# Nursing and Midwifery Council

## Fitness to Practise Committee

### Substantive Hearing

**Thursday, 30 November- Friday, 8 December 2023**

**Wednesday, 3 January- Thursday, 4 January 2024**

Hybrid Hearing

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|---|---|
| **Name of Registrant:** | Milena Koleva Stancheva |
| **NMC PIN** | 16J0001C |
| **Part(s) of the register:** | Registered Nurse – Sub part 1<br>Adult Nursing (RN1) – 03 October 2016 |
| **Relevant Location:** | Hampshire |
| **Type of case:** | Misconduct |
| **Panel members:** | Patricia Richardson (Chair, Lay Member)<br>Philip Sayce (Registrant Member)<br>Paul Leighton (Lay Member) |
| **Legal Assessor:** | Nigel Mitchell |
| **Hearings Coordinator:** | Angela Nkansa-Dwamena |
| **Nursing and Midwifery Council:** | Represented by Shoba Aziz, Case Presenter |
| **Mrs Stancheva:** | Not present and not represented |
| **Facts proved:** | Charges 1a, 1b, 1e, 2ai, 2aii, 2aiii, 2aiv, 3, 4, 5, 6. |

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|---|---|
| **Facts not proved:** | Charges 1c, 1d and 2b. |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Striking-off order** |
| **Interim order:** | **Interim suspension order (18 months)** |

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Mrs Stancheva was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 17 October 2023.

Ms Aziz, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and venue of the hearing and, amongst other things, information about Mrs Stancheva's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In light of all of the information available, the panel was satisfied that Mrs Stancheva has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

**Decision and reasons on proceeding in the absence of Mrs Stancheva**

The panel next considered whether it should proceed in the absence of Mrs Stancheva. It had regard to Rule 21 and heard the submissions of Ms Aziz who invited the panel to continue in the absence of Mrs Stancheva.

Ms Aziz referred the panel to an email from Mrs Stancheva to the NMC, dated 7 December 2022. In the email, Mrs Stancheva stated that she would no longer be returning to the nursing profession and would cease to engage further with the NMC. Ms Aziz submitted that Mrs Stancheva has been sent the Notice of Hearing letter and has been provided with all the information regarding these proceedings. She submitted that the NMC is ready to proceed with this case and has scheduled

witnesses, and although Mrs Stancheva has a right to attend and be represented, she has not taken the opportunity to attend.

Ms Aziz submitted that Mrs Stancheva has not made an application to adjourn this hearing and there was no reason to believe that an adjournment would secure her attendance on some future occasion. She further submitted that there is a public interest in the expeditious disposal of the case and adjourning would inconvenience the witnesses who are scheduled to attend and give live evidence.

Ms Aziz submitted that Mrs Stancheva has not provided a witness statement in response to the charges and her absence means that she will not be able to test evidence adduced against her. However, Ms Aziz submitted that Mrs Stancheva has been sent all the evidence and the panel will be able to test this evidence on her behalf (*McDaid v NMC* [2013] EWHC 568 (Admin), para 43-44).

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel had regard to the email from Mrs Stancheva to the NMC, which stated:

> *'I've already notified my ex RCN representative…that I have decided to give up nursing. Regardless of the outcome of my case I will not come back to the nursing profession anymore. This is decision [sic] I haven't taken lightly but after a lot of consideration and of what happened I feel this is the right one for me.*
>
> *…*
>
> *So for these reasons I cease to engage any further.'*

The panel decided to proceed in the absence of Mrs Stancheva. In reaching this decision, the panel considered the submissions of Ms Aziz and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5 *and General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Stancheva has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing since December 2022;
- Mrs Stancheva has voluntarily absented herself from these proceedings;
- No application for an adjournment has been made by Mrs Stancheva;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Not proceeding may inconvenience the witnesses required to attend, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020 and further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of this case.

There is some disadvantage to Mrs Stancheva in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her registered email address via secure email, she has made no response to the allegations. Mrs Stancheva will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs

Stancheva's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel decided that it is fair to proceed in the absence of Mrs Stancheva. The panel will draw no adverse inference from Mrs Stancheva's absence in its findings of fact.

**Details of charge**

That you, a registered nurse:

1) In relation to Resident A's end of life care on 1 April 2020:

    a) Failed to conduct any welfare checks and/or
    b) Failed to ensure care staff were carrying out regular welfare checks;
    c) Failed to reposition the resident as required and/or
    d) Failed to ensure care staff were repositioning the resident as required;
    e) Failed to administer PRN medication as required.

2) Following the death of Resident A:

    a) Failed to appropriately verify death in that you:

        i) Failed to listen for heart sounds using a stethoscope;
        ii) Failed to check eyes using a torch;
        iii) Failed to carry out 5 minutes of respiratory effort observations;
        iv) Failed to carry out a check for pain response following 5 minutes of continuous observation.

    b) Failed to provide any after death care.

3) Signed Resident A's welfare chart indicating you had performed an hourly check.

4) Your actions in charge 3 above were dishonest in that you knew you had not carried out the hourly check.

5) Signed Resident A's repositioning record indicating you had carried out checks and/or care.

