Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 8 January 2024 – Friday 12 January 2024
Monday 15 January 2024 – Tuesday 16 January 2024

Virtual Hearing

Name of Registrant:	**Leigh Bamber**
NMC PIN	78Y1786E
Part(s) of the register:	Registered Nurse Adult Nursing L2 – July 1980 Adult Nursing L1 – April 2005
Relevant Location:	Plymouth
Type of case:	Misconduct
Panel members:	Peter Fish (Chair, lay member) Helen Chrystal (Registrant member) Christine Moody (Lay member)
Legal Assessor:	Paul Hester
Hearings Coordinator:	Shela Begum
Nursing and Midwifery Council:	Represented by Rebecca Butler, Case Presenter
Miss Bamber:	Present and represented by Timothy Akers, (instructed by the Royal College of Nursing)
No case to answer:	1b, 1c, 1d and 4c
Facts proved by admission:	4a and 4b
Facts proved:	1a and 2
Facts not proved:	1e, 1f, 1g, 3a, 3b and 5
Fitness to practise:	Stage not reached yet

Sanction:	Stage not reached yet
Interim order:	**Interim conditions of practice order (18 months)**

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

At the outset of the hearing, Mr Akers made a request that parts of this case be held in private [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Butler did not oppose the application [PRIVATE].

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session [PRIVATE] as and when such issues are raised.

Decision and reasons on application for the panel to recuse itself

At the outset of the hearing, Mr Akers, on your behalf, made an application for the panel to recuse itself because it had been supplied with the wrong statement and exhibit bundles prior to this hearing. He submitted that these bundles which had been put before the panel in error contained highly prejudicial, unfair and irrelevant material, which would lead a fair minded and informed observer to conclude that the panel was biased.

Mr Akers informed the panel that on 21 December 2023, the NMC approved proposed redactions to the witness statements of Witness 1, Witness 2, and Witness 3 and the relevant exhibits. It was agreed that the redactions would be made to the final bundles which were anticipated to be provided in the first week of January 2024.

Mr Akers submitted that in light of this agreement regarding redactions, it appears that the wrong bundles have been served on the panel. He referred the panel to Rule 31(1) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). He reminded the panel that Rule 31(1) stipulates that the only evidence that should be admitted in these proceedings is evidence that is fair and relevant. He submitted that the evidence that the panel has seen in error is wholly unfair, irrelevant and prejudicial.

Mr Akers referred to Article 6 of the European Convention on Human Rights which is incorporated into domestic law by the Human Rights Act. Article 6 requires a tribunal to be independent and impartial. In relation to impartiality, there can be actual bias or a perception of bias.

Mr Akers referred to the case of Porter v Magill [2001] UKHL 67.

Mr Akers referred the panel to the evidence before it which should have been redacted as agreed.

In relation to the evidence of Witness 1, he stated that some of what is said by her is a ‘damning indictment of your professional ability’. He submitted that the comments made by Witness 1 do not relate to matters which would necessarily have a direct bearing on your professional conduct but that these comments are highly prejudicial, albeit they are general statements.

Mr Akers submitted that Witness 2’s evidence consisted of hearsay evidence. In addition, he informed the panel that her evidence speaks to CCTV evidence with the inclusion of her opinions on the CCTV footage. He told the panel that the CCTV footage is not something which the NMC has provided to you or to the panel. However, he submitted that the NMC intend on relying on the stills of the CCTV footage exhibited within the documentary evidence before the panel. He invited the panel to consider how it would be able to fairly rely upon evidence and hear opinion evidence on the CCTV footage when the NMC is not prepared to serve the CCTV footage in itself.

In relation to Witness 3’s statement, Mr Akers submitted that aspects of this consist of highly emotive and prejudicial language, and effectively concludes with something of a character assassination. He submitted that aspects of Witness 3’s evidence is opinion evidence.

For the reasons set out, Mr Akers submitted that the material before the panel is highly prejudicial, unfair and irrelevant. He submitted that taking into account the magnitude of the material, the only proper conclusion that can be formed is that the panel is now unable to present an appearance of independence, and that a fair minded and informed observer would consider there to be a real possibility of bias in these circumstances. He submitted that this is not necessarily about actual bias, but it is about the appearance of apparent bias.

Mr Akers submitted that the overall fairness of these proceedings and the requirement for a safe decision-making process demands that the panel recuses itself in this particular instance.

Ms Butler addressed the panel on behalf of the Nursing and Midwifery council (NMC). She submitted that the basic principle is that a court or tribunal must be impartial, and that justice should not only be done, but should manifestly and undoubtedly be seen to be done. She referred to the case of R v Sussex Justices, ex parte McCarthy ([1924] 1 KB 256, [1923] where this was first enunciated as a principle.

Ms Butler accepted that it is desperately important that justice be done and accepted that there are passages within the evidence as identified by Mr Akers which are inadmissible. She acknowledged that the evidence which should have been redacted is potentially prejudicial.

Ms Butler submitted that there had been an agreement between the NMC and between your representatives at the Royal College of Nursing (RCN) that what is considered as deeply prejudicial comments by Witnesses 1, 2 and 3 would be inadmissible and therefore should be redacted. She submitted that due to an administrative error the incorrect bundles, without the relevant redactions, have been served on the panel. However, she submitted that this is a professional panel and that the panel is capable of overcoming any bias that it may deem was evidence from the comments as set out in the witness statements and evidence.

However, Ms Butler submitted that she did not agree with Mr Akers in respect of the CCTV stills. She submitted that witnesses can be examined, and cross examined in relation to the CCTV stills and that a running footage of the CCTV is not required. She submitted that it might be desirable to have the CCTV footage.

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

The panel carefully considered the submissions from Mr Akers and from Ms Butler.

The panel noted that it is important that the public should remain confident in the administration of justice.

The panel carefully considered and applied the test in Porter. The panel firstly ascertained all the circumstances which have a bearing on the suggestion that it may be biased. The panel then asked itself whether those circumstances would lead a fair minded and informed observer to conclude that there is a real possibility that the tribunal was biased.

In order to ascertain the circumstances, the panel carefully read the passages in the various statements which Mr Akers submitted are prejudicial to the extent that the panel should recuse itself. The panel also at this stage, carefully considered the charges. The charges, save for charges 4b and 5, are all drafted in terms of alleged failures. In this regard, the panel noted that it is for the NMC to prove on the balance of probabilities that you did not do something which you should have done to a given professional standard. It is for the NMC to establish that there was, at the relevant time, a clear duty or responsibility or obligation upon you as a registered nurse to act in a given way in certain circumstances.

