Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 31 March 2025 – Friday, 4 April 2025
Monday, 1 December 2025 – Friday, 12 December 2025

Virtual Hearing

Name of Registrant:	James Marvin Langford
NMC PIN	19G0805E
Part(s) of the register:	Nurses part of the register Sub part 1 RNMH, Registered Nurse - Mental Health (30 September 2019)
Relevant Location:	North Somerset
Type of case:	Misconduct
Panel members:	Stacey Patel (Chair, Lay member) Pam Campbell (Registrant member) Anne Rice (Lay member)
Legal Assessor:	Graeme Sampson
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by: Raj Joshi, Case Presenter (31 March – 4 April 2025; Giedrius Kabasinskas (1 – 12 December 2025)
Mr Langford:	Present and represented by Neomi Bennett, Equality 4 Black Nurses (EB4N) (31 March – 4 April 2025; Present and unrepresented (1 – 12 December 2025)
No case to answer:	Application refused
Facts proved:	Charges 2a, 2b, 2d, and 2e
Facts not proved:	Charge 1 in its entirety and Charge 2c

Fitness to practise:	Impaired
Sanction:	Suspension order (3 months) without a review
Interim order:	Interim suspension order (18 months)

Details of charge (as read)

That you, a registered mental health nurse:

1) On or around February 2023:

    a) Did not follow Resident A's Positive Behaviour Support ('PBS') care plan in that you:
        i) Locked Resident A in their flat without clinical justification.
        ii) On one or more occasions did not observe Resident A whilst eating.
        iii) On one or more occasions removed Resident A's shoes without clinical justification.

2) Having accepted undertakings during the fitness to practise process, failed to comply with one or more in that you:

    a) Did not provide your NMC case officer with your employer's contact details as per undertaking 1b.
    b) Did not immediately give a copy of the undertakings to your agency as per undertaking 3b.
    c) Did not allow your case officer to share details of your performance and progress towards completing the undertakings as per undertaking 5.
    d) Did not disclose your undertakings to your agency and your employer whilst working in two settings via an agency as per undertaking 6.
    e) Worked on one or more occasion without the supervision of a Band 5 nurse as per undertaking 7.

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

Application for Special Measures (Day two)

Mr Joshi made an application under Rule 23 of The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (the Rules) to have your camera switched off while Witness 2 gave evidence. He referred the panel to Rule 31 of the Rules, NMC guidance CMT-12 'Supporting people to give evidence in hearings' as well as to the case of *PSA v GPhC & Anor* [2024] EWHC 3335 (Admin).

Mr Joshi submitted that Witness 2 can be considered as vulnerable and she is anxious and nervous about giving evidence. He told the panel that she has someone with her to support to her.

Mr Joshi invited the panel to grant the application

Ms Bennett opposed the application. She submitted that Witness 2 is being permitted to request shielding from you, a [PRIVATE] male professional nurse, without any evidence of trauma and without a safeguarding referral or any psychiatric assessment. She submitted that this is institutionalised racism in action.

Ms Bennett submitted that there is no legal, ethical or procedural justification for this and it contradicts the principles of natural justice. She further submitted that it denies you equal standing in this process, and it mirrors a wider pattern that the NMC has been criticised for, namely, the disproportionate and dehumanising conduct.

Ms Bennett invited the panel to reject the application, or at the very least if she could be provided with written evidence of the clinical necessity or risk as to the justification for this application.

The panel accepted the advice of the legal assessor, who referred it to the NMC guidance Reference CMT-12.

Panel decision

The panel carefully considered the application. It noted its duty under CMT-12 to make witnesses as comfortable as possible without being unfair to either party before it.

The panel was of the view that there has been no evidence put forward to show that this is a racial issue. The panel determined that you can still participate in the hearing and can still hear and see Witness 2 whilst she is giving evidence. The panel further determined that you are represented in the hearing by Ms Bennett who also has two assistants present in the hearing who can also see and hear Witness 2. The panel was satisfied therefore, that your interests in this regard are well protected.

The panel noted that it is commonplace for witnesses to be granted special measures in cases such as this and it has given particular attention to certain facts of this case and taken into account as well, the points in the Witness 2's witness statement that she *'... didn't feel that I had a voice to be able to raise my concerns working with people who had a bigger personality then I did.',* and instances where she felt uncomfortable speaking up against this you in the past.

The panel decided that Witness 2 would achieve her best evidence with you having your camera switched off. In these circumstances and for the above-mentioned reasons, the panel decided to allow the application for you to have your camera switched off while Witness 2 gives evidence.

The panel granted the application.

Rule 19 application (Day four)

During cross-examination of Witness 4, the panel heard an application made by Ms Bennett for her Rule 19 application to be made in private under Rule 19, without Witness 4 and the observers present. She submitted that it relates to her cross-examination of Witness 4.

Ms Bennett submitted that her request relates to the framing of cross-examination and addresses concerns about procedural fairness, bias and the exclusion of key content relevant to Witness 4's testimony.

Mr Joshi opposed the application. He submitted that Ms Bennett does not have any ground for the Rule 19 application to be made. He submitted that not only has Ms Bennett provided insufficient detail, nothing of the nature of the concern has been outlined to the panel as far as Witness 4 is concerned. He submitted that Witness 4, whom Ms Bennett would have had notice of, has nothing more than an administrative involvement by way of an exchange of emails and the results of that interaction.