6) Your actions in charge 5 above were dishonest in that you knew you had not carried out the checks and/or care.

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

**Background**

The NMC received a referral from Sussex Care UK Nursing and Residential Care Services (the Organisation), on 24 November 2020, raising concerns about Mrs Stancheva.

The charges arose whilst Mrs Stancheva was employed as the Deputy Manager of Pear Tree Court (the Home), a residential and nursing care home. Mrs Stancheva's role was to provide leadership and support to staff and act as a nurse on shift.

In March 2020, Resident A became unwell and was showing symptoms of COVID-19. On 31 March 2020, Resident A's health declined and staff at the Home contacted Resident A's relative, Relative A. Resident A died the next day. On 1 May 2020, Relative A submitted a complaint regarding the end-of-life care that Resident A had received.

A formal investigation was launched, and the Organisation reviewed written and electronic records for Resident A and interviewed staff at the Home. Relative A informed the Organisation that she had video footage of Resident A's last day at the Home. The recording device had been placed in Resident A's room at an earlier date due to an unrelated matter. The footage reportedly showed that the care that was

recorded did not take place, namely, that the hourly welfare checks, and the appropriate medications were not provided, and Resident A had died in a distressed state.

**Decision and reasons on application for covert footage to be viewed in private**

On Day 2, Ms Aziz made an application for covert footage to be viewed by the panel in private. [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

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.

Having heard that the covert footage showed [PRIVATE].

**Decision and Reasons on Application for a 'Waiting Period'**

Following the conclusion of Witness 3's evidence on Day 3, Ms Aziz made an application for the hearing to enter a 'waiting period' until Friday 8 December 2023 (Day 7). She submitted that Witness 1, who had previously been unable to give her evidence earlier in these proceedings, had indicated that the only time she would be available to give her evidence again would be after she had returned to the United Kingdom.

Ms Aziz submitted that there is nothing to suggest that the charges against Mrs Stancheva in this case are uncontested. She submitted that Mrs Stancheva is not represented at this hearing, she has not provided a witness statement and has not made any admissions to the charges set out in this case therefore, it is imperative for Witness 1 to give live evidence as she is the NMC's main witness for this case. She further submitted that Witness 1 had viewed the covert footage and would be able to identify the relevant parts and would also be able to answer specific questions in relation to the footage and subsequent investigations.

Ms Aziz submitted that the NMC is keen to present its case in the manner it wishes, in order to prove the charges against Mrs Stancheva, which includes presenting a live witness. She further submitted that the NMC would not be amenable for Witness 1's witness statement to be read into the record under Rule 31, as all attempts have been made to secure her attendance and she will be present on 8 December 2023.

In response to a panel query, Ms Aziz submitted that this is neither an application for an adjournment nor a postponement as the NMC intends to present a live witness within the time allocated for this hearing. She clarified that during this 'waiting period', the case is ongoing, and the panel should remain sitting on this case. She submitted that the panel should remain on standby in case there were any changes in the circumstances.

The panel carefully considered this application and concluded its deliberations on the morning of Day 4. The panel decided to accept the NMC's application for a 'waiting period' and concluded that it should remain seated on this case, ready to reconvene on 8 December 2023, or earlier if there were any changes in the circumstances.

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

The hearing resumed on the morning of Friday 8 December 2023.

After hearing live evidence from Witness 1, Ms Aziz made a retrospective application for parts of Witness 1's evidence to be marked as private on the transcript. [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

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 accepted this application and decided to mark parts of Witness 1's evidence as private on the transcript to [PRIVATE].

**Decision and reasons on facts**

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

The panel has drawn no adverse inference from the non-attendance of Mrs Stancheva.

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

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

- Witness 1: Regional Director of the Organisation, who conducted the investigation at the time of the incident.
- Witness 2: Clinical Lead Nurse at the Home, at the time of the incident.
- Witness 3: Relative A

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

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

**Charge 1a**

That you, a registered nurse:

1) In relation to Resident A's end of life care on 1 April 2020:

    a. Failed to conduct any welfare checks and/or

**This charge is found proved.**

In reaching this decision, the panel took into account the written witness statements of Witness 1 and 3, Witness 1 and 2's oral evidence, the covert footage and Resident A's Welfare Check Record Sheet (Welfare Record) dated 1 April 2020.

The panel first considered whether Mrs Stancheva had a duty to conduct welfare checks.

The panel acknowledged that Mrs Stancheva was the Deputy Manager of the Home and on the day in question, she was the only registered nurse in the building. This was confirmed by Witness 2 during her oral evidence:

> *'…she would have been the only RN, the main RN.*
>
> *…*
>
> *I am not sure about [the Home Manager's] status, whether he was registered or not. If he was registered, she would have been one of two. If not, she would have been the only RN in the building…'*

Witness 2 further stated:

*'…that nurse is responsible for everybody in the home…'*

The panel concluded that Mrs Stancheva, as the sole registered nurse on duty at the time, would have had a duty to conduct welfare checks on Resident A.

The panel then went on to consider whether Mrs Stancheva had failed to conduct any welfare checks on Resident A.

