Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
30 August – 7 September 2022
20 – 23 September 2022
26 – 27 June 2023
26 - 29 September 2023

Virtual Hearing

Name of registrant:	**Roque L Asotigue**
NMC PIN:	01K1954O
Part(s) of the register:	Nursing, Sub part 1 RN1, Registered Nurse – Adult (27 November 2001)
Relevant Location:	Somerset
Type of case:	Misconduct/Lack of competence
Panel members:	Patricia Richardson (Chair, Lay member) Hartness Samushonga (Registrant member) Florence Mitchell (Registrant member)
Legal Assessor:	Breige Gilmore (30 August 2022 – 7 September 2022, 20 – 23 September 2022) Charles Apthorp (26 – 27 June 2023) Graeme Dalgleish
Hearings Coordinator:	Tyrena Agyemang (30 August 2022 – 7 September 2022) Megan Winter (20 – 23 September 2022) Sharmilla Nanan
Nursing and Midwifery Council:	Represented by Muneeb Akram, Case Presenter (30 August 2022 – 7 September 2022, 20 – 23 September 2022) Represented by Michael Smalley, Case Presenter (26 – 27 June 2023) Represented by Brittany Buckell, Case Presenter

Mr Asotigue:	Present and represented by Jennifer Agyekum instructed by the Royal College of Nursing (RCN) (30 August 2022 – 7 September 2022, 20 – 23 September 2022) Present and represented by Alexandra Monaghan instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charges 1a ii, 1a iii, 1a iv, 1b iii, 1b v, 1b vi, 1b vii, 1b viii, 1b ix, 1b x, 1b xiii, 1c, 1e, 1f, 1g, 1h i, 1h ii, 1h iii, 1h iv, 1j i, 1j ii, 1k, 1l, 4, 5, 6, 7a and 7d
No case to answer:	Charges 1b i, 1b ii, 1bxi, 1i i-iv, 1j iii and 1j iv
Facts proved:	Charges 1b xii, 1d, 2a, 2b, 2c, 2d, 3, 7b and 7c
Facts not proved:	Charges 1a i and 1b iv
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

1) Between 6 May 2019 and 9 July 2020 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that:

a) On unknown dates before 2 July 2019:

i) Did not escalate a high NEWS score;

ii) Removed your tunic to wash patients;

iii) On one or more occasion slept on the ward;

iv) On 2 July 2019 told a patient their date of birth meant “death” in China;

b) On 18 July 2019:

i) Only took handover for 4 patients;

ii) Were unable to identify the needs or monitoring requirements of your patients;

iii) Were unable to identify that a patient was prescribed saline in their nebuliser;

iv) Used an opened ampule of saline;

v) On one or more occasion tipped a pot of Patient C’s tablets directly into their mouth;

vi) Failed to arrange a bladder scan for Patient A;

vii) Required prompting to identify changes in prescriptions and / required monitoring for your patients;

viii) Did not administer Patient A’s 12pm dose on time;

ix) Did not safely dispose of a used syringe;

x) Required prompting to identify that Patient B was prescribed antibiotics and administer them;

xi) Did not adequately monitor urine output for one or more patients with catheters;

xii) Did not share all relevant information in your written and / or verbal handover;

xiii) Referred to your patients by their bed number;

c) Around 20 September 2019 told a patient they were “bigger up top” or words to that effect;

d) On an unknown date around September or October 2019 did not escalate and / or handover to the night shift that one of your patients had a high NEWS score

e) On 4 November 2019:

i) Did not introduce yourself or explain why you were there to a patient;

ii) Administered half doses of medication on two occasions;

iii) Did not dissolve soluble aspirin before giving to patient;

iv) Did not allow for ten seconds’ absorption before removing needle after administering insulin;

v) Gave one or more patients their medication on a spoon;

vi) Did not include sufficient information on a district nurse referral;

f) Before 18 November 2019:

i) Sent a patient home with enoxaparin and supplements which had not been prescribed;

ii) Left a bottle of paracetamol on a patient’s table;

iii) Omitted medication due to one or more patients;

iv) Did not check one or more patients' wristbands;

v) Did not include sufficient information on MRSA screening labels;

vi) Did not document handing over obtaining a patient's medication to another nurse;

g) Before 13 December 2019 in relation to the patient in bed 26:

i) Did not complete documentation after 9.19am;

ii) Did not refer to pressure care and / or nutrition and / or hydration and / or mobility;

h) Before 13 February 2020:

i) Gave a patient tablets on a spoon;

ii) Washed a patient while they were on the toilet;

iii) Left one or more boxes of medication on patients' tables;

iv) Did not complete documentation adequately

i) After 12 February 2020 during one or more supervised drugs rounds:

i) Did not identify correct dosages;

ii) Did not check patient identities;

iii) Did not check drugs;

iv) Did not check drug expiry dates;

j) On 9 July 2020 did not administer the below medication to Resident A:
i) Amitriptyline
ii) Atorvastatin
iii) Senna
iv) Paracetamol

k) On 9 July 2020 recorded administration of Senna and / or Paracetamol on Resident A's MAR chart

l) On 9 July 2020 administered Resident B's Alendronic acid to Resident C

2) On 8 April 2020:

a) Entered a Covid-positive patient's room without donning personal protective equipment ('PPE');

b) Left a Covid-positive patient's room and entered another patient's room without washing your hands;

c) Entered a patient's room without donning personal protective equipment ('PPE');

d) Left a Covid-positive patient's room and went into the sluice without removing your PPE;

3) On 9 April 2020 entered a patient's room without donning personal protective equipment ('PPE');

4) Before 30 July 2020 did not inform ICG Medical / Cromwell Staffing about a disciplinary investigation by your employer, Somerset NHS Foundation Trust;

5) Before 30 July 2020 did not inform ICG Medical / Cromwell Staffing that you had been referred to the Nursing and Midwifery Council ('NMC');

6) On 21 May 2020 incorrectly told ICG Medical / Cromwell Medical Staffing that there were no concerns and / or complaints about your practice;

7) Your actions at 4 and / or 5 and / or 6 above were dishonest in that:

a) You knew you had been the subject of action plans and / or capability processes and / or disciplinary action by Somerset NHS Foundation Trust;
b) You knew you had been referred to the NMC;

c) You knew you were required to inform ICG Medical / Cromwell Medical Staffing of any disciplinary investigation and/or NMC referral;

d) You intended to mislead ICG Medical / Cromwell Medical Staffing to accept there were no concerns about your practice;

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence in relation to charge 1 and / or your misconduct.

Application to withdraw admission to Charge 7c

The panel heard an application made by Ms Agyekum under Rule 24(1) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) to withdraw your admission to charge 7(c).

Ms Agyekum referred the panel back to the admissions made on your behalf at the outset of the hearing. She told the panel that she had mistakenly made the admission to the totality of 7(c), which reads as:

c) *You knew you were required to inform ICG Medical / Cromwell Medical Staffing of any disciplinary investigation or NMC referral;*

Ms Agyekum told the panel that you have always denied the allegation in relation to the NMC referral as referenced in 7(b) and 7(c) and that the mistake was an oversight on her part. She reminded the panel that she did make it clear during the admissions, that you denied the allegation in relation to the NMC referral.