Mr Joshi submitted that if there were matters concerning your personal, private or health matters those may apply. However based on Ms Bennett's application none of these seem to apply.

The panel accepted the advice of the legal assessor.

Following a request by Ms Bennett for a brief pause in proceedings, she returned and informed the panel that she has decided to reserve her position to make the application later.

Decision and reasons on applications to adduce the hearsay evidence of Witness 5 (Day five)

Mr Joshi made an application under Rule 31 to allow the witness statement of Witness 5 into hearsay evidence. He referred the panel to the NMC guidance DMA-6 on 'Evidence' and to the relevant principles in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

Mr Joshi submitted that Witness 5's statement is not the sole and decisive evidence as there is other evidence, notably from Witness 4, who refers to the same and / or similar matters in relation to the undertakings. In relation to the nature and extent of the challenge he referred to Ms Bennett's expressed opposition to the application. He submitted that in relation to whether Witness 5 had any reason to fabricate her allegations, he submitted that she provides clear, cogent and reliable evidence. He

submitted that Witness 5 was acting in the performance of her duties in her capacity as an NMC compliance officer.

In relation to the impact as far as the good reason for non-attendance is concerned, he submitted that as far as all of these statements, the bundles, including the final bundles are concerned, you and Ms Bennett had been notified of them ahead of this hearing. He submitted that Witness 5's knowledge of the concerns is only in relation to the documentary evidence and any questions in terms of a challenge or otherwise would be to the documentation. He submitted that all of the evidence relating to the charges and undertakings were notified to the you and Ms Bennett in any event, so there is no shock or surprise as regards the contents of Witness 5's statement.

In conclusion, Mr Joshi submitted that the hearsay evidence was relevant to the charges and that no unfairness would be caused to you if Witness 5's written statement was admitted into evidence.

Ms Bennett opposed the application.

Ms Bennett submitted that Witness 5 had initiated the escalation of your case to the Fitness to Practise Committee by interpreting the events as a serious breach of your undertakings. She submitted that this is a critical judgement call that underpins charge 2, yet Witness 5 is not available to give oral evidence, meaning that you cannot challenge her assessment of what the breach was, whether it was serious or whether informal alternatives were available.

She submitted that Witness 5's conclusion resulted in the revocation of undertakings and a full Fitness to Practise referral. She submitted that Witness 5's input is not administrative, but substantive and decisive.

Ms Bennett referred the panel to paragraph 8 of Witness 5's witness statement:

> *'On 6 September 2024 I emailed Mr Langford and his representative to notify them of the serious breach of the undertakings and that the matter would be*

referred to the CEs for assessment of the evidence of a serious failure to comply with the undertakings. I exhibit at **[Witness 5]** ***/1*** *my email to Mr Langford and his representative dated 6 September 2024.'*

She submitted that Witness 5's statement shows that she referred you without speaking to you to notify you of the alleged serious breach. She submitted that this application is procedurally unfair particularly where your explanation of working nights with no access to notifications would have materially altered her assessment.

Ms Bennett submitted that Witness 5 did not verify disclosure with your actual line manager [PRIVATE] before publication. She submitted that Witness 5 simply accepted hearsay from Witness 4 [PRIVATE] who was not your line manager. She submitted that this resulted in a material omission and created one-sided evidence. She submitted that Witness 5's statement is therefore incomplete, yet it was presented as final, authoritative and relied entirely on e-mail correspondence with Witness 4.

Ms Bennett submitted that the alleged breach took place over a weekend from the 28 to 30 June, with no employer contact. The NMC published the undertakings late on Friday 28 June, and it was discovered on Monday 1 July. No patient harm occurred and you took corrective action immediately upon realising the error. Ms Bennett submitted that these are mitigating circumstances that Witness 5 failed to consider. She submitted that Witness 5's conclusions go to the heart of a disputed charge and you must be able to cross-examine her as the person who assessed the alleged breach. Ms Bennett submitted that to admit Witness 5's statement denies you the opportunity to challenge the basis of charge 2 via cross-examination.

Given the weight placed on Witness 5's interpretation and the fact that she is unavailable to be cross-examined, Ms Bennett submitted that to admit her evidence would undermine the fairness of these proceedings and is not in the interest of justice.

In conclusion, Ms Bennett submitted that she objects to the admission of Witness 5's witness statement as hearsay as her conclusions are solely based on second-hand communications which are neither neutral or administrative.

Panel decision

The panel heard and accepted the legal assessor's advice on the issues it should consider in relation to this application. This included the guidance under Rule 31 of the Rules, which provides that, so far as it is 'fair and relevant', a panel may accept evidence in various forms and circumstances, whether or not it would be admissible in civil proceedings. He further advised the panel on the guiding principles set out in the case of *Thorneycroft*.

The panel gave consideration to the application to admit Witness 5's witness statement into hearsay evidence. The panel considered that there is no reason to suggest that the statement may have been fabricated. It noted that the statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement… is true to the best of my information, knowledge and belief*', and had been signed by Witness 5. The panel determined that Witness 5's role at the NMC is administrative and the documents and associated exhibits are merely a chronology of documents which are administrative procedures and factual in nature. Witness 5 is not commenting on the documents but is merely producing them for the hearing.