During her oral evidence, Witness 1 had stated that Mrs Stancheva should have been going in regularly to check on Resident A but had failed to do so within the period she was on shift. This was consistent with her witness statement which stated the following:

'*The registrant failed to check on the residents at any point during her shift.*
*…*
*The registrant didn't go into Resident A's room at all aside from the one time after Resident A had died.*
*…*

*The registrant should have gone in to see Resident A after handover. The registrant started her shift at 7/8am and was only seen on the footage seeing Resident A at 1620 hours, after her death.'*

This was also supported by the covert footage and the witness statement of Witness 3 which stated:

*'The hourly welfare and repositioning did not happen.'*

The panel also had regard to Resident A's Welfare Record. The record showed that Mrs Stancheva's initials *'MS'* were signed against the times 16:10 hours and 16:40 hours, suggesting that welfare checks were conducted by her at these times.

The covert footage was an hour behind as it had not been adjusted to account for Daylight Savings Time. The panel noted that had Mrs Stancheva gone into the room at the times she had said, the times would have been 15:10 hours and 15:40 hours but the footage at those times did not show her in the room at all.

The panel bore in mind the evidence of Witness 1, who confirmed that when shown the covert footage, Mrs Stancheva admitted to not attending to Resident A at the times particularised by her signature in the patient records.

The panel accepted the oral and documentary evidence of Witness 1, 2, 3 and the evidence contained within the covert footage alongside the Welfare Record. The panel concluded that although the covert footage did not provide a full view of the room, it was evident that Mrs Stancheva had not entered Resident A's room to conduct welfare checks at all during the course of her shift. The panel noted that Mrs Stancheva was only seen in the room after she had been informed about Resident A's death.

In light of the above, the panel determined that Mrs Stancheva did in fact have a duty to conduct welfare checks on Resident A as the sole registered nurse on shift and she had failed to carry them out.

Accordingly, the panel found Charge 1a proved on the balance of probabilities.

**Charge 1b**

That you, a registered nurse:

1) In relation to Resident A's end of life care on 1 April 2020:

    b) Failed to ensure care staff were carrying out regular welfare checks;

**This charge is found proved.**

In reaching this decision, the panel took into account the written witness statements of Witnesses 1 and 3, the oral evidence of Witness 1 and 2, the covert footage, Resident A's Welfare Record and the Home's *'Observation of Residents' Policy*, issued in March 2016.

The panel also took into account that it had previously established Charge 1a proved and determined that Mrs Stancheva, as the registered nurse on duty, had a duty to ensure welfare checks were conducted on Resident A had she not personally carried these out.

The panel noted that Witness 1 and 3 had stated in their witness statements that no welfare checks were conducted by Mrs Stancheva or other members of staff.

Witness 1 had stated in her written statement that:

> *'The health care assistants Resident A saw briefly. Once in the morning and once at lunch time. Both times limited care was provided. There was a lack of care and compassion. The registrant failed in the care provided to Resident A.'*

This was also confirmed by the covert footage.

The panel had regard to the Home's *'Observations of Residents'* Policy which stated:

> *'With the agreement of the resident, all residents that are on their own and in their own rooms and therefore at risk of social isolation will be checked as a minimum hourly to ensure that wellbeing, safety and care needs have been met.'*

The frequency of check documented on Resident A's Welfare Record was recorded as hourly. Witness 1 also stated during her oral evidence that the expected

frequency would be hourly, which was supported by Witness 2 who had stated that 'at least' one hourly checks for end-of-life care was an appropriate frequency.

The panel accepted the oral and documentary evidence of Witnesses 1, 2 and 3, the covert footage and the Home Policy. The panel concluded that as the nurse in charge of the shift, Mrs Stancheva had a duty to ensure that care staff were conducting regular welfare checks on Resident A. The panel were of the view that the brief morning and lunch time checks conducted by the care assistants were insufficient to amount to regular welfare checks of a resident on end-of-life care. In these circumstances, the panel considered that 'regular' pertained to the continuation of checks as opposed to the frequency of checks.

In light of the above, the panel determined that Mrs Stancheva did in fact have a duty to ensure that all care staff were carrying out regular welfare checks on Resident A, and she had failed to oversee this.

Accordingly, the panel found Charge 1b proved on the balance of probabilities.

**Charge 1c**

1) In relation to Resident A's end of life care on 1 April 2020:

    c) Failed to reposition the resident as required and/or

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1 and 3, the covert footage and Resident A's 24-hour Repositioning Record dated 1 April 2020.

The panel noted that Witness 1 had stated the following in relation to repositioning of Resident A:

*‘This was the repositioning chart where she signed at various times to say the Resident A [sic] had been repositioned when she had not.*

*…*

*The Carers repositioned Resident A…’*

The panel also noted that Witness 3 had an expectation that repositioning would be undertaken by Mrs Stancheva:

*‘The hourly welfare checks and repositioning did not happen.’*

The panel considered if Mrs Stancheva had a duty to reposition Resident A. It noted that during her oral evidence, Witness 1 had stated that repositioning could have been undertaken by the care staff and/or the nurse on duty, but it was usually undertaken by the care staff. The panel considered the oral evidence of Witness 1 and concluded that Mrs Stancheva was not solely responsible for repositioning Resident A and Resident A had been repositioned by care staff. The panel also considered that there was no evidence before it, namely a policy or Resident A’s care plan, to establish that there was a requirement for Resident A to be repositioned. The panel took into account that the Repositioning Record suggested a four hourly repositioning frequency however, it determined that Mrs Stancheva did not have a personal duty to carry this out.