The panel noted that Mr Akers in making this application did not submit that there is actual bias. He submitted that this application is based upon subjective bias in that there may be a perception or appearance of bias if the panel was to hear this case having read the prejudicial material.

In considering the Porter test, the panel noted that there has to be a real possibility of bias. The phrase ‘real possibility’ sets the bar relatively high before a panel should recuse itself.

The panel carefully considered each of the redacted paragraphs separately and collectively and further considered their impact on the question of apparent bias.

It noted that one passage in Witness 2’s statement related to hearsay evidence. In this regard, the panel is a professional tribunal which is well used to receiving hearsay

evidence during the course of a hearing which it then has to disregard. The panel noted that this an isolated passage of hearsay evidence which it can readily put out of its mind.

The panel carefully read the other passages to which Mr Akers took it. It noted that these passages contain opinion evidence as to your general competence and suitability to be a registered nurse. These comments are restricted to certain isolated paragraphs within the various statements. In terms of isolation, the comments are identifiable and do not go specifically to the charges. The panel noted that the charges are very specific and narrow in that they are allegations of various failures. The panel decided that in light of the charges that it could readily put the general prejudicial comments out of its mind and focus solely upon the alleged failures and what the NMC has to prove, on the balance of probabilities, specifically.

In reaching its decision, the panel detached itself and looked in from the outside as a fair minded and informed observer. The panel decided that a fair minded and informed observer would, in the above circumstances, conclude that a professional panel could safely hear this case and that there is no appearance of bias.

CCTV footage

The panel noted that there remained at this stage, a discrete matter on the question of disclosure relating to the CCTV footage. The panel noted that this is evidence which would be relevant to the charges and considered whether it would be fair to proceed without this CCTV footage having been disclosed.

The potential CCTV footage disclosure arose on the basis that Witness 2's evidence refers to stills of the CCTV footages and the NMC seeks to rely on these stills. Mr Akers informed the panel that the RCN were of the understanding that these passages of Witness 2's evidence were to be redacted but in the event that they are not agreed to be redacted, the CCTV footage should be disclosed.

Ms Butler submitted that it would be disproportionate to obtain the CCTV footage because it is sufficient to rely upon the stills as they are exhibited. She stated that the stills provide timestamps, and it would be possible to proceed on the basis that the witnesses could provide explanations on the stills of the CCTV.

After seeking instructions, Mr Akers informed the panel that there is no further objection to the passages of Witness 2's statement which refer to CCTV stills being admitted into the evidence. He therefore indicated that he would not be pursuing a disclosure request for the CCTV footage and was content to proceed with evidence as currently presented to the panel.

Details of charge

That you, a registered nurse:

1. During a shift between 8 to 9 February 2021, between approximately 12.45am to 05.20am you failed to:
    a. Assist colleagues with the tracheotomy round at approximately 02.00am;
    b. Check Patient B's blood sugar readings/levels;
    c. Check Patient C's saturation levels;
    d. Carry out tracheotomy care to Patient D;
    e. Assist colleagues with any nursing duties in addition, otherwise than in charge 1a – 1d above;
    f. Provide any patient care, with the exception of administering medication to 3 residents;
    g. Ensure that you were in good health to provide appropriate patient care and/or assistance to colleague/s.

2. During a shift between 8 to 9 February 2021 you failed to make arrangements for someone to cover your shift.

3. Before finishing a shift between 8 to 9 February 2021, between approximately 05.20am and 06.40am, you failed to enquire with colleagues:
    a. Whether they required assistance;
    b. the health of patients that colleagues had cared for.

4. On 10 February 2021:
    a. Failed to administer medication to Patient A during the morning medication round;
    b. Signed the MAR chart for Patient A to indicate that medication had been administered when it had not;

c. Failed to give Patient A tracheotomy care when it was due on or around 6 o'clock in the morning.

5. Your action at charge 4b above was dishonest in that you intended others to believe that medication had been administered to Patient A when it had not.

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

Witness 3

Ms Butler informed the panel that the NMC no longer intends on relying on the written statement of Witness 3 and therefore invited the panel to disregard this statement.

Witnesses 4 and 5

Ms Butler informed the panel that the written statements of Witness 4 and Witness 5 have been agreed by the parties and invited the panel to accept these statements as evidence.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Akers that there is no case to answer in respect of charges 1b, 1c, 1d, 1f and 4c. This application was made under Rule 24(7). Mr Akers provided written submissions in which he stated:

> *1. "This is an application to dismiss pursuant to Rule 24(7) of the Nursing and Midwifery Council (Fitness to Practise) Rules 20014 ("the Fitness to Practise Rules").*
> *2. It is submitted that insufficient evidence has been presented to find the facts proved and that the Registrant has no case to answer in respect of the following allegations:*
>
> *1. During a shift between 8 to 9 February 2021, between approximately 12.45am to 05.20am you failed to:*
>
> > *b. Check Patient B's blood sugar readings/levels; it is submitted that the NMC has been unable to establish the identity of Patient B to the requisite standard and / or that no / insufficient evidence has been adduced on Patient B's blood sugar readings/levels in order to find the facts proven in relation to it;*
> >
> > *c. Check Patient C's saturation levels; it is submitted that the NMC has been unable to establish the identity of Patient C to the requisite standard and / or that no / insufficient evidence has been adduced on Patient C's saturation levels in order to find the facts proven in relation to it;*
> >
> > *d. Carry out tracheotomy care to Patient D; it is agreed that Patient D does not have a tracheotomy and it is submitted that this Charge therefore must fall away.*

f. Provide any patient care, with the exception of administering medication to 3 residents; [Witness 1] accepted in her evidence that Ms Bamber undertook the first tracheotomy care round on the night shift of 8-9 February 2021, and the "detailed daily care plan documentation for Patient A" exhibited by [Witness 5] as exhibit [Witness 5/05 establishes that Ms Bamber provided care to Patient A as follows (at page 111 of the NMC "final" exhibits bundle):

4. On 10 February 2021:

c. Failed to give Patient A tracheotomy care when it was due on or around 6 o'clock in the morning. The "detailed daily care plan documentation for Patient A" exhibited by [Witness 5] as exhibit [Witness 5]/05 establishes that Ms Bamber provided care to Patient A when it was due as follows (at page 109 of the NMC "final" exhibits bundle):

Conclusion

3. In accordance with Rule 24(7) of the Fitness to Practise Rules, it is submitted that insufficient evidence has been presented to find the facts proved in respect of Allegations 1.b, 1.c, 1.d, 1.f and 4.c; it follows that they should proceed no further."

