Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 13 November 2023 – Wednesday, 15 November 2023
Monday, 13 May 2024 – Friday, 17 May 2024
Monday, 20 May 2024 – Tuesday, 21 May 2024

Virtual Hearing

Name of Registrant:	**Annita Nyasha Nyabunze**
NMC PIN:	11E0374E
Part(s) of the register:	Registered Nurse Learning Disabilities Nursing – December 2011
Relevant Location:	Norfolk
Type of case:	Misconduct
Panel members:	Anthony Mole (Chair, lay member) Frances Clarke (Registrant member) Jocelyn Griffith (Lay member)
Legal Assessor:	Richard Tyson (13 – 15 November 2023, 20 May 2024) Michael Levy (13-17 May 2023)
Hearings Coordinator:	Ruth Bass (13 – 15 November 2023) Max Buadi (13 - 20 May 2024) Anya Sharma (21 May 2024)
Nursing and Midwifery Council:	Represented by Simon Gruchy, Counsel instructed by the NMC
Ms Nyabunze:	Present and represented by Hywel Evans, Counsel instructed by the Royal College of Nursing (RCN)
Facts proved:	Charges 1, 2a and 2b

Facts not proved:	None
Fitness to practice:	**Impaired**
Sanction:	**Conditions of Practice Order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Application to postpone the hearing

At the outset of the hearing Mr Evans, on your behalf, made an application to postpone the hearing.

Mr Evans submitted that, due to the number of hearing days having been curtailed from six to three and a half, there would be insufficient time to deal with the facts stage of the case, causing the case to go part heard which would cause unfairness to you. He submitted that going part-heard and resuming several months later would be unfair to you, and would result in having to cross-reference witness evidence some time after hearing from them.

Mr Evans submitted that it would be in everyone's best interest to deal with the matter expeditiously, and postponement would cause some inconvenience for the witnesses ready to give evidence today, but that this did not outweigh the prejudice to you in proceeding and adjourning during the facts stage. He submitted that the evidence would not be fresh in everyone's mind when the hearing resumed.

Mr Evans informed the panel that there had been some confusion regarding the acceptance of the expert witness' report. He informed the panel that you denied the charges, the expert evidence was not agreed, and that you would be seeking to challenge the report of the expert witness. Mr Evans accepted that in the Case Management form the evidence bundle had been agreed to the effect that there was no issue with the expert witness' evidence being read. However, he submitted that there was now a contradiction where the facts are denied yet the evidence is agreed, and that it would be unfair to you if you were not able to challenge the evidence of the expert witness. Mr Evans further submitted, in light of his intention to cross-examine the expert witness during live evidence, that there would be insufficient time in this sitting for the expert witness' evidence to be completed, and that going part-heard during her evidence would result in further unfairness.

Mr Gruchy, on behalf of the Nursing and Midwifery Counsel (NMC), informed the panel that the NMC were ready to proceed in line with the acceptance of the information contained in the Case Management Form dated 12 September 2023, which recorded your position as all statements and witness evidence having been agreed. He submitted that it was regrettable that this application was now being made due to the sensitivities of the case. Mr Gruchy accepted that there was plausible argument for the expert witness' evidence not going part-heard, and acknowledged the issue of fairness to you should a hearsay application be made in respect of this witness. However, he maintained that the NMC was ready to proceed today.

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

The panel was of the view that, although it was unsatisfactory that the evidence and witness statements had been previously agreed on your behalf by your representative, in all fairness the expert witness would need to be called to give live evidence in light of the fact that you are denying the allegations and had always maintained this position. It therefore decided to proceed with the case and hear evidence from the two live witnesses available, who were present at the time of the alleged incidents, to avoid any further potential memory fade. The panel further decided that it would hear evidence from the expert witness, despite previous agreement made by the RCN, to allow you to put your case fully. However, it determined that it would not hear such evidence until the hearing resumed to avoid the expert's evidence going part heard. In making this decision, the panel also took into account the fact that it would have the benefit of transcripts for the evidence heard, and determined that there would be no unfairness to you as a result.

Details of charge

'That you, a registered nurse, on 28 April 2018, in relation to Resident A:

1) *Failed to commence and/or instruct others to commence cardiopulmonary resuscitation when it would have been clinically appropriate in the light of Resident A's presentation.*

2) *As the nurse in charge, failed to demonstrate leadership throughout the emergency in that:*
   a) *You failed to manage the clinical team in light of the situation;*
   b) *You failed to allocate tasks appropriately in light of the competencies and experiences of the clinical team.*

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

After the charges was read, the panel heard from Mr Evans, who informed the panel that you denied all the charges.

Decision for parts of the hearing to be heard in private

During the course of Witness 1's evidence, [PRIVATE]. The panel of its own volition made a retrospective decision that any matters [PRIVATE] should be heard in private, in accordance with Rule 19 (3) of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) to protect their right to privacy. There were no objections from either party to this proposal.

Consideration of an interim order upon hearing being adjourned

Having determined to adjourn the hearing due to time constraints, the panel considered whether an interim order was necessary in accordance with Rule 32 (5) of the Rules, and invited representations from the parties.

Mr Gruchy informed the panel that there was no interim order currently in place, and that the NMC would not be making an application for one to be imposed. He submitted that the issue of imposing an interim order was entirely a matter for the panel.