Ms Agyekum referred the panel to section 24(1) of the Rules and submitted that the panel have the power to consider and grant the application and in doing so, it must consider the issue of prejudice, justice, and fairness to the NMC and also to you. Ms Agyekum told the panel that if it were to grant the application that there would be no unfairness or injustice to the NMC. She told the panel that she alerted Mr Akram to her mistake as soon as possible and that as the hearing is still at the facts stage and the NMC has not yet closed its case, if there was any impact to the NMC, Mr Akram could still address the issues and recall any witnesses if required. She submitted that there is no prejudice to the NMC in the panel allowing the application to withdraw the admission.

Ms Agyekum submitted that if the application were not granted, that there would be injustice and prejudice to you. She told the panel that your position would remain unknown in relation to charge 7(c) and that you would not be able to provide evidence to support your position.

Ms Agyekum submitted that the mistake was an oversight on her part and that if the panel were to refuse the application you would be prejudiced as a result. She therefore invited the panel to grant the application to withdraw the admission made to charge 7(c) in relation to the NMC referral.

Mr Akram opposed the withdrawal application. He told the panel that in the context of the charge the application would not make much impact. He conceded that there would be minimal, if any prejudice to the NMC should the application be allowed.

Mr Akram referred the panel to '*The Regulation of Healthcare Professionals: Law, Principle and Process (Second Edition)'*. Paragraph 25-063 reads as follows:

> *"**Where a legal representative for a registrant seeks to resile from a formally admitted fact***
>
> *The position varies according to the procedural rules. Where the rules refer neither to the law of evidence in civil or criminal proceedings, reference is likely to be made, it is submitted, to the criminal rules. In both criminal and civil proceedings, the court's permission is required to withdraw a formal admission. Clear evidence of mistake or misunderstanding is likely to be required to withdraw an admission, where that admission was made formally and with the benefit of legal advice:* ***R v Kolton*** **[2000] Crim L.R. 761** at [30]."

Mr Akram also referred the panel to the case of *Gould* [2021] EWCA Crim 447 and submitted that such applications must only be granted in the interests of justice.

Mr Akram agreed the admission made, was a mistake on the part of Ms Agyekum. He outlined that the panel have already heard from Witness 8, who confirmed in her live evidence and in her exhibits before the panel, that you were required to notify your employer about any referral made to the NMC. He told the panel that he does not intend to recall the witness on this basis.

Mr Akram submitted there is no measurable risk of prejudice to the NMC and that it is a minor withdrawal sought on your behalf.

The panel accepted advice from the legal assessor.

The panel carefully considered Ms Agyekum's application. It noted Ms Agyekum's submissions that you have denied the allegation of dishonesty in relation the NMC referral from the outset and that this is also in line with your response to charge 7(b).

The panel took into account the legal advice, section 24(1) of the Rules and agreed that it does have the discretion to hear, grant or refuse the application in relation to the admission withdrawal.

The panel further acknowledged Ms Agyekum's submission that she alerted the NMC to her mistake as soon as she realised and that Mr Akram has also acknowledged, should the application be granted that there would be minimal injustice or prejudice towards the NMC.

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. It also bore in mind that you are entitled to a fair hearing and that there would be prejudice and injustice towards you should the application be refused. The panel accepted that there would be very little injustice towards the NMC as its case has not yet closed.

The panel noted Mr Akram's reference to the case of *Gould,* however were mindful of the differences between a criminal trial in which the defendant personally enters a plea and a regulatory hearing where admissions are generally made by a representative.

In considering this application to withdraw an admission to charge 7(c) the panel had regard to the genuineness of the mistake made by Ms Agyekum on your behalf and distinguished this from deliberate conduct. In addition, the panel took into account the minimal if any prejudice to the NMC if the application were granted and also the

potential prejudice to you if it were not granted. The panel had regard to your right to a fair hearing and to the interest of justice generally. In carrying out what was a balancing exercise the panel concluded that it would grant Ms Agyekum's application to set aside the admission to the entirety of charge 7(c) and have determined that that charge should now be found proven in part only.

Application to amend charge 7(c)

The panel heard an application made by Mr Akram, to amend the wording of charge 7(c) under Rule 28(1) of (the Rules).

The proposed amendments, outlined by Mr Akram were he submitted, minor amendments in order to make the charge clearer. Mr Akram submitted that the amendments would add clarity, as without them there is the potential for some confusion when reading the charge. He submitted that the amendments can be made without any injustice or unfairness to you or any other party.

The suggested amendments are as follows:

> *"That you, a registered nurse:*
>
> 7) *Your actions at 4 and / or 5 and / or 6 above were dishonest in that:*
>
> c) *You knew you were required to inform ICG Medical ~~/~~**and/or** Cromwell Medical Staffing of any disciplinary investigation **and/or** ~~or~~ NMC referral;*
>
> *And in light of the above, your fitness to practise is impaired by reason of your misconduct."*

The panel heard submissions from Ms Agyekum, that she was aware of the application relating to the second amendment and not the first. However, she did not seek to make any representations on your behalf, she agreed that the amendments to the charge were minor. She invited the panel to consider what, if any injustice would be caused to you as result of the amendments.

Ms Agyekum submitted that you have already made a partial admission to the charge namely that relating to the disciplinary investigation. She submitted that the amendment is for the panel's consideration and that she makes no objections to them.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of (the Rules).

The panel carefully considered the proposed amendments. It was of the view that the first amendment as applied for, was not in the interest of justice. The panel considered that the amendment at this stage would be unfair to you, as you have already entered a partial admission to the charge. Furthermore, the amendment would not, in the view of the panel, lead to greater clarity and has the potential to cause confusion as if amended would differ from the preceding three charges for no apparent reason. The panel decided to refuse the first limb of Mr Akram's application.

The panel went on to consider the second amendment to the charge. It was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed.

Having considered the merits of the case, the panel determined that it was therefore appropriate to allow the second amendment, as applied for, to provide some needed clarity and eliminate any potential confusion when reading the charge.

Submissions on application of no case to answer

The panel considered an application from Ms Agyekum that there is no case to answer in respect of charges 1bi, 1bii, 1bxi, 1i in its entirety, 1j iii and 1j iv. This application was made under Rule 24(7). She also referred the panel to the cases of *R (on the application of Sharaf) v GMC* [2013] EWHC 3332 (Admin), and *R v Galbraith* [1981] 1WLR 1039.

Ms Agyekum submitted, in light of the case law referred to that the panel must assess the strength of the NMC's evidence for the individual charges and ask itself whether that

evidence is such that a properly directed panel could properly find the charge proved on that evidence alone. She further submitted that the panel must assume it will not hear from the registrant.

Ms Agyekum went on to address each charge as follows:

Charge 1(b)(i)

Ms Agyekum told the panel the NMC relies on the evidence of Witness 4, who told the panel that you had been allocated to a four bedded bay area and that you *'only took handover for his patients'*. Ms Agyekum stated that during her oral evidence, Witness 4 confirmed that you received a written and verbal handover for all the patients, not just your four patients, with the rest of the staff. Witness 4 accepted that you could have read the written handover you received and in cross examination she confirmed that she did not know what you wrote on the handover sheet during the verbal handover as she could not see what you were writing.

Ms Agyekum submitted that the evidence adduced by the NMC to support this charge, is weak and inherently inconsistent, such that a properly directed panel could not find this charge proved.