The panel considered that it is not the sole and decisive evidence in support of the charges. It was of the view that there is other supporting evidence from Witness 4. The panel was of the view that the points Witness 5 raises in her witness statement speaks to what actually occurred and is uncontroversial. Furthermore, you had been sent the documents in advance of this hearing.

In terms of whether there is a good reason for Witness 5's non-attendance, the panel determined that her evidence speaks to the facts of the case and are a matter of record. The panel was of the view that it would have no questions for Witness 5 from the panel's perspective and it saw no reason to go behind her decision.

In terms of fairness to you, the panel noted that the NMC have not provided the panel with any evidence that they have tried to call Witness 5 to give evidence. However, given that she is only a witness of record, the panel sees little reason in having her

called as a live witness and accepts the NMC's view that it would be a waste of resources.

The panel considered Ms Bennett's objection as to whether alternatives were considered as a warning prior to publishing the alleged breach of undertakings. It had regard to the letter dated 6 September 2024 from Witness 5 informing you that it was not her decision to look into the breach rather it was a decision made by the Case Examiner.

Further, you had knowledge beforehand that Witness 5 was not going to attend the hearing to give evidence and you made no application for her to attend prior to today.

The panel also considered all of the documentary exhibits attached to Witness 5's witness statement and concluded that they should also be admitted as they bring Witness 5's witness statement into context.

The panel was of the view that it was in the public interest to explore the issues and if the Witness 5's witness statement was not admitted, it would deprive the panel of considering all available and relevant evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written witness statements of Witness 5 and corresponding documentary exhibits into evidence as hearsay evidence. The panel determined that there would be no undue disadvantage to you in doing so and it would give what it deemed the appropriate weight once the panel had heard and evaluated all the evidence before it.

The panel decided to grant the application to allow Witness 5's witness statement as hearsay evidence.

Decision and reasons on applications to admit written statements of Witness 6 as hearsay evidence (Day five)

Mr Joshi referred the panel to the hearsay documentation bundle of Witness 6 and her witness statement therein, which includes:

> *'My relationship with James was good. We were very close, we cooked together at work and brought food for sharing. James is a jolly, jokey and friendly person, we got along well. James and I became close because we worked together a lot and we got to spend time together when we took Resident A for her drives. Sometimes I took the lead as I knew the floor well.'*

He submitted that her witness statement is a fair and accurate description of the working relationship she had with you.

Witness 6 goes on to say:

> *'James is very good at his job but he has an attitude. James would not talk to me or other staff. James would not respond to us and just walk off to the flat with Resident A to do his observations. James should not have been going into Resident A's flat alone because a lot can happen given her heightened behaviour. It should have been a three-to-one visit. James was supposed to have someone with him when he went to see Resident A in her flat but he would not talk to us and went to give medications on his own.'*

Mr Joshi submitted that Witness 6's evidence is very relevant to aspects of your character heard in live evidence by other witnesses in this case, notably from Witness 2.

In relation to the reason for Witness 6's non-attendance at this hearing, Mr Joshi submitted that the reason is clear in her witness statement:

> *'I also received a phone call from someone, I don't know who. They said that James said all sorts of things about me. I received threats, I do not know for*

whom as it was over the phone and the number was unknown and the person's voice on the phone wasn't clear. I look over my shoulder when I am going to work. When Mr 2 *called me I said I didn't want to assist the NMC with the investigation because raising concerns affected me, it traumatized me. I just wanted to keep a low profile and not get involved. I told my manager at Freeways,. They have threatened me and my whole family. I don't have a social life and all I do is work.'*

He submitted that there had been communication between Witness 6 and the NMC who have done everything in the normal course of events to obtain and provide a statement and secure her attendance. In relation to the reliability of Witness 6's statement, he submitted that the progress and chasing undertaken by the NMC can be seen from the communications to have the statement signed and returned. He referred to the email from the NMC dated 21 August 2023 stating that the NMC had called to check and tried to contact Witness 6. A further email dated 13 October 2023 from the NMC, speaks to the threats that had allegedly been received and the advice given by the NMC to report those threats to the police and other assistance was offered.

Mr Joshi submitted that Witness 6's statement is not the sole and decisive evidence in support of the charges. In relation to the nature and extent of the challenge he submitted that the panel will hear more from Ms Bennett on that point in due course. He submitted that there is no reason for Witness 6 to fabricate her allegations. He referred to Witness 6's witness statement and the compliments she made about you. He submitted that it is a fair and balanced statement and would be far more-one sided and critical of you if it were fabricated.

In relation to the seriousness of the charge and the good reason for Witness 6's non-attendance, he referred the panel to the various chasing emails from the NMC to Witness 6 and her response to having received threats, and as a result of that, she no longer wished to attend the hearing to give evidence. He submitted that the NMC had taken reasonable steps to secure Witness 6's attendance and in terms of prior notice that the Witness 6's witness statement would be read, the document bundle itself is a hearsay application and has been with you and Ms Bennett for some time.

Mr Joshi invited the panel to admit Ms 1 witness statement into evidence as hearsay.

Ms Bennett opposed the application to admit the hearsay statement of Witness 6.

Ms Bennett submitted that the witness statement lacks a signature and authentication. She submitted that the NMC had been contacting Witness 6 since August 2023 and there has been no formal confirmation or approval of its final content. She referred the panel to an email dated 7 December 2023, which includes:

> *'...Although I have drafted it on your behalf, it is your statement, and it is important that you ensure that it is accurate.'*

She submitted that no signed version exists. She submitted that Witness 6 made it clear that she did not wish to assist the NMC and felt traumatised by the process. She submitted that this undermines the reliability of any untested statement allegedly given under stress.