Mr Evans confirmed that you are currently working as a registered nurse. He also submitted that this was a matter for the panel, but invited the panel to consider the fact there is no interim order currently in place.

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

The panel gave anxious consideration to the imposition of an interim order. Whilst having made no findings of fact, the panel had regard to the evidence provided so far but was mindful that it has yet to hear all the evidence in this case, including hearing evidence from you.

The panel was of the view that in light of the seriousness of the allegations and that there arose from these matters the possibility of a risk of harm to the public, an interim order appeared desirable, but this did not reach the threshold of necessity required for an interim order now to be imposed.

In reaching this view, the panel took into consideration that you have been working for a considerable period of time without restriction and without any apparent difficulties. It also had regard to the reference from your current employer dated 13 January 2023 which recorded that you had undertaken training in resuscitation and your performance was being monitored. The panel found the reference to be generally positive, despite there being two minor concerns which it noted were not connected to resuscitation. It therefore concluded that any risk of repetition of the alleged events, at this stage, was low. The panel therefore concluded that an interim order was not necessary at this stage to protect the public, be otherwise in the public interest, nor in your interest.

That concludes this determination.

The hearing resumed on 13 May 2024 and Witness 3 gave evidence.

Background

The NMC received a referral on 9 March 2019 from Jeesal Group where you had been employed since 2014.

At the time of the alleged concerns, you were working as a registered nurse at the Lodge, Cawston Park Hospital, Aylsham ("the Lodge"). On 27 April 2018, you were working at a night shift at the Lodge which is an inpatient secure unit for adults with learning disabilities and mental health conditions. You were the only nurse on shift with two carers short that evening.

At approximately 03:13 on 28 April 2018, Patient A was found to be unresponsive in her room by a carer, who called for your assistance. When you attended to Patient A, your initial assessment was that you could not find a pulse and that it was difficult to assess if Patient A was breathing.

You went to obtain some equipment to check Patient A's blood oxygen level. However, you allegedly failed to recognise that Patient A was in cardiac arrest. It is alleged that you failed to respond to the emergency situation as expected by starting resuscitation procedures and giving clear instructions/leadership to the staff on duty.

The ambulance was called at some stage, however it is alleged that you still did not recognise the urgency of the situation. It is alleged that cardiopulmonary resuscitation (CPR) was not commenced until the paramedics arrived, 18 minutes after Patient A was first found to be unresponsive.

The efforts of the paramedics were unsuccessful.

You were initially moved to non-clinical duties as an alternative to suspension but were suspended when a criminal investigation commenced.

You remained suspended until February 2020 when the police decision was to take no further action.

You returned to work on 17 February 2020. A coroner's inquest was held in November 2020. You continued to work at Cawston Park Hospital until it closed in May 2021.

Decision and reasons on application to admit the evidence of Witness 5 and Witness 6 as hearsay evidence

The panel heard an application from Mr Gruchy to admit the police statements and inquest statements of Witness 5 and Witness 6 as hearsay evidence. He submitted that there are also telephone notes of Witness 5, dated 24 March 2022, and Witness 6, dated 13 April 2022, and conceded that the hearsay evidence is not as strong when it comes to admitting telephone notes into evidence.

Mr Gruchy referred the panel to the case of Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin) which pertains to the admissibility of hearsay evidence. He submitted that the statements are clearly relevant to the charges and they are not sole and decisive.

Mr Gruchy referred the panel to the hearsay bundle and submitted that the NMC had made attempts to secure the attendance of both Witness 5 and Witness 6 but had been unable to do so.

Mr Gruchy submitted that the police statement and inquest statements were provided in a formal setting and therefore they could be considered reliable. He submitted that the aforementioned telephone notes, in the exhibit bundle, did not meet the same threshold of reliability. He further submitted that the telephone notes of Witness 5 and Witness 6 are detailed notes of conversations and the contents are supported by their respective police statements and inquest statements.

Mr Evans submitted that he did not oppose the application as far as the admissibility of the evidence of Witness 5 and Witness 6. He submitted he would address what weight the panel should apply to the evidence in his closing submissions on the facts.

The panel heard and accepted the legal assessor's advice, during which he referred the panel to the guidance in *Thorneycroft*.

The panel determined that the evidence of Witness 5 and Witness 6 was not the sole and decisive evidence in support of the charges. It noted the statements from Witness 5 and Witness 6 had been taken in an official capacity and the telephone notes were broadly in line with the original statements the witnesses had given for the purposes of the investigation which were taken nearer to the incident date. The panel noted it had already heard evidence from Witness 1 and Witness 2 whose evidence appeared to support the evidence of Witness 5 and Witness 6. The panel also noted that it is due to hear more evidence from other witnesses.

The panel found that the evidence of Witness 5 and Witness 6 was relevant to the charges as they were both present on the night in question. It also noted that Mr Evans did not oppose the application so it was accepted that there would be no unfairness to you. The panel considered it could give the statements of Witness 5 and Witness 6 the appropriate weight, acknowledging that the evidence would not be subject to questioning and cross examination by you.

In light of the above, the panel decided that it would be fair and relevant to admit the evidence of Witness 5 and Witness 6 as hearsay evidence.

