Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 13 – Friday 17 May 2024

Virtual Hearing

Name of registrant:	**Madona John Moses**
NMC PIN:	99L1317O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (17 December 1999)
Relevant location:	Birmingham
Type of case:	Misconduct
Panel members:	Debbie Hill (Chair, Lay member) Margaret Marshall (Registrant member) Carson Black (Lay member)
Legal Assessor:	Attracta Wilson
Hearings Coordinator:	Sherica Dosunmu
Nursing and Midwifery Council:	Represented by Michael Smalley, Case Presenter
Ms Moses:	Not present and unrepresented at the hearing
Facts proved:	Charges 1, 2, 3, 4, 5
Facts not proved:	Charge 6
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 Ms Moses was not in attendance and that the Notice of Hearing letter had been sent to Ms Moses' email address on 8 April 2024. Mr Smalley, on behalf of the Nursing and Midwifery Council (NMC), acknowledged that Ms Moses' registered email address detailed in Notice of Hearing documents was different from the email address the Notice of Hearing letter was sent to. However, he referred the panel to a Personal Contact and Employer Details Form (PCED) completed and signed by Ms Moses on 20 March 2019, in which she provided the email address used by the NMC as her contact for communication.

Mr Smalley submitted that the NMC had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004' (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 allegation, the time, dates and means of joining the virtual hearing and, amongst other things, information about Ms Moses' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Moses 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 Ms Moses

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

Mr Smalley referred the panel to a recent email from Ms Moses, dated 11 May 2024, in which she stated:

> '*I'm Madona Moses, I have given up on nursing.*
> *I will not attend the meeting and do not want to proceed this matter further.*
> *Thank you.'*

Mr Smalley submitted that given the clarity in Ms Moses' position in her most recent communication with the NMC, there was no reason to believe that an adjournment would secure her attendance on some future occasion. He reminded the panel that there are four witnesses lined up to give evidence at this hearing who will be impacted by an adjournment. Further, he submitted that there is public interest in the expeditious disposal of this case.

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'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Ms Moses. In reaching this decision, the panel has considered the submissions of Mr Smalley and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* 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:

- Ms Moses has informed the NMC on 11 May 2024 that she did not intend to attend the hearing;
- No application for an adjournment has been made by Ms Moses;
- There is no reason to suppose that adjourning would secure her attendance at some future date;

- Four witnesses are due to give evidence, and may be caused inconvenience if there was a delay to this hearing;
- The charges relate to events that occurred in 2018;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Moses in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Ms Moses, she will not be able to challenge the evidence relied upon by the NMC 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 Ms Moses' 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 has decided that it is fair, appropriate and proportionate to proceed in the absence of Ms Moses. The panel will draw no adverse inference from Ms Moses' absence in its findings of fact.

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

At the outset of the hearing, Mr Smalley made a request that parts this case be held in private on the basis that proper exploration of Ms Moses' case involves [PRIVATE]. The application was made pursuant to Rule 19.

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 there will be reference to [PRIVATE], the panel determined to hold those parts of the hearing in private.

Details of charge (as amended)

That you, a registered nurse, on 6 July 2018:

1. Muted the alarm on Patient A's monitor. **[PROVED]**

2. Altered the alarm settings to stop Patient A's alarm from sounding. **[PROVED]**

3. Failed to escalate Patient A's deterioration to a senior member of staff. **[PROVED]**

4. Failed to assist Colleague A in treating Patient A when requesting help. **[PROVED]**

5. Your conduct at 1 and/or 2 and/or 3 and/or 4 was lacking in integrity. **[PROVED]**

6. Incorrectly said to Patient A's next of kin that Patient A was being kept artificially alive for organ donation, or words to that effect. **[NOT PROVED]**

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

Decision and reasons on application to amend charge 6

The panel heard an application made by Mr Smalley to amend the wording of charge 6. The proposed amendment was to change the wording from '*in*' to '*kin*', in order to correct a typographical error.