Ms Bennett referred to the Note of Telephone Call dated 5 January 2024, where Witness 6 stated that she does not want to get involved and '*does not feel ok to do it'*. In Witness 6's witness statement she states that she does not want to assist the NMC with the investigation because raising concerns has affected and traumatised her. She submitted that Witness 6's statement was not voluntary in the full sense and is not suitable for use without cross-examination.

Ms Bennett submitted that she strongly objects to the admission of Witness 6 unsigned witness statement as hearsay. She submitted that the witness statement is untested, unsigned and tainted by an admitted personal conflict with you. It is not corroborated by contemporaneous evidence and the NMC has not taken steps to verify or balance the account with testimony from key [PRIVATE] colleagues who work regularly with you, or others present during the relevant shifts.

Ms Bennett submitted that in the interest of fairness and justice, it would be wholly

inappropriate to admit this witness statement as hearsay evidence, and furthermore, it is the word of an untrained unregistered person.

Ms Bennett submitted that she wished to share some observations about the document in terms of the reasons she believes Witness 6's witness statement should not be given any weight by the panel. She submitted that there are some racialised expectations, such as you having an *'attitude'* that needs to be worked on. She submitted that these are subjective assessments of personality, not professional misconduct. Further, she submitted that [PRIVATE] men are often perceived as aggressive or standoffish when assertive, or withdrawn. She submitted that this framing risks invoking racial stereotypes.

Ms Bennett submitted that Witness 6's statement should not be given weight as she has identified some racial bias and racialised language used in her statement.

Referring to Rule 31, she submitted that Witness 6's evidence must not be admitted as hearsay evidence if it causes unfair prejudice to you. It denies you of a fair opportunity to challenge the evidence by cross-examination.

Ms Bennett submitted that the evidence is structurally one-sided and introducing it as hearsay will reinforce that imbalance. She submitted that it would neither be fair nor in the interest of justice to allow the unsigned statement as hearsay evidence

Panel decision

The panel heard and accepted the legal assessor's advice on the issues it should consider in relation to this application. This included the guidance under Rule 31, which provides that, so far as it is 'fair and relevant', a panel may accept evidence in various forms and circumstances, whether or not it would be admissible in civil proceedings. He further advised the panel on the guidance set out in the case of *Thorneycroft*.

The panel considered whether Witness 6's statement is the sole and decisive evidence in support of the charges. It decided that this was not the case because it had heard live

evidence from Witness 1, Witness 2 and Witness 3 who gave evidence in separate parts in relation to Charge 1. In relation to the nature and extent of the challenge to the contents of the statement, the panel considered Ms Bennett's submission that the statement had racial undertones. However, the panel was of the view that the truth of the statement was not being challenged. The panel considered whether there was any suggestion that Witness 6 had any reason to fabricate her allegation. The panel was of the view that she had no reason to fabricate her evidence. The panel determined that the threats Witness 6 is alleged to have received were never attributed to have come from you. She says in her statement that she was threatened and appears to be fearful for herself and family.

The panel acknowledged why Witness 6 would feel vulnerable and how allegedly being threatened would be enough to make her disengage with the process. In relation to whether Witness 6 had a good reason for non-attendance, the panel was satisfied that the NMC had made all reasonable efforts to secure her attendance as detailed in the numerous emails and telephone calls made to secure her attendance.

The panel considered Ms Bennett's submission that this is all about racial stereotypes and *'tone policing'* and that there is an allegation that Witness 6 has simply made wild accusations with racial stereotypes of [PRIVATE] men. The panel considered that Witness 6 described you as '*a jolly, jokey and friendly person'* and it could see no foundation for the allegation of racial undertones in Witness 6's statement. The panel determined that it was being aided by the probative value of the statement. The panel determined that it would attach relatively little weight to the statement but that it would corroborate other evidence contained in the bundle.

The panel also considered the public interest in the issues being explored fully and that this supported the admission of this evidence into the proceedings.

The panel determined that you and Ms Bennett had sufficient notice of this hearing and previously did not raise that the statement had racial undertones and the truth of the statement was not challenged.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written witness statement of Witness 6 as hearsay evidence, however it would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

The panel decided to grant the application to admit Witness 6's witness statement as hearsay evidence.

The hearing went part heard on Friday, 4 April 2025 (Day five), due to insufficient time.

The hearing resumed on Monday 1 December to Friday 12 December 2025.

Decision and reasons on application of no case to answer (Day 6)

You made an application pursuant to Rule 24(7) the Rules in respect to all charges. You referred the panel to the test derived from the case of *R v Galbraith* [1981] 2 All ER 1060.

The first limb of the test is if there is no evidence to find a charge proved, the charge would fall. The second limb of the test is if there is some evidence but it is tenuous because of weakness and vagueness, a panel properly directed could not find the charge proved.

The same effect is obtained by this panel asking itself the question *'is there any evidence upon which a properly directed panel could find the allegations proved?*' If the answer is *'yes, it could'* (not that it would), then the panel should not accept the application.