Charge 1(b)(ii)

Ms Agyekum submitted that in order to find this charge proved, the panel would need to find that you could not identify the needs or monitoring requirements of your patients. Ms Agyekum submitted that the NMC relies on the evidence of Witness 4, who stated: '*Roque found it difficult to identify what he needed to do for each patient…'* but during her oral evidence, Witness 4 could not remember the conversation, but she stated you *"could not give me a direct answer."* During cross examination, Witness 4 confirmed that you were able to identify the needs and monitoring of patients with prompting. In Witness 4's witness statement she also stated that you were *'able to identify the medications required and the number of tablets', "Roque identified that he would need to bladder scan patient A", and "…After some prompting he was able to tell me that*

Patient B had had his ABX changed and that Patient B was prescribed simple linctus."
"…with some more prompts, he stated that Patient A needed a bladder scan and if post void there was more than 300mls he would need to be re-catheterised."

Ms Agyekum submitted it was clear you could identify the needs and monitoring requirements of your patients. She further submitted that taking this evidence at its highest, the evidence is vague and inherently inconsistent and therefore, a properly directed panel could not find this charge proved.

Charge 1(b)(xi)

Ms Agyekum submitted the NMC relies on the evidence of Witness 4. In her oral evidence Witness 4 told the panel that she could not remember how she came to the conclusion that you did not adequately monitor the urine output for the patients with catheters. Witness 4 also stated that she could not recall what you did or did not do for those patients. Indeed, there was no evidence in relation to what adequate monitoring of the urine output would have been for any of these patients.

Ms Agyekum submitted that the NMC's evidence at its highest is tenuous and vague such that a properly directed panel could not find this charge proved.

Charge 1(j) (i) – (iv)

Ms Agyekum submitted that in relation to this charge, in order to find it proved in its entirety, the panel will have to find that you carried out supervised drugs rounds with Witness 9 after 12 February 2020. She submitted that there is no evidence of any supervised ward rounds with Witness 9 after 12 February 2020.

Ms Agyekum told the panel that the NMC relies on paragraph 6 of Witness 9's witness statement. However, Ms Agyekum submitted, the statement does not state that after 12 February 2020 you did not identify correct dosages, did not check patient identities and that you did not check drugs or expiry. There is no identification of when Witness 9 says these alleged actions took place.

In the alternative, Ms Agyekum submitted, the evidence relied upon in support of this charge is weak, tenuous and inherently vague. There is no indication of when Witness 9 says these things occurred or which patients, drugs and doses were involved. Ms Agyekum also submitted that there is also no documentary evidence in support of this allegation. She therefore submitted that a properly directed panel could not find this charge proved.

Charges 1(j) (iii) and (iv)

Ms Agyekum referred the panel to the evidence relied upon by the NMC namely Witness 10's witness statement. She submitted that the evidence before the panel at its highest is weak, inconsistent and unchallenged hearsay from a resident which is unreliable. She submitted that the inherently inconsistent results of a medication count carried out by another nurse who had come on shift 24 hours after the medication was given. As 24 hours had passed, it cannot be said to reflect the position on or at the end of the night shift of 9 July 2020. She further submitted it is also evident that the MAR chart is riddled with errors after 9 July 2020. At its highest, this charge rests on tenuous inference.

Ms Agyekum went on to address the charge relating to the paracetamol. With regard to the paracetamol, Ms Agyekum submitted, in her evidence, Witness 10 confirmed that after your shift there were a further three times where another person had been involved in providing this resident with her medication. Consequently, in her evidence Witness 10 confirmed that it was *"impossible"* to say when any tablets had not been given and she agreed that by the end of your shift the tablet count was correct, as if the medication had been given and she also agreed that by the end of your shift that it appeared that the tablets had been given.

In relation to the Senna tablets, Ms Agyekum submitted that the evidence of Witness 10 indicates that on or at the end of your shift the medication count would have been correct to show that the medication had been given. During her cross examination, Witness 10 was directed to her crossed out total count on the MAR Chart and was

asked whether she had in fact first written 23 in her entry on 10 July 2020. Her first answer was that she *"can't remember"*. In any event, Witness 10 agreed that she could not say that you had not given the medication to the resident.

Ms Agyekum submitted that it is evident that the contemporaneous documentary evidence from the night shift of the 9 July 2020, demonstrates a medication count and signatures which would indicate that the medication was administered. Ms Agyekum submitted that the evidence presented to support this charge is tenuous, vague and is inherently inconsistent with other evidence presented such, that a properly directed panel could not find this charge proved.

Mr Akram agreed with the case references provided by Ms Agyekum and referred the panel to the relevant case law namely *Sharaf* and *Galbraith* and to the evidence matrix produced by the NMC for the panel's consideration.

In relation to Charge 1b i, Mr Akram submitted that during the oral evidence of Witness 4 the panel heard that she didn't believe you listened to the handover of the other patients, but she did acknowledge there was a written handover as well as a verbal handover. Witness 4 said in her oral evidence that you could have read the handover sheet, but she did not observe you doing so. Mr Akram submitted that taking this evidence at its highest the panel could find this charge proved.

In relation to charge 1b ii, Mr Akram pointed the panel to the paragraphs of Witness 4's written statement where she stated that she asked you what you needed to do for each patient, and said that you found it difficult to identify these needs, who needed reviewing and what needed to be monitored. In her oral evidence to the panel, she reiterated that you could not give direct answers as to the needs of your patients.

Mr Akram went on to charge 1b xi. He referred the panel to Witness 4's witness statement and submitted that Witness 4 was concerned that you did not see the monitoring of urine being passed as a priority. She was also concerned about your level of understanding.

Mr Akram went on to charge 1i i- iv and told the panel that the NMC relies on the evidence of Witness 9 and the evidence that she undertook supervised drug rounds with you. He referred the panel to her evidence where she states she was quite shocked at how poor your medication administration was. He told the panel that Witness 9's evidence could be relied upon and that the charge could be found proved.

Mr Akram finally addressed charge 1j iii and iv. He submitted that the hearsay evidence was admitted, but it is for the panel to determine how much weight it places on this evidence. He told the panel that it has heard direct evidence from Witness 10 that she counted the tablets and there were 184 when there should have been 186. He told the panel that the patient told Witness 10 directly that her medication was missed. Mr Akram submitted that it is incontrovertible that there are errors on the MAR Chart, but he told the panel that it is more likely than not that tablets were not administered to the patient.

Mr Akram submitted that on a balance of probabilities it is more likely than not that medication was missed and that the panel can rely on this evidence to find the charge proved.

Decisions and reasons on application of no case to answer

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 considered the submissions of both Ms Agyekum and Mr Akram, as well as the evidence before it.

The panel considered each charge and determined the following:

Charge 1(b) (i)

In relation to charge 1 b i, the panel noted the evidence given by Witness 4 that you were present at the verbal handover and that you had the same written handover information as the other staff present. The panel noted her evidence that the handover sheet was updated prior to the handover and that you were required to listen to the handover of all of the patients, including those that were not under your care. The panel was of the view that Witness 4's concerns that she did not see you take notes was her belief rather than tangible evidence. Further, there was no evidence to prove on the balance of probabilities that whilst present you had only listened to the verbal handover of your four patients. The panel considered the evidence in support of this charge, to be vague and inconsistent with other evidence given by this witness.

The panel concluded that even if properly directed, it would not be able to find this charge proved and find that there is no case to answer in relation to this charge.

Charge 1(b) (ii)

The panel referred to the witness statement of Witness 4. It carefully considered the evidence before it and could not find any evidence that you were unable to identify the needs or monitoring requirements of your patients. The panel heard evidence that you found it difficult, however after prompting you were able to identify the needs and monitoring of patients.