In light of the above, the panel determined that in the absence of supporting documentary evidence, this charge could not be found proved, on the balance of probabilities, as the NMC has not discharged its burden of proof concerning this matter.

Accordingly, the panel found Charge 1c not proved on the balance of probabilities.

**Charge 1d**

That you, a registered nurse:

1) In relation to Resident A's end of life care on 1 April 2020:

    d) Failed to ensure care staff were repositioning the resident as required;

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1, the covert footage and Resident A's Repositioning Record.

The panel first established that as the nurse on duty, Mrs Stancheva had a duty to ensure that care staff were repositioning Resident A.

Witness 1 had previously stated during her oral evidence that repositioning was usually undertaken by care staff. The panel acknowledged that the suggested frequency for repositioning of Resident A was recorded as four hourly on the Repositioning Record.

Witness 1 had stated the following in her witness statement:

> *'At or about 8am, the day shift commenced…From the footage, you can see Carer A entering the room, followed by Carer B. The Carers repositioned Resident A… the registrant was not in attendance.*
>
> *…*
>
> *There was no further intervention until just after midday when Carer A and Carer B entered the room for the second check.*
>
> *During the second check, Carer A and Carer B entered the room and repositioned Resident A...I can confirm that the registrant was not in attendance during that second check.'*

The panel had regard to Resident A's Repositioning Record which showed that repositioning had taken place at 08:15 hours and 12:05 hours as suggested by Witness 1 and confirmed by the covert footage.

The panel accepted the above evidence and concluded that Carer A and Carer B had in fact repositioned Resident A on two occasions, approximately four hours apart, as stated on the Repositioning Record.

In light of the above, the panel determined that Mrs Stancheva did not fail to ensure that care staff were repositioning Resident A as required. It also determined that this charge could not be found proved, on the balance of probabilities, as the NMC has not discharged its burden of proof concerning this matter.

Accordingly, the panel found Charge 1d not proved on the balance of probabilities.

**Charge 1e**

That you, a registered nurse:

1) In relation to Resident A's end of life care on 1 April 2020:

    e) Failed to administer PRN medication as required.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1, the documentary evidence of Witness 3 and the covert footage.

The panel noted that both Witness 1 and Witness 2 had identified that Resident A had been prescribed PRN medications. Witness 1 had stated during her oral evidence that as the only registered nurse in the building, Mrs Stancheva was solely responsible for the administration of these PRN medications.

Witness 1 had stated the following in her witness statement:

> *'The registrant also failed to check the resident at any time to see if she was distressed or required any ambulatory medication that she had been prescribed.*
>
> *…*
>
> *At or about 3pm [covert footage timing], I watched Resident A die in a distressed manner with very laboured breathing and gasping for air without medical intervention.*
>
> *…*
>
> *Had the registrant checked up on Resident A, she would have realised that Resident A's breathing had become laboured.'*

This was supported by Witness 3 in her witness statement:

> *'The GP stated anticipatory medication had been ordered for [Resident A] in the event she was struggling towards the end. She wasn't checked to ascertain whether she needed medication therefore no medication was given.'*

The panel accepted the above evidence. The panel concluded that Mrs Stancheva had a duty to administer the PRN medications to Resident A. The panel was satisfied that as a result of not checking in on Resident A, Mrs Stancheva did not make herself aware of when PRN medications became required and therefore failed to administer them when they were.

In light of the above, the panel determined that Mrs Stancheva did fail to administer PRN medications to Resident A as required, resulting in Resident A dying in a *'distressed manner'*.

Accordingly, the panel found Charge 1e proved on the balance of probabilities.

**Charges 2a(i)-2a(iv)**

2) Following the death of Resident A:

    a. Failed to appropriately verify death in that you:

        i. Failed to listen for heart sounds using a stethoscope;
        ii. Failed to check eyes using a torch;
        iii. Failed to carry out 5 minutes of respiratory effort observations;
        iv. Failed to carry out a check for pain response following 5 minutes of continuous observation.

**These charges are found proved.**

The panel considered each of these charges individually. In reaching its decision, the panel took into account the oral evidence of Witness 1 and 2, the covert footage and the Home's *'Death of a Resident'* Policy, issued in May 2020.

Witness 1 clarified during her oral evidence that the *'Death of a Resident' Policy* before the panel would have been similar to the policy that was in place at the time of the incident.

The panel noted that during her oral evidence, Witness 2 had described what the death verification checks would entail:

> *'Checking the carotids for a couple of minutes, checking all the pulses, taking a stethoscope and listening to the chest.*
>
> *…*
>
> *Touching the patient's ear or a finger to see if they had any reflexes, just lightly pinching the ear, see if there was a pain reflex. If you were doing the*

*checks properly it would probably take you about ten minutes because you would go away for a few minutes and then go back and repeat the process again.'*

The panel noted that this was similar to what was outlined within the Home's policy.