Ms Butler submitted that she had no submissions in respect of charges 1b, 1c, 1f, and 4c and that in relation to charge 1d, she was professionally required to indicate that she had no submissions to make.

The panel took into account the submissions made by both parties and accepted the advice of the legal assessor.

The panel noted that the test governing submissions of no case to answer is the criminal authority of R v Galbraith (1981) 73Cr App R124. The panel noted both limbs within that

test in relation to whether there is any evidence and when there is some evidence whether it is of a tenuous character because of inherent weakness or vagueness or because it is inconsistent with other evidence. The Galbraith test can be properly redacted for regulatory proceedings by the panel asking itself the question ‘is there any evidence upon which a properly directed panel could find the alleged facts proved in relation to each separate charge?’.

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 in respect of charges 1b, 1c, 1d and 4c.

In respect of charges 1b and 1c, the panel noted that the evidence in support of this charge is that of Witness 1’s evidence and it noted that in her written statement she stated: *“I had to do all the tracheostomy round at 2am, whilst keeping a check on Patient B blood sugar readings and Patient C saturation levels as these levels effect the amount of oxygen that Patient C should be receiving.”*

The panel considered that charges 1b and 1c allege a failure by you to check Patient B’s blood sugar levels and check Patient C’s saturation levels. The panel determined that there is no evidence before it, under the first limb of Galbraith, which establishes whether there was a duty, responsibility or obligation on you to conduct these assessments on either patient. Further, the panel noted that there is no evidence before it which identifies who Patients B or C were, nor did it have sight of their care plans to be able to determine whether or not blood sugar levels or saturation levels had to be and were checked.

The panel therefore determined that in respect of charges 1b and 1c, there was no prospect that it would find these charges proved. It therefore determined that there is no case to answer for charges 1b and 1c.

In respect of charge 1d, the panel noted that this charge alleges a failure by you to carry out tracheotomy care to Patient D. The panel heard that evidence had been agreed by the NMC and you that Patient D did not have a tracheotomy and therefore would not have required tracheotomy care. It determined that there is no evidence before it in support of this charge and there was not a realistic prospect that this charge could be found proved. It therefore decided that there is no case to answer in respect of charge 1d under the first limb of Galbraith.

In respect of charge 4c, the panel noted that this charge alleges a failure by you to give Patient A tracheotomy care when it was due around 6am. The panel had regard to Patient A's Detailed Care Plan Notes which reflected that you provided tracheotomy care to Patient A prior to 6am. The panel also heard evidence from Witness 2 who, during cross-examination, accepted that Patient A did receive tracheotomy care. The panel had regard to the tracheotomy care plan which did not indicate at what times the tracheotomy care should be given. The panel was not satisfied that the NMC has provided sufficient evidence which clearly establishes a duty on you to have provided tracheotomy care specifically at or around 6am. 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 4c proved. It therefore determined that there is not a case to answer in respect of this charge.

In respect of charge 1f, the panel noted that the stem of the charge refers to the period between 12:45am – 05:20am. In evidence, Witness 1 accepted that you had completed tracheostomy care between 10-11pm. The detailed care plan notes in relation to Patient A indicated that you had provided care to Patient A at around 10pm and again at 6pm however, it noted that although there were multiple entries in relation to other members of staff in the care plan notes, it had no evidence that you had provided care between these times. In addition, there was some evidence, both in oral evidence of Witness 1 and in the Job Description document that as the registered nurse in charge, you had overall responsibility for care during the shift. In these circumstances, the panel was of the view

that, taking account of the specific times as set out in this charge, it could not be satisfied that there was no evidence or insufficient evidence in support of this limb of the charge.

Background

The charges arose whilst you were employed as a registered nurse by Meadowside and St Francis Nursing Home (the Home).

It is alleged that during a night shift between 8 and 9 February 2021, you failed to assist colleagues with nursing duties including providing assistance with the tracheotomy round and providing patient care.

During this shift you experienced progressive symptoms [PRIVATE], and it is alleged that you failed to ensure that you were in good health to fulfil your nursing duties as the sole nurse in charge of the shift. It is alleged that as a result [PRIVATE], you failed to make arrangements to cover your shift by an alternative staff member. It is further alleged that you failed to enquire with colleagues whether they required assistance and about the health of the patients.

It is also alleged that during a night shift on 10 February 2021, you failed to administer to Patient A the morning medication but signed the MAR chart for as having administered the medication and, further, did so dishonestly.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Akers, who informed the panel that you made admissions to charges 4a and 4b. You confirmed that you admit to these charges.

The panel therefore finds charges 4a and 4b proved, by way of your admissions.

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

- Witness 1: Healthcare Assistant, Meadowside and St Francis Nursing Home (at the time of the incidents)

- Witness 2: Clinical Manager, Meadowside and St Francis Nursing Home (at the time of the incidents)

The panel noted and accepted the witness statements of Witnesses 4 and 5 which were agreed as between the NMC and you.

The panel heard evidence from you under affirmation.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and by you and the submissions made by both parties.

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 then considered each of the disputed charges separately and made the following findings of fact.

Charge 1

1. During a shift between 8 to 9 February 2021, between approximately 12.45am to 05.20am you failed to:
    a. Assist colleagues with the tracheotomy round at approximately 02.00am;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and your evidence as well as the documentary evidence before it.

The panel considered whether there was a duty, responsibility, or obligation on you to assist colleagues with the tracheotomy round. It had regard to the Job Description for the Registered General Nurse which set out that your responsibilities were as follows:

> "**ROLE:** *To plan, implement and supervise nursing care in designated area of responsibility. To be physically involved in the nursing care of the residents and to meet all service users individual needs, either personally or through delegation. […]*
>
> ***Duties***
>
> 1. *[…]*
> 2. *[…]*
> 3. *[…]*
> 4. *To lead and supervise a team of care assistants in carrying out their key worker roles."*

The panel was satisfied that the evidence before it established that there was a duty on you as the sole nurse in charge of the shift to have overall responsibility and that this included the requirement to assist colleagues with the tracheotomy round. Further, the panel noted that you accepted during your oral evidence that you were responsible, in collaboration with another colleague, to provide assistance for the tracheotomy round at approximately 02:00am.

The panel heard during evidence that Witness 1 was capable of providing tracheotomy care and that during this shift it was agreed that you and Witness 1 would equally divide the patients which required tracheotomy care. Witness 1 informed the panel that you did not assist in providing tracheotomy round at approximately 02:00am.

The panel heard from you that you were not feeling well during this shift due to progressive symptoms of a urinary tract infection (UTI). During your evidence you accepted that you failed to assist colleagues in providing tracheotomy care during the tracheotomy round at approximately 02:00am.