The panel therefore find there is no case to answer in relation to this charge.

Charge 1(b) (xi)

The panel considered the evidence before it. It took into account the submissions of both Ms Agyekum and Mr Akram. The panel acknowledged the only evidence it has is that Witness 4 felt you did not properly monitor the patients. There was no information

to demonstrate what level of monitoring was required to satisfy the requirement of '*adequate monitoring'*, namely the process and steps and what was expected of you.

The panel determined that the evidence supporting this charge is weak and vague and insufficient to support the charge.

It therefore finds there is no case to answer in relation to this charge.

Charges 1(i) (i) – (iv)

The panel took into account the evidence before it. The panel considered that there is limited evidence to support these charges. It noted that there is some evidence that you were supervised whilst completing your drug rounds, but there is no evidence to indicate the dates on which this took place. The charge against you states a timeline in which the errors took place but on close inspection of the evidence the panel found the evidence to support this charge to be vague, with there being no way of identifying when the drug rounds took place.

The panel acknowledged Witness 9's evidence and the Investigation meeting minutes dated 26 May 2020 stating that she supervised you on some drugs rounds, but there is no reference to dates and the panel could not be certain that they happened after 12 February 2020. The panel also noted the letter sent to you dated 13 February 2020 and subsequent dates, in which there was no mention of any drug round errors.

The panel therefore finds there is no case to answer in relation to these charges.

Charge 1(j) (iii)

The panel took into account the submissions of both Ms Agyekum and Mr Akram and the evidence before it. The panel acknowledged Witness 10's evidence and noted that she could not be sure who failed to administer the paracetamol to the patient. The panel carefully examined the times the medication was due to be given, the time it was signed to have been given and the total counts indicated on the MAR Chart. The panel

considered the MAR chart cannot be relied upon to be true and accurate as the recordings conflict with each other.

The panel noted that there was no evidence before it to show which member of staff was working on 10 July 2020, the day of the count, and Witness 10 could not recall either. The panel considered the hearsay evidence provided by Witness 10 and decided to place little or no weight on it as the resident herself was unclear whether she had been given the medication.

The panel noted your acknowledgement that you were the nurse that administered the medication on 9 July 2020, but it noted there was also another individual who administered the medication, who could not be identified.

The panel was therefore not satisfied there was sufficient evidence to demonstrate you were the nurse responsible for administering the paracetamol and therefore finds there is no case to answer in relation to this charge.

Charge 1(j) (iv)

The panel went on to considered whether you were also responsible for failing to administer the Senna tablet. It noted that Witness 10, could not say for certain that you did not give the resident the medication. It referred to the MAR Chart and the inaccuracies and concluded that even if properly directed that it could not find this charge proved.

The panel was satisfied that there is some evidence that you may have been responsible for failing to administer the medication, however the panel determined that the evidence before it is vague and unclear and insufficient for the panel to find this charge proved. It therefore finds there is no case to answer in relation to this charge.

The panel therefore allowed Ms Agyekum's application.

Decision and reasons on facts

Following the panel finding no case to answer in relation to charges 1b i, 1b ii, 1b xi, 1I i-iv, 1j iii and 1j iv, it went on to consider the disputed facts, being charges 1a i, 1b iv, 1b xii, 1d, 2a, 2b, 2c, 2d, 3, 7b and 7c. The panel took into account all of the evidence in this case together with the submissions made by Mr Akram and Ms Agyekum. The panel also had regard to your good character evidenced by the references provided in your bundle.

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

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

- Witness 1: Senior Hospital Matron
- Witness 2: Junior Sister
- Witness 3: Neighbourhood Service Lead
- Witness 4: Community Nurse
- Witness 5: Ward Sister
- Witness 6: Matron
- Witness 7: Registered Manager
- Witness 8: Head of Nursing
- Witness 9: Senior Sister
- Witness 10: General Nurse

The panel also heard live oral evidence from you.

Charge 1(a) (i)

1) Between 6 May 2019 and 9 July 2020 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that:

a) On unknown dates before 2 July 2019:

i) Did not escalate a high NEWS score;

This charge is found NOT proved.

In reaching this decision, the panel took into account all the relevant information before it, including the documentary and oral evidence provided by Witness 2 and by you.

The panel noted that the NMC's evidence in relation to this charge is hearsay as Witness 2 was not present at the time of the incident and so is reliant on the recollection of what has been relayed to her by another person. It took into account that there is no specific information regarding this charge in Witness 2's witness statement. During her oral evidence, she could not recall whether she knew about this event from a verbal report directly to her from another nurse or through somebody else. Further, she could not recall exactly what documentation she reviewed or what was written. The panel took into account that her evidence was based solely on hearsay and considered that it could be given little weight.

The panel heard from you in relation to this charge. You stated that you were working in a Health Care Assistant (HCA) role on that day and that it was your second shift during your induction period. You informed the panel that as you were working in a HCA role, you were not working as the nurse with overall responsibility for this patient and the nurse in charge already had a student nurse working with her. The panel took into

account that having recently joined the team, you did not have patients allocated to you as a registered nurse.

You told the panel that you did escalate the NEWS score to the nurse and her student as soon as you took the observations. Witness 2 confirmed in her oral evidence that escalating to someone senior on shift would be regarded as a form of escalation. You further told the panel that, in response to the high NEWS score, you suggested calling for a review from the in house doctor who was due to come on ward rounds. Witness 2 confirmed this also to be a form of escalation in her evidence.

The panel took into account Witness 2's evidence who told the panel it is not always necessary to send a patient to the acute hospital if there is a high NEWS score as further investigation would need to be done to determine why the score was high. This would in turn determine what specific action would need to be taken at that point. The panel also took into account the fact you were employed as a registered nurse but working in a supernumerary position, which meant that you were not counted in the numbers for registered nurses and that you were working under the supervision of another nurse. Furthermore, this incident took place on your second shift during your induction. The panel was of the view that whilst you were accountable as a band 5 nurse, caring for a patient, to escalate a high NEWS score, your evidence of your escalation to a nurse of greater experience and seniority, with whom you were working, was sufficient escalation to discharge your responsibility.

For the reasons as set out above and having regard to the limited evidence available to support the charge, the panel decided that on the balance of probabilities, it is more likely than not that you did escalate the patient's condition.

The panel therefore found this charge not proved.

Charge 1(b) (iv)

1) Between 6 May 2019 and 9 July 2020 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that:

b) On 18 July 2019:

iv) Used an opened ampoule of saline;

This charge is found NOT proved.

In reaching this decision, the panel took into account all the relevant information before it, including the documentary and oral evidence provided by Witness 4 and by you.

In relation to this charge, the NMC solely relies upon the evidence of Witness 4. In her oral evidence, she stated that you used the opened ampoule. However, the panel noted that in both Witness 4's record of that shift (her local statement dated 18 July 2019) and witness statement state that you asked if you *should* use the opened ampoule. Witness 4 then stated that she suggested you use a new ampoule and says in her witness statement *"he then went on to use that ampule in the nebuliser"* [sic]. The panel noted that Witness 4's statement was silent on whether you used the open ampoule. Therefore, the panel accepted your evidence that you used the new ampoule after Witness 4 suggested it.

The panel had regard to your evidence. The panel noted that you were clear and consistent with your evidence in relation to this charge in that you were going to use the opened ampule but did not after you were advised not to do so.

