charge but did not consider was required to do so. The NMC case concluded without any concern being expressed with regards to the wording of the charge. There was no unfairness to you as you had seen all of the papers and will be well aware that the allegations only related to the period of your employment at the Home.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Denholm on behalf of the NMC and by Dr Akinoshun, on your behalf.

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:

- Ms 1: Regional Care Specialist at Hallmark Care Home

- Mr 1: Senior Nurse at Mayfair Manor Care Home
- Ms 2 Manager Support at Mayfair Manor Care Home, at the time of the incidents.
- Ms 3 Senior Care Assistant at Maycroft Manor Care Home
- Ms 4 Senior Healthcare Assistant at Maycroft Manor Care Home
- Ms 5 General Manger at Maycroft Manor Care Home, at the time of the incident
- Mr 2 Registered Manager at Maycroft Manor Care Home

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1a

1) On 18 October 2018 in relation to an unwitnessed fall by Resident A:

a) Inappropriately moved the resident from the floor onto the bed before a full examination had been carried out;"

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence.

It was not in dispute that on 18 October 2018 Resident A had a fall while you were on night duty. You were the nurse in charge and attended Resident A who complained, to you, of a sore head. It was then discovered, when you hoisted him, that he had a fractured hip. He was taken to hospital by ambulance that night.

The panel determined that you did not follow the falls policy in place. You admitted to Ms 1 at the investigation meeting on 30 October 2018 that you did not do so. You said '*I totally forgot about not following procedure of not moving and I apologise for this*'. However, the panel acknowledged that your intentions were in the best interest of Resident A in terms of comfortability, but it was not the best clinical option in terms of managing risk of harm to the resident.

The panel was of the view that as a registered nurse you should have had more suspicions of injury due to the fall being unwitnessed and happening in a cramped location. Also, as the resident complained of pain in his head, this further indicated that you should not have moved him prior to an assessment. The panel also asked you about the possibility of any internal injury to Resident A that would not be visible. You indicated in your responses that you had not considered this at the time of the incident.

The panel accepted the evidence of Ms 1 and Ms 5, who both confirmed the details of the falls policy and the correct actions that would be required of a registered nurse in these circumstances.

Therefore, the panel found this charge proved.

Charge 1b)

"1) On 18 October 2018 in relation to an unwitnessed fall by Resident A:

b) Failed to inform the resident's family or next of kin of the fall;"

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence, which included evidence from Ms 1 and Ms 4.

The panel determined that you were under a duty to inform Resident A's next of kin of the fall, and during your oral evidence you stated that you tried to get in contact with the family but did not get an answer, but said that you delegated the responsibility of doing so to a carer.

The panel also heard from Ms 1, who stated that Resident A's family came to visit the care home next day, but Resident A was in hospital as a result of the fall and that they were evidently unaware of the incident.

The panel had sight of Ms 6's statement which noted that it is not normal practice for carers to inform the resident's next of kin. The panel acknowledged that Ms 4 supports this wherein she stated it would be the nurse's responsibility to inform next of kin following a fall. Finally, the panel had reference to the care home's falls policy which makes provision under the nursing section for the nurse to inform residents' next of kin following a fall.

In the initial investigation meeting of 30 October 2018, you said you were unaware of the procedure and whose responsibility it was to inform the next of kin following a fall.

Therefore, the panel found this charge proved.

Charge 1d)

"1) On 18 October 2018 in relation to an unwitnessed fall by Resident A:

d) Failed to follow up your recommendation for a sensor mat for the resident."

This charge is found not proved.

In reaching this decision, the panel took into account live and documentary evidence, including Ms 1 and your oral evidence.

The panel determined that there had been insufficient evidence provided to suggest that you were under a duty to follow up on your recommendation and in oral evidence you mentioned that you did make the recommendation for Resident A to have a sensory mat.

The panel also took into account the evidence from Ms 1, that Resident A was taken to hospital straight after the fall, therefore there was no incumbent duty on you or the other nurses to follow up on the recommendation.

Furthermore, the panel was aware that Resident A was on the residential unit and not on the nursing unit, as such the responsibility to follow up on the acquisition of a sensor mat would have fallen under the jurisdiction of the senior care team of that unit.

Therefore, the panel found this charge not proved as the NMC has not proved that you had the duty to follow up on your recommendation.

Charge 2a)

"2) On 5 April 2019 in relation to an unwitnessed fall by Resident B:

a) Failed to respond in a timely manner to the emergency call bell"

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence from Ms 3, Mr 2 and yourself.

The panel accepted Ms 3's statement that outlined that she informed you that Resident B had fallen in the lounge which was within the nursing unit. Ms 3 stated that when she informed you, you responded '*can't you see I am busy*?'.

The panel also accepted Mr 2's evidence which confirms these facts during the course of his investigation. Furthermore, the panel had regard to your oral evidence where you stated that having taken a blood glucose reading for another resident you could not leave the resident in that way. Additionally, you stated that your delay was also due to your need to wash your hands following the procedure.

Balancing all the evidence before it, the panel determined that you did not understand that the emergency situation alerted by the emergency bell should take greater priority than that of a non-urgent procedure.

Therefore, the panel finds this charge proved.

Charge 2b)

"2) On 5 April 2019 in relation to an unwitnessed fall by Resident B:

b) Failed to attend immediately when requested to do so by a colleague"

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence from Ms 2 and you.

The panel had regard to Ms 2's investigation outcome report in her written evidence which indicated that you were approached by a care assistant to respond to Resident B's fall after Ms 3 had already informed you of the fall previously.

The panel was not convinced that in light of your oral evidence that you were minded to prioritise your response to this fall over another non-urgent procedure with another resident.

Therefore, the panel finds this charge proved.

Charge 2c)

"2) On 5 April 2019 in relation to an unwitnessed fall by Resident B:

c) Failed to carry out post fall observations."

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence from Ms 2, Ms 4, Mr 2 and you.

The panel accepted the evidence provided by Ms 2 and supported by Mr 2's written statement which indicated that a particular protocol for post-fall observation was to be carried out several times overnight following a fall such as the one suffered by Resident B.

However, you stated during your oral evidence that you only took one initial set of clinical observations immediately following Resident B's fall. Furthermore, you stated that you left Resident B to sleep all night whilst also delegating further monitoring to care assistants.

The panel had regard to Ms 4's oral testimony which indicated that care assistants did not have access to the equipment required to take vital observations and that only nurses and senior care assistants had access to it. Furthermore, during Ms 4's oral testimony she indicated that care assistants were not trained to take vital signs observations.

Furthermore, the panel took into account written evidence that stated there were no senior carers allocated to work on the nursing floor.