Decision and reasons on facts

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

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: At the relevant time, agency healthcare assistant at the Lodge;
- Witness 2: At the relevant time, a Paramedic for the East of England Ambulance NHS Trust;
- Witness 3: Expert Witness, registered nurse, practitioner with a specialist interest in Cardiology;
- Witness 4: At the relevant time, Support worker at the Lodge.

The panel also heard evidence from you under oath.

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) Failed to commence and/or instruct others to commence cardiopulmonary resuscitation when it would have been clinically appropriate in the light of Resident A's presentation.

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence, the exhibits and your evidence.

The panel first considered whether you had failed to commence CPR when it would have been clinically appropriate in the light of Resident A's presentation.

In order to find this part of the charge proved, the panel had to be satisfied that you had a duty to commence CPR when it would have been clinically appropriate in the light of Resident A's presentation.

The panel took account of the evidence of Witness 3. In her "Nursing Practice Report" under the heading "Part Two – Nursing Standards Expected at Time of Material Event" she stated:

> *"…the basic principles of BLS are taught during pre-registration training through simulation and competence assessment with a mannequin. BLS knowledge and skills are again revisited through mandatory training, which incorporates theory and practice, including competency assessments through simulation with a mannequin. The expectation is that the registered nurse maintains these skills and can apply them in practice as required.*
>
> *… I would expect all registered nurses to be trained in BLS and attend mandatory updates. I would expect all registered nurses to be able to recognise cardiac arrest, call for help and initiate CPR, with or without the use of an automated external defibrillator."*

Witness 3 reiterated the above in her oral evidence. She further stated that unless there is a “Do not attempt cardiopulmonary resuscitation” order in place, a registered nurse is duty bound to resuscitate.

The panel bore in mind that it had heard evidence that stated that staff at the Lodge were trained every three years in CPR.

In light of the above, the panel was satisfied that you had a duty to commence CPR when it would have been clinically appropriate to do so.

The panel then moved on to consider if you had failed in your duty to commence CPR for Resident A. The panel therefore had to consider if and when it would have been clinically appropriate to commence CPR on Resident A. Witness 3 in her “Nursing Practice Report” stated:

> *“Upon receiving the summons to an unresponsive patient, the registrant should have undertaken a rapid assessment of Resident A as per BLS guidance...The absence of a pulse and absent or abnormal breathing should have triggered recognition of cardiac arrest. CPR should have been commenced immediately. As per the medical emergency resuscitation policy, a ‘code blue’ emergency call for assistance should have been made, along with a 999 call. Emergency equipment should have been brought to Resident A’s room. Additional registered nurses should have responded to the ‘code blue’ emergency call to assist.”*

The panel noted that Witness 3 in her oral evidence stated that when a patient is collapsed, a registered nurse is checking for “signs of life” and “breathing”. She stated that a registered nurse, if confident to do so, can check a pulse while at the same time checking to see if a patient is breathing. She stated that in the absence of breathing you start CPR.

Witness 3, in her “Nursing Practice Report” stated:

"For each minute that passes without CPR, the chances of survival diminish, and by four minutes, critical organs, such as the brain, suffer irreversible damage."

Witness 3 stated in her oral evidence that starting chest compressions as soon as possible was the most important thing in the "chain of survival"

The panel bore in mind that in your own evidence, you stated that when you were alerted to Resident A's condition, you went to her room. In your Police Statement, dated 12 February 2019, you stated:

"At about 03:20 am [Witness 5] came to me very distresses asking me to check Resident A. I immediately went with him to her room and I saw Resident A was on her back but slightly on her right side facing the wall…I could not immediately see if she was breathing and so I shook her and calling her name. I opened her airway and I put her in the recovery position. I checked for a pulse at her wrist but couldn't tell if she had one…"

In your inquest statement, dated 20 May 2019, you stated:

"I was also incredibly shocked to see [Resident A] in this condition. I observed Resident A laying on her right side and there was blood on the right side of her face and on the pillow, the blood appeared dark in colour and her eyes were closed. I shook her shoulders and called out her name but unfortunately, there was no response. I left her laying on her right side and proceeded to open the airway and put her into her recovery position. I checked the radial pulse but it was difficult to locate and I could not tell if she had one. Resident A's hand felt slightly warm; however, it was very difficult to tell I Resident A was still breathing, as I could not seem to find a pulse or get a response.

At this point, I requested [Witness 5] to go to the nurse's station where the phones and radio handsets were on charge and call for help/999."

In light of your accounts, the panel bore in mind the evidence of Witness 3. It determined that when you found that Resident A was in a collapsed state, unresponsive, demonstrating no signs of life and was not obviously breathing, then it was clinically appropriate for you to commence CPR. It also bore in mind that Witness 5, who was not a registered nurse, recognised that Resident A was not breathing and alerted you immediately. Witness 5 in his police statement, dated 3 March 2019, stated:

> *"I realised straightaway something was very wrong. She was not breathing. She was very stiff and her left arm was on her chest…"*

However, it was clear to the panel that, by your own evidence, you did not commence CPR when you first entered and examined Resident A with Witness 5.