The panel considered all of the evidence before it and preferred the evidence provided by you. It considered Witness 4's evidence to be inconsistent as her contemporaneous note from that day did not make reference to the incident, the first time she stated that you used the opened ampoule was during her oral evidence. The panel therefore determined that it is more likely than not that you did not use an opened ampoule of saline.

For the reasons as set out above and having regard to the limited evidence available to support the charge, the panel decided that on the balance of probabilities, it is more likely than not that you did not use an opened ampoule of saline.

The panel therefore found this charge not proved.

Charge 1(b) (xii)

1) Between 6 May 2019 and 9 July 2020 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that:

b) On 18 July 2019:

xii) Did not share all relevant information in your written and / or verbal handover;

This charge is found proved.

In reaching this decision, the panel took into account all the relevant information before it, including the documentary and oral evidence provided by Witness 4 and by you.

The panel had regard to the evidence of Witness 4 who stated *"At lunchtime I asked Roque to give handover to the HCA's who were coming onto the late shift. I listened into this handover, and I found it hard to follow as Roque was not clear about what he was handing over."* In her oral evidence, when asked what was missing from the verbal and written handover, she stated *"the antibiotic changes".* In cross examination, Witness 4 stated that you wrote down some changes on your handover sheet.

The panel also had regard to your partial admission to this charge in that you accepted that you did not hand over all of the relevant information to the HCA's in a written handover. The panel therefore was of the view that, if the information was not

mentioned in a written handover, it was more likely than not that you did not mention this in your verbal handover.

The panel therefore found this charge proved.

Charge 1(d)

1) Between 6 May 2019 and 9 July 2020 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse in that:

   d) On an unknown date around September or October 2019 did not escalate and / or handover to the night shift that one of your patients had a high NEWS score

This charge is found proved.

In reaching this decision, the panel took into account all the relevant information before it, including the documentary and oral evidence provided by Witness 2 and by you.

Witness 2 stated that you had been on the day shift and that during that shift you had two patients in your care. She stated that she started the shift at 19:00 and took handover from the dayshift who finished the shift at 19:30. She stated that you finished your shift and left the ward without giving her any form of handover. Witness 2 said when she came on the ward at 19:40 she checked on one of the patients and found that her NEWS score was high, she was not responsive and dehydrated. Witness 2 gave the patient fluids and her catheter started draining again, she became responsive again later in the morning.

Witness 2 said she challenged you about this when you came on duty again in the morning. She said your response was that she got better because you *had "prayed for her"*. Witness 2 said she explained to you that she got better because she resuscitated her and that you laughed.

You gave an inconsistent account of the incident. You said that the patient was fine during the daytime however you also described her as sleepy most of the time and that she did not eat or drink much that day, despite being encouraged to drink more fluids, and had little urine output. You said her NEWS score was ranging from 3 to 4 that day. You explained that you gave a handover to your mentor and all incoming night staff including the NEWS score taken after teatime of the patient who suddenly deteriorated that night after your shift. You said that you also recorded all of her physiological observations and NEWS scores in the RIO computer system on the day of the shift.

The panel took into account that you accepted that there were some concerns regarding the patient in respect of their fluid intake and that they were sleepy during the shift. It noted that you stated you did handover to your mentor and all incoming staff, however, Witness 2 was an incoming member of staff and stated that she did not receive any handover from you. You accepted that Witness 2 challenged you the following day about the lack of handover. When challenged, you could give no explanation for the lack of handover. The panel therefore found Witness 2's account of the incident more plausible. The panel also had regard to the email dated 5 July 2019 from Witness 2 to you which outlined the concerns raised, it considered this documentary evidence to be contemporaneous.

For the reasons as set out above, the panel decided that on the balance of probabilities, it is more likely than not that you did not escalate and / or handover to the night shift that one of your patients had a high NEWS score.

The panel therefore found this charge proved.

Charge 2(a)

2) On 8 April 2020:

a) Entered a Covid-positive patient's room without donning personal protective equipment ('PPE');

This charge is found proved.

In reaching this decision, the panel took into account all the relevant information before it, including the documentary and oral evidence provided by Witness 1 and by you.

The panel had regard to Witness 1's evidence who stated that she saw you go into the room of a Covid-positive patient without wearing PPE. She said that when you came out of the room, you did not wash your hands and then went into the room of another patient. Witness 1 said that this was at the start of the pandemic and that there had already been Covid related deaths on the ward, all staff were aware of their responsibilities and had received training on Infection and Prevention Control.

Witness 1 stated that she warned you about the first incident and that you apologised. However, almost immediately after she had spoken to you, she was informed by a member of the cleaning staff that you had just done it again. Witness 1 said that she saw you in the room of another patient, again without wearing PPE.

You attended a meeting to discuss your failure to reach and maintain a safe standard of practise where Witness 1 and Witness 9 were present. Given the continuing concerns and despite several action plans including personalised training programmes having been implemented, you were suspended from duty due to the serious omissions in your practise and the recent and consistent lack of adherence to the Infection Control policies and procedures.

You denied that this encounter took place and said that you would have been wearing PPE when entering a Covid-positive patient's room, and that you would have doffed it in the bin provided in the patient's room.

The panel considered the witnesses' documentary and oral evidence in relation to this charge and also took into account the evidence of Witness 9 in relation to charge 2b. The panel found both of their accounts to be corroborative of each other. It found Witness 1's oral evidence to be very persuasive, despite the discrepancy as to the

location of the doffing station. The panel was persuaded by Witness 1's evidence in that she saw you enter the room without wearing PPE. It also noted that you accept that the PPE would have been donned outside the room.

For the reasons as set out above, the panel decided that on the balance of probabilities, it is more likely than not that you entered a Covid-positive patient's room without donning PPE. The panel therefore found this charge proved.

Charges 2(b) and 2(c)

2) On 8 April 2020:

b) Left a Covid-positive patient's room and entered another patient's room without washing your hands;

c) Entered a patient's room without donning personal protective equipment ('PPE');

These charges are found proved.

The panel noted that the evidence available to it in relation to charges 2b and 2c is the same evidence which it considered in relation to charge 2a, namely Witness 1's evidence.

Having been satisfied with Witness 1's evidence on the balance of probabilities, the panel was also satisfied that her evidence in relation to this charge for the same reasons as above was reliable.

The panel therefore found charges 2b and 2c proved.

Charge 2d

2) On 8 April 2020:

d) Left a Covid-positive patient's room and went into the sluice without removing your PPE;

The panel found this charge proved.

In reaching this decision, the panel took into account all the relevant information before it, including the documentary and oral evidence provided by Witness 9 and by you.

The panel had regard to Witness 9's evidence. She was on duty at the time of the incident and said that she saw you come out of a Covid-positive patient's room wearing PPE. You then walked into the sluice and, when you came back out of the sluice, made your way to the kitchen, whilst wearing the same PPE. Witness 9 said that when she challenged you about this incident, you laughed. Witness 9 explained that normal practice would have been to remove your PPE before you came out of the patient's room in order to reduce the risk of any possible infection.

You denied that this encounter took place. You stated that when you were in the sluice, you had a clean mask on as it was *"smelly"*. You maintained throughout your evidence that you were not wearing dirty PPE in the sluice.

