Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday 22 – Tuesday 23 January 2024

Virtual Meeting

Name of Registrant:	Ereck Koworera
NMC PIN	07I0510E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nurse – Level 1 (25 February 2008)
Relevant Location:	Liverpool
Type of case:	Conviction and Misconduct
Panel members:	Debbie Hill (Chair, Lay member) Lorna Taylor (Registrant member) David Newsham (Lay member)
Legal Assessor:	Richard Tyson
Hearings Coordinator:	Sophie Cubillo-Barsi
Facts proved:	Charges 1 and 2
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mr Koworera's registered email address by secure email on 13 December 2023.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, that the meeting was to be held on or after 22 January 2024 and the fact that this meeting was heard virtually.

In the light of all of the information available, the panel was satisfied that Mr Koworera has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

> That you, a registered nurse:
>
> 1) On 27 January 2023 at Liverpool Crown Court, were convicted of wilful neglect by a care worker contrary to sections 20 – 25 of the Criminal Justice and Courts Act 2015
>
> 2) Failed to notify the NMC that you had been charged and/or convicted of a criminal offence in a timely manner or at all
>
> AND in light of the above, your fitness to practise is impaired by reason of your conviction at charge 1 and by reason of your misconduct at charge 2.

Background

At the relevant time Mr Koworera was working through Allocations for Care ('the Agency') for the Hillside Nursing Centre ('the Home') as the nurse in charge of the night shift. On 7

February 2023, a member of the public made a referral to the NMC in respect of Mr Koworera. In the referral it was set out that during the referrer's father's ('Patient A') stay at the Home, Mr Koworera had failed to take appropriate action when Patient A had fallen and suffered a fractured neck of femur.

Patient A had been admitted to the Home on 8 April 2020 for respite care. On the evening of 8 April 2020, Patient A was found at approximately 8.30pm to have fallen in his room. This fall was unwitnessed. Mr Koworera was called to assess Patient A as the nurse in charge of the night shift. Mr Koworera failed to carry out a proper initial assessment of Patient A for injuries sustained, and therefore did not realise Patient A had suffered a fractured neck of femur. Mr Koworera did not call an ambulance. He also failed to carry out further appropriate checks on Patient A throughout the rest of the night of 8 April 2020 to determine if he had suffered any head injury.

On the morning of 9 April 2020, the nurse in charge of the day shift called an ambulance for Patient A after they were informed by a health care assistant from the night shift of Patient A's fall. Patient A was subsequently admitted to hospital, and unfortunately died on 11 April 2020 for unrelated reasons.

This matter was referred to the Police. After investigation, Mr Koworera was charged with wilful neglect by a care worker contrary to sections 20 – 25 of the Criminal Justice and Courts Act 2015. Mr Koworera initially pleaded not guilty to the offence. However, during his trial at Liverpool Crown Court in January 2023, Mr Koworera changed his plea to guilty on 27 January 2023. Mr Koworera was subsequently sentenced on 17 April 2023 to five months imprisonment, suspended for 12 months; and to pay a victim surcharge of £122.

Decision and reasons on facts

Charge 1 concerns Mr Koworera's conviction and, having been provided with a certified copy of the certificate of conviction, the panel finds that the facts of charge 1 are found proved in accordance with Rule 31 (2) and (3). These state:

*'**31.—** (2) Where a registrant has been convicted of a criminal offence—*

(a) a copy of the certificate of conviction, certified by a competent officer of a Court in the United Kingdom (or, in Scotland, an extract conviction) shall be conclusive proof of the conviction; and

(b) the findings of fact upon which the conviction is based shall be admissible as proof of those facts.

(3) The only evidence which may be adduced by the registrant in rebuttal of a conviction certified or extracted in accordance with paragraph (2)(a) is evidence for the purpose of proving that she is not the person referred to in the certificate or extract.'

In addition, the panel had regard to the prosecution's opening of facts and the Judge's sentencing remarks.

In reaching its decision on the remaining charge, the panel took into account all the documentary evidence in this case.