The panel also noted that in your inquest statement, dated 20 May 2019 you stated:

> *"I was unable to decide whether Resident A was breathing nor was I able to locate her pulse so I went to get the relevant equipment to check the vital observations. I decided to use the equipment because it would have provided me a more accurate response as to whether Resident A was breathing. I went to obtain the Pulse Oximetre, which is a method for monitoring a person's oxygen saturation, the blood pressure machine and the temperature thermometer; these were in the clinic room about 50 metres away from Resident As room…*
>
> *… I arrived back at the room and attempted to get a reading of oxygen saturation from Resident A. When I tried to use the finger pulse oximeter I noticed that Resident A's fingers had changed colour and I could not obtain a reading."*

The panel bore in mind the evidence of Witness 3. It was of the view that when you could not obtain a reading, after returning to Resident A with monitoring equipment, this would have been another clinically appropriate time to commence CPR. However, you did not do this.

The panel further noted that at the inquest and at this hearing you stated that you had left Resident A on the first occasion to obtain the emergency bag (the green bag), the

defibrillator and oxygen. You stated you could not find it as it was missing and the only equipment you could find was the vital signs monitoring equipment. The panel considered that this was different from your original account to the Police that clearly stated you went to find the monitoring equipment and you made no mention at that time of looking for the emergency bag. The panel accepted that this incident was stressful and shocking to all parties and it was understandable that your recollection would have changed over the significant period of time that has passed.

However, based on your earlier account to the police and the evidence of the other witnesses, the panel found, on the balance of probabilities, that you left Resident A's room on the first occasion with the intention only of obtaining the monitoring equipment. On your first examination of Resident A, despite the lack of response, you failed to recognise CPR was required immediately and that you should have done so.

The panel concluded it was more likely than not that you only realised the urgency of the situation when you returned with the monitoring equipment and noticed a physical change in Resident A's fingers and were still unable to obtain any response. However, again you did not initiate CPR when you should have done so.

The panel found that it was at this point Witness 6 had independently, as seen on the CCTV, left the corridor to make the 999 call for an ambulance. After you left Resident A for a second time you took over this call from Witness 6.

The panel further noted on the CCTV when you left Resident A's room on the second occasion, before you took the 999 call, you appeared to speak briefly to the staff in the corridor and then left. You did not appear to ensure any appropriate action was taking place. The ambulance staff arrived shortly afterwards after you assisted them with entry to the premises.

The panel also noted that in your oral evidence, you said that you could not move Resident A by yourself and that due to her position on the bed (she was lying on her right hand side), she was morbidly obese and that the bed was pushed against a wall

meant that it was not safe to commence CPR. You also said that if Resident A was rolled onto her back, she would have fallen to the floor.

However, the panel was of the view that you had enough support staff, in very close proximity, who you could have instructed to assist you in moving Resident A, either onto her back or onto the floor, so you could commence or attempt to CPR. The panel had no evidence before it of any attempt to resolve this potential safety issue in an emergency situation from your own account or from the evidence of the healthcare assistants on duty.

The panel also noted that there is no evidence within the witness statements of Witness 1 or the police statement of Witness 5 and Witness 6, all of whom were present, that there was an attempt to move Resident A into a position so that CPR could be performed when it was clinically appropriate. Additionally, the panel had sight of the CCTV footage of the incident and, whilst there was no sound, there was no physical indication that you instructed or attempted to seek others to assist you.

The panel also bore in mind that when the paramedics arrived, including Witness 2, and that they along with Witness 5, were able to get Resident A onto the floor to commence CPR. In the panel's view a registered nurse with support staff would have been able to get Resident A onto the floor to commence CPR.

In light of the above, the panel was satisfied that, on the balance of probabilities, you failed to commence CPR when it would have been clinically appropriate in the light of Resident A's presentation.

The panel then moved on to consider whether you failed to instruct others to commence CPR when it would have been clinically appropriate in the light of Resident A's presentation.

Witness 3 in her "Nursing Practice Report", under the title "Leadership as a Registered Nurse" stated:

"The responsibilities of a registered nurse include team leadership and delegation. Where the nurse is in charge of a shift, the expectation is that they will have oversight of the clinical setting and manage the team, including the delegation of tasks, as per the Code…

…In an emergency, such as with an unresponsive patient, I would expect the nurse to recognise the urgency of the situation, take charge, lead the response, and actively manage team members, particularly where the team members are unregistered support workers."

The panel was satisfied that that you had a duty to instruct others to commence CPR and to ensure they were following your instructions to ensure emergency procedures were followed correctly. It had already established that it had been clinically appropriate to do so when you first saw Patient A after being alerted to her condition by Witness 5. It therefore had to establish if you had instructed the support workers to do this.

The panel then took account of Witness 1's witness statement where she stated:

"When Annita came…The three of them went to Patient A's room, and [Witness 6] followed shortly after. I could not hear anything from the room. Annita was in there for less than a minute. She walked past me with the radio in her hand and went to the office. She returned moments later holding in one hand a small bowl/basket that usually held the pulse machine and the radio in the other. I saw her go into Patient A's room for about a minute and she started to walk towards me, whilst holding the radio and the pulse machine.

[Witness 6], who was by Patient A's room, raised her voice and asked Annita something along the lines of 'don't you think you need to do CPR?' or 'won't you do CPR?' Annita turned her back to me and said, 'you guys should do it'. Sarah said they i.e., she, [Witness 6], and [Witness 4], could not do it because they did not have the training. Annita just walked off to the office and did not return."