Therefore, the panel concluded that your duty to conduct further vital observation checks could not have been reasonably delegated to care assistants within your team overnight.

Consequently, the panel found this charge proved.

Charge 3a)

"3) On 9 April 2019 in relation to an unwitnessed fall by Resident C:

a) Failed to respond in a timely manner to the emergency call bell"

This charge is found not proved.

In reaching this decision, the panel took into account live and documentary evidence from Ms 2, Ms 4 and you.

The panel took into account your oral evidence, in which you stated that Resident C was on the nursing floor and as such was under your direct care. The panel has also considered Ms 4's written and oral evidence that the emergency bell had been rung following Resident C's fall, and that you had taken approximately 20 minutes to respond to the bell. Furthermore, Ms 4 stated that she searched for you and found you in the residential floor administering medication.

The panel acknowledged that you denied the version of events described by Ms 4 and stated that you did respond to the bell in a timely manner. The panel noted that Ms 4's live evidence was mainly consistent with the account provided to Ms 2 in her investigation report.

However, the panel had regard to the fact that no disciplinary concern by the employer was raised regarding a failure to respond in a timely manner to this incident, within the investigation report.

Therefore, the panel was not convinced it should give greater weight to Ms 4's evidence over your evidence.

Consequently, the panel finds this charge not proved.

Charge 3b)

"3) On 9 April 2019 in relation to an unwitnessed fall by Resident C:

b) Failed to inform the patients family or next of kin of the fall"

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence from Ms 4, Mr 1 and you.

The panel had regard to your oral testimony in which you stated that you did not contact Resident C's next of kin following the fall overnight, you further stated that this was a deliberate decision to respect the next of kin's request to not be contacted overnight. The panel noted that you compiled an incident report shortly after the incident which confirms that you did not call the next of kin. The panel was satisfied this evidence was consistent.

The panel had regard to Ms 4's written statement in which she relayed that you did not request her to inform the next of kin, and it was not the responsibility of carers to do so.

The panel considered Mr 1's evidence in which he stated that you did not handover a request for him to inform Resident C's next of kin as the incoming day shift nurse that morning.

Consequently, the panel found this charge proved, in that you failed to inform Resident C's next of kin or indeed make provision for that to be done at the earliest suitable time.

Charge 3c)

"3) On 9 April 2019 in relation to an unwitnessed fall by Resident C:

c) Failed to complete:

i) Moving and handling risk assessment

ii) Falls risk assessment

iii) Post falls observation tool”

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence from Mr 1 and you.

The panel had regard to Mr 1’s written and oral evidence in which he indicated that you did not complete any of the three documents listed under this charge, that were required to be completed following Resident C’s fall as per the care home’s falls policy.

Mr 1 was the incoming day shift nurse and indicated that it would have been too late for him to complete ‘post-falls observations’ as the fall occurred on the previous shift and too long after the fall to properly complete the observations within the timeframe specified in the falls policy.

The panel considered to your oral evidence in which you stated that you completed an ‘incident form’ but did not indicate whether you had completed these three documents.

The panel found that Mr 1’s evidence that he had subsequently completed these three forms to be logically consistent with you not having completedms 8 them.

Consequently, the panel finds this charge proved.

Charge 4a)

“4) On 11 April 2019 in relation to an unwitnessed fall by Resident D:

a) Failed to take charge of the situation”

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence from Ms 2, Ms 3, Mr 2 and you.

The panel had regard to Ms 2's oral and written evidence which stated that the registered nurse had full responsibility for clinical decision making in emergencies, such as Resident D's fall and subsequent injuries.

Furthermore, the panel bore in mind Mr 2's evidence that there was an expectation for a registered nurse to take the lead within an emergency situation. You admitted in your oral evidence that you should have taken charge of this situation but Ms 3 was '*shouting and screaming at me*'.

The panel had significant regard to Ms 3's oral and written evidence which confirmed that she was attitudinally obstructive to you responding to this situation.

The panel preferred the evidence of Ms 3 and Mr 2 and concluded that on the basis of the evidence that you were in charge of the Home. The managers' expectations of a registered nurse indicated that this challenge did not absolve you of your duty to take charge of this emergency situation.

Furthermore, the panel bore in mind that you had confirmed in your oral evidence that once on the scene with Resident D, you had subsequently left to obtain further dressings. The panel determined that this was further evidence of your failure to delegate such tasks and therefore to take charge of the situation.

Consequently, the panel found this charge to be proved.

Charge 4b)

"4) On 11 April 2019 in relation to an unwitnessed fall by Resident D:

b) Failed to carry out a post fall assessment"

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence from you.

The panel had reference to your oral testimony in which you stated that you left the situation saying that Ms 3 '*did not want me there*', and given her confrontational demeanour '*there was nothing else I could do'*. Also, you did not confirm during your evidence that you had completed the post-falls assessment.

The panel concluded that while a challenge existed for you in completing or delegating the post-falls assessment, by walking away you did fail in your duty to carry out this assessment.

Consequently, the panel found this charged proved.

Charge 4c)

"4) On 11 April 2019 in relation to an unwitnessed fall by Resident D:

c) Failed to provide emergency care"

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence from Ms 2, Mr 2 and you.

The panel reviewed your oral evidence, in which you stated that you had left the site of Resident D's fall to obtain further dressings.

Furthermore, you stated that as Ms 3 did not want your intervention at the scene there was nothing else you could do, and this you walked away.

The panel had regard to Ms 2 and Mr 2's evidence in which as managers they set out the expectation on the role of a registered nurse in managing an emergency situation and providing emergency care.

Consequently, the panel concluded that you failed in your duty to provide emergency care and the support that unqualified colleagues would require from a registered nurse in that situation.

The panel therefore found this charge proved.

Charge 4d)

"4) On 11 April 2019 in relation to an unwitnessed fall by Resident D:

d) Failed to provide details and/or a handover to ambulance personnel"

This charge is found proved.

In reaching this decision, the panel took into account live and documentary evidence from Mr 2 and you.

The panel had regard to your oral evidence in which you stated that as you had been prevented from assessing Resident D by Ms 3, you had taken the decision to absent yourself from the situation and were satisfied that the senior carer would hand over details to ambulance personnel.

The panel bore in mind Mr 2's evidence that there was an expectation that you as a registered nurse would take the lead in an emergency, which would include following it to its conclusion in the form of a handover to paramedics.

The panel noted that you did not return to the scene to obtain an update or request to be notified when the paramedics arrived.

The panel therefore found this charge proved.