The panel considered all the evidence before it and found the evidence of Witness 9's reflective account to be more reliable. It noted that a letter of suspension was sent to you in relation to the concerns as set out in charges 2a-c and which made reference to your non-adherence to the Infection Control policy as one of the grounds leading to your suspension. The panel therefore find it difficult to accept your evidence that there was no discussion with you at the time of suspension in relation to your lack of adherence to the PPE guidance. The panel was persuaded by the evidence of Witness 9 who was clear as to what she had witnessed, her account corroborated the evidence provided by other witnesses who also witnessed PPE adherence failings by you on the same day.

For the reasons as set out above, the panel decided that on the balance of probabilities, it is more likely than not that you left a Covid-positive patient's room and went into the sluice without removing your PPE. The panel therefore found this charge proved.

Charge 3

3) On 9 April 2020 entered a patient's room without donning personal protective equipment ('PPE');

The panel found this charge proved.

In reaching this decision, the panel took into account all the relevant information before it, including the documentary and oral evidence provided by Witness 1 and by you.

Witness 1 witnessed a further incident involving you going into a patient's room without PPE on 9 April 2020. She stated, *'this was just ridiculous and I really lost my temper with him'.* A meeting was arranged to discuss your failure to reach and maintain a safe standard of practise, Witness 1 and Witness 9 were present. Given the continuing concerns despite several action plans and personalised training programmes having been implemented, you were suspended from duty due to the serious omissions in your practise and the recent lack of adherence to the Infection Control concerns.

You maintained throughout your evidence that this incident did not occur, however, the panel was persuaded by the evidence provided by Witness 1. It was of the view that, on the balance of probabilities, it is more likely than not that on 9 April 2020 you entered a patient's room without donning PPE.

The panel therefore found this charge proved.

Charge 7(b)

7) Your actions at 4 and / or 5 and / or 6 above were dishonest in that:

b) You knew you had been referred to the NMC;

The panel found this charge proved.

In reaching this decision, the panel took into account all the relevant information before it, including the documentary and oral evidence provided by the NMC screening officer in charge of your case and by you.

The NMC screening officer confirmed in his statement that an email was sent to you on 22 July 2020 notifying you of the referral. The NMC received an email from you on 25 July 2020 acknowledging the email and notifying the NMC that you had a representative at the RCN. On 29 July 2020, the RCN emailed the NMC requesting the documentation which had been sent to you. Following this, the necessary documentation relating to the referral was sent to you at a later date on 30 July 2020.

It is your position that you were aware of the referral before 30 July 2020, however, you had contacted the NMC and provided them with your agency's contact details. You state that you were told in an email that the NMC would contact the various agencies that you worked for and therefore you believed that you did not need to do so. The panel noted that this email was not part of the documentation provided to the panel. Having considered the test for dishonesty as outlined in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67*, the panel concluded that your belief that the NMC would contact the agencies you worked for to make them aware of the NMC referral was not a genuinely held belief.

The panel considered the evidence before it and noted that you responded to your screening officer's email on 25 July 2020. It was therefore of the view that you had knowledge of the NMC referral, at the very latest, on 25 July 2020.

Having considered the admissions you made at charges 4, 5, 6, 7a, 7d and partial admissions to 7c, the panel was satisfied on the balance of probabilities that your actions were dishonest in relation to charges 4, 5 and 6 as you were aware that you had

been referred to the NMC and you intended to mislead ICG Medical/Cromwell Medical Staffing to accept that there were no concerns regarding your practice.

The panel therefore found this charge proved.

Charge 7(c)

7) Your actions at 4 and / or 5 and / or 6 above were dishonest in that:

c) You knew you were required to inform ICG Medical / Cromwell Medical Staffing of any […] NMC referral;

The panel found this charge proved.

In reaching this decision, the panel took into account all the relevant information before it, including documentary and oral evidence provided.

The panel heard direct evidence from you that you signed to indicate you had read the ICG Medical Temporary Worker handbook (the handbook) on two occasions, one being the updated version sent by email. The panel noted your response contained in NMC Exhibit MP/3 in which you indicated that you have read and understood the contents of the handbook. However, you said that you had not actually read through all of the handbook including the part that stated that you had a duty to notify the agency of any referral to NMC. You stated that you had received similar handbooks from previous agencies and whilst employed in the hospital and that they were all generally the same. Your oral evidence was conflicting as you stated that you did not know that you had to notify the agencies, as the NMC would do so, however, you accepted in later questioning that you were aware that an NMC referral was a serious matter and that you knew you would have to inform the agency, it was common sense.

The panel therefore found your actions at charges 4, 5 and 6 were dishonest in that you knew you were required to inform ICG Medical / Cromwell Medical Staffing of any NMC referral and did not. The panel was of the view that by applying the objective standards

of ordinary decent people, your actions in relation to this charge would be regarded as dishonest. The panel therefore found this charge proved.

This hearing went part heard on 23 September 2022 and resumed on 26 June 2023.

Decision and reasons on application for a short adjournment

On 26 June 2023, Ms Monaghan, on your behalf, submitted that she was newly instructed defence counsel to this case and that she had not been provided with the determination of the hearing so far or the transcripts for the past hearing dates despite the RCN requesting the transcripts from the NMC a month prior to this hearing. She submitted that she also did not have the NMC evidence and statement bundles, therefore she was not in a position to make submissions today. She requested a short adjournment until 27 June 2023 so that she could read through the case papers and transcripts, take instructions from you and prepare her submissions for the next stage of the hearing. She noted that she has an impairment bundle which was over 100 pages for the panel to review, however as she had not considered the papers or taken instructions from you, she was not yet ready to hand this up to the panel.

Mr Smalley, on behalf of the NMC, submitted that this case is old and has not sat for a long period of time. He acknowledged that Ms Monaghan was not in a position to proceed today but that may mean that this may not conclude in this listing. He also submitted that you are subject to an interim order which had been extended by the High Court and was due to expire in November 2023. He noted that if this case did not conclude in this listing this may result in further applications being made to the High Court to extend the interim order.

The panel accepted the advice of the legal assessor.

The panel considered Ms Monaghan's request for an adjournment. It noted that Ms Monaghan should have received the NMC case papers from the RCN prior to the hearing. The panel noted that Ms Monaghan had an updated impairment bundle to circulate but bore in mind that an impairment bundle of 27 pages had previously been

circulated at the last hearing. It noted that Ms Monaghan had not seen this bundle or any of the other bundles in relation to this case to prepare your defence for the next stage of the hearing.

The panel noted that the transcripts that it had been provided with only went up to 7 September 2022 and that it had no transcripts available to it for the dates inclusive of 20 – 23 September 2022.

The panel determined that it was appropriate and in the interests of justice to grant Ms Monaghan's application for a short adjournment until 27 June 2023. It noted this would allow her time to review the exhibits in the case, the determination and the transcripts available so she can take instructions and prepare her submissions for the next stage of the case on your behalf. The panel also noted that this would provide time to the NMC to locate the missing transcripts. The panel stated to parties that it expected an update from the parties later in the day with their progress.

Decision and reasons on application for an adjournment

When the hearing reconvened later in the day, Ms Monaghan submitted that missing transcripts for 20 – 23 September 2022 contained your evidence namely, your cross examination. She submitted that it was pivotal for her to review this part of the transcript to complete the work for the next stage of the hearing. She noted the length of time that it has taken her to review the exhibits, determination and transcripts which have now been made available to her. She noted that she still had a significant portion of the transcripts to review and had still not received the additional transcripts from the last three days of the hearing. She acknowledged that it was unfortunate and unsatisfactory that this documentation had not been provided to her prior to the hearing. She submitted that for you to be adequately represented and for fairness to be maintained, this hearing should be adjourned to be considered on another date. She submitted that she would not be in a position to finalise her review of the documentation, take instructions from you and prepare written submissions by tomorrow.