Charge 1

You referred the panel to Witness 1's witness statement and oral testimony. You submitted that Witness 1 in her oral testimony stated that there were weekly meetings

for staff to discuss best practice and raise concerns in relation to patient well-being. You submitted that no one raised any concerns about your nursing practice, and in fact it was you yourself who had raised a concern in relation to how medication affected the patient. You submitted that Witness 1 did not have any concerns about your practice until allegations were made against you.

You referred the panel to Witness 2's witness statement and oral testimony. You submitted that Witness 2 alleges that she observed the Resident A's door being locked in her flat over ten times and you did not observe Resident A whilst eating as you should have done. Witness 2 further stated that she was afraid to approach you on over ten occasions about Resident A allegedly being locked in their flat and that she had spoken to the manager but nothing was done. Witness 2 also stated that she was new on the job but had experience in the care sector prior to commencing at [PRIVATE] (the Home) and did not know how to raise concerns or report safeguarding concerns. During the hearing Witness 2 testified that Resident A usually requests that the door is locked when they want to have privacy.

You referred the panel to Witness 3's witness statement and oral testimony. You submitted that Witness 3 in his oral evidence stated that he worked with you for about two to three weeks before being moved to a different unit and that he did not see anything wrong with your practice prior to moving to a different unit. Witness 3 stated that he was only made aware of the allegation the day he visited the Home, when he raised concerns together with Witness 2, but failed to follow up on his concerns.

You submitted that in relation to training, Witness 3 stated that he interviewed Witness 2 for the job and emphasised to her the importance of raising concerns and safeguarding. Witness 3 expressed that he was surprised that Witness 2 was not able to raise concerns on over ten occasions after having reportedly observed these allegations.

You referred the panel to the witness statement of Witness 6. You submitted that Witness 6 took almost a year to provide her statement to the NMC after several attempts by the NMC to obtain it. You submitted that Witness 6's statement is not signed and that she alleges that she was afraid for her life and did not want to take part

in these proceedings. You submitted that Witness 6's failure to engage may in itself raise questions about her own professionalism.

You submitted that documentation is of critical importance to the NMC's case and is often the main source of evidence the NMC uses to assess whether a nurse meets their professional standards. You submitted that, as an NMC professional, you always prioritise your patients, practice effectively, preserve safety and promote professionalism. You submitted that no staff rota has been presented to the NMC as to who was on shift at the time of the ten alleged incidents and there is no record provided of you not performing observations. You submitted that no documentation of entries on the day have been provided to NMC of the alleged incidents of not supervising the patient when eating or having their shoes removed.

You submitted that the manager at that time and deputy manager were present at the Home from Monday to Friday, at times on Saturday, between 9:00 AM to 5:00 pm. You questioned why they did not observe these allegations or were not approached by staff to raise concerns to enable you to reflect on your practice during the relevant times.

Charge 2

You submitted that the alleged breach of your undertakings was unintentional. You submitted that you were given a letter on 27 June that the undertakings were going to be published. You said that you spoke to your line manager who told you to wait until the undertakings are published. You submitted that you were ill-advised by him and by your solicitor at the time. You said that you did not know the implications of the undertakings and had sent a statement to the NMC of the various places where you had been working, therefore the NMC allowed you to work from that period.

In conclusion, you referred the panel to the case *Galbraith.* You asked the panel to have a fair judgment on your case and to review the fact that you have no case to answer. However, if the panel deems that you have a case to answer you are prepared to answer.

Mr Kabasinskas referred the panel to relevant case law including *Galbraith, Hindle v NMC [*2025] EWHC 373 (Admin) and *Re B (Children) (Care Proceedings: Standard of Proof)* [2009] 1 AC 11.

Charge 1

Mr Kabasinskas submitted that in relation to charge 1 there is evidence from witness statements and oral testimony to support these allegations. He referred to the Positive Behaviour Support ('PBS') care plan is a key document in evidence that outlines the care and support for residents that should be followed as a starting point in determining *'clinical justification'.* He submitted that your failure to follow the PBS care plan may have resulted in harm or risk of harm to residents. He further submitted that the NMC relies on the various witness statement and oral testimony from various witnesses, including those from Witness 1, Witness 2 and Witness 3 in support of charge 1.

Mr Kabasinskas submitted that under limb one of the *Galbraith* principle there is evidence to support this charge. He submitted that on most of the charges the panel will have to determine the witnesses reliability and credibility therefore based on this, it should proceed with charge 1 as it does not meet the exception that the evidence is weak or tenuous.

Charge 2

In relation to the alleged breach of undertakings in charge 2, Mr Kabasinskas submitted that there is sufficient evidence to proceed with this charge. Citing the case of *Galbraith*, he submitted that the evidence of Witness 1, Witness 2 and Witness 3 is reliable and sufficient to determine the credibility of the witnesses and your compliance with the undertakings.

Mr Kabasinskas submitted that undertakings were clearly set out. You were under a duty to comply with them and there is evidence which includes your failure to provide your employer contact details to the NMC and not providing a copy of the undertakings to an agency.

Mr Kabasinskas submitted that there is no ambiguity in the undertakings and in relation to the evidence heard there is nothing to suggest that any of the evidence is tenuous or unreliable. He submitted that there is sufficient evidence to proceed with charge 2 at this stage.

Panel decision

The panel accepted the advice of the legal assessor who referred it to Rule 24(7) of the Rules, relevant case law including *Galbraith* and to NMC guidance DMA-6 on 'No case to answer', as well as the issues to take into account when considering the application and the submissions made by you and Mr Kabasinskas.