Charge 5)

> "5) On an unknown date between 29 August 2017 and 12 April 2019 used racially offensive language calling Colleague A 'rude little white girl' or similar words to that effect."

This charge is found not proved.

In reaching this decision, the panel took into account live and documentary evidence from Ms 3 and you.

The panel had reference to Ms 3's written and oral evidence. She said that she had reported this most serious allegation to the then manager of the care home, but there was no further investigation or outcome. She said that the incident had also been witnessed by Ms 7. There is no evidence of Ms 7 being asked about this incident.

The panel had regard to your oral evidence in which you denied having made this remark or a desire to ever utilise such language.

The panel noted that as such evidence before it was in contest, the panel bore in mind two further considerations. Firstly, that there had been no record of this allegation being made let alone any subsequent investigations, or outcome. Secondly, the panel was concerned that this serious allegation could not be pinned down to a specific time frame, but rather was alleged to have occurred within an extremely wide timeframe of years.

Consequently, on this basis the panel has found this charge not proved.

Charge 6)

> "6) On one or more occasions during 2019 and 2020, failed to preserve the safety of residents by sleeping whilst on duty."

This charge is found not proved.

In reaching this decision, the panel took into account live and documentary evidence from Ms 4, Ms 8, Mr 2 and you.

The panel had regard of Ms 4's oral and written testimony in which she stated that she had raised concerns to management about you allegedly sleeping whilst on duty. The panel also had reference to Ms 8's evidence that confirmed Ms 4's original version of events. Ms 8 provided a telephone statement to Ms 2 in which she claimed that she could guarantee that you would always be asleep for two hours despite being on duty. However, panel bore in mind that Mr 2's evidence was that, whilst he was aware of these allegations, that his unannounced visits did not result in finding you asleep.

The panel made reference to your oral testimony in which you stated vehemently that you never slept whilst on duty and were aware of the importance of your responsibilities of remaining awake to support the team and preserve patient safety.

Furthermore, the panel bore in mind that an inconsistency existed in Ms 4's evidence, in that in her written evidence she stated you were '*always asleep'* whilst on duty, however, when questioned during oral evidence, she changed this statement and confined the allegation to '*one week of shifts'*. The panel was unable to attach any weight to the evidence of Ms 8 as it was hearsay and as such was unable to test it. In light of the fact that Ms 4 made a dramatic change in her evidence the panel did not consider it could rely on it.

Consequently, the panel gave greater weight to your evidence over that of Ms 4's.

The panel considered that were you to have been asleep on duty for several hours during the night there would have been more complaints from a larger amount of staff members. There were around 15 staff on duty every night.

Therefore, the panel found this charge not 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. For timetabling reasons, the panel separated this decision from the next stage of deciding whether (if there was misconduct) your fitness to practise is currently impaired. The panel did so having accepted the advice of the Legal Assessor that it could do so under the preamble to Rule 24 of the Rules. There was no objection to this course of action by the Representatives.

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.

Submissions on misconduct

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

Ms Denholm invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives and nursing associates 2018' (the Code) in making its decision.

Ms Denholm submitted that the specific, relevant standards where your actions amounted to misconduct were:

*'**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.

4 To act in the best interests of people at all times.

8 Work co-operatively

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' staff

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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 of the information they need.

13 Recognise and work within the limits of your competence

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

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

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'

Ms Denholm submitted that the misconduct in this case concerns your clinical practice and at the centre of this your ability to safely respond to emergencies in a timely manner. She further highlighted to the panel that the concern is that you have gone against the Home's Falls Policy and moved a Resident causing them significant pain.

Ms Denholm submitted that you failed to prioritise responding to an emergency over a non-urgent clinical procedure and failed to take charge in an emergency situation by not providing necessary emergency care. Ms Denholm stated that your role as the registered nurse, is one where you are the only qualified person on the shift. Consequently, you were the person in charge, and your conduct resulted in an unqualified person dealing with a serious injury.

Ms Denholm submitted that the further concerns relate to the fundamental failure to carry out essential post fall observations and not completing the necessary risk assessments. This conduct places patients, who have had unwitnessed falls, at a serious risk of harm.

Ms Denholm further submitted that you failed to notify patients next of kin on more than one occasion, you also failed in your professional duty of candour.

Ms Denholm submitted that the failings are a serious departure from the standards expected and has placed multiple patients at risk of harm. Timely response to emergencies, and providing safe care is at the heart of safe nursing practice.

Ms Denholm invited the panel to take the view that the facts found proved amount to misconduct. Ms Denholm submitted that your actions fell well below standards expected of a registered nurse given your experience and were all basic failures that should not have occurred.

Dr Akinoshun submitted that the facts found proved by the panel do not impair your fitness to practise.

Dr Akinoshun invited the panel to take the view that the facts found proved amount to misconduct but that they do not constitute impairment.

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 and the expectations of your employers.

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

Charge 1a

The panel determined that charge 1a did amount to misconduct. The panel concluded that in your failing to follow the Home's expectations of a registered nurse you fell significantly short of the Code. Specifically:

> *'1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*
>
> ***4 Act in the best interests of people at all times***

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment
4.2 make sure that you get properly informed consent and document it before carrying out any action
4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process
4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

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

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

16 Act without delay if you believe that there is a risk to patient safety or public protection
16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training
16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can
16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so'

Charge 1b

The panel determined that charge 1b did amount to misconduct. By your failure to follow the Home's expectations as set out in the 'Falls policy flow chart', the panel determined that you fell significantly short of the Code.
Specifically:

> *'14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers'*

Charge 2a

The panel determined that charge 2a did amount to misconduct. By your failure to act in line with the Home's policy, the panel determined that you fell significantly short of the Code. Specifically:

> *'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.*
>
> *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
>
> *13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*
>
> *15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly'*

Charge 2b

The panel determined that charge 2b did amount to misconduct. By your failure to act in line with the Home's managerial expectation to prioritise urgent care of a fall over a non-

urgent procedure, such as taking a blood glucose reading, the panel determined that you fell significantly short of the Code. Specifically:

> *'1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*
>
> *15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly*
>
> *25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'*

Charge 2c

The panel determined that charge 2c did amount to misconduct. By your failure to adhere to the Home's policy, the panel determined that you fell significantly short of the Code. Specifically:

> *'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.*
>
> *6.2 maintain the knowledge and skills you need for safe and effective 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*

11 Be accountable for your decisions to delegate tasks and duties to other people

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard'

Charge 3b

The panel determined that charge 3b did amount to misconduct. By your failure to follow the Home's expectations as set out in the 'Falls policy flow chart', the panel determined that you fell significantly short of the Code. Specifically:

'14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers'

Charge 3c

The panel determined that charge 3c (iii) did amount to misconduct. The panel concluded that, in failing to complete this document, which itself mandated further clinical observations to be taken for Resident C, you placed the resident at increased risk of harm.