Witness 4 in his witness statement stated:

"When Annita left to get "her stuff" she did not tell me or [Witness 5] to do anything so we waited."

However, Witness 4 in his oral evidence could not recall if you had instructed him to commence CPR to Resident A.

In your inquest statement, dated 20 May 2019, you stated:

"I left the clinic and I was talking to the operator on the telephone. I walked with [Witness 6] out of the office going in the direction of Resident A's room and [Witness 5] was in the corridor. I then saw the ambulance lights outside and then I asked Sarah and [Witness 5] to go start CPR to which [Witness 6] answered, "you come and do it". [Witness 5] answered, "I don't know how to do it". I was surprised… I felt that when I gave instructions to the support staff they were not acting on my instructions."

You reiterated this in your oral evidence. The panel noted that you asked Witness 5 to perform CPR at some stage during the incident with Resident A.

The panel considered the evidence of Witness 3. It noted Witness 3 explained that if you were to "instruct" someone to commence CPR, then that would mean that you provide clear direction of what is expected. It was of the view that you would have to ensure that those you instructed knew how to perform CPR and were actually performing CPR before you left the scene.

The panel accepted your oral evidence that on the second attendance to Resident A's room, you said to Witness 5 "We need to do CPR". However, you also said that this was not safe and the panel found that any instruction given to a colleague would have been unclear and confusing. In addition, the panel found that if you had specifically requested CPR be commenced by Witness 5, or any other person, you are under a duty to ensure that they understand the instructions and are capable of carrying out the task. The panel

concluded that in this incident, after examining Resident A, you left the scene and no such action was undertaken by you.

The panel noted that Witness 5 in his inquest witness statement, dated 3 March 2019, stated:

> *"I thought Anita should have taken the lead and instructed us what to do…On that night the paramedics turned up in a few minutes. It was very quick. Once they came into the room they asked us if we had done CPR? I said "no"…They asked me to help them and I did chest compressions how they told me. I felt able to do this because they told me how to do it."*

The panel bore in mind that Witness 5 reiterated the fact that he assisted the paramedics with CPR in his Police record of interview dated 11 July 2019.

The panel was mindful that this was hearsay evidence from Witness 5. However, it accepted his explanation and was of the view that this demonstrated that he was given no clear instruction from you to perform CPR, nor did you in your evidence satisfy the panel that you had given clear instructions other than referencing "We need to do CPR". Nevertheless, when Witness 5 was given clear instruction by the paramedics to commence CPR, he was able to do so.

In addition the panel noted that no support workers had commenced CPR until the paramedics instructed Witness 5 to do so. This is also supported in Witness 2's Coroner's statement, dated 11 April 2019, where he stated:

> *"To note there was no CPR being undertaken by the staff or any signs of an AED or resus trolley."*

Witness 2 repeated this in NMC witness statement, dated 18 September 2023:

> *"…when we arrived in Patient A's bedroom, she was lying on her side, with a very mottled colour in appearance and no movement, and there was no CPR*

being undertaken by hospital staff, nor were there any signs in the room of an Automated External Defibrillator ('AED') or resuscitation trolley. This was despite the fact that when the call for dispatch was received, [the second paramedic] and I were told that CPR was underway."

The panel therefore found that when you had indicated CPR should be commenced to the staff present that night, this was a mere request and not an instruction as per your obligation as a registered nurse. Additionally, there is no evidence before the panel that you had ensured that your instruction had been understood and that CPR had been commenced.

The panel accepted that you were on an unfamiliar ward having been allocated at short notice. The panel also noted that the support staff had stated they were shocked and it is possible that they were hesitant in taking action. This included yourself. The panel further noted that this was an unexpected and stressful situation. However the panel did not consider that this absolved you of your duties as a registered nurse in that you must show leadership and give clear direction in any emergency situation especially as the nurse in charge with junior staff.

In light of the above the panel was of the view that, on the balance of probabilities, you failed to instruct others to commence CPR when it would have been clinically appropriate in the light of Resident A's presentation.

The panel therefore found this charge proved.

Charges 2a and 2b

2) As the nurse in charge, failed to demonstrate leadership throughout the emergency in that:
    a) You failed to manage the clinical team in light of the situation;
    b) You failed to allocate tasks appropriately in light of the competencies and experiences of the clinical team.

These sub-charges are found proved.

The panel considered each of these sub-charges separately but as the evidence in relation to each was broadly similar it dealt with them under one heading.

The panel noted that in your oral evidence, you stated you were not supposed to be working at the Lodge on the night in question. You stated that the agency staff who was supposed to do the night shift cancelled at the last minute and therefore you were asked to cover. The panel bore in mind that on this night, you were the only nurse on shift thus making you the nurse in charge.

The panel took account of the evidence of Witness 3. In her "Nursing Practice Report" under the heading "Part Two – Nursing Standards Expected at Time of Material Event".

Witness 3 in her report under the sub-heading "What Should Have Happened" stated:

> *"As the nurse in charge, the registrant should have demonstrated leadership throughout the emergency response by remaining calm and authoritative, delegating tasks, and ensuring that they were completed. The initial tasks to allocate include calling for help ('code blue' and a 999 call), commencing CPR, and obtaining emergency equipment."*

The panel noted that in your own evidence, you stated that you had made an attempt to instruct members of your team to commence CPR and call emergency services. However, you stated that they were not responding and therefore felt like you had to do everything yourself.