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 had regard to the written statement of the following witness on behalf of the NMC:

- Witness 1: Member of the Registration Investigation Team.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The panel then considered the remaining charge, charge 2, and made the following findings.

Charge 2

2) Failed to notify the NMC that you had been charged and/or convicted of a criminal offence in a timely manner or at all

This charge is found proved.

In reaching this decision, the panel took into account evidence of an NMC Memo Pad (the NMC's system for recording contact from registrants), communication attempts between the NMC and Mr Koworera and the witness statement of Witness 1.

The panel noted that on 2 January 2023, Mr Koworera applied for revalidation onto the NMC's register. At that time, Mr Koworera completed the online revalidation and in answer to the question as to whether he had received any police charges, cautions and/or convictions, he answered 'no'. The panel was of the view that at the time of revalidation, Mr Koworera would have been aware that he had been charged with an offence as a Crown Court trial date had been listed for 23 January 2023 and therefore he should have, or would have known, that he was required to declare this information to the NMC. Indeed 15 days later at Liverpool Crown Court , on 27 January 2023 during the course of his trial, Mr Koworera changed his plea of 'not guilty' to 'guilty' of wilful neglect by a care worker contrary to sections 20 – 25 of the Criminal Justice and Courts Act 2015.

The panel noted that Mr Koworera was sentenced on 17 April 2023 and that Mr Koworera only informed the NMC of his conviction and sentencing on 19 April 2023, at which time he stated:

'… I wish to let you know that the court has sentenced me to 5 months wholly suspended for a period of 12 months….'

In light of the information before it, the panel was satisfied on the balance of probabilities that Mr Koworera failed to notify the NMC at all that he had been charged; and that, by delaying by some three months following his conviction, he failed to inform the NMC in a timely manner of this conviction.

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 at charge 2 amount to misconduct and, if so, whether Mr Koworera's fitness to practise is currently impaired as a result of both charges 1 and 2. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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 in charge 2 amount to misconduct. Secondly, only if the facts found proved on that charge amount to misconduct, the panel must decide whether, in all the circumstances, Mr Koworera's fitness to practise is currently impaired as a result of that misconduct and the fact of his conviction.

Representations on misconduct and impairment

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

The NMC invited the panel to take the view that the facts found proved at charge 2 amount to misconduct. The NMC identified what, in the NMC's view, are specific and relevant breaches of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ("the Code") in Mr Koworera's case.

The NMC asked the panel to bear in mind its overarching objective to protect 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.

The NMC invited the panel to find Mr Koworera's fitness to practise is impaired on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved at charge 2 amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mr Koworera's 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*
>
> ***13 Recognise and work within the limits of your competence***
>
> *To achieve this, you must:*
> *13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care*

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

To achieve this, you must:
15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

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
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to

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:
23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)'

The panel were aware that breaches of the Code do not automatically result in a finding of misconduct. However, the panel noted that Mr Koworera's failures, which resulted in his conviction, were serious and placed a patient at an unwarranted risk of harm. It further noted that following his charge or conviction Mr Koworera did not inform the NMC of this information until much later. The panel had evidence before it that Mr Koworera only confirmed the details of his conviction in response to the NMC's investigation in April 2023.

The panel therefore determined that Mr Koworera's failure to inform the NMC that he had been charged and/or convicted of a criminal offence, resulted in breaches of the Code and therefore fell seriously short of the conduct and standards expected of a registered nurse. In light of this, the panel determined that charge 2 amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of his misconduct and conviction, Mr Koworera's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 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 also had regard to the NMC's guidance on convictions and cautions ('FTP-2c'), which states:

> *'If the criminal offending was directly linked to the nurse, midwife or nursing associate's professional practice, it's very likely this would be serious enough to affect their fitness to practise.'*

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 *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) …'*

The panel noted that Mr Koworera's conviction directly related to his clinical and professional practice as a registered nurse. It was of the view that his neglect of a patient

in his care, placed the patient at an unwarranted risk of harm. The panel determined that Mr Koworera's conviction and misconduct had breached the fundamental tenets of the nursing profession and subsequently brought its reputation into disrepute.