However, the panel was of the view that charges 3c (i) and (ii) were not sufficient to be deemed misconduct, in that the documents in question could have been completed by the incoming day shift. However, your conduct in respect of charge 3c (iii) was of a different category, you should have prioritised observation of Resident C. The panel

determined, that in respect of this matter you fell significantly short of the Code. Specifically:

‘8.2 maintain effective communication with colleagues

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’

Charge 4a

The panel determined that charge 4a did amount to misconduct. By your failure to follow the managerial expectation of a registered nurse to provide leadership and to take charge in an emergency situation. As the most senior member of staff in the building you were responsible for ensuring that Resident D was protected and that the care team was led effectively. The panel determined that you fell significantly short of the Code. Specifically:

‘1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

2.1 work in partnership with people to make sure you deliver care effectively

8.2 maintain effective communication with colleagues

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is

maintained and improved, putting the needs of those receiving care or services first'

Charge 4b

The panel determined that charge 4b did amount to misconduct. By your failure to adhere to the Home's policy in not undertaking the post fall assessment, the panel determined that you fell significantly short on the Code. Specifically:

'1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

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

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

Charge 4c

The panel determined that charge 4c did amount to misconduct. By your failure to adhere to the managerial expectations of you as a registered nurse to provide emergency care, the panel determined that you fell significantly short of the Code. Specifically:

'1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care
11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly.'

Charge 4d

The panel determined that charge 4d did amount to misconduct. The panel found that whilst there was no evidence presented to it of a specific written policy in the Home, the panel determined that misconduct existed, in that you breached the following aspects of the NMC code. Specifically:

'1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

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

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care
11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard'

The panel found that your actions and omissions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Change of NMC Representation

This hearing adjourned part heard on Monday 14 November 2022. It resumed on Monday 18 September 2023, with Ms Kyriacou representing the NMC.

Submissions on impairment

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

Ms Kyriacou invited the panel to consider the test established in *Grant*. Which sets out:

> *'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) […].'

In respect of limb a), Ms Kyriacou submitted that you have in the past acted, and are in the future liable to act, so as to put a patient or patients at unwarranted risk of harm. She submitted that, by moving residents inappropriately following a fall you placed them at a further unwarranted risk of harm, but did not address in the course of your evidence how you may manage this situation differently.

Further, Ms Kyriacou submitted that Resident B was placed at an unwarranted risk of harm when you failed to respond to his emergency call be in a timely manner, as well as when you failed to attend immediately when requested to do so by a colleague, and your failure to carry out observations. Ms Kyriacou highlighted that, at this point, you did not know the scale or severity of the emergency when you decided to finish a non-urgent task; this could have resulted in serious harm. Furthermore, she submitted that your failure to carry out post-fall observations could have had serious consequences for Resident B had there been an internal injury, which would have gone undetected,

In respect of Residents C and D, Ms Kyriacou submitted that your failure to complete the post falls observation tool, as well as the failure to provide emergency care and hand over to paramedics in respect of Resident D, led to an unwarranted risk of harm. Ms Kyriacou said that you did not protect residents and minimise risk to residents following their falls, which she submitted was a serious failing.

In consideration of whether you are liable in the future to place patients at an unwarranted risk of harm, Ms Kyriacou submitted that there remains such risk today as the panel has not received evidence from you to demonstrate your insight and reflection on past events.

Ms Kyriacou submitted that limb b) of the *Grant* test is engaged as members of the public would be extremely concerned to hear of such conduct. She said that the family members of Residents A and C would have been shocked and upset not to have been informed of the falls, particularly Resident A's family who attended the Home to visit them, and found out that they were in hospital. Ms Kyriacou further submitted that your

actions in respect of Resident D, when you failed to take charge of the situation to assess them to provide emergency care, would have brought the profession into disrepute, were a member of the public to know of your actions.

Ms Kyriacou submitted that limb c) of *Grant* is also engaged. She said that the fundamental tenets of the nursing profession are to prioritise people, practise effectively, preserve safety and to promote professionalism and trust, and that you have breached these fundamental tenets.

Ms Kyriacou next addressed the panel on the factors established in *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin), the first of which being whether the conduct is remediable. Ms Kyriacou submitted that the misconduct found by the panel is remediable. She stated that the second question to consider is whether such conduct has been remedied. She outlined that there is evidence which has been placed before the panel today of training which you have undertaken in some relevant areas including, but not limited to, manual handling and first aid. However, Ms Kyriacou asked the panel to consider whether you have sufficiently reflected, and whether you have since applied your learning.

Ms Kyriacou highlighted that you have provided for the panel positive references and testimonials which raise no concerns or issues about your practice, therefore the panel may consider that you have demonstrated strengthened practice. However, she reiterated that you have not put before this panel any in-depth insight or reflection which could persuade the panel that you have learnt a lesson, or understand what could be implemented differently in the future should such situations arise again.

Ms Kyriacou addressed the panel on the final factor of the *Cohen* test, whether there is a risk of repetition. She submitted that the conduct found proved spanned over a period of six months and, although it occurred four years ago and there have been no incidents since. Furthermore, she submitted that part of the panel's assessment is to consider whether you have demonstrated, via strengthened practice and reflection on what you have learned, that the risk of repetition has been minimised.

Ms Kyriacou invited the panel to consider the NMC Guidance "*Insight and Strengthened Practice"* (FTP-13), which states:

> *"Evidence of the nurse, midwife or nursing associate's insight and any steps they have taken to strengthen their practice will usually be central to deciding whether their fitness to practise is currently impaired."*

She submitted that, whilst there have been no further instances of the concern alleged and the panel has before it your training courses and positive references, the missing element is the lack of detailed reflection or insight to demonstrate that you have really learnt from these incidents and have put steps and measures in place to ensure that such misconduct does not happen again.

Accordingly, Ms Kyriacou invited the panel to find that your fitness to practise remains impaired on both public protection and public interest grounds.

Dr Akinoshun told the panel that you are an exemplary nurse who had worked competently as a NMC registered nurse since 2003 without similar allegations before you were referred to the NMC in October 2018 and April 2019 respectively. He reminded the panel that it must consider your current impairment, and not your impairment at the time the concerns arose. He said that, as part of this assessment, the panel must take into consideration that you have continued to work as a registered nurse without any further regulatory concerns about your practice or conduct. He submitted that this demonstrates that your fitness to practise is not currently impaired , and that you are carrying out tasks safely and competently.