On the balance of probabilities, the panel therefore finds this charge proved.

Charge 1e and 1f

1. During a shift between 8 to 9 February 2021, between approximately 12.45am to 05.20am you failed to:
    e. Assist colleagues with any nursing duties in addition, otherwise than in charge 1a – 1d above;
    f. Provide any patient care, with the exception of administering medication to 3 residents;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it which included your evidence and the documentary evidence. Whilst these are two separate sub-charges, the panel considered them together as the evidence which covered these sub-charges was largely the same.

The panel noted that charge 1e and 1f in and of themselves are somewhat conflicting. Charge 1e alleges that you failed to assist colleagues with any nursing duties. Charge 1f alleges that you failed to provide any patient care, with the exception of administering medication to 3 residents, thereby contradicting charge 1e.

The panel considered the evidence before it in support of these charges.

The panel noted that it did not hear specific evidence from the healthcare assistants on duty during that shift which specifically alleged that you did not provide any assistance or provide any patient care during these times. The panel did not have sight of the tracheotomy care records for any patients nor any care plan records other than for Patient A.

The panel heard from you during your evidence [PRIVATE], you stated that you were able to leave the room on more than one occasion, speak to some of the healthcare assistants and check on some patients and sit them up where appropriate.

The panel noted that the evidence you provided varied as to what your capabilities were during this shift [PRIVATE]. However, the panel was not satisfied that the NMC has discharged its burden of proof in respect of these charges.

The panel therefore could not conclude that, on the balance of probabilities, it was more likely than not, you failed to assist colleagues with any duties or failed to provide any patient care between 12:45am and 05:20am. It therefore finds these charges not proved.

Charge 1g

1. During a shift between 8 to 9 February 2021, between approximately 12.45am to 05.20am you failed to:
    g. Ensure that you were in good health to provide appropriate patient care and/or assistance to colleague/s.

This charge is found NOT proved.

In reaching this decision, the panel took into account, Witness 1’s evidence, your evidence and the documentary evidence

The panel heard from you that you had worked two consecutive night shifts at the Home whilst you were on annual leave from your substantive employer. You told the panel that you were not used to working consecutive night shifts.

It also heard that when commencing your shift, you were not experiencing the symptoms [PRIVATE], and this was consistent with the evidence it has heard from Witness 1. It is also consistent with the contemporaneous email sent by Witness 1 dated 12 February 2021. In this email Witness 1 described you as ‘happy and joking throughout the handover and for the following few hours’.

The panel heard from you in evidence that at the beginning of the shift you were sufficiently healthy and were able to carry out your duties as required for this period. It noted that the progressive symptoms [PRIVATE] appeared once you had already commenced your shift, [PRIVATE]. [PRIVATE].

The panel concluded that you were in sufficiently good health at the start of your shift and the symptoms [PRIVATE] appeared when you were in the midst of your shift and therefore these were matters beyond your control. The panel was not satisfied, on the balance of probabilities, that it could conclude that there was a failure by you to ensure that you were in good health to provide appropriate patient care and/or assistance to colleagues. It therefore finds this charge not proved.

Charge 2

2. During a shift between 8 to 9 February 2021 you failed to make arrangements for someone to cover your shift.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence, the evidence of Witnesses 1 and 2 and your evidence.

The panel had regard to the Home's Job Description of a Registered General Nurse which sets out that your duties included:

> *"8. To ensure coverage of the Care Centre at all times, making the best possible use of staff resources"*

The panel also had regard to the Home's Sickness and Absence policy which sets out:

> *"If a member of staff is away from work due to sickness or an accident or believe they may be suffering from an infectious or contagious disease or illness they must conform to the following procedure:*
> *Staff must telephone their manager at the earliest opportunity and no later than 3 hours before their shift starts on the first day of absence, giving the reason for the absence and the date that they expect to return to work. Staff are expected to telephone personally and not to pass a message through a third party. However, if a member of staff is unable to telephone personally due to the circumstances of their illness (i.e. loss of voice), they may ask a relative or friend to telephone for them. Text or email is not acceptable."*

The panel was satisfied that the evidence, as set out above, established that there was a duty on you to make arrangements for someone to cover your shift in that you would have been responsible for contacting your manager and informing them that you were not fit for duty.

The panel heard during your evidence that despite experiencing the symptoms [PRIVATE], you were not completely unable to perform tasks in that you were able to walk around from room to room and sit residents up. The panel therefore concluded that based on this, you would have been capable of contacting the relevant member of staff to inform them that you were not feeling well.

The panel noted that Witness 1 made one call possibly two telephone calls to Witness 2. Witness 2 did not answer these calls. You were made aware by Witness 1 that the call or calls to Witness 2 were unsuccessful. In these circumstances, and in relation to the duty imposed on you within your contract of employment, the panel decided that there were insufficient attempts to find someone to cover your shift. Further, the panel noted that you could have contacted other senior members of management who could have arranged suitable cover so that you could go off sick. The duty was upon you to make arrangements as the sole registered nurse on duty for someone to cover your shift and thereby safely staff the nursing home.

The panel concluded that, based on the evidence before it, it is more likely than not, that you failed to make arrangements for someone to cover your shift. It therefore finds this charge proved.

Charge 3a and 3b

3. Before finishing a shift between 8 to 9 February 2021, between approximately 05.20am and 06.40am, you failed to enquire with colleagues:
    a. Whether they required assistance;
    b. the health of patients that colleagues had cared for.

This charge is found NOT proved.

In reaching this decision, the panel took into account your evidence and Witness 1's evidence. The panel considered these two sub-charges together as the evidence was coterminous.

The panel heard from you that you did liaise with Witness 1 during the shift between 05:20am and 06:40am. The panel also heard from Witness 1 who corroborated this during her live evidence and further that in her written statement, Witness 1 stated:

"Leigh came on to middle floor at 05-20am, she said she felt slightly better, but was only going to do the bare minimum. She gave medications to three residents [...] Leigh came to see how I was getting on at 06-40 am"[sic]

The panel was not satisfied that the NMC has discharged its burden of proof in respect of these charges in that there is clear evidence before it that there was some interaction between you and Witness 1. Further, the panel heard during evidence that during the interaction you had discussed the care of residents in the Home.

The panel therefore could not conclude that, on the balance of probabilities, it is more likely than not that you failed to enquire with colleagues whether they required assistance or about the health of patients that colleagues had cared for. It therefore finds these charges not proved.