The panel took account of the CCTV evidence. When Witness 5 called you to Resident A's room, the panel noted that you spent less than a minute in her room. You then left Resident A's room, for approximately four minutes, to get the vital signs monitoring equipment. You were not in the room for very long and then subsequently left. Witness 1 in her witness statement stated:

"Annita just walked off to the office and did not return. In total she was in Patient A's room for a maximum of two minutes. I do not remember her saying anything else to us e.g., instructions on what to do etc."

The panel noted that upon being alerted to a medical emergency, it appears that you did not provide the team with any specific direction or instructions. You did not call a "code blue", nor did you call 999.

In your inquest statement, dated 20 May 2019, you stated:

"I requested [Witness 5] to go to the nurse's station…and call for help/999. [Witness 5] appeared petrified…So again, I told him to go and find [Witness 6] and tell her to call for help…I was unable to call the ambulance from Resident A's room as the handset…was on charge at the nurse's station…I was unable to undertake the telephone call to the ambulance service and undertake vital observations…at the same time".

However, Witness 6 in her inquest statement, dated 1 March 2019, where she stated that she, of her own volition, called the ambulance service:

"I heard a colleague [Witness 5] shout "[Witness 6] I think we lost". I went with him to her room and we checked Resident A…I asked [Witness 5] had anyone called the nurse or asked for an ambulance? [Witness 5] told me no as the first person he'd called was me. At this point Annita, the nurse came. I said to her "Are you going to do CPR?" and she said "no I can't". I asked "what do you mean you can't?" She just replied "no, I can't". At this point I made the decision to call an ambulance, I went into the office to do this. I called 999 and answered questions about Resident A. There were some questions about Resident A's medication I couldn't answer so I went to get Annita. When I went into Resident A's room, no one was doing CPR. I wasn't trained in CPR so I couldn't do it but I felt that somebody should have done it..."

The panel was mindful that this was hearsay evidence from Witness 6. However, Witness 1 in her witness statement stated:

> *"When Annita came…The three of them went to Patient A's room, and [Witness 6] followed shortly after. I could not hear anything from the room. Annita was in there for less than a minute. She walked past me with the radio in her hand and went to the office. She returned moments later holding in one hand a small bowl/basket that usually held the pulse machine and the radio in the other. I saw her go into Patient A's room for about a minute and she started to walk towards me, whilst holding the radio and the pulse machine.*
>
> *[Witness 6], who was by Patient A's room, raised her voice and asked Annita something along the lines of 'don't you think you need to do CPR?' or 'won't you do CPR?' Annita turned her back to me and said, 'you guys should do it'. Sarah said they i.e., she, [Witness 5], and [Witness 4], could not do it because they did not have the training. Annita just walked off to the office and did not return. In total she was in Patient A's room for a maximum of two minutes. I do not remember her saying anything else to us e.g., instructions on what to do etc."*

The panel bore in mind that Witness 3 in her oral evidence stated that she would expect support workers in a care setting would listen and follow instruction from a person who was taking a leadership role in the circumstances. She stated that a registered nurse cannot do everything alone all at once. She further stated that CPR is the priority along with a call for help. The panel was of the view that Witness 1's statement and the CCTV footage supported Witness 6's inquest witness statement and demonstrated that there appeared to be no clear instruction or direction from you.

The panel also noted that you had stated in your inquest witness statement that Witness 5 was "petrified", and in your police statement said he was "distressed". However, you asked him to commence CPR. It noted that Witness 3 in her oral evidence stated if a nurse had doubts that a team member was unable to follow an instruction due to distress, they should know that that task is not going to be undertaken properly and therefore should not delegate instructions in those circumstances.

The panel also noted that you stated nobody was responding to your instructions. Witness 3 in her oral evidence stated that in such circumstances, a registered nurse would have to be calm and authoritative and instruct somebody clearly to go and call 999. She also stated that if nobody listened to instructions, CPR should be the priority in these circumstances.

While it accepted that some basic requests were made, due to the limited time you were in Resident A's room and the limited interaction you had with the staff it was of the view that it was unlikely you had provided clear instructions.

The panel was of the view, after having viewed the CCTV footage, that you spent more time away from the emergency situation in Resident A's room than being present in the room managing the situation and allocating tasks appropriately in light of the competencies and experiences of the clinical team.

The panel therefore found these sub-charges proved.

Fitness to practise

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

Submissions on misconduct

Mr Evans informed the panel that you are prepared to concede misconduct and accept that you are currently impaired.

Mr Gruchy invited the panel to take the view that the facts found proved amount to misconduct. He directed the panel to Witness 3's "Nursing Practice Report" where she specified paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified where she believed your actions amounted to misconduct.

Mr Gruchy submitted that Witness 3, in her report, also cited your failure to follow and engage properly with basic life support skills and your failure to engage in organisational policies of your employer. He further cited Witness 3's comment in her report that "any reasonable nurse would find it abhorrent that CPR was not commenced immediately upon recognition of cardiac arrest."

Mr Gruchy invited the panel to find that the facts found proved amounted to serious misconduct.

Submissions on impairment

Mr Gruchy 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.