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

Charge 1

The panel was satisfied that there is sufficient evidence to show that there was a PBS care plan in place, you allegedly did not observe Resident A eating, locked Resident A in her room and removed her shoes. Further, the panel heard from written and oral evidence from Witness 1, Witness 2 and Witness 3 who gave evidence in relation to all of these points which corroborate the allegations. The panel was of the view that the evidence was not tenuous, inherently weak, vague or inconsistent with other evidence.

In these circumstances, the panel considered that there was sufficient evidence to support a case to answer in respect of charge 1 in its entirety.

Charge 2

The panel was satisfied that it has been provided with sufficient evidence from Witness 4 who discovered the undertakings from a spot check. The panel was of the view that it

had evidence from both the NMC and Witness 4. The panel considered your submissions in relation to the timing of the publication of the undertakings late on a Friday and you had been working over that weekend leaving a gap before you had sight of it. The panel was of the view that this point would be looked at when it had heard all of the evidence and once they have had an opportunity to ask questions in order to make an informed decision on the matter.

In these circumstances, the panel considered that there was sufficient evidence to support a case to answer in respect of charge 2 in its entirety.

In conclusion, the panel was of the view that there was sufficient evidence produced that could potentially support all of the charges at this stage. Accordingly, your application was dismissed.

The panel will determine these charges having heard all the evidence in due course. This decision in relation to submissions of no case to answer should not be taken as indicating that the NMC's case has been accepted or that the charges have already been found proved. The panel will only determine the charges once your evidence has been considered.

Background

You were employed as a Mental Health Nurse by the [PRIVATE] (the Agency) from 22 November 2022 until February 2023.

The Agency worked closely with [PRIVATE] (the Charity), a charity that provides residential care home, supported living and community based services for adults with learning disabilities and Autism.

You were placed at the Home as a Nurse in Charge caring for Resident A. Resident A presented with challenging behaviour, severe autism, mild learning disability, anxiety and emotional dysregulation leading to aggression. Resident A communicated mostly through her behaviour and pictorial references as she is only partially verbal.

Concerns were raised by colleagues that as the Nurse in charge, you allegedly failed to provide care in accordance with Resident A's PBS care plan and risk assessment and that you did not work cooperatively. Colleagues raised concerns that you allegedly altered the amount of food given to Resident A and that you did not monitor Resident A whilst eating despite there being a high risk of choking. Furthermore, it is alleged that you removed Resident A's shoes and locked Resident A in her room alone for extended periods of time without clinical justification.

Your case was considered by the Case Examiner on 22 May 2024 who concluded that there was a case to answer. The Case Examiner recommended that this matter could be dealt with by way of agreed undertakings. You agreed to the undertakings which mirrored, as far as relevant, the requirements of the Order put in place by the Council.

In a letter dated 28 May 2024, the NMC informed you of its recommendation that undertakings are a suitable method of managing your case. You agreed to the undertakings which took effect on 27 June 2024. It is alleged that you breached these undertakings and as a consequence, the Case Examiner revoked the undertakings on 23 September 2024 and referred your case to a Fitness to Practice Committee hearing.

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 respective submissions made by Mr Joshi and Mr Kabasinskas on behalf of the NMC, as well as those made by Ms Bennett and you 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 evidence from the following witnesses called on behalf of the NMC:

- Witness 1: PBS Lead Practitioner at the Charity at the material time
- Witness 2: PBS Assistant at the Charity, at the material time
- Witness 3: PBS Assistant Manager at the Charity, at the material time
- Witness 4: Compliance manager at the Agency, at the material time

The panel also heard evidence from the following witnesses on your behalf:

- Witness 7: Your former colleague at the Home and character witness, at the material time
- Witness 8: Your former colleague at the Home and character witness, at the material time
- Witness 9: Your former line manager at a different setting and character witness
- Witness 10: Your former colleague at the Home and character witness, at the material time
- Witness 11: Your former colleague at the Home and character witness, at the material time

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. In reaching its decisions, the panel took account of all the relevant evidence which included the written statements, corresponding documentation and oral evidence of the NMC witnesses, the witness statements of Witnesses 5 and 6; the written character references and oral evidence from Witnesses 7, 8, 9, 10 11 on your behalf.

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

Charge 1a(i)

That you, a registered mental health nurse:

1) On or around February 2023:

a) Did not follow Resident A's Positive Behaviour Support ('PBS') care plan in that you:

(i) Locked Resident A in their flat without clinical justification.

This charge is found NOT proved.

In reaching this decision the panel had regard to all of the relevant evidence.

The panel had regard to Witness 1's witness statement dated 21 September 2023 and oral evidence. The panel heard evidence that the door to Resident A's flat was locked as and when needed as part of her PBS care plan. It had sight of the details of Resident A's restrictions under the Deprivation of Liberty Safeguards (DOLS), which includes:

'...Windows are on restrictors, not actually locked and this is required because Res A is likely to try and climb in or climb out of windows putting at risk of harm. At times Res A needs to be restricted to her flat as staff need to withdraw when Res A is escalated and in distress...'

...

'Res A's backdoor is kept open at all times however, will ask for staff to lock the door, this is recorded on a form so we can identify and collect data on how often res A requests this. If res A behaviours are heightened and there is a risk opposed to herself or others, staff are to lock the door and complete observations until it is safe for res A to engage with staff. This must be monitored at all times on a recording form'

Witness 1 further stated that she had no concerns about your nursing practice until it was brought to her attention by Witness 6. The panel noted that there was said to be ill-feeling between you and Witness 6.