Mr Smalley opposed this application. He addressed the panel in respect of the missing transcripts, 20 – 23 September 2022, and noted that the transcripts had not been requested at the end of the last hearing. He stated that the NMC had since been in touch with the transcription company who stated they would be able to provide the transcripts tomorrow morning at 11am. He submitted that since the last listing of this hearing on 23 September 2022, he expected that the RCN would have taken instructions from you on the next stage of the hearing. He submitted that the RCN had more than enough time to prepare the next stage of the case and that it would be fair to you to continue with the hearing. He submitted that the application for adjournment was made prematurely and addressed the panel on Rule 32 of the Rules which outlined the circumstances of adjourning a hearing. He noted that he was in a position to address the panel on your misconduct and lack of competence, and he had provided the panel with a copy of his written submissions.

The panel accepted the advice of the legal assessor.

The panel considered the application for an adjournment and noted the unfortunate circumstances of this case. The panel bore in mind the public interest for the expeditious disposal of cases. The panel considered fairness to both parties and noted that the NMC would need to make an application to the High Court to extend any interim order which you are currently subject to if this case was not concluded before November 2023. However, the panel noted the submissions made by your representative that she had not had an opportunity to review all of the documents to take your instructions in respect of the next stage of the hearing furthermore she stated that she would require an opportunity to consider the transcript from the last hearing, which she had not yet received in order to complete her written submissions. The panel were advised by the NMC that the missing transcripts would not be available until 11am on 27 June 2023. The panel noted that Ms Monaghan was of the view that she was not satisfied that she would be able to adequately or appropriately represent you should the hearing continue without her being given sufficient time to review the further documentation, take instructions and collate your impairment bundle.

In light of all this information, the panel determined that in the interest of fairness to you there was insufficient time remaining in this listing to allow Ms Monaghan to review the outstanding documents. In addition, Ms Monaghan would need time to take instructions and also time would need to be allowed for the panel to hear submissions from both parties, take legal advice and to make its decision on competence, misconduct and impairment.

It determined to grant this application to relist this hearing for a date in the future.

The panel requested that Ms Monaghan liaises with the RCN to confirm to the NMC whether there is any outstanding documentation which it does not have available to it at least 14 days before the hearing is due to resume. It requested that a response to the NMC's written submissions on impairment and any final impairment bundle provided on your behalf should be provided at least seven days prior to the resuming hearing.

This hearing went adjourned part heard on 27 June 2023 and resumed on 26 September 2023.

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 in charges 1, 2, 3, 4, 5, 6 and 7, and/or lack of competence in charge 1. If the panel determined that your conduct did amount to misconduct or a lack of competence, it would then go on to consider whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. The panel had regard to the NMC's guidance on impairment, dated 27 March 2023, which states:

> *"The question that will help decide whether a professional's fitness to practise is impaired is: "Can the nurse, midwife or nursing associate practise kindly, safely and professionally?" If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired."*

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct in charges 1, 2, 3, 4, 5, 6 and 7, and/or lack of competence in charge 1. Secondly, only if the facts found proved amount to misconduct and/or a lack of competence, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and lack of competence

Ms Buckell, on behalf of the NMC, provided the panel with written submissions. The written submissions referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.' I*t also referred the panel to the judgment in the case of *Calheam v GMC* [2007] EWHC 2606, *Nandi v General Medical Council* [2004] EWHC 2317 and *R (on the application of Calhaem) v General Medical Council* [2007] EWHC 2606 (Admin).

The written submissions outlined that it was a matter for the panel as to whether the facts found proved amount to misconduct and/ or a lack of competence. The written submissions referred to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and identified the specific, relevant standards where your actions amounted to misconduct and a lack of competence.

The NMC has defined a lack of competence as:

'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'

Ms Buckell in her oral submissions stated that lack of competency, in relation to charge 1, needs to be assessed using the following process:

- Is there evidence that you were made aware of the issues around your competence?
- Is there evidence that you were given the opportunity to improve?
- Is there evidence of further assessment?

If the panel do not find a lack of competency in relation to charge 1, the panel should consider whether it is appropriate to find misconduct in respect of this charge.

Ms Monaghan provided written submissions to the panel for its consideration. In her written submissions she invited the panel to find, notwithstanding any findings of lack of competence and/or misconduct, that your fitness to practise is not currently impaired. She referred to the judgments in *R (Remedy UK Ltd) v GMC* [2010] EWHC 1245 (Admin)*, Meadow v GMC* [2007] 1 All ER 1, *Calhaem v GMC* [2007] EWHC 2606 (Admin), *Holton v GMC* [2006] EWHC 2960 (Admin) and *Zygmunt v. General Medical Council* [2008] EWHC 2643 (Admin). She referred the panel to the NMC guidance.

In relation to the question of your lack of competence, Ms Monaghan in her written submissions referred to the NMC guidance that states that a nurse, midwife or nursing associate is usually a safe and competent professional, but something may have happened that got in the way of them delivering safe care. She noted the longevity of your nursing career and that the allegations happened during a period in which you worked in an environment which was unfamiliar to you. She referred to the live evidence that the panel heard at the facts stage which suggested that you did not receive consistent support from a mentor on the ward and that this may have hindered your progress.

Submissions on impairment

Ms Buckell moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin).

Ms Buckell referred the panel to the NMC's written submissions. Within it, it is submitted that your fitness to practice is impaired as all four limbs of the test outlined in *Grant* are engaged by reason of your misconduct and impairment. The submissions stated that impairment is a forward-thinking exercise which looks at the risk that your practice will pose in the future and whether you have put the concerns right and whether there is a risk of repetition.

In Ms Monaghan's written submissions, she referred the panel to the NMC's guidance that current impairment of fitness to practise as meaning a registrant's suitability to remain on the register without restriction. She referred to the judgments in *Meadow v GMC* [2007] 1 All ER 1, *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), *Professional Standards Authority for Health and Social Care v NMC* [2017] CSIH 29 and *Nicholas-Pillai v. General Medical Council* [2009] EWHC 1048 (Admin). She referred the panel to the relevant NMC guidance. She submitted that you have made many admissions including to charges of dishonesty. She submitted the incidents related to a short period of time in an otherwise unblemished and lengthy nursing career. She referred the panel to your lengthy reflective statement, additional training, testimonials and references you have submitted. She also asked the panel to consider the context of the environment that you were working in. Her written submissions addressed the test set out in *Grant* and also addressed the public confidence concerns.

The panel accepted the advice of the legal assessor which included reference to the above judgments and NMC guidance.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct in charges 1, 2, 3, 4, 5, 6 and 7, and/or a lack of competence in charge 1, the panel had regard to the terms of the Code.

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

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

6 Always practise in line with the best available evidence

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:

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

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

To achieve this, you must:

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

23 Cooperate with all investigations and audits

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

23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel was of the view that your failings took place over a lengthy period of time and were wide ranging in nature.