Mr Gruchy referred the panel to documents you have provided including training certificates and testimonials. He submitted that there is no particular reference to leadership skills or CPR skills. He also submitted that there is no evidence of any participation in emergency physical health procedures, even in a supervisory role, by you since the concerns raised in 2018.

Mr Gruchy submitted that there is a lack of evidence of strengthened practice. He further submitted that there is a lack of insight into your lack of action and the potential

risk of harm not only to patients but also to the public confidence in the wider nursing profession.

Mr Gruchy invited the panel to find that your fitness to practice is impaired.

Mr Evans submitted that you had in fact undertaken basic life support and intermediate life support training in December 2022 and again in January 2024. He conceded that there are no testimonials to reflect your use of CPR in a clinical setting.

Mr Evan also referred the panel to a testimonial which refers to your leadership stating that you can seamlessly be a team leader and a team player.

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

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.5 work with colleagues to preserve the safety of those receiving care

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

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

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

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

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

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel determined that the facts found proved amounted to serious misconduct. It was of the view that in an emergency situation, namely upon recognition of cardiac arrest, any reasonable practitioner and/or any reasonable person would find it deplorable that you had either not commenced CPR or not ensured that CPR was commenced by another on Resident A.

The panel considered that you also should have demonstrated effective communication and leadership and ensured that the support staff were operating effectively in an emergency situation.

The panel was of the view that your actions in this situation fell well below the standards of a registered nurse, particularly as you had been trained in basic life support and were the nurse in charge.

In light of the above the panel determined that the charges found proved individually and collectively amounted to a serious departure from appropriate standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

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. 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) *...'*

For reasons already set out above in relation to misconduct, the panel determined that limbs a, b and c were engaged by your misconduct, both in the past and in the future.

The panel concluded that you had in the past acted so as to put Resident A at unwarranted risk of harm by failing to do immediate CPR and/or ensuring the staff under your leadership took appropriate steps in the management of the emergency with Resident A.

The panel determined that your failings breached fundamental tenets of nursing practice and that your misconduct is liable to bring the nursing profession into disrepute. In the panel's judgement, the public do not expect a nurse to act as you did as they require nurses to adhere at all times to the appropriate professional standards and to safeguard the health and wellbeing of patients.

The panel recognised that it must make an assessment of your fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether you would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether you have provided evidence of insight and remorse.

Regarding insight the panel noted that you had denied the charges. It recognised your right to contest the charges and noted that upon reading the panel's determination regarding facts, you now accept the facts found proved amount to misconduct and impairment.

The panel noted that, at this stage, you have not provided a detailed reflective statement. While the panel acknowledged that you accept misconduct, it did not have a detailed recognition from you as to the impact your misconduct had on Resident A, her family, your colleagues and the nursing profession. Additionally, the panel do not have any information which would demonstrate how you would approach similar circumstances in the future.

The panel also considered that it had received no evidence as to your remorse in failing to respond to an emergency situation. It noted that during your oral evidence on the facts, you appeared to reiterate that your response to the emergency situation was correct.

Nevertheless, the panel recognised that you have accepted that your actions amounted to serious misconduct and that your fitness to practice is currently impaired. As a result,

the panel determined that you have shown some limited insight, but this is early in its development.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you had taken steps to strengthen your practice. The panel took into account the training certificates you provided and noted that you are up to date with your basic life support and intermediate life support training.

The panel also took account of the testimonials you had provided. It noted that a HCA, in a testimonial dated 10 May 2024, stated:

> *"She is a dedicated and compassionate caregiver, who seamlessly doubles as a team leader and a team player."*

The panel was of the view that this was a limited indication of your leadership and was not specific to an emergency or stressful situation.

The panel acknowledged that, as evidenced by the testimonials you had provided, in your general nursing practice you could practice kindly, safely and professionally. However, it noted that you had not presented sufficient evidence of the practical progress you have made in addressing the weaknesses in your performance when dealing with critical situations nor have you demonstrated steps taken to strengthen your practice and remedy the concerns identified in relation to the matters in this hearing.

The panel had no current information before it to demonstrate your abilities in an emergency situation, your leadership skills as a registered nurse or that would reassure the panel that you would act as expected in a similar situation. It was therefore not persuaded that, in an emergency situation, you would be able to practice safely and professionally.

The panel concluded that that while your insight is limited but developing, it considered that your lack of remediation means there remains a risk of repetition of the misconduct found proved. The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

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

The panel was satisfied that, having regard to the nature of the misconduct in this case, “the need to uphold proper professional standards and public confidence in the profession would be undermined” if a finding of current impairment were not made. It was of the view that a reasonable, informed member of the public would be very concerned if your fitness to practise were not found to be impaired.

For all the above reasons the panel determined that a finding of impairment on public interest grounds is required.

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

Sanction

The panel has considered this case and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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 Gruchy submitted that the NMC sanction bid in relation to this case is one of a suspension order with a review. He submitted that, while the panel may consider that your actions and misconduct are remediable in this case, it is the NMC's position that in this particular case there remains an absence of remorse, an absence of strengthened practice and an absence of insight.

Mr Gruchy invited the panel to carefully consider all of these matters and decide whether or not a more serious sanction than a suspension order is required in this case. He submitted that this is a case that where, although the panel has already noted you were entitled to deny the charges, this can still be considered as an aggravating feature.