<u>Original charge:</u>

6. *Incorrectly said to Patient A's next of in that Patient A was being kept artificially alive for organ donation, or words to that effect*

Proposed charge:

6. *Incorrectly said to Patient A's next of **k**in that Patient A was being kept artificially alive for organ donation, or words to that effect*

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

The panel was of the view that such amendment would not change the nature of the charge, but simply correct a typographical error. The panel was satisfied that there would be no prejudice to Ms Moses and no injustice would be caused to either party by the proposed amendment being allowed. It determined that it was therefore appropriate to allow the amendment to ensure clarity and accuracy.

Background

The NMC received a self-referral from Ms Moses on 8 March 2019 regarding concerns relating to her fitness to practise. At the time of the alleged concerns, Ms Moses was working as a band 5 registered nurse for Heartland Hospital (the Hospital), part of University Hospitals Birmingham NHS Foundation Trust (the Trust).

On 5 July 2018, Ms Moses was working on a night shift at the Hospital in the Intensive Care Unit (ICU). During this shift, Ms Moses was allocated to the care of Patient A [PRIVATE]

During the night shift, Patient A began to deteriorate. At around 5:50, in the morning of 6 July 2018, Colleague A conducted a review of Patient A and noted that the patient had deteriorated and became unstable. Colleague A saw that in Patient A's observation chart, it was recorded that the patient had [PRIVATE] from roughly 3:15, which should have triggered immediate escalation. It is alleged Ms Moses failed to escalate this to a senior nurse or the medical team. Further, it is also alleged that during this review,

Colleague A noticed that Ms Moses had turned all Patient A's monitoring alarms off to stop Patient A's alarm from sounding.

On 6 July 2018 it was documented that the likelihood of a poor outcome was discussed with the family of Patient A. It was also documented in the notes that Patient A was a potential candidate for organ donation and that referral for organ donation was awaited. However, it was also documented that no formal decisions regarding withdrawal of treatment or organ donation had been made at that point. It is alleged that Ms Moses incorrectly said to Patient A's next of kin that Patient A was being kept artificially alive for organ donation, or words to that effect.

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 Mr Smalley on behalf of the NMC and Ms Moses' written responses to the regulatory concerns.

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:

- Colleague A: ST4 Anaesthetics Registrar at the Hospital;

- Colleague B: Critical Care Nurse Consultant and Lead Advanced Critical Care Practitioner at the Hospital;

- Colleague C: Band 7 Senior Sister at the Hospital;
- Colleague D: Clinical Nurse Educator at the Hospital.

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

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

Charge 1

1. Muted the alarm on Patient A's monitor.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, Colleague B and Colleague C, as well as Ms Moses' responses during the Trust's investigation and to the NMC regulatory concerns.

The panel noted the following evidence from Colleague A's witness statement:

> *'I could also see that all the monitoring alarms in Patient A's bed space were turned off, which was concerning. It is part of the routine nursing checks on each shift to ensure that all the monitoring alarms on the patient's bed space equipment are enabled, appropriately set and functioning properly.'*

The panel found that Colleague A's account was corroborated by Colleague C, in which she stated:

‘At the handover the safety checks should have been done including making sure that the patent alarms were working. As a registered nurse Madona had responsibility for providing adequate care to Patient A and that the medical equipment for Patient A was in working order.

When patient’s blood pressure drops to a critical level the alarm sounds with a specific pitch tone. At the time of the incident Madona was within three bed spaces away from me and I would have heard the tone from Patient A’s bed space. She obviously disabled Patient A’s alarms as they did not go off when Patient A’s blood pressure dropped to a critical level…’

The panel also noted the following from Colleague B’s witness statement:

‘*She silenced the alarms on patient’s monitor, despite the patient’s blood pressure had dropped to a critical level. The registrant wilfully turned the monitor alarms off and silenced the monitor.’*

The panel had regard to Ms Moses’ written statement provided within the Trust’s Management Case report as part of its investigation in October 2018. In the statement provided by Ms Moses, she stated:

‘The monitor in my bed-space was alarming and I didn’t want bother the other members of staff, nor did I wanted to annoyed anybody so I adjusted the alarm limit in my bed-space.’