Charge 5

5. Your action at charge 4b above was dishonest in that you intended others to believe that medication had been administered to Patient A when it had not.

This charge is found NOT proved.

In reaching this decision, the panel carefully took into account the evidence before it.

In its consideration of this charge, the panel applied the test for dishonesty in Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67 which is as follows:

"[74]. When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is

genuinely held. When once his actual state of mind as to knowledge or belief as to the facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate what he has done is, by those standards, dishonest."

The panel also had regard to the authority of Lavis v Nursing and Midwifery Council, 2014 WL 6826679 (2014). It noted that when considering an allegation of dishonesty, a panel must not just consider dishonesty but whether there is any other possible explanation for the conduct in question. The panel further noted that it should explicitly consider other possible explanations which may include acting in an unthinking way; acting out of habit; acting in a slapdash way; acting while distracted; acting carelessly; acting without proper attention; and acting outside of normal practice. In this regard, the panel gave careful regard to your evidence.

The panel further had regard to the authority of Lawrance v General Medical Council [2015] EWHC 586. The panel noted from this authority that it should only find dishonesty established if it is satisfied that there is cogent evidence of dishonesty. The civil standard applies but where dishonesty or a particular serious offence is alleged the panel must be aware of the need for such cogent evidence.

The panel firstly considered the first limb of the test for dishonesty in Ivey.

The panel noted that you have admitted charge 4b in that you signed the MAR chart for Patient A to indicate that medication had been administered when it had not. The panel therefore carefully examined the evidence as to your actual state of knowledge at the time. The panel noted that there is photographic evidence which shows six medication pots, which appeared to have medication in them. This indicates that you were in the process of administering medication. Your evidence was that you were interrupted during this process by an emergency call to another patient who required tracheotomy care. In these circumstances, the panel decided on the balance of probabilities that having signed the

MAR chart you had been subsequently distracted and called away before being able to administer the medication as intended by you. The panel could find no positive evidence that you intended not to administer the medication having signed the MAR chart. The panel noted that in signing the MAR chart it appears that you may well have done so carelessly and without proper attention to approved practice when administering medication and completing the necessary records.

Having decided your actual state of mind, the panel went on to determine whether your conduct was honest or dishonest by applying the standards of ordinary decent people. Given the panels decision on the first limb of Ivey as to your actual state of knowledge as to the facts the panel determined that your action was not dishonest by the standards of ordinary decent people. It therefore finds 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 and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Misconduct

The panel heard submissions on misconduct and, upon invitation from the parties, determined whether misconduct was established or not discreetly from the question of impairment. The panel handed its decision down on misconduct before hearing submissions on impairment.

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 Butler provided written submissions in respect of misconduct which stated:

"Pursuant to Article 22(1)(a) Nursing and Midwifery Order 2001 it is the role of this committee to decide whether the Registrant Nurse's fitness to practise[1] is impaired.

The question for the committee to ask itself is "Can the nurse, midwife or nursing associate practise kindly, safely and professionally?" It is the NMC position that the registrant's fitness to practise is currently impaired by virtue of misconduct and she is not able to practise kindly, safely and professionally based on the following factors:

Charges established as proven after the fact or by admission:

1. During a shift between 8 - February 2021, between approximately11-45 pm to 0520 am you failed to:

a) Assist colleagues with the tracheotomy round at approximately 2 am. ***(Admission)***

2. During a shift between 8 to 9 February 2021 you failed to make arrangements for someone to cover your shift. ***(Proven)***

4. On 10 February 2021:

a) Failed to administer medication to Patient A during the morning medication round: ***(Admission)***

b) Signed the MAR chart fro[sic] Patient A to indicate that medication had been administered when it had not. ***(Admission)***

The determination of the panel reflects the past poor clinical actions of the Registrant that put resident A and potentially the other residents at unwarranted risk of harm and thereby amount to Misconduct.

1. The Nature of the concern

Misconduct

Misconduct can be described as "a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious".[3]
There are no closed categories and the appropriate standard is a matter for the Committee to decide. It is not restricted to conduct which is morally blameworthy. It could, as I have indicated, include seriously negligent treatment or failure to provide treatment measured by objective professional standards.[4]

The standards by which this registrant may be judged objectively in determining whether her actions amount to misconduct are contained within the NMC Code of Conduct.[5]
Prioritise people
1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.2 *make sure you deliver the fundamentals of care effectively*

It is established that the registrant did not deliver the fundamentals of care as identified in Charge 1 a). Not assisting with the early morning tracheostomy round left the patients compromised. This procedure is potentially life-saving and is life-preserving as a routine matter.

Practise effectively
8 Work cooperatively
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*
8.3 *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
8.5 *work with colleagues to preserve the safety of those receiving care*

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

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

Preserve safety

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

To achieve this, you must:

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

Promote professionalism and trust

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.9 *maintain the level of health you need to carry out your professional role*

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

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*

- *The facts established in this case demonstrate that the registrant's colleagues were compromised during her absence from the clinical area of the Nursing Home. She had removed herself to a room on the lower floor of the nursing home. The evidence was clear that the most unwell and dependent patients with diabetes and tracheostomies were all on the middle floor.*
- *As identified in charge 2, If the registrant had made proper arrangements for the on-call registered nurse to cover her shift, rather than leaving it to the*

more junior Band 4 Nursing Assistant, the registrant has abrogated her responsibility. In so doing, collaborative working and patient safety was compromised. On this count, she did not preserve safety or promote professionalism as required by the code. The registrant knew she was sufficiently unwell and her infection was developing when she described rigors during the evidence. By offering this evidence, she explicitly acknowledged how unwell she actually was on the night of 8th February 2021.

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:

10.1 *complete all 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*

- *The registrant admitted the medication charges at 4. Clearly the records were inaccurate and therefore misleading to the nurses taking over on the day shift. It also resulted in Patient A not receiving essential medications.*
- *By not answering phone calls from the Nursing Home manager, the answer to the questions raised by the HCA finding the un-administered medications could not be answered.*
- *This is a failure to preserve safety, to communicate effectively for the benefit of her patients and to provide leadership.*

It is submitted by the NMC that judged by the objective standards as set out in the Code of Conduct (above) the registrant's actions amount to Misconduct."

Mr Akers addressed the panel on your behalf. He referred the panel to the case of Roylance and to the case of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Mr Akers identified that the case of Roylance sets out that the professional misconduct must be serious in order for misconduct to be established. He identified that as set out in the case of Nandi, Mr Justice Collins states that serious misconduct has been referred to in other contexts as conduct which would be regarded as deplorable by fellow practitioners and whether it can properly be regarded as serious professional misconduct must depend on the circumstances.