The panel considered Witness 2's witness statement dated 11 October 2023, which includes:

'...The door was locked for major amounts of time from 8:00 to 20:00. I know this because it stated on the handover forms where Resident A was, because she was on a 15 minute observations daily. I worked with Resident A for about 100 days and the door was locked most of the time. I would estimate that the door was unlocked for about 10 days from when I was working with Resident A...'.

The panel noted that Witness 2 first states that she worked with Resident A for '*about 100 days'.* Later on in her witness statement she states *'I worked with Resident A between 19 December 2022 until 24 February 2023'.* The panel noted that on any calculation these dates were far from the *'about 100 days'* she had originally stated. Her statement also says that although she commenced work at the Home on 19 December 2022 for the first month she was shadowing staff. Further, Witness 2 stated that the times when Resident A's back door was locked this was recorded on the *'handover forms'* however these were not provided as evidence. Witness 2 said in oral evidence

that Resident A would ask for the door to be locked when she wanted some private time and this was confirmed by all of the other witnesses. The panel also heard from Witness 2 and other witnesses that there were numerous other occasions when the door would be locked for both clinical and non-clinical reasons.

The panel assessed Witness 2's credibility as a witness. It noted that her role was a PBS Assistant for those with learning difficulties at the Home. This was her first care role and she was a new team member faced with caring for Resident A who she stated was *'challenging at times'* and required three-to-one care. Given all of the above, the panel did not consider Witness 2's evidence reliable in this regard.

Witness 3 said that he visited Resident A in her flat following the allegations and found her back door locked. However, he also stated that there was a flood in the bathroom at the time and it was never asked of him if this amounted to a clinical justification. The panel was therefore unclear as to the precise circumstances leading up to this incident.

The panel took account of Witness 7's oral evidence. Witness 7 who had worked with you on opposite ends of the same shift and said in oral evidence that *'everyone had their own ideas about caring for Resident A which sometimes caused friction but he* [you] *made everything quite cohesive'*. The panel heard evidence from more than one of your witnesses who said that you were someone who '*did things by the book'*, you were '*proactive...a leader who made sure everyone knew what they were doing'.*

The panel assessed Witness 7 to be a credible witness and his evidence reliable and it was not put to him the he was mistaken or was dishonest at all. It considered that Witness 7 was experienced in working in a care setting and therefore had a more realistic understanding of Resident A's circumstances.

Panel questions revealed that Witnesses 7, 8 and 10 had not observed any difference in the care of Resident A between you and any other registered nurses caring for her.

The panel was of the view that on balance, there is insufficient evidence before it to show that you locked Resident A in her flat without clinical justification. The panel

therefore finds this charge not proved.

Charge 1a(ii)

ii) On one or more occasions did not observe Resident A whilst eating.

This charge is found NOT proved

In reaching this decision, the panel took account of all the relevant evidence.

The panel had regard to Resident A's PBS plan, which includes:

> ***'Important*** *– to be observed at all times when eating; It has been confirmed by SALT that observations need to take place from outside her flat, it was identified that slows down her eating when she is on her own and it was reducing the risk of her eating fast however, she still needs to be observed at all times'*

Witness 2 in her witness statement includes that she watched Resident A eat through the window in case she ate too quickly.

The panel had sight of the email dated 16 December 2022 from the speech therapist to Witness 3, which clarifies the degree of observation required:

> *'In terms of supervision, I think it is fine for staff to remain in the room at a distance or stand on the other side of the door and look/listen from there. It is important staff remain focused on her eating until they know she has finished safely whether they are in or outside of the room and listen out for any signs of coughing or distress.'*

Witness 3 in his oral evidence said that Resident A ate more slowly if not directly observed.

Witness 3 in his witness statement, includes:

‘On 9 December 2022, I sought guidance because staff reported when they observe Resident A she feels pressured and eats quickly without enjoying her meal. The response I received was that she was a chocking risk and had to be visually observed whilst eating. There is a large window in her flat from floor to the celling and outside is a bench. Staff started to go outside to observe her through the window with the back door open. Resident A then slowed down and enjoyed her meals.

On 16 December 2022, I received a response from [Ms 1]*, Highly Specialist Speech and Language Therapist.* [Ms 1] *said that because Resident A is a chocking risk she needs to be either visibly or audibly observed. A copy of this correspondence can be found at Exhibit* [Witness 3] */2. Discussions were held with staff on how to support the resident. Resident A has a large window in her flat from floor to the ceiling and outside that window there is a bench. Staff started to go outside on the bench to observe the resident with the back door open. Since then, the resident started to slow down and enjoy her meals without the pressure on her.’*

Witness 1’s witness statement includes:

‘Resident A when she is agitated or off baseline can eat her food quickly and this puts her at a higher risk of chocking [sic] *and potentially dying. This means that she has to be observed at all times. This can be either from inside her flat if she will let staff in there whilst she is eating. Staff do not make it obvious that they are watching her. Staff look over at her from time to time. If Resident A refuses to let staff in, then staff can observe her from outside of her flat.’*

Your written response of 25 February 2023, includes:

‘...As a nurse, I take these code of practice seriously, hence, I challenged the deputy manager when he approached me asking that a staff member should stand watching the patient eat as the patient was at risk of choking after being

assessed by SALTs as level 7. I informed the deputy manager that my patient should be respected and the privacy of the patient is important. I went on to explain that from my observation, the patient choking risk increases if staff is standing over the patient watching her eat as the patient eats faster, hence, I will ask staff to observed every 15 minutes as per agreed observation plan. Furthermore, it is evident that the patient eats slowly when not observed reason I was yet to assessed. There was no incident of choking during my period of working with the patient, and there were no previous incident of choking noted.'