This is consistent with her response to the NMC regulatory concerns on 20 March 2019, in which she stated:

‘*At 4.50am, I heard the patient’s alarm on bed 6 go off. I was over-whelmed and tired looking after two alarming patients. There was a lapse in my judgement and I silenced my patient’s alarm before attending to the patient in bed 6.’*

The panel found that Colleague A, Colleague B and Colleague C's accounts were consistent in indicating that Patient A's alarm was silenced by Ms Moses, which is also supported by her explanation of what happened.

The panel acknowledged that the wording of the charge refers to muting Patient A's alarm, whereas Colleague A and Colleague C's evidence indicate that the alarm was '*turned off*'/ '*disabled*'. However, it considered the charge within the context of muting the alarm and switching it off having the same outcome of silencing its sound (as referred to in Colleague B's evidence and by Ms Moses). It determined that the slight discrepancy does not change the nature of the actions alleged.

The panel therefore concluded that there was clear, consistent evidence which indicated that Ms Moses muted the sound of the alarm on Patient A's monitor on 6 July 2018.

Accordingly, the panel found charge 1 proved.

Charge 2

2. Altered the alarm settings to stop Patient A's alarm from sounding.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, Colleague B and Colleague C, as well as Ms Moses' responses during the Trust's investigation and to the NMC regulatory concerns.

When considering this charge, the panel bore in mind its findings for charge 1. It determined that, on the basis of the evidence before it, Ms Moses' actions found proved in charge 1 is consistent with altering the sound of the alarm settings on Patient A's monitor to stop the alarm from sounding.

Accordingly, the panel found charge 2 proved.

Charge 3

3. Failed to escalate Patient A’s deterioration to a senior member of staff.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, Colleague B and Colleague C.

The panel noted the following evidence from Colleague A’s witness statement:

> *‘When I got to Patient A’s bed space at about 5:50 am I saw on the monitor that* [PRIVATE]*. When questioned Madona turned away from me and did not say anything.*
>
> *When Patient A’s* [PRIVATE] *this should have triggered Madona’s emergency escalation of Patient A to* [Colleague E, Colleague C] *or me, likely by activating the bed space emergency alarm.*
> *[…]*
>
> *While I was working to stabilise Patient A* [Colleague C] *was talking to Madona, I was not present for that conversation. After Patient A’s condition was stable I went through Patient A’s ongoing clinical management plan (**Exhibit SM/1**) with Madona and* [Colleague C]*. Madona appeared to be withdrawn and did not offer any explanation as to why she had not escalated Patient A’s clinical deterioration.’*

The panel found that Colleague A’s account was corroborated by Colleague C, in which she stated:

> ‘[PRIVATE]
> *[…]*

I asked Madona how long Patient A's [PRIVATE] *and why she had not escalated Patient A's* [PRIVATE] *incident to me or the doctor as we were available for assistance* [PRIVATE]*. Her attitude was very cold and she told me that she had not recovered from the previous HR incident, that she had been badly treated by the trust, however she did not reflect on the impact her actions had had on Patient A.'*

The panel also noted the following evidence from Colleague B's witness statement:

'The investigation identified issues with the registrant's practice as a nurse. The main issue was that she failed to escalate the deteriorated patient in her care.
[…]

The registrant wilfully made the omission to appropriately respond to the patient monitor alarm and to escalate the deteriorating patient, it was not done by mistake. Her omission could have been caused by stress and anxiety, she may have found it difficult to handle the pressure subsequently impairing her judgement. She said that she was tired from looking after two patients during the colleague's break, however this does not excuse her failings. It is common practice for all nurses at the unit to look after two patients while a colleague nurse is on break.'

The panel found that Colleague A, Colleague B and Colleague C all provided clear, consistent accounts which generally indicated that Ms Moses was aware of Patient A's deteriorating condition before the intervention of her colleagues and it was her responsibility to escalate this. On the basis of the consensus in witness evidence that Patient A's deterioration should have been escalated and it was not, the panel determined that Ms Moses demonstrated a failure in respect of this charge.

Accordingly, the panel found charge 3 proved.

Charge 4

4. Failed to assist Colleague A in treating Patient A when requesting help.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A, Colleague B and Colleague C.