The panel took into account of Witness 1's oral evidence:

*'I did not see at any time in that footage where Milena had done anything more than stick her two fingers on the carotid artery to try and find a pulse for about three seconds. To me that is not verifying death.'*

The panel acknowledged that this was demonstrated on the covert footage.

The panel also took into account the following assertions made by Mrs Stancheva during the local investigation:

*'When Resident A had passed away [Mrs Stancheva] explained how she had verified the death, checking for pulses, torch in the eye for pupil reaction, she had her stethoscope with her and the process took about 10 minutes. She ten [sic] informed the Doctor and then went and repeated the checks a second time…'*

The panel accepted the evidence of Witness 1 and 2. The panel concluded that it was evident on the covert footage that Mrs Stancheva had not undertaken the proper assessments to appropriately verify Resident A's death. The panel noted that Mrs Stancheva had not entered the room with a stethoscope and had clearly not undertaken the checks she had described during the local investigation. The panel however did take into account that the sole action Mrs Stancheva took to certify Resident A's death was to briefly touch her neck to check for a pulse.

In light of the above, the panel determined that Mrs Stancheva had a duty to appropriately verify Resident A's death by carrying out the assessments detailed in

the charge. The panel was satisfied that these checks had not been performed by Mrs Stancheva, despite it being solely her responsibility as the only nurse on duty at the time.

Accordingly, the panel found Charges 2a(i)-2a(iv) proved on the balance of probabilities.

**Charge 2b**

2) Following the death of Resident A:

    b. Failed to provide any after death care.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account Witness 1's witness statement, the Home's *'Death of a Resident'* Policy, local investigation documents and the covert footage.

The panel had regard to the Investigation Meeting Minutes dated 28 July 2020 in which Witness 1 had expressed the expectations of after death care:

> *'There has been no wash and [Resident A] has just been laid flat- hair not brushed'*

Within the Investigation Report, it is reported that Mrs Stancheva had stated that she had left the carers to wash Resident A however, this was not seen on the covert footage.

The panel had regard to the Home's *'Death of a Resident'* Policy which after death care of a resident was outlined. It included procedures such as informing the GP or Out of Hours Service, verifying the resident's death, informing the resident's family and preparing the resident for the family to pay their last respects whilst maintainin

their privacy and dignity, adhering to infection control measures and contacting the undertakers and completing relevant paperwork, amongst other things.

The panel considered the evidence of Witness 1 in that Resident A was expected to have been washed however, the panel noted that there was no such requirement contained within the Home's policy. The panel considered the wording of the charge, namely *'failed to provide'*. It concluded that although the care Mrs Stancheva provided to Resident A may not have been entirely sufficient in accordance with the expectations of Witness 1 and Resident A's family, it was satisfied that nevertheless, Mrs Stancheva did provide after death care in accordance with the Home's policy as the GP, Resident A's family and the undertakers had been informed of Resident A's death.

In light of the above evidence, the panel determined that the NMC had not adduced sufficient evidence to suggest that there was a duty on Mrs Stancheva or other members of staff to wash Resident A after her death, therefore she did not fail to provide this. The panel also determined that this charge could not be found proved, on the balance of probabilities, as the NMC has not discharged its burden of proof concerning this matter.

Accordingly, the panel found Charge 2b not proved on the balance of probabilities.

**Charge 3**

3) Signed Resident A's welfare chart indicating you had performed an hourly check

**This charge is found proved.**

In reaching this decision, the panel took into account Resident A's Welfare Record and the covert footage.

The panel noted that Mrs Stancheva's initials *'MS'* were signed against 16:10 hours and 16:40 hours, suggesting that welfare checks were conducted by her at these times. However, when the above timings were cross referenced with the covert footage, it was clear to see that neither Mrs Stancheva nor any care staff were present in Resident A's room at the specified times to undertake these checks.

The panel noted the evidence of Witness 1, who informed the panel of Mrs Stancheva's explanation during the local investigation, where she accepted she had signed the forms presented to her without checking.

In light of the above evidence, the panel determined that Mrs Stancheva did sign Resident A's welfare chart indicating she had performed an hourly check, when she had not done so.

Accordingly, the panel found Charge 3 proved on the balance of probabilities.

**Charge 4**

4) Your actions in charge 3 above were dishonest in that you knew you had not carried out the hourly check.

**This charge is found proved.**

The panel first considered its previous findings with respect of Charge 3.

Having found this charge proved, the panel went on to consider whether or not Mrs Stancheva's actions in Charge 3 were dishonest. It had regard to the test set out in *Ivey v Genting Casinos* [2017] UKSC 67, which outlines the following*:*

- What was the defendant's actual state of knowledge or belief as to the facts; and
- Was the conduct dishonest by the standards of ordinary decent people?