Dr Akinoshun reminded the panel that the purpose of fitness to practise proceedings is not to punish a practitioner for its past misdoings, but to protect the public and uphold public interest. He reminded the panel that the public interest also includes the safe return of experienced practitioners to unrestricted practice. He submitted that you do not pose a risk as your safe practice has been tested in your work as an agency nurse. He submitted that, in view of the lack of similar occurrences up to date and the remedial steps in terms of the training, your fitness to practise is not currently impaired.

Dr Akinoshun submitted that the concerns expressed in the charges have been remedied and the risks arising from those charges have been remedied. He highlighted that this referral was made over four years ago. He invited the panel to take account of the NMC Guidance, which outlines:

> *"If the nurse, midwife or nursing associate has fully addressed the problem in their practice that led to the incident, and already poses no further risk to patients, we won't usually need to take action to uphold public confidence or professional standards."*

Dr Akinoshun told the panel that you were previously subject to an interim conditions of practice order which was imposed upon an assessment of the risk, and you were allowed to practise under supervision. He said that a later Investigating Committee panel revoked the interim order in November or December 2021, as it deemed the risk of repetition to be nil, and highlighted that there have been no further concerns since this interim order was revoked. He said that this previous panel was so confident to revoke the interim order because it noted that you had remedied the failings in your practice. Dr Akinoshun accepted that the previous panel is independent from the current hearing, and this panel is not bound by any decisions which it made, however he submitted that it ought to be taken into account when this panel considers impairment.

Dr Akinoshun submitted that you continue to demonstrate insight by not putting yourself or a patient in a similar situation, and highlighted that you have undertaken relevant training.

Dr Akinoshun asked the panel to consider the factors set out in *Cohen,* in respect of whether the conduct is remediable, he submitted that it is. In response to whether the conduct has been remedied, Dr Akinoshun submitted that you have remedied the concerns, as you have undertaken several training courses and made efforts to strengthen your practice in the last four years. Finally, in consideration of whether it is highly unlikely that this conduct will be repeated, Dr Akinoshun submitted that repetition is highly unlikely. He said that, if the concerns were to be repeated, why has it not

happened in the last two years when you have been working independently and without restrictions.

Dr Akinoshun invited the panel to consider the bundle of documentation before it and outlined that you have taken relevant courses and worked to strengthen and remedy the gaps in your nursing practice. He said that you are determined to self-develop and consistently update your skills to work towards the concerns identified by the NMC. Further, he invited the panel to take account of the references from people who you have worked directly with, including the family of one of your patients, who can speak directly to your nursing skills and fitness to practise.

Accordingly, Dr Akinoshun submitted that the risk of repetition is nil and your fitness to practise is not currently impaired as you do not currently pose risk to patients or members of the public.

In respect of public interest, Dr Akinoshun submitted that this consideration also demands an assessment of the public interest of a competent nurse being permitted to practise. He submitted that the public interest would side with allowing you to practise, rather than losing you from the profession, due to your skills, knowledge and passion for nursing.

Decision and Reasons for Adjournment on 18 September 2023 to Provide Further Information

At the conclusion of the submissions, the panel highlighted that your bundle on impairment was created on the morning of the resuming hearing, and noted that further individual documents had been provided to the panel in a piecemeal manner throughout the day, requiring several short adjournments. However, the panel noted that this documentation contained no information, such as an up to date reflective piece, to demonstrate your current attitude towards the charges found proved, your insight or remediation.

Dr Akinoshun said that some information was previously submitted to a panel of the Investigating Committee in respect of your previous interim order, which was revoked. He asked the panel for some time to identify and provide such documents.

Following a further adjournment, at around 15:10, the panel was informed, via the hearings coordinator, that Dr Akinoshun had indicated that there was further material to be provided to the panel. Accordingly, the panel adjourned the hearing until the morning of 19 September 2023, and indicated that Dr Akinoshun must provide all further documents relied upon by 09:00.

Panel Questions Following Provision of Further Information

Dr Akinoshun provided the panel with further documentation to support his submissions, including your reflective piece and Personal Development Plan (PDP). The panel indicated that, on the basis of this information, some questions arose from the panel.

Dr Akinoshun indicated that you did not wish to give evidence at this stage, and he would take instructions on the panel's questions, which related to how your insight has developed despite your denial of the charges, how you continue to develop insight and how you handover patients to paramedics, which he would then address in further submissions.

Further Submissions on Impairment

Dr Akinoshun made further submissions on impairment. He addressed the panel's questions in turn. In respect of your denials of the charges and the impact of this on your insight. He said that you were quite clear, even during the interim order stage, that you never admitted the charges. However, he said that you have reflected on the regulatory concerns because you believe that a denial of concerns does not prevent any registered nurse from reflecting on and learning from any incident. Dr Akinoshun invited the panel to have regard to your reflective piece, which sets out:

"Even though I denied all the charges, but as an experienced nurse, I am fully aware that reflective practice is something that all the registered nurses should undertake, whether they are undergoing NMC referral or not and whether they admit the charges against them or not. Demonstrating during my practice that I continue to learn from my actions and omissions, whether good or bad is the key to becoming a better nurse hence the need for this reflective piece."

Dr Akinoshun submitted that you have continued to develop insight and strengthen your practice by developing self-awareness when working within a team, when considering your own behaviour and the behaviour of others, especially when managing behaviours without impacting the care or patients. He said that this has helped, and will continue to help you when dealing with difficult and confrontational junior and senior colleagues.

Dr Akinoshun told the panel that you have changed your ways of working and have developed a conflict resolution approach at work, due to the inherent challenges of nursing, which you must adapt to. Further, he said that you have read about conflict resolution at work and are using this knowledge to your advantage.

Dr Akinoshun submitted that you undertake regular training and are committed to completing further training beyond that which is mandated by your employer. He said this allows you to keep developing, so that you may keep your practice in check and do not find yourself in a similar situation in the future. Further, he said that you talk to your colleagues at the end of every shift and seek feedback about your practice, which you find useful in improving your practice.

Dr Akinoshun told the panel that you have learned from the past and that any reasonable nurse should afford themselves the opportunity to learn. He said that you are clear that, despite your denials you accept that you have lots to learn. He reiterated that you know the importance of being a reflective nurse and have been doing so in your current workplace.

Further, Dr Akinoshun submitted that, immediately following your referral to the NMC, you found an experienced mentor who is a community clinician with whom you meet regularly and speak to about your concerns. He said that you have found this helpful as it has given you guidance and support.