Mr Akers submitted that, taking only the charges found proved, misconduct could not be established to the requisite standards as set out in the cases of Roylance and Nandi.

Mr Akers submitted that, in respect of charge 1a, at the relevant time, you were incapacitated. He submitted that Witness 1 was effectively able to cover the tracheotomy round and ‘no harm whatsoever resulted to the patients’. He submitted that by not assisting in undertaking the tracheotomy round, you took a period of rest which enabled you to be fit enough to assist with the next tracheotomy round at 06:00am. He therefore submitted that the risk of harm was reduced as much as possible in the circumstances, albeit subject to the charges that have been found proven. He submitted that there had been situations in the past where you were required to undertake the tracheotomy round alone on occasions, in effect taking care of six tracheotomy patients without any assistance for multiple rounds.

Mr Akers submitted that, in respect of charge 2, you were perhaps ‘stuck between something of a rock and a hard place’ as the shift progressed, and you became more unwell. He informed the panel that you accept its findings in relation to this charge. However, he submitted that you did ensure that the home complied with its regulatory obligations by remaining at the Home when the only other registered nurse who could have attended realistically would have been Witness 2.

Mr Akers addressed charges 4a and 4b. he submitted that these relate to the same incident and perhaps go hand in hand. He informed the panel that you did perform tracheotomy care for this particular patient but failed to administer their medication. He reminded the panel that it has not found a positive finding in respect of the dishonesty which was alleged relating to this incident. He submitted that you bore no ill will towards Patient A, and accordingly there was no evidence of dishonesty. He submitted that the circumstances which led to these charges were that you had undertaken two night-shifts, which was unusual for you in any case, and that these were taken in excess of your normal contracted working hours of 12 hours per week. He further informed the panel that it was not your preference to undertake those two shifts and that there was an agreement that if somebody else became available, you would stand down and allow somebody else to carry out those shifts as at the time [PRIVATE].

Mr Akers referred the panel to the evidence of Witness 4 which addresses that whilst the medication had not been administered to Patient A, there were no apparent adverse effects or harm resulting due to the failure to administer the medication to Patient A.

In conclusion, Mr Akers submitted that in respect of the specific charges that have been found proven and admitted by you in this case, in all of the circumstances, the panel may take the view that when one takes into account all of the factors, including your good intentions, your conduct would not be regarded as deplorable by fellow practitioners.

Decision and reasons on misconduct

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

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of ‘The NMC code of professional conduct: standards for conduct, performance and ethics (2015)’ (the Code) in making its decision.

The panel was of the view that as a result of the charges found proved, the following parts of the Code were breached;

'1 Treat people as individuals and uphold their dignity
1.2 *make sure you deliver the fundamentals of care effectively*

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.*
10.1 *complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
10.2 *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
10.3 *complete records accurately […], taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

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*

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
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'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the charges individually and made the following findings.

In respect of charge 1a, the panel noted that your actions demonstrated a deviation from best practice. However, it considered the circumstances which were present at the time. The panel noted that you were not feeling well and that you agreed with Witness 1, who as a band 4 was trained in the relevant area, that she was to perform the tracheotomy care to the six patients. Whilst the panel decided that there was a breach of the Code, it was not satisfied that your actions as set out in this charge were sufficiently serious to amount to misconduct.

In relation to charge 2, the panel noted that you were the sole nurse in charge of the relevant shift. It noted that under the terms of your contract it was your responsibility '*to ensure coverage of the care centre at all times, making the best possible use of staff resources'*. It further noted that under paragraph 25 of the Code, you have an obligation to *'provide leadership to make sure people's well being is protected and to improve their experiences of the healthcare system'*. This includes in particular at paragraph 25.1 the obligation to '*identify priorities, manage time, staff and resources effectively and deal with risk […]'*.

Whilst the panel acknowledged your evidence that you were unwell owing to the onset of a UTI, the panel did note your evidence that this was a condition which you were familiar with and that you were not so unwell as to being unable to perform some duties. You told the panel during your evidence that you were able on more than one occasion to walk around the floor to check on patients and on occasion sit them up. The panel noted that it was incumbent upon you as the sole registered nurse on duty and in accordance with your job description to ensure that if you were unable to perform your duties that you find suitable cover. Having carefully considered the evidence, the panel decided that you were able to take steps so that the cover could be put in place. The panel noted the patients

who were under your care. These patients were extremely vulnerable in that they may have needed care at any stage during your shift putting them at an unwarranted risk of serious harm. Whilst you spoke to Witness 1, to find cover the panel determined that in the above circumstances it was your duty to find cover. The panel decided that whilst you took some steps, those steps were not sufficient and in all the circumstances this amounts to misconduct.

The panel considered charges 4a and 4b individually but noted that these charges relate to the same incident. In respect of charge 4a, the panel determined that, whilst a failure to administer medication is serious in that it directly impacts on patient care, it took the view that a single instance of a failure to medication was not sufficient, on its own, to amount to misconduct. However, the panel determined that charge 4a was compounded by charge 4b. In respect of charge 4b, the panel determined that signing a patient record to indicate that medication had been administered when it had not is sufficiently serious to amount to misconduct. The panel determined that this directly impacts on patient care and gives rise to a serious risk to the patient. The panel found that keeping accurate records is a fundamental aspect of nursing care and your actions as set out in charge 4 demonstrated a serious departure from what would be proper in the circumstances. The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Impairment

After handing down its decision in relation to misconduct, the panel began hearing submissions on impairment.

During the course of the NMC's submissions on impairment, Ms Butler informed the panel that there had been a separate referral linked to your registration which the case examiners (CE) recommended undertakings. She referred the panel to the CE's letter which set out the regulatory concerns which were pursued by the NMC for that referral which were as follows:

"1. Lack of competence – failure to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a band 5 nurse in that you exhibited the following:

- *failure to delegate effectively*
- *failure to follow reasonable management instructions*
- *failure to provide leadership and support*
- *failure to provide safe and effective handovers*
- *failure to prioritise workload and complete tasks*
- *failures in relation to organisation and time management*
- *failure to ensure safe and effective communication with others*
- *failure to promptly catheterise a patient putting them at risk of harm"*

These regulatory concerns related to incidents which are said to have taken place between July 2020 and May 2022. The letter from the case examiners in respect of that case highlighted, by way of context, that you suffer from some [PRIVATE] issues and that the case examiners had regard to evidence [PRIVATE].