Mr Gruchy also invited the panel to look at the aggravating features and mitigating features in this case and make a decision on what is proportionate. He submitted that this is not an exercise in punishment, but an exercise in protection of the public and the upholding of the profession.

Mr Evans submitted that this case arises from an incredibly tragic and sad event, and that the cause of death has been considered by an inquest and any criminality has been dealt with via a police investigation. Mr Evans further submitted that the consequences of the incident were not part of the sanction decision. He said the misconduct and impairment findings were due to your inaction, that is not performing CPR and not showing leadership. Mr Evans submitted that the concerns in this case can be dealt with by way of conditions of practice which would provide appropriate and proportionate conditions which would ensure the protection of the public and maintain public confidence.

Mr Evans submitted that since this event took place some six years ago, there is no evidence before the panel of any further incident. He referred the panel to the positive testimonials and submitted that these demonstrate someone who has shown leadership, is caring, kind, professional and has no incidents or complaints against them. The testimonials also set out that you are adept at managing the demands of the

ward, you turn up on time to shifts consistently and are dependable in all situations. Mr Evans submitted that it is however appreciated that the panel might consider that further assistance is required, which can be dealt with by way of conditions of practice.

Mr Evans submitted that there is some evidence of developing insight in this case. You have accepted the findings of the panel amounted to misconduct and impairment. You have also ensured that your training was kept up to date, not only with basic life support, but also intermediate life support, which the panel has evidence of. You have been open and honest with your employers, and you are not someone who has 'buried her head in the sand'. You have engaged not only with this process over the six years it has taken but have also engaged with the inquest and any other investigations.

Mr Evans submitted that the panel's position that you have developing insight is appreciated, and that you could be supported with a conditions of practice order as opposed to a suspension order, which would be a punitive measure in this case, considering that for the better part of the last six years, you have carried on working without any incident.

Mr Evans submitted that the panel should take into account the contextual issues and the circumstances at the time of the event. He submitted that the team were shocked and hesitant and that this was the first time you had ever encountered such an unexpected situation.

Mr Evans submitted that the panel will also need to consider the risk of repetition in this case. He submitted that this was a low risk as demonstrated by the six years of practice where there has been no further incident. Mr Evans set out that it is accepted that you for the most part have not been the nurse in charge and that conditions of practice would be appropriate and deal with the issues in this case.

Mr Evans submitted that a conditions of practice order which would deal with supervision, not being the nurse in charge, regular meetings, ensuring that training is kept up to date and further leadership training would allow you to develop further insight, address the regulatory concerns in this case. He suggested conditions would protect the public and ensure that public confidence in the nursing profession is maintained.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Limited insight into failings
- Conduct which put Resident A at risk of suffering harm.
- Failure to recognise an emergency situation
- Lack of reflection and remorse

The panel also took into account the following mitigating features:

- Early stages of insight
- Isolated and unusual incident in this setting
- No further incidents in the six years since this event
- Positive testimonials regarding your nursing practice

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your

misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *…*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that this incident happened a long time ago and that, other than this incident, you have had an unblemished career of 12 years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to safe practice as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order and the public can be sufficiently protected by this order.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will also mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

In making this decision, the panel carefully considered the submissions of Mr Gruchy in relation to the sanction that the NMC was seeking in this case. However, the panel considered that to impose a suspension order or a striking-off order would be disproportionate and would not be a reasonable response in the circumstances of your case.

The panel determined that the following conditions are appropriate and proportionate in this case:

> 'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.
>
> 1. You must restrict your practice to a single substantive employer, currently Hertfordshire Partnership University Foundation Trust. You must not work for an agency.
>
> 2. You must ensure that you are not the nurse in charge and that you are supervised by a registered nurse at any time you are working. Your supervision must consist of:
>
>   - Working at all times on the same shift as, but not always directly observed by, a registered nurse.
>
> 3. You must work with your clinical supervisor to create a personal development plan (PDP). Your PDP must include:

a) a repeat of your intermediate life support training, which is to include a formal written assessment from your trainer
b) feedback and development regarding assertiveness
c) feedback and development regarding leadership skills particularly in any urgent or emergency situations.

You must:

- Send your case officer a copy of your PDP prior to the review of this order.
- Send your case officer a report from your clinical supervisor prior to the review of this order. This report must show your progress towards achieving the aims set out in your PDP.

4. You must engage with your clinical supervisor on a frequent basis to ensure that you are making progress towards aims set in your personal development plan (PDP), which include:
    - Meeting with your clinical supervisor at least every three months to discuss your progress towards achieving the aims set out in your PDP.
    - Monthly reflective discussions with your clinical supervisor.

5. You must keep us informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

6. You must keep us informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).
    c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

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

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- A written reflective piece using a recognised model of reflection

- Up-to-date training records
- Your continued engagement with the NMC
- Your attendance at any future review hearing of this order

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the conditions of practice sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Gruchy. He submitted that it is the NMC's view to leave this as a matter for the panel to consider in this case. He submitted that whilst the NMC is conscious of the fact that there has not been an interim order on your nursing practice to date, it is also conscious of the conditions of practice order that has now been made by the panel. In light of this, the panel may consider making an interim order in similar terms of the substantive conditions of practice order.

Mr Evans said that he would leave the matter of an interim order for the panel's consideration.

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

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover any appeal period.

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

That concludes this determination.