When considering this charge, the panel bore in mind its findings for charge 3. It noted that in charge 3 it was found that Ms Moses failed to escalate Patient A's deterioration despite being aware of this several hours before the intervention of Colleague A and her other colleagues. In particular, the panel noted the following from Colleague A's witness statement:

> '[PRIVATE] *When questioned Madona turned away from me and did not say anything.'*

The panel was of the view that it was Ms Moses' duty as a nurse to be engaged and provide proactive assistance to support Colleague A for the welfare of the patient in her care and the evidence indicates that she did not. On this basis, the panel determined that Ms Moses demonstrated a failure in respect of this charge.

Accordingly, the panel found charge 4 proved.

Charge 5

5. Your conduct at 1 and/or 2 and/or 3 and/or 4 was lacking in integrity.

This charge is found proved.

When considering this charge, the panel bore in mind its findings for charges 1, 2, 3 and 4. The panel noted that Ms Moses' actions found proved included, muting/altering the

alarm on Patient A's monitor to silence it, failing to escalate the patient's deterioration and failing to assist her colleague to treat the patient when the patient required help.

The panel also considered this charge in the context of the wide ethical responsibilities of a nurse, to act with integrity to ensure the treatment and safety of patients within their care. It concluded that Ms Moses' conduct in charges 1, 2, 3 and 4 were not in accordance with this and fell short of the professional standards and integrity expected of a nurse.

Accordingly, the panel found charge 5 proved.

Charge 6

6. Incorrectly said to Patient A's next of kin that Patient A was being kept artificially alive for organ donation, or words to that effect.

This charge is found NOT proved.

In reaching this decision, the panel took into account that the evidence for this charge refers to a conversation that Ms Moses allegedly had with Patient A's family. It considered that none of the direct witnesses of this conversation (Patient A's family) gave evidence during these proceedings, therefore the accounts given of the alleged conversation have not been tested in evidence.

Having noted that the conversation was not directly witnessed by any of the witnesses who gave evidence during these proceedings, with no direct evidence of the wording specifically used by Ms Moses, the panel was not satisfied that the NMC discharged its burden of proof.

It was therefore not satisfied that on the balance of probabilities, that Ms Moses said to Patient A's next of kin that Patient A was being kept artificially alive for organ donation, or used words to that effect.

Accordingly, the panel found charge 6 not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Moses' fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

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

Mr Smalley invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision. He stated that the Code sets out the professional standards that nurses must uphold, and these are the standards that patients and members of the public expect from health professionals. He submitted that on the basis of the charges found proved Ms Moses

has breached the following sections of the Code: 1.1, 1.2, 1.4, 3.1, 8.2, 8.5, 8.6, 13.1, 13.2, 16.1, 20.1 and 20.2.

Mr Smalley identified the specific, relevant standards where he submitted that Ms Moses' actions found proved in charges 1 to 5 amounted to professional misconduct.

Submissions on impairment

Mr Smalley 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. It also included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Mr Smalley submitted that the first three limbs of the test set out by Dame Janet Smith in the fifth Shipman report and adopted in *Grant* were engaged in this case:

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 profession into disrepute;
c) Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession;
d) …

Mr Smalley submitted that Ms Moses placed Patient A at unwarranted risk of harm. He submitted that through her failure to provide care to Patient A, she breached fundamental tenants of the profession, thereby bringing the profession into disrepute.

Mr Smalley submitted that given the panel's findings in relation to lack of integrity, it can be said that the concerns in this case are more difficult to put right. He referred to Ms

Moses' response during the Trust's investigation and to the NMC regulatory concerns, where there have been some admissions. However, he submitted that there has been a degree of deflection in terms of responsibility in Ms Moses' responses. He submitted that on this basis the concerns raised in this case have not been fully remediated, and there is a risk of repetition. He submitted that therefore a finding of impairment is necessary to protect the public.

Mr Smalley submitted that a finding of current impairment is also necessary in the public interest to uphold professional standards. He submitted that public confidence in the profession would be undermined if a finding of impairment were not made in these particular circumstances, which involved lack of integrity in the provision of care to an extremely vulnerable patient.