[PRIVATE]. However, Mr Akers stressed that the [PRIVATE] report dated June 2021 indicated that you felt you were able to complete your work duties as long as certain adjustments were put in place in order [PRIVATE]. He informed the panel that these adjustments included regular breaks and staying hydrated. [PRIVATE].

Submissions in relation to impact of the new information [PRIVATE]

Ms Butler submitted that, after taking instructions from the NMC [PRIVATE], the issues [PRIVATE] do relate to current impairment and the panel cannot now disregard this information having been apprised of it. In taking instructions from the NMC Ms Butler provided documentation to the panel concerning [PRIVATE] the time of the first referral.

Ms Butler referred the panel to the letter [PRIVATE] dated November 2022 in which the concluding paragraph stated:

“[PRIVATE].”

Ms Butler submitted that [PRIVATE] has been unable to comment on whether [PRIVATE] have or may have the potential to impact on your fitness to practise. She further submitted that at this stage of the hearing, the panel must apply the objective of protecting the public and with the information that is now before the panel, she suggested that there are two ways in which the panel could proceed.

Ms Butler submitted that the panel could, under Rule 32 of the Rules, of its own volition adjourn these proceedings to order a further expert report on this matter. She submitted that alternatively, the panel could go on to consider current impairment but that it would have to be very clear in its reasons why it considered that [PRIVATE] did not have any impact on impairment in these proceedings.

Ms Butler submitted that the introduction of these [PRIVATE] matters into this hearing arose in light of the earlier referral which has been disposed of by the CEs. She submitted that this was a closed case and therefore it would not be fair to suggest the NMC should have been aware of those matters in respect of this case. She submitted that given that the panel has knowledge of these matters now, it would be wrong not to consider this when determining whether current fitness to practise is impaired. [PRIVATE]. She submitted that this is a matter which relates directly to patient safety which is what the panel is firmly seized of today.

Ms Butler submitted that the matters raised cannot be used as mitigation without the panel having regard to further evidence in relation to it as this relates directly to a matter of public safety. She submitted that a nurse suffering from [PRIVATE] cannot be providing care in circumstances when she is the sole nurse in charge of any shift at a nursing home. In response to a question from the panel, Ms Butler accepted that this is a case in which the charges relate solely to misconduct. However, she submitted that there is the presence of [PRIVATE] in this case and that such matters are relevant to the panel’s

consideration on impairment. [PRIVATE]. She submitted that the NMC's position is that the panel must consider whether [PRIVATE] affect your ability to practice safely as of today's date.

Ms Butler submitted that if the panel disregarded [PRIVATE] matters now and went on to consider impairment without further [PRIVATE] information, if something did resurface in the future, it is open for the Professional Standards Authority to determine that this is a matter which ought to have been dealt with at this hearing.

Mr Akers submitted that it is not accepted that the panel does have jurisdiction to incorporate [PRIVATE] at this late stage of the case, when, as the panel has already rightly observed, [PRIVATE]. He submitted that the NMC had already had regard to all of this information [PRIVATE] and did not incorporate these [PRIVATE] matters into the allegations you faced.

Mr Akers acknowledged that the matters [PRIVATE] might have been dealt with by the CEs. He accepted that for some reason, this information may not have been communicated by the CEs to the reviewing lawyer for this case. However, he submitted that it is not your responsibility to ensure that information is passed from one hand at the NMC to another hand.

Mr Akers referred the panel to the letter from the RCN dated 20 April 2023 which set out the context and response to the concerns of the linked case as follows:

> *"We believe it is important for the case examiners to understand the context in which these issues have been raised and provide some relevant background to the registrant's time with Livewell and Mount Gould. We do not provide this information to avoid legitimate criticism or concern but rather to provide context and understanding as to why a nurse without previous concern in her lengthy career has found herself in this position.*

Firstly, the registrant suffers form [PRIVATE] matters which do impact on her daily life and additional support she may need. The registrant experienced great difficult and obstacles to even being provided with the relevant equipment to allow her to crush medication [PRIVATE].
[PRIVATE]."

Mr Akers referred to the [PRIVATE] Report which he submitted did not raise any issues of concerns based on the information gathered on 14 May 2021. [PRIVATE].

Mr Akers submitted that if the panel determines that it does have jurisdiction [PRIVATE], then it has before it all the information which it needs to decide the matter. He submitted that when it considers the material that has now been provided, it should have regard to the letter [PRIVATE] dated 22 November 2022. He submitted that this letter sets out the issues [PRIVATE]. [PRIVATE].

Mr Akers acknowledged that the letter was unable to comment to whether [PRIVATE] which may have potential to impair your ability to work as a nurse. However, he submitted that since January 2023, you have worked tirelessly to meet all of the objectives set on your personal development plan and have met them successfully. He informed the panel that you have been signed off in relation to objectives without any further issue being raised [PRIVATE] affecting your ability to practice as a nurse.

Mr Akers submitted that there has been no issues raised by your current employer and that there has been no cause to obtain any further input or report [PRIVATE].

Mr Akers submitted that the references [PRIVATE] were provided by way of explanation as a result of the introduction of the new information. Contrary to the submissions of Ms Butler, they had not been submitted by way of mitigation. [PRIVATE].

Mr Akers submitted that there is a clear view as to the issues flagged by the NMC [PRIVATE] and that it is regrettably something that has been blown up out of all proportion

and was ‘a storm in a teacup’. He submitted that the issues have properly been considered, but the panel can now safely arrive at the position to make a decision in relation to impairment.

Mr Akers submitted that Rule 32 (2) sets out that there are certain considerations that the panel should take into account when adjourning proceedings of its own motion. He submitted that the key consideration is that there should be no injustice caused to the parties. He submitted that the panel may find if it were to adjourn the hearing at this stage, there would be a gross injustice to you.

Mr Akers submitted that these two referrals have been hanging over you for two and a half years and your professional career has been hanging in the balance.

Mr Akers submitted that given the totality of the evidence that the panel is now in receipt of, the panel can properly proceed and that to adjourn the proceedings at this late stage would be manifestly unfair towards you.

Panel’s decision to adjourn the hearing

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

The panel has given careful regard to the submissions from Ms Butler and Mr Akers.

The panel noted that the matters raised in the present case [PRIVATE], were raised by way of contextual background. The panel also noted that the further [PRIVATE] issues raised have only been raised in this hearing by the introduction of the information relating to an earlier and separate referral to the NMC. It further noted that the charges brought against you by the NMC in this case relate to misconduct [PRIVATE]. [PRIVATE].