The panel did not have any evidence before it to suggest that Mr Koworera has demonstrated insight into his misconduct and/or conviction. Mr Koworera has failed to meaningfully engage with the NMC. The only communication received from Mr Koworera was made in April 2023, at which time he made attempts to go behind the facts of the conviction. The panel noted that at no point during that communication did Mr Koworera attempt to address the seriousness of his failings and/or suggest how he would act differently should a similar situation arise in the future. The panel further noted Mr Koworera's longstanding absence of any remorse and the obvious effects of his failings on Patient A's family.

The panel did not have any information before it to suggest that Mr Koworera has made attempts to remediate his failings and/or strengthen his practice. To the contrary, the panel has seen communication from Mr Koworera requesting to be removed from the NMC register.

In the complete absence of insight or remediation, the panel was of the view that Mr Koworera's actions in wilfully neglecting a vulnerable patient and his subsequent conviction and misconduct, are extremely serious and that there is a real and serious risk of repetition in his case. In light of these matters, the panel further considered that Mr Koworera was liable in the future to put patients at unwarranted risk of harm, to bring the nursing profession into disrepute and to breach fundamental tenets of the nursing profession. The panel therefore determined 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.

Given the seriousness of Mr Koworera's failings, his subsequent conviction and misconduct, the panel determined that a finding of impairment on public interest grounds is also required in order to uphold professional standards. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this regard.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Koworera off the register. The effect of this order is that the NMC register will show that Mr Koworera has been struck-off the register.

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.

Representations on sanction

The NMC invited the panel to impose a striking off order. It highlighted what, in the NMC's view, were aggravating and mitigating factors in Mr Koworera's case.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Mr Koworera's failings resulted in actual patient harm;
- Mr Koworera's conviction is serious and inextricably linked to his professional practice;
- Mr Koworera was found to be responsible for exposing a patient to neglect;
- Mr Koworera has shown no evidence of insight or remediation;
- Mr Koworera failed to inform the NMC that he had been charged and/or convicted of a criminal offence in a timely manner; and
- There has been minimal engagement by Mr Koworera with the NMC, his regulator.

The panel could not identify any mitigating circumstances in Mr Koworera's case.

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 Mr Koworera's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Koworera's misconduct was not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice on Mr Koworera's registration would be a sufficient and appropriate response. Whilst there are some aspects of Mr Koworera's case which are capable of remediation, namely in relation to his clinical practice, the panel had not received indication that Mr Koworera would be willing to engage with any conditions which may be formulated. In any event, the panel determined that the placing of conditions on Mr Koworera's registration would not adequately address the seriousness of this case and would not protect the public nor address the public interest concerns identified.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *'A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;'*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel determined that Mr Koworera's misconduct was not a single incident as the incident in April 2020 was followed by a prolonged, repeated and deliberate decision to not notify the NMC that he had been charged and/or convicted of a criminal offence. In the absence of any insight or remorse, the panel could not be satisfied that Mr Koworera does not pose a significant risk of repeating the behaviour which resulted in his conviction and misconduct.

The panel noted the serious breach of the fundamental tenets of the profession evidenced by Mr Koworera's actions and therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Mr Koworera's actions were significant departures from the standards expected of a registered nurse, bringing to light questions about his professionalism and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Koworera's' actions were serious and to allow him to continue practising would not sufficiently protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mr Koworera's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to protect the public, 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.

This will be confirmed to Mr Koworera in writing.

Interim order

As the striking-off 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 Mr Koworera's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that an interim suspension order for a period of 18 months is necessary for the protection of the public

and is otherwise in the public interest in order to cover the initial appeal period of 28 days before the sanction comes into effect.

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 imposed an interim suspension order for a period of 18 months in order to cover any potential appeal period.

If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after Mr Koworera is sent the decision of this hearing in writing.

That concludes this determination.