The panel first considered your conduct in charge 1 and whether your failings in this charge amounted to misconduct or were a result of a lack of competence. It had regard to the NMC's submission. The panel considered that it had a fair sample of your work. Despite the support you received and your lengthy professional experience, the panel has found that your practice was deficient in a wide range of basic areas. It decided, in light of your twenty years of service as a qualified nurse, that you should have had the skills required for the basic nursing skills which underpin the failings identified. The panel concluded that, given your professional experience, the failings in your nursing practice were not as a result of a lack of competence, but instead were a serious falling short of what would have been proper and amount to misconduct.

The panel considered the failings which underpin charges 2 and 3, conduct that was closely related in nature and time. The panel decided that the conduct in these two charges was serious as it ignored the guidance on the use of PPE and infection control, and as a result you unnecessarily put at risk the health of patients and colleagues on more than one occasion, particularly during a pandemic. You repeatedly failed to follow important basic guidance on the use of PPE. The panel concluded that this conduct was serious and amounts to misconduct.

The panel considered the failings which underpin charges 4, 5 and 6. It has found that your conduct in these three charges was dishonest, as set out in charge 7. The panel was of the view that the failings in these charges, collectively and individually, are serious given that they relate to your lack of honesty, a core aspect of your professional role. The panel therefore decided that they amount to misconduct.

The panel were therefore satisfied that the totality of your failings in the charges found proved are sufficiently serious to amount to professional misconduct. The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, your fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel was satisfied that all the limbs of the test were engaged.

The panel finds that patients were put at risk of potential harm as a result of your misconduct. Your misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that despite the wide range of misconduct in this case, it is capable of being addressed.

The panel first considered that your level of insight and was of the view that it is developing. It had regard to the admissions you have made and your reflective

statement which has demonstrated some understanding of how your actions put patients at a risk of harm. It noted your reflective statement has also demonstrated some understanding of why what you did was wrong and how this impacted negatively on the reputation of the nursing profession. The panel decided that whilst you had shown some insight, you had not shown sufficient insight, and you did not appear to accept ownership for the reasons for the wide ranging failures but instead placed the reason for the failure on the demands on the ward and being very busy.

The panel noted the remorse expressed in your reflective statement for your misconduct and it was of the view that your remorse is genuinely held.

The panel went on to carefully consider the evidence before it, as to whether or not you have taken steps to strengthen your practice. It took account of the considerable relevant training you have undertaken. It also took into consideration the experience that you have gained working as a health care assistant, which was limited, as you have been unable to work as a nurse due to the interim suspension order currently imposed on your nursing practice. The panel took account of the positive references and testimonials provided on your behalf which suggest there has been no issues with your work as a health care assistant. The panel acknowledged that the responsibilities of a health care assistant are different to those expected of a nurse and that in this role you have not had the opportunity to administer medication.

The panel decided that you have not sufficiently strengthened your nursing practice in relation to the charges found proved for dishonesty, communication and medication administration. It concluded that you still have some reflection to undertake into your failings, particularly regarding your dishonesty.

In all of the circumstances, the panel is of the view that there remains a real risk of repetition of your misconduct based on your developing but insufficient insight and your lack of progress in sufficiently strengthening your practice. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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 decided that a finding of impairment on public interest grounds is required because public confidence in the profession would be undermined if a finding of impairment were not made in this case. Consequently, it finds that your fitness to practise is impaired on the grounds of public interest. In all the circumstances, the panel was not satisfied that you could kindly, safely and professionally return to unrestricted nursing practice at this time.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

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 Buckell invited the panel to impose a striking off order in light of its finding that your fitness to practise is currently impaired. She submitted that it was a matter for the panel's professional judgement. She provided submissions in relation to the mitigating and aggravating features of this case. In her submissions, she outlined the sanctions available to the panel. She also referred the panel to the judgment in the case of

Solicitors Regulation Authority v Sharma [2010] EWHC 2022 (Admin). She submitted that in the circumstances the only appropriate sanction to protect the public is a striking off order.

The panel also bore in mind Ms Monaghan's written submissions which she briefly supplemented with oral submissions. She submitted that the principle of proportionality requires that the panel's decision on sanction must be no more than is necessary. She outlined the relevant mitigating factors to the panel to consider in relation to your insight, good practice and personal mitigation. She referred the panel to the judgements in the cases of *Bijl v. General Medical Council* (Privy Council, 2 October 2001), *Parkinson v. Nursing and Midwifery Council* [2010] EWHC 1989 and relevant NMC guidance. In all the circumstances, she invited the panel to impose a conditions of practice order to address the concerns identified.

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:

- You have demonstrated insufficient insight.
- Your conduct put patients at risk of harm.
- Wide ranging areas of misconduct which include dishonesty.

The panel also took into account the following mitigating features:

- You made early admissions to the majority of the charges, including charges of dishonesty.

- You demonstrated some insight, though it is developing.
- You have expressed genuine remorse.
- You have completed considerable training.
- There was some evidence that you were not fully supported during the induction process on the ward.
- You have had a long nursing career during which there is no evidence of similar clinical failings or dishonesty.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict 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 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 considered the factors outlined in the SG. The panel decided that whilst the failings in this case were wide-ranging over a period of time, it rejected the NMC's submission that you had demonstrated deep-seated attitudinal concerns. The panel did so give your demonstration of remorse, your developing insight and the steps you have taken to strengthen your practice.

The panel was of the view that whilst there are some identifiable areas of your nursing practice which can be addressed by way of assessment and/or retraining and therefore

may appropriately be subject to conditions, such as administration of medication, infection control and handover and communication reports. The panel concluded however, that the misconduct in relation to your dishonesty could not be so addressed.

The panel therefore concluded that it could not formulate any conditions which are practical, proportionate, measurable and workable to address the concerns of dishonesty. The panel decided that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG outlines the factors where a suspension order may be appropriate. The panel considered the factors in the SG in relation to this case.

The panel noted that this was not a single incident of misconduct but was instead a single period of misconduct over a 20 year nursing career of no similar failings, which took place in a new environment, a ward setting, that you had not been exposed to previously in your nursing career.

It has concluded that you have demonstrated ‘no evidence of harmful deep-seated personality or attitudinal problems’ as previously outlined above.

The panel bore in mind that there has been ‘no evidence of repetition of behaviour since the incident’ as you have been unable to work as a nurse and there is no suggestion that there have been any concerns raised during your recent career as a healthcare assistant (although the panel bore in mind that the responsibilities between these roles are different). The panel was satisfied that you have insight.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a

suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

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

The panel was mindful that you have been subject to an interim suspension order for three years however it decided that a suspension order for a period of 12 months was appropriate and proportionate in this case to mark the seriousness of the misconduct. The panel was also of the view that this time would allow you to reflect on your dishonest misconduct and how you have addressed it.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case may be assisted by:

- Continued engagement with the NMC including your attendance at any future hearing.
- A reflective account or oral evidence which indicates you have developed your insight into how you have addressed the dishonesty charges found proved.
- Your plans in relation to your nursing career in the future.
- Any up-to-date references in relation to your current practice from your most recent employer.

This will be confirmed to you in writing.

Interim order

As the suspension 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 suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Buckell. She submitted that an interim order is necessary on the grounds of public protection and public interest to cover any potential period of appeal. She invited the panel to impose an interim suspension order for a period of 18 months.

The panel also took into account that Ms Monaghan had no observations on Ms Buckell's application.

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 an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore decided

that it was necessary to impose an interim suspension order for a period of 18 months to protect the public and cover any potential period of appeal.

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

That concludes this determination.