The panel also had regard to the NMC guidance entitled *'Making decisions on dishonesty charges' (reference DMA-7)* dated 12 October 2018. Within this guidance, Fitness to Practise Committee (FtPC) panels are advised to decide whether the conduct indeed took place and if so, what was the registrant's state of mind at the time. Panels are reminded to consider the following:

- *'What the nurse, midwife or nursing associate knew or believed about what they were doing, the background circumstances, and any expectations of them at the time*
- *Whether the panel considers that the nurse, midwife or nursing associate's actions were dishonest, or*
- *Whether there is evidence of alternative explanations, and which is more likely.'*

In reviewing the evidence, the panel considered the evidence of Witness 1, Resident A's Welfare record and the covert footage. It found that Mrs Stancheva had signed her initials against 16:10 hours and 16:40 hours, indicating that she had conducted the welfare checks at these times. The panel noted that when cross referenced with the covert footage, Mrs Stancheva was not present in the room. The panel noted that Witness 1 had stated in her witness statement that Mrs Stancheva had reported that she was presented with forms by care staff to sign, which she had done. The panel considered that the covert footage also demonstrated that care staff were also not present in Resident A's room at these times.

The panel accepted Witness 1's evidence in which she had stated that Mrs Stancheva had not attended to Resident A since commencing her shift at 08:00 hours until being informed of Resident A's death at around 16:20 hours. The panel was of the view that Mrs Stancheva knew that she had not carried out the hourly welfare checks on Resident A, despite signing that she had done so. The panel considered that Mrs Stancheva's conduct in relation to Charge 3 was dishonest and would be regarded as dishonest by the standards of ordinary decent people.

Accordingly, the panel found Charge 4 proved on the balance of probabilities.

**Charge 5**

5) Signed Resident A's repositioning record indicating you had carried out checks and/or care.

**This charge is found proved.**

In reaching this decision, the panel took into account Resident A's Repositioning Record and the covert footage.

The panel noted that again Mrs Stancheva had signed her initials against 10:00 hours and 15:00 hours on Resident A's Repositioning Record with another colleague, indicating that she had repositioned Resident A at these times. The panel noted that this was not evident on the covert footage.

In light of the above evidence, the panel determined that Mrs Stancheva did sign Resident A's Repositioning Record indicating that she had carried out checks and/or care.

Accordingly, the panel found Charge 5 proved on the balance of probabilities.

**Charge 6**

6) Your actions in charge 5 above were dishonest in that you knew you had not carried out the checks and/or care.

**This charge is found proved.**

In reaching this decision, the panel took into account its findings with regards to Charge 5. It also had regard to NMC guidance (DMA-7), and the test set out in *Ivey v Genting Casinos*.

The panel was of the view that Mrs Stancheva was dishonest. In reviewing the evidence, it found that Mrs Stancheva was aware that she had not undertaken checks/care in relation to the repositioning of Resident A when she had signed the Repositioning Record. The panel considered that Mrs Stancheva's conduct in relation to Charge 5 would be regarded as dishonest by the standards of ordinary decent people.

In light of the above, the panel determined that Mrs Stancheva was dishonest in her actions in that she knew that she had not repositioned Resident A as she had documented.

Accordingly, the panel found Charge 6 proved on the balance of probabilities.

**Decision and reasons on service of Notice of Hearing**

The hearing resumed on Wednesday 3 January 2024. The panel was informed at the start of the resumed hearing that Mrs Stancheva was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 11 December 2023.

Ms Aziz submitted that the NMC had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs

Stancheva's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In light of all of the information available, the panel was satisfied that Mrs Stancheva has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

**Decision and reasons on proceeding in the absence of Mrs Stancheva**

The panel next considered whether it should proceed in the absence of Mrs Stancheva. It had regard to Rule 21 and heard the submissions of Ms Aziz who invited the panel to continue in the absence of Mrs Stancheva.

Ms Aziz submitted that Mrs Stancheva has had the opportunity to attend this resumed hearing but has decided to not take this opportunity. She further submitted that there is no representative present on Mrs Stancheva's behalf, and she has neither made an application to adjourn, nor put forward further information.

Ms Aziz submitted that in the absence of Mrs Stancheva, the panel should proceed with this hearing as there is no information to suggest that adjourning would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel decided to proceed in the absence of Mrs Stancheva. In reaching this decision, the panel considered the submissions of Ms Aziz and the advice of the legal assessor. The panel had regard to its previous decision in relation to proceeding in the absence of Mrs Stancheva and determined that the same reasons were applicable.

In these circumstances, the panel decided that it is fair to proceed in the absence of Mrs Stancheva. The panel will draw no adverse inference from Mrs Stancheva's absence in its findings of fact.

**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 Mrs Stancheva's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's 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 amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Stancheva's fitness to practise is currently impaired as a result of that misconduct.

**Submissions on misconduct**

Ms Aziz referred the panel to the case of *Roylance v GMC* [2000] 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.'*

As per *Roylance*, Ms Aziz submitted that misconduct must be sufficiently serious to warrant a finding of impairment.

With regards to seriousness, Ms Aziz referred the panel to the case of *R (Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin) which categorises seriousness into two principal kinds:

> *'…sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise.'*

And misconduct that is:

> *'…of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the [profession] and thereby prejudices the reputation of the profession.'*

Ms Aziz also referred the panel to NMC guidance (*reference FTP-3*) and the case of *Nandi v GMC* [2004] EWHC 2317 (Admin). She invited the panel to take the view that the charges found proved against Mrs Stancheva amount to serious misconduct. Ms Aziz submitted that Mrs Stancheva has breached the terms of *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2018) (the Code), namely Sections 1, 10, 17, 20 and 21.