The panel accepted the advice of the legal assessor which included reference 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 Ms Moses actions did fall significantly short of the standards expected of a registered nurse, and that Ms Moses' actions amounted to a breach of the Code. Specifically:

> '***1 Treat people as individuals and uphold their dignity***
> *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*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***

3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages

8 Work co-operatively
8.2 maintain effective communication with colleagues
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

13 Recognise and work within the limits of your competence
13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required

16 Act without delay if you believe that there is a risk to patient safety or public protection
16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered the charges individually and collectively as well as the circumstances of the case as a whole.

The panel considered that in charges 1 to 4 Ms Moses altered the alarm on a vulnerable patient's monitor to silence it while the patient was in a critical and deteriorating state,

failed to escalate the deterioration in his state, and failed to assist with treatment to preserve the patient’s life. It found that Ms Moses’ actions caused a vulnerable patient unwarranted harm. The panel was of the view that as an experienced nurse, the nature of Ms Moses’ clinical omissions and failures demonstrated an unacceptable standard of professional practice.

The panel found Ms Moses’ actions in charges 1 to 4 compounded by lack of integrity found proved in charge 5. It regarded integrity as fundamental to the nursing profession, and by wilfully omitting to respond appropriately to a patient’s monitor alarm, to escalate or help the deteriorating patient, Ms Moses’ lack of integrity as a nurse creates an unsafe environment for patients. It determined that individually and collectively Ms Moses’ actions would be considered deplorable by fellow practitioners and damaging to the trust that the public places in the profession.

The panel therefore concluded that Ms Moses’ actions found proved in charges 1 to 5 fell 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, Ms Moses’ fitness to practise is currently impaired.

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

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

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

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

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

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

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

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

d) ....'

The panel determined that the first three limbs in the above test were engaged in this case.

Taking into account all of the evidence adduced in this matter, the panel found that Patient A was caused actual harm as a result of Ms Moses' misconduct. The panel determined that Ms Moses' misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel next went on to consider the matter of insight. It noted initially that Ms Moses had made some admissions at the local level investigation and in response to the NMC regulatory concerns. However, the panel noted that the written reflections became self-centred and there were attempts to deflect the responsibility of her actions onto others. It found that it had not received any evidence to suggest that Ms Moses has demonstrated an understanding of how her actions caused patient harm, how this impacted negatively on the reputation of the nursing profession and how she would handle situations differently in the future. It determined that Ms Moses demonstrated limited insight and remorse.

The panel determined that the misconduct in this case evidenced behaviour that is inherently more difficult to put right, since it raises concerns about Ms Moses' integrity as a nurse. It carefully considered the evidence before it in determining whether or not Ms Moses has taken steps to strengthen her practice. However, the panel has not received any information to suggest that Ms Moses has taken any steps to address the specific concerns raised about her practice, such as deeper reflection on the consequences of her actions or testimonials.

The panel was of the view that due to the limited insight and remorse, as well as the lack of evidence of strengthened practice, there remains a risk of repetition. The panel considered that Ms Moses' actions set out in the charges found proved demonstrated behaviour that lacks integrity and fails to acknowledge clinical protocols, which inevitably led to unsafe practice. On the basis of all the information before it, the panel decided that there is a risk to the public, which requires a finding of current impairment on public protection grounds.

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 concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Moses' fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Moses 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 Ms Moses off the register. The effect of this order is that the NMC register will show that Ms Moses 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

Mr Smalley informed the panel that the NMC was seeking the imposition of a striking-off order.

Mr Smalley outlined aggravating features he identified in this case:

- Significant harm caused to Patient A, in addition to distress caused to the family of Patient A;
- Neglect of a vulnerable patient, who was entirely reliant on one-to-one care from Ms Moses;

- Limited insight.

Mr Smalley referred the panel to the NMC guidance on sanctions for serious cases (reference: SAN-2), in particular, the section relating to 'a*buse or neglect of children or vulnerable people'.* He stated that Patient A was at his most vulnerable, and entirely reliant on the care provided by Ms Moses. He highlighted that the guidance states that '*any allegation involving the abuse or neglect of children or vulnerable people will always be treated seriously… any nurse, midwife or nursing associate who is found to have behaved in this way will be at risk of being removed from the register.'* He submitted that as a result, this was not a case where there are reasons to depart from the imposition of a striking-off order.