The panel considered whether it could proceed with this hearing and make a determination in relation to current impairment based on the evidence before it. The panel

has heard what appears to be detailed information relating to your [PRIVATE]. The panel carefully considered the [PRIVATE] report which was written by a registered nurse following a telephone consultation with you. The panel in its professional view considered this report to be somewhat short and cursory [PRIVATE]. [PRIVATE]. The panel noted that you gave some evidence during the facts stage [PRIVATE]. [PRIVATE]. Further, the panel has not heard evidence from you at the impairment stage as to [PRIVATE] any associated impacts on your ability to practise safely as a registered nurse.

The panel had regard to the NMC's guidance on determining impairment.

The panel considered that in determining impairment it must consider the question as set out in the guidance as follows: *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?".* The panel acknowledged that the guidance goes on to say that before the committee decides whether a professionals fitness to practise is impaired, it will have to make a decision on what facts it finds proven.

The guidance goes onto posit the question as to What factors are relevant when deciding whether a professional's fitness to practise is impaired? In relation to this, the guidance states:

> *"A decision about whether a professional's fitness to practise is impaired is always dependent on the individual circumstances surrounding each concern. The Fitness to Practise Committee will look at a range of different factors. A decision about impairment will very rarely be based on one factor alone. Rather, a holistic approach will be taken so that anything that's relevant is considered."*

The panel noted that in considering the question of impairment it must apply the Shipman test approved of in CHRE v NMC (Grant) [2011] EWHC 927 (Admin), para 76. This test is both backward and forward looking. Consequently, the panel can consider the first referral, in light of the present case and towards the future.

The guidance sets out that the panel must take into account the 'Context of the error/conduct involved in the concern'. The factors to be considered when looking at context include the personal factors relating to the professional. In relation to this, it goes on to state:

> *"These areas are important for the Fitness to Practise Committee to consider because they may have adversely affected the professional's ability to practise safely and professionally. By the time the Fitness to Practise Committee considers impairment, where these contextual factors no longer exist or they have been appropriately managed, the professional might be able to demonstrate that they are currently able to practise kindly, safely and professionally."*

The panel lastly noted in the guidance the question as to whether the factors set out in the guidance are the only factors which a panel will consider when determining impairment. The answer to this question in the guidance is as follows:

> *"No. The above list is not a list of every single factor that the Fitness to Practise Committee will consider when deciding whether a professional's fitness to practise is impaired. A Fitness to Practise Committee may consider other factors that are relevant to the case that they are deciding. Each case has its own individual facts and circumstances, which is why the above factors are a guide."*

The panel considered that the matters [PRIVATE] are important to take into account by way of context to the circumstances of this case. It was of the view that the overarching considerations of patient safety would demand that the panel have regard to sufficient evidence, [PRIVATE], including the extent to which [PRIVATE] impacts on your ability to practise safely as a registered nurse. The panel took the view that it was not in a proper position to make a determination on your current fitness to practise without this information.

In coming to a decision to adjourn the panel acknowledged that there may be some unfairness to you. The NMC in drafting and bringing these charges did not appear to have regard to the first referral or to have considered the significance [PRIVATE] in relation to the referrals severally or jointly. You have attended and participated in this hearing in the expectation that the present charges would be resolved by today. The charges have been over you for a considerable period of time causing understandable stress. [PRIVATE].

The panel balanced this unfairness to you with the overarching need to protect the patients. The panel determined that the overarching objective is paramount and that an adjournment would be the interests of justice.

In deciding whether or not to adjourn this hearing under Rule 32, the panel considered the potential injustice caused to either party. The panel noted that in this case, [PRIVATE] this hearing relates to matters which date back over 2 years. Further, it noted that the information [PRIVATE] has been raised at a late stage in this hearing by the NMC introducing the first referral. It noted that a period of adjournment would cause some unfairness to you. In the circumstances of this case, the protection of patients required an adjournment to properly explore these matters and this outweighed the unfairness to you of the further delay that an adjournment would inevitably give rise to.

Under Rule 32 of the Rules, the panel also considered the public interest in the expeditious disposal of the case. It noted that there is a public interest in considering fitness to practise expeditiously in order to protect the public and maintain confidence in the professions. However, it determined that in order to fulfil its overarching objective of protecting the public, it would require [PRIVATE] evidence in relation to the impact [PRIVATE] on your ability to practise safely as a registered nurse to be able to make a well-informed decision in relation to current impairment.

The panel decided to adjourn this hearing and make the following directions:

1. [PRIVATE].
2. This hearing to be relisted as a matter of urgency with a time estimate of 4 days.

For all the reasons above, the panel has decided to adjourn this hearing.

Interim order

As the panel is adjourning this matter after it has made its findings in relation to facts and misconduct, it invited the parties to make representations on the matter of whether an interim order is required.

Submissions on interim order

The panel took account of the submissions made by Ms Butler. She informed the panel that there is currently an interim conditions of practice order in place upon your registration. She invited the panel to continue the current interim conditions of practice and invited the panel to add a condition. The condition she proposed was to impose a condition which requires you to give your consent and that you cooperate with her NMC Case Officer in obtaining any reports that the panel seeks to order.

The panel took into account the submissions of Mr Akers. He submitted that he did not seek to strenuously object to Ms Butlers proposed addition to the current interim conditions of practice that your registration is subject to but that he did not think it was strictly necessary.

Decision and reasons on interim order

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

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 its findings in relation to misconduct but decided that the present

conditions of practice adequately protects patients and addresses the wider public interest.

The panel concluded that, at this stage, an interim suspension order would be disproportionate. It therefore determined that the suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. It considered the proposed addition by the NMC but concluded that it was not necessary given your duty to cooperate with the NMC and your participation in the proceedings so far.

The panel made the following interim conditions of practice:

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 limit your nursing practice to Livewell Southwest, Tavistock Road, Derriford Plymouth, PL6 5UF.*

2. *You must meet with your line manager, supervisor or mentor at least every four weeks to discuss your progress with regard to:*

    i. *Medicines management and administration*
    ii. *Tracheostomy care*
    iii. *Catheterisation*
    iv. *Leadership*
    v. *Record keeping*
    vi. *Communication during handover*
    vii. *Prioritisation of your workload*

3. *You must provide your NMC case officer with a report from your line manager, supervisor, or mentor addressing your progress regarding the issues set out in condition 2 prior to the next NMC review hearing.*

4. *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.*

5. *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.*

    You must immediately give a copy of these conditions to:
    c) *Livewell Southwest.*
    d) *Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.*

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

7. *You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:*
    a) *Any educational establishment.*

b) *Any other person(s) involved in your retraining and/or supervision required by these conditions*

The panel decided to impose this interim conditions of practice order for a period of 18 months.

That concludes this determination.