In respect of your practice in handing over patients to paramedics, Dr Akinoshun submitted that you do this personally in your workplace, and invited the panel to consider your PDP, in which you outlined an incident in 2021 when you called an ambulance and outlined the actions which you took to support a resident.
Dr Akinoshun told the panel about the process you take when handing over a patient to the paramedics, which consists of:

1. Assessing a patient to determine whether the paramedics are required;
2. Taking and recording a patient's vital signs;
3. Noting changes in a patient's presentation;
4. Asking another colleague to collect a patient's medical records to handover;
5. Recording any intervention, such as painkillers, given to the patient;
6. Ensuring that the patient is made comfortable; and
7. Asking another member of staff to inform the patient's next of kin of the incident, including keeping them updated.

Dr Akinoshun said that you then hand over this information to the paramedics, and you are aware that it is your responsibility to ensure that delegated tasks are executed properly, and you follow up with other staff to ensure that they have been done. Further, he said that when a patient is taken to the hospital, you organise a briefing with the team with whom you are working to assess how well the incident was managed and learn lessons from this.

In light of the provision of this further information, Ms Kyriacou made further submissions on impairment. She acknowledged that you have provided information to support your strengthened practice, however she said that there remains a concern about your reflective statement, which she described as "*conflicted*". Ms Kyriacou questioned what insight you have developed when you continue to deny the charges, and highlighted that insight and strengthened practice are distinct issues. She accepted that there is strong evidence to support your strengthened practice, however submitted that your insight remains wavering as a result of your continued denial of the allegations.

Ms Kyriacou submitted that it is a matter for the panel to determine whether you have demonstrated insight, sufficient reflections or strengthened practice. However, she said that as a result of the absence of in-depth insight, the NMC maintains that your fitness to practise remains impaired.

Dr Akinoshun submitted that you have done everything in your power to demonstrate the effort that you have made and show the panel that there is no risk of repetition. He repeated his submissions in respect of the factors outlined in *Cohen* and invited the panel to take into account all of the information before it, including the steps you have taken to strengthen your practice and reflect on what has happened in the course of these proceedings, and make a finding of no current impairment.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cohen, Grant, Sawati v* GMC [2022] EWHC 283 (Admin)*; GMC v Awan* [2020] EWHC 1553 (Admin)*; and Amao v* NMC [2014] EWHC 147 (Admin).

Decision and reasons on impairment

In considering the issue of insight, the panel recognised that you were within your rights to maintain your denial of the charges found proved. It noted that you had reflected upon the events that led to the charges. The issue for this panel was whether you had demonstrated sufficient remorse, strengthening of practice and insight.

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. 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 first considered whether patients were in the past put at risk of harm. It concluded that there is sufficient evidence before it on the basis of the charges found proved that residents in your care were put at risk of, and were caused, actual harm as a result of your misconduct, namely inappropriately moving patients, delays in calling an ambulance, failing to take control of an emergency situation and failure to undertake a full assessment and necessary observations on vulnerable patients in your care.

The panel bore in mind that impairment is a forward-looking exercise, and the first limb of *Grant* also requires it to consider whether you are liable in the future to act so as to put a patient or patients at unwarranted risk of harm. It took account of all of the information before it at this stage, including your reflective statement, PDP, positive testimonials and evidence of training which you have undertaken. The panel concluded that you have provided it with evidence of strengthened practice in the time since the charges arose. However, it noted that your PDP documentation relates to 2021 and was seemingly prepared to address the interim conditions placed on your practice. It also noted that your employment references were provided by your agency employer who could only speak to third party reports which it had received, and not comment from a management perspective on your day-to-day clinical practice and interaction with your

colleagues. In light of this, the panel concluded that you remain liable in the future to act so as to put a patient or patients at unwarranted risk of harm.

In respect of limb b), the panel concluded that your misconduct brought the nursing profession into disrepute, especially when considering the vulnerability of the residents in your care and the position of responsibility which you held as a registered nurse with management responsibility for other members of staff. The panel took account of the challenging context in which you worked but determined that, despite this, an informed member of the public would consider that your misconduct brought the profession into disrepute.

In relation to limb c), the panel bore in mind that the charges found proved are serious and concern a six-month period of poor practice. It therefore determined that the breaches of the code identified at the misconduct stage amounted to breaches of the fundamental tenets of the nursing profession.

The panel next went on to consider the factors as outlined in *Cohen*, namely:

- Is the misconduct easily remediable?
- Has it been remedied?
- Is it highly unlikely to be repeated?

The panel concluded that the misconduct identified in this matter is remediable. It noted that there is no evidence of any deep-seated or attitudinal concerns which are often more difficult to put right.

In consideration of whether you have remedied the concerns, the panel first took account of the evidence before it in relation to your strengthened practice which included positive testimonials, your PDP and relevant training records. The panel noted that your mandatory and voluntary training addressed the areas of regulatory concern and, in 2021, a panel of the Investigating Committee was satisfied that the risk of harm was so low that an interim order was no longer necessary. The panel bore in mind that you have been working independently since the interim conditions of practice order was

revoked in 2021 and noted that there have been no further concerns about your fitness to practise reported in this time.

The panel next considered your reflection and insight. It bore in mind Dr Akinoshun's submissions, that although you continue to deny the allegations, you have reflected on the regulatory concerns. The panel accepted that you have provided some evidence of developing insight through your reflective piece and the instructions which you gave Dr Akinoshun in response to the panel's questions. However, it bore in mind that although there is evidence that you have successfully strengthened your practice, much of the information relating to your insight is from 2021 and appears to have been for the purpose of your interim order hearing. It found you have not provided any recent or in-depth insight to this panel today, such as a continued or recent PDP. The panel also considered that you had an extended period between November 2022 and September 2023 when this hearing was adjourned to provide further reflection and insight, and have not done so. Accordingly, the panel was not satisfied that you could consistently balance clinical demands with leading and managing junior staff in the workplace at this time, if any conflict arose.

In respect of the third *Cohen* factor, although it considered that many of your clinical failings have now been remedied, the panel concluded that there is a risk of repetition based on your limited insight. Furthermore, the panel was concerned that you have not as yet fully addressed and developed insight into how you would act differently within a leadership role whilst working in a challenging situation. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required as a result of your lack of fully developed, and absence of more recent, insight. The panel took account of its findings that vulnerable residents were not safely managed and not properly cared for and concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on the grounds of both public protection and public interest.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your 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

Ms Kyriacou submitted that the NMC sanction bid is a suspension order for a period of three months, with a review.

Ms Kyriacou submitted that the following aggravating features are present in this matter:

- Repeated similar concerns over a six-month period;
- Your position of responsibility at the Home; and
- The vulnerability of the residents in your care.