Mr Smalley also outlined mitigating features he identified in this case:

- Some admissions at local level investigation and in response to the NMC regulatory concerns;
- Misconduct occurred during the course of one shift.

Notwithstanding the mitigating features identified, Mr Smalley submitted that making no order or imposing a caution order would be inadequate given the public protection concerns in this case.

Mr Smalley submitted that a conditions of practice order would not be appropriate given the panel's findings of lack of integrity, which is attitudinal in nature. He submitted that in this respect, there are no workable conditions that could be imposed to protect the public and address public interest.

Mr Smalley highlighted that the next available sanction would be a suspension order. However, he submitted that given the serious departure from professional standards, this case is too serious to deal with by way of a suspension. He submitted that, therefore a striking-off order was the only sanction which would sufficiently protect the public and maintain public confidence in the profession.

Decision and reasons on sanction

Having found Ms Moses' 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:

- Conduct which has caused serious harm to a patient, as well as distress to the patient's family;
- Neglect of a vulnerable patient, who was entirely reliant on one-to-one care from Ms Moses;
- Limited insight into failings; and
- Misconduct which relates to a two-hour period when the patient was being continuously monitored. During this time Ms Moses had a duty to escalate Patient A's deterioration to a senior member of staff in order to maintain the patient's safety.

The panel also took into account the following mitigating features:

- Some admissions at local level investigation and in response to the NMC regulatory concerns;
- Misconduct factually occurred on one date.

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 Ms Moses' 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 Ms Moses' 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 Ms Moses' 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 and seriousness of the charges in this case. It identified that the misconduct in this case relates to lack of integrity and is reflective of attitudinal problems, which is difficult to address through conditions of practice. The panel therefore concluded that the placing of conditions on Ms Moses' registration would not adequately protect the public or satisfy the public interest.

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 panel considered that whilst the misconduct in this case occurred on one date, the incident occurred over a period of two-hours where Ms Moses disregarded multiple opportunities to provide adequate care to maintain a patient's safety. It took the view

that Ms Moses' actions reflected attitudinal problems. The panel acknowledged that it has not been presented with any evidence of repetition of similar behaviour since the referral. However, it noted that Ms Moses has not worked in a clinical setting since the referral. The panel also took into account that it had limited evidence of insight and remorse, therefore it found a consequent risk of repetition.

The conduct, as highlighted by the facts found proved, was 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 Ms Moses' actions is fundamentally incompatible with remaining on the register. 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?*

The panel noted that Ms Moses demonstrated limited insight and remorse into the misconduct in the case, and where she has reflected there has been notable attempts to deflect blame and responsibility. Additionally, it noted that there was no evidence to demonstrate that Ms Moses has strengthened her practice in respect of the specific concerns in this matter.

The panel considered that the misconduct in this case related to Ms Moses demonstrating serious failures in her neglect of Patient A at a time when Ms Moses was aware that Patient A's condition was deteriorating. The panel was therefore concerned regarding her lack of integrity as a nurse. It noted that Ms Moses' actions impacted on the safety of Patient A and presented a risk of harm to patients if she were to act in a

similar manner in the future. The panel found that Ms Moses has not demonstrated that she can be trusted as a registered nurse to maintain a safe working environment, which raises fundamental questions about her professionalism. It reached the conclusion that public confidence in the profession would not be maintained if Ms Moses remained on the register. Taking account of the SG and the guidance on serious cases, the panel concluded that in Ms Moses' case nothing less than a striking-off order would maintain professional standards, keep the public protected and address the public interest.

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 Ms Moses' actions in bringing the profession into disrepute by adversely affecting the public's view of how registered nurses should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

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 Ms Moses in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period or the conclusion of an appeal, the panel has considered whether an interim order, until the striking-off order takes effect, 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 is in Ms Moses' own interests.

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

Submissions on interim order

The panel took account of the submissions made by Mr Smalley. He submitted that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest. He invited the panel to impose an interim suspension order for a period of 18 months for the reasons stated in 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 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 to allow time for any possible appeal.

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

That concludes this determination.