**Submissions on impairment**

Ms Aziz moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included references to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), *General Medical Council v Meadow* [2006] EWCA Civ 1390, *Cohen v GMC* [2015] EWHC 581 (Admin) and *Nicholas-Pillai v General Medical Council* [2009] EWHC 1048 (Admin).

Ms Aziz submitted that it is for the panel to determine whether or not Mrs Stancheva is able to practise safely, kindly and professionally. She stated that the factors that the panel should take into account are the wellbeing of patients, the maintenance of professional standards and the integrity of the nursing profession.

Ms Aziz submitted that there is evidence before the panel to demonstrate that impairment compromised Mrs Stancheva's practice, and this posed a risk to patient safety. She further submitted that Mrs Stancheva has not demonstrated sufficient insight, admitted to the charges or accepted her behaviour.

Ms Aziz submitted that Mrs Stancheva's behaviour violated professional standards and there were issues that have impacted her ability to practise safely and effectively since the incident, as there has been no insight. Ms Aziz submitted that therefore, behaviour of this nature is fundamentally incompatible with Mrs Stancheva remaining on the register.

In relation to the test set out in *Grant*, Ms Aziz submitted that all the limbs are engaged in this case. She submitted that Mrs Stancheva's behaviour brought the nursing profession into disrepute and a vulnerable resident was affected. Ms Aziz further submitted that Mrs Stancheva's failure to provide end of life care to Resident A meant that Resident A was in distress during the last remaining hours of her life and had died alone. Mrs Stancheva's dishonesty was an attempt to cover up this failure to provide care, which is particularly serious and Mrs Stancheva's misconduct would have not been uncovered, had it not been for the covert footage.

Ms Aziz submitted that the footage exposed Mrs Stancheva's dishonesty and this calls into question her trustworthiness as a registered professional, especially since she tried to cover up her actions. She submitted that there is sufficient evidence to demonstrate that Mrs Stancheva poses a risk to the public and the level of nursing care she provided fell well below the standards expected of a registered nurse.

Ms Aziz submitted that Mrs Stancheva has demonstrated insufficient insight into this matter and there is no evidence to show that she has strengthened her practice or has had a sustained period of current safe practice, therefore there is a risk of repetition of her behaviour. Ms Aziz invited the panel to find that Mrs Stancheva's fitness to practise is currently impaired.

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

**Decision and reasons on misconduct**

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

The panel was of the view that Mrs Stancheva's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Stancheva'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*
>
> ***1.5** respect and uphold people's human rights*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***

*To achieve this, you must:*

*…*

***3.2** recognise and respond compassionately to the needs of those who are in the last few days and hours of life*

*…*

***10 Keep clear and accurate records relevant to your practice***

*This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*

*To achieve this, you must:*

*…*

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

*…*

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

*To achieve this, you must:*

*…*

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

*…*

***20 Uphold the reputation of your profession at all times***

*To achieve this, you must:*

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

***20.2*** *act with honesty and integrity at all times…*

*…*

***20.5*** *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*

*…*

***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 panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges proved did amount to serious misconduct. The panel considered Mrs Stancheva's failure to conduct welfare checks on a resident on end-of-life care, failure to verify Resident A's death, which is a clear and important process, falsification of patient records and her dishonesty were in and of themselves serious departures from the standards that could be properly expected of a nurse. Mrs Stancheva's fellow professionals and the public would find such a grave departure from standards as deplorable in the care of a vulnerable person. The panel was of the view that Mrs Stancheva's failures related to fundamental components of a registered nurse's role and her actions did fall

seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

The panel next went on to decide if as a result of the misconduct, Mrs Stancheva'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.'*

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

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence*

*in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

*'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel concluded that all limbs of the *Grant* test are engaged in this case. The panel was of the view that Resident A, a vulnerable patient, was put at a risk of unwarranted harm as a result of Mrs Stancheva's misconduct. Further, Mrs Stancheva's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if the NMC, as its regulator, did not find charges relating to dishonesty extremely serious.

The panel was aware that this is a forward-looking exercise, and accordingly it went on to consider whether Mrs Stancheva's misconduct was remediable and whether Mrs Stancheva had strengthened her practice.

The panel had regard to the case of *Cohen* and considered whether the misconduct identified was capable of remediation. The panel had reservations about Mrs Stancheva's dishonesty. Not only had she been dishonest, but she had continued to maintain the dishonesty until she was confronted with irrefutable evidence that was contrary to her initial account, despite being given many opportunities to tell the truth. The panel was of the view that this made the dishonesty even more significant. The panel determined that Mrs Stancheva's misconduct was serious and that it had no evidence before it of strengthening of practice or remediation from her.

Accordingly, the panel went on to consider whether Mrs Stancheva remained liable to act in a way that would put patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future.