Ms Kyriacou submitted that the following mitigating feature is relevant to this case:

- You were working in challenging circumstances, particularly in respect of Resident D.

Ms Kyriacou invited the panel to have regard to the NMC guidance on sanctions, which sets out:

> *"[A suspension order] may be appropriate in cases where the misconduct isn't fundamentally incompatible with the nurse, midwife or nursing associate continuing to be a registered professional, and our overarching objective may be satisfied by a less severe outcome than permanent removal from the register."*

She submitted that the key issues to weigh up before imposing such an order includes assessing whether the seriousness of the case requires temporary removal from the NMC register, and also whether a period of suspension would be sufficient to protect patients and maintain public confidence in the nursing profession.

Ms Kyriacou referred the panel to the NMC guidance on serious concerns which could result in harm to patients if not put right, which sets out:

> *"Conduct or failings that put patients or service users at risk of harm will usually involve a serious departure from standards. Standards, such as our Code, are intended to ensure that nurses, midwives or nursing associates practise safely and effectively."*

She outlined that the panel has already found that you placed patients at risk of harm and that patients were actually harmed and there remains a risk of harm due to the lack of recent in-depth insight. She submitted that your conduct falls far below what is expected of a registered nurse.

Ms Kyriacou further invited the panel to consider the guidance on serious concerns based on public confidence or professional standards, which sets out:

> *"Sometimes we may need to take regulatory action against a nurse, midwife or nursing associate because of our objectives to promote and maintain professional standards and the public's trust and confidence in nurses, midwives and nursing associates.*
>
> *This means we may need to take action even if the nurse, midwife or nursing associate has shown that they have put serious clinical failings right, if the past incidents themselves were so serious they could affect the public's trust in nurses, midwives and nursing associates"*

Ms Kyriacou submitted that a short period of suspension with a review would be sufficient to protect patients, uphold public confidence in the nursing profession and maintain professional standards. She said that a three-month period of suspension would also serve to reflect the seriousness of the concerns and allow you to provide an in-depth reflection on what you could have done differently, comment on any remorse you now have and provide a future reviewing panel with a personal development plan.

Ms Kyriacou submitted that the seriousness of this case requires temporary removal from the NMC register as a result of the risk of harm caused to residents in your care, and also the serious impact that your misconduct had on public confidence in the nursing profession, which could have resulted in a reluctance of members of the public, and especially your vulnerable residents, to access healthcare. Accordingly, she said that the misconduct is so serious that a temporary removal from the register is justified, and the proposed suspension order is sufficient as it would be reviewed by a future panel, who can assess whether you have adequately reflected, demonstrated insight and satisfied any reviewing panel that any risk of harm has been minimised.

Ms Kyriacou submitted that, should the panel not consider suspension as an appropriate and proportionate sanction, it should consider imposing an interim conditions of practice order for a period of up to three years. She invited the panel to consider the NMC Guidance on Conditions of Practice, which sets out:

> *"The key consideration for the panel, before making this order, is whether conditions can be put in place that will be sufficient to protect patients or service users, and if necessary, address any concerns about public confidence or proper professional standards and conduct.*
>
> *Conditions may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):*
>
> - *no evidence of harmful deep-seated personality or attitudinal problems*
> - *identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining*
> - *no evidence of general incompetence*
> - *potential and willingness to respond positively to retraining*
> - *[…]*
> - *patients will not be put in danger either directly or indirectly as a result of the conditions*
> - *the conditions will protect patients during the period they are in force*
> - *conditions can be created that can be monitored and assessed."*

Ms Kyriacou submitted that the panel has found that there is no evidence of harmful deep-seated personality or attitudinal problems. However, she submitted that there may be difficulty in identifying areas of your practice in need of assessment and/or retraining, in light of the evidence of the extensive training which you have undertaken. She submitted that that there is no evidence of general incompetence and you have demonstrated your willingness to respond positively to retraining, through the courses which you have undertaken. She highlighted that it is a matter for the panel to assess

whether patients will not be put in danger either directly or indirectly as a result of the conditions, and whether measurable, workable and proportionate conditions could be formulated to protect patients during the period they are enforced.

Ms Kyriacou suggested that, if the panel is minded to impose a conditions of practice order, the following conditions may be appropriate:

1. Indirect supervision;
2. Working with a line manager, mentor or supervisor to create a personal development plan to address:
    a) Falls management;
    b) Documentation and record keeping;
    c) Prioritisation of care; and
    d) Conflict resolution
3. Monthly meetings with your line manager, mentor or supervisor.
4. To provide an in-depth reflective piece to address the concerns raised.

Dr Akinoshun submitted that there is a need for proportionality in determining which sanction the panel should impose. He invited the panel to consider the sanction with the least impact on you which would also be sufficient for public protection. He reminded the panel that any sanction which it may impose must strike a fair balance between public protection and public interest. He highlighted that public interest also includes allowing an experienced nurse to return to safe practice.

Dr Akinoshun accepted the following concerns as aggravating features:

- The charges found proved involved failings involving vulnerable residents; and
- Such failings occurred over a period of six months.

In respect of mitigating features, Dr Akinoshun made the following submissions:

- You had a previously unblemished record as a nurse before these incidents took place over a relatively short six-month period at the Home;

- The extensive steps you have taken in the last four years to strengthen your practice and ensure and demonstrate that there is no further risk of harm to patients in your care;
- You have demonstrated your insight and understanding of concerns through your reflective statement, action plan and outlining how you have since dealt with similar situations in the workplace;
- You have continued to reflect and learn in an effort to become a better and safe practitioner;
- There is no evidence of any repetition of the concerns alleged since the referral was made;
- You have kept up to date with areas of concern and attended relevant training which addressed the charges, which you self-financed;
- The nursing agency for whom you work has provided a positive reference to this panel based upon the feedback it has received from your direct clinical colleagues;
- The evidence before this panel of the difficulties at the Home at the relevant time, including challenges with your workload and the professional relationship between yourself and some colleagues;
- You have fully engaged with the NMC;
- There have been no previous regulatory concerns pertaining to care delivery raised against you;
- There is no evidence of a pattern of misconduct; and
- You have provided positive testimonials for this panel's consideration.

Dr Akinoshun next turned to the relevant sanction. He submitted that the fact that you were previously subject to an interim order, between 5 July 2019 and 24 November 2021 is a relevant factor. He submitted that you suitably satisfied the panel who revoked this order that you had addressed the regulatory concerns and minimised the risk to patients in your care.

Accordingly, Dr Akinoshun submitted that a caution order would be the appropriate sanction as it would mark that your behaviour was unacceptable. He said that the public would be protected as this sanction would be recorded, published and disclosed to any person enquiring about your fitness to practise history. Furthermore, he said that this order would allow you to continue to learn and develop your practice, which is something which you have taken seriously. Dr Akinoshun submitted that there is no risk to patients or members of the public as you have been practising as a nurse independently without any further risk of harm for the past two years, therefore a caution order would be appropriate in these circumstances.

Dr Akinoshun submitted that a further conditions of practice order would serve no useful purpose as you have worked successfully towards an interim conditions of practice order, which was revoked when you were able to satisfy a previous panel that there was no risk of harm to patients which warranted an interim order. He said that any conditions have been fulfilled and you have accomplished the aim of such an order.

Dr Akinoshun submitted that a three-month suspension order would be inappropriate and serve no useful purpose. He accepted the panel's findings on impairment, that there remains some concern about your insight which requires development, and said that you would unlikely be able to develop this if you are not permitted to practise as a nurse.

[PRIVATE].

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- A repetition of similar concerns over a period of six months;
- You breached a position of seniority and trust as the only registered nurse at the Home. This breach of trust was significant when considering the trust placed in you by the family members of the residents in your care;
- Your misconduct involved inappropriate care of vulnerable residents, which included actual harm caused to residents; and
- You have demonstrated inadequate recent remorse, reflection and insight on the impact which your misconduct had on the residents in your care as well as the wider nursing profession.

The panel also took into account the following mitigating features:

- You have made some attempts to address the concerns outlined in the charges, such as relevant training and your engagement with a PDP;
- You have some developing insight into your misconduct;
- You were working in challenging circumstances at the time the charges arose, including the pressures of your workload and conflict with colleagues;
- You have no previous regulatory findings against you;
- You have provided for this panel two positive testimonials from previous colleagues which speak highly of your character and clinical practice;

- There is evidence before this panel that you have worked safely since the concerns arose, including in compliance with a previous interim conditions of practice order; and
- You have provided this panel with historic evidence of strengthened practice.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection and public interest issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel concluded that the outstanding concerns which resulted in its finding of impairment are matters which would require regulatory oversight and review, which would not take place were a caution order to be imposed. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *[…];*

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

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel bore in mind Dr Akinoshun's submissions that you have previously successfully complied with an interim conditions of practice order. The panel did not accept that this would render an order of substantive conditions of practice to be redundant, as it bore in mind that this panel's function is different to one assessing risk at an interim stage. However, the panel accepted that, as you have previously successfully complied with an interim conditions of practice order, it is likely that you would be willing to comply with conditions of practice.

The panel had regard to the fact that these incidents happened around four years ago and that, other than these incidents, you have had an unblemished career of a number of years as a nurse. It further took into account that the failings are neither wide-ranging in respect of your clinical practice, nor are they as a result of any attitudinal concerns. Accordingly, the panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case because, although it would serve you a period of time to fully reflect on your failings, it would deprive you of the opportunity to work under direct managerial oversight, or seek feedback from your manager, workplace mentor or supervisor to assist you to develop your insight. In making this decision, the panel carefully considered the submissions of Ms Kyriacou in relation to the sanction that the

NMC was seeking in this case. However, the panel considered that the public could be suitably protected by workable, measurable and proportionate conditions of practice, and the public interest would be marked by the imposition of such an order.

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 only work for one substantive employer. This must not be an agency or NHS bank placement.
>
> 2. You must complete an extensive up-to-date reflective piece which addresses your insight, remorse and the impact which your misconduct had on the patients in your care, their families, your colleagues and the reputation of the nursing profession. This reflective piece must be sent to your NMC case officer no later than 14 days before any review of this order.
>
> 3. Prior to any review of this order, you must provide an up-to-date reference from your line manager, who must be aware of the charges found proved. This reference must be sent to your NMC case officer no later than 14 days before any review of this order.

4. Prior to any review of this order, you must provide a document outlining recent examples of how you have handed over a patient in your care to a paramedic/ general practitioner/ any other clinician, and how you have reflected on this. This document must be sent to your NMC case officer no later than 14 days before any review of this order.

5. Prior to any review of this order, you must provide a document outlining recent examples of how you have managed interpersonal conflict in the workplace, and how you have reflected on this. This document must be sent to your NMC case officer no later than 14 days before any review of this order.

6. You must work with your line manager to create a personal development plan (PDP). Your PDP must continue to address the concerns about:

    - Appropriate techniques for moving and handling patients;
    - Informing patients' next of kin about clinical incidents;
    - Balancing competing priorities in the workplace;
    - Carrying out observations;
    - Dealing with emergency situations, including handover to other healthcare professionals;
    - Managing interpersonal conflict in the workplace;
    - Record keeping; and
    - Providing emergency care

    A copy of this PDP must be sent to your NMC case officer no later than 14 days before any review of this order.

7. You must meet with your workplace manager, who must be aware of the charges found proved, at least once a month to discuss your progress on your PDP. You must provide evidence of each of your monthly one-to-one meetings, signed and dated by yourself and your

manager to your NMC case officer no later than 14 days before any review of this order.

8. You must send your NMC case officer a report from you line manager no later than 14 days before any review of this order. This report must show your progress towards achieving the aims set out in your PDP.

9. 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.

10. 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.

11. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).
    c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
    d) 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

12. 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.

13. 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 12 months to provide you with sufficient time to engage with conditions of practice and develop your insight so that a future reviewing panel may assess your fitness to practise.

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

Any future panel reviewing this case would be assisted by:

- Evidence of your compliance with these conditions of practice, in particular evidence of your reflections on the impact of your misconduct on residents, their families, and the reputation of the nursing profession;
- Evidence of your continued engagement with the NMC; and
- Evidence of the personal responsibility that you have taken in preparing your reflections and reports for the next review of this order.

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the conditions of practice sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Kyriacou. She submitted that an interim order is required as the substantive order will not come into force until the end of the 28-day appeal period. She submitted that an interim conditions of practice order, mirroring the substantive order, for a period of 18 months is required to give assurance that some order would be in place, should you lodge an appeal against this panel's decision. She said that this period is required to allow for this appeal to be heard, and if no such appeal is made, the interim order will fall away in 28-days.

The panel also took into account the submissions of Dr Akinoshun. He submitted that, having heard the panel's determination, an interim conditions of practice order is not necessary for the next 28 days. He said that you have been working safely and competently to date. He said that an interim conditions of practice order would not be suitable at this stage and members of the public would not be put at harm should no interim order be imposed in this matter.

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 for the same reasons and in the same terms as the substantive conditions of practice order, in order to uphold public protection for the period which it may take to resolve any potential appeal of this substantive order.

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

That concludes this determination.