The panel considered that Mrs Stancheva sought to falsify documentation pertaining to Resident A's care to cover up her failure to provide adequate care. The panel was of the view that Mrs Stancheva's failings were wide ranging and related to concerns around her clinical practice and integrity as a registered nurse. Regarding insight, the panel considered that there was no evidence before it, such as a written reflective piece, to demonstrate Mrs Stancheva's insight or attempts to strengthen her practice. The panel determined that this indicated that Mrs Stancheva has not yet accepted responsibility for her actions, neither has she reflected on them or their impact on others and the public's perception of the nursing profession.

In light of this, the panel concluded that there was a risk to the public and there was a high likelihood of this conduct being repeated. The panel noted that Mrs Stancheva has not engaged with the NMC, since her correspondence in December 2022, and there have been no indications of her insight or any remediation. The panel took into account that Mrs Stancheva has not acknowledged the seriousness of her actions and the panel did not accept her account that her actions were as a result of a busy

and stressful work environment. The panel was of the view that due to her lack of insight and recognition of the seriousness of her actions, meant there was a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required as a member of the public and other members of the nursing profession would be concerned as Mrs Stancheva's failings were wide ranging and demonstrated a lack of integrity as a registered nurse. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment was not made in this case and therefore also finds Mrs Stancheva's fitness to practise impaired on the grounds of public interest.

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

**Sanction**

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

**Submissions on sanction**

Ms Aziz submitted that many of the legal principles that she outlined at the misconduct and impairment stage were applicable at this stage. She also referred the panel to its previous findings and the NMC SG.

Ms Aziz submitted that the aggravating features in Mrs Stancheva's case are the abuse of a position of trust, lack of insight into her failings, a pattern of misconduct over a period of time and conduct which put a patient at risk of suffering and harm in the future. She submitted that Mrs Stancheva has displayed no insight into her behaviour whatsoever. She further submitted that Mrs Stancheva was in a managerial position at the time of the misconduct and nevertheless undertook deliberate actions which represented widespread and multiple breaches of the Code.

Ms Aziz submitted that this case was not suitable for no further action to be taken as the concerns are very serious and relate to fundamental nursing care of a highly vulnerable resident at the end of their life. She further submitted that Mrs Stancheva's conduct seriously undermined the trust the public place in nurses and the gravity of the concerns are aggravated by her dishonesty as this would not have been uncovered if the covert camera footage had not been put forward.

Ms Aziz also submitted that in light of the above, a caution order would also be a wholly insufficient sanction at this stage.

In relation to a conditions of practice order, Ms Aziz submitted that the evidence in this case demonstrates that this would not be a sufficient sanction. Mrs Stancheva knew what should have been done but chose not to do it and even when she was confronted with the covert camera footage, the evidence demonstrates that she still did not admit to her wrongdoings, which indicates a harmful attitudinal problem. Ms Aziz submitted that there are no conditions that could be formulated to adequately address these concerns.

Ms Aziz submitted that a suspension order is not being pursued by the NMC as the seriousness of this case would require Mrs Stancheva's removal from the register.

Ms Aziz submitted that even though the concerns arose from a single incident, Mrs Stancheva's misconduct occurred over a prolonged period of time, at the end of a resident's life, to which Mrs Stancheva has shown no insight. Ms Aziz submitted that in these circumstances, the only proportionate sanction that would promote confidence in the nursing profession would be a striking off order.

**Decision and reasons on sanction**

Having found Mrs Stancheva's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel bore 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:

- Lack of insight into failings
- Prolonged dishonesty
- Abuse of a position of trust
- Conduct which put a vulnerable resident at risk of suffering and harm
- Lack of engagement with the NMC

The panel also carefully considered mitigating features and determined that there were no significant mitigating features in this 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 Mrs Stancheva'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 Mrs Stancheva'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 Mrs Stancheva's registration would be a sufficient and appropriate response. The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and Mrs Stancheva's lack of engagement. The panel was of the view that Mrs Stancheva's misconduct could not be addressed through retraining to effectively manage the risks identified and her dishonesty was not something that could be sufficiently addressed with conditions. Furthermore, the panel concluded that the placing of conditions on Mrs Stancheva's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG 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, were a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Stancheva's actions are fundamentally incompatible with Mrs Stancheva remaining on the register. The panel was of the view that Mrs Stancheva's adherence to her denial despite being given a number of opportunities to tell the truth was evidence of a harmful deep-seated attitudinal problem.

In this particular case, the panel 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?*

Mrs Stancheva's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Stancheva's actions were serious and to allow her to continue practising, in light of her dishonesty, 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 effect of Mrs Stancheva's actions in bringing the profession into disrepute by adversely affecting the public's

view of how a registered nurse should conduct themself, the panel concluded that nothing short of this would be sufficient in this case to protect the public.

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

This will be confirmed to Mrs Stancheva 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 Mrs Stancheva's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

**Submissions on interim order**

The panel took account of the submissions made by Ms Aziz. She invited the panel to impose an interim order for a period of 18 months on the grounds of public protection and otherwise in the public interest. She submitted that as the striking off order will not take effect until after the 28-day period therefore, an interim order is necessary to cover this intervening period to protect the public and meet the public interest in light of the panel's findings.

**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 determined that the charges found proved are so serious that they warrant a striking

off order therefore, Mrs Stancheva should be restricted from practice during the appeal period.

The panel has therefore imposed an interim suspension order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.