In your oral evidence you said that you allocated tasks at the beginning of each shift to observe Resident A eating through the window, as if directly observed this increased the speed at which she ate which increased the risk of choking.

The panel accepted your evidence that in this circumstance, observed means not standing over Resident A to watch her eat and also that you discussed this with Witness 3. Further, all of the NMC witnesses accept that watching Resident A from a window was permitted practice.

The panel therefore determined that there is insufficient evidence to prove that you did not observe Resident A whilst eating. The panel therefore finds this charge not proved.

Charge 1a(iii)

iii) On one or more occasions removed Resident A's shoes without clinical justification.

This charge is found NOT proved.

In reaching this decision, the panel took account of all the relevant evidence.

The panel had regard to Resident A's PBS care plan and noted that it refers to Resident A's clothing but there is no specific reference regarding shoes:

'Staff will choose Res A clothing for the day ensuring that it is appropriate for the weather Res A will be given a choice of outfits to wear Res A clothes are kept in the staff flat, this is to reduce ripping them apart'

The panel noted that only Witness 2 gave evidence that you stopped Resident A wearing shoes. No other witness gave evidence to that effect. Other witnesses noted that Resident A could put on and take off her own shoes. Witness 3 gave an alternative view that Resident A's risk of hurting herself was less likely with her shoes on.

Your evidence was that occasionally shoes would be moved so as to be out of her reach because Resident A could damage property, in particular blocking the toilet with them.

The panel was of the view that there has been no evidence put before it to show that shoes specifically formed part of Resident A's '*clothes'* in this case and it could not impliedly include shoes into the equation. The panel determined that there is no factual evidence to show that you removed Resident A's shoes without clinical justification. The panel therefore finds this charge not proved.

Charge 2a

2) Having accepted undertakings during the fitness to practise process, failed to comply with one or more in that you:

    a) Did not provide your NMC case officer with your employer's contact details as per undertaking 1b.

This charge is found proved.

In reaching this decision, the panel took account of all the relevant evidence.

The panel had regard to the agreed undertakings dated 28 May 2024 and an email from your former representative dated 25 June 2024 which included confirmation of your acceptance of the undertakings,

In your evidence you accepted that you failed to provide the NMC with your employer's contact details, however you said that you were discussing the matter with Mr 1 your line manager and your solicitor at the time. You stated that their advice to you was to not do anything until the NMC published the undertakings on its website.

The panel considered the witness statement of Witness 5, which includes:

> *'On 9 July 2024* [Witness 4] *the compliance manager of the agency* [PRIVATE] *that Mr Lanford was registered with for work as a nurse, emailed me to inform of the agency's concerns that the above undertakings had been breached by Mr Langford.*
> *...*
> *On 6 September 2024 I emailed Mr Langford and his representative to notify them of the serious breach of the undertakings and that the matter would be referred to the CEs for assessment of the evidence of a serious failure to comply with the undertakings.'*

The panel was of the view that you would have been aware of what the undertakings entailed, as you had the letter detailing them one month prior. In addition, you had met with your solicitor to discuss them prior to you accepting them. However you failed to act on them. The panel determined that on a factual basis and on your own admission in oral evidence, you did not provide your NMC case officer with your employer's contact details as per undertaking 1b. The panel therefore finds this charge proved.

Charge 2b)

b) Did not immediately give a copy of the undertakings to your agency as per undertaking 3b.

This charge is found proved.

In reaching this decision, the panel took account of all the relevant evidence.

The panel determined that you were aware of the agreed undertakings on 27 June 2024, as you received a letter from the NMC a month previously, before you had any conversation with Mr 1 or your solicitor. In your oral evidence you made a tacit admission that you did breach the undertaking, that it was *"unintentional"* and you were "*ill-advised".* You explained that you were working a weekend night shift and the undertakings were published on Friday 28 June 2024 and that you did not check your emails during this period of time.

The panel considered that whilst it is plausible that you did speak with Mr 1 about waiting for the undertakings to be published, it had seen no evidence before it to show that this conversation took place with Mr 1 and Witness 4 said that it was not documented in any agency correspondence. Further, the panel was of the view that there is a difference between giving a copy of the published undertakings and having discussed the undertakings prior to you agreeing to them.

The panel determined that on a factual evidential basis, it has seen no evidence put before it to show that you gave a copy of the undertakings to your agency. The panel determined that the onus was on you to address and immediately act on them as agreed. The panel therefore finds this charge proved.

Charge 2c)

c) Did not allow your case officer to share details of your performance and progress towards completing the undertakings as per undertaking 5.

This charge is found NOT proved.

In reaching this decision, the panel took account of all the relevant evidence.

The panel heard in your oral evidence that you were unable to gain employment once the undertakings had been published. Further, the panel had no evidence before it to show the contrary. The panel accepted your evidence and was of the view that you did not have the opportunity to share details of your performance and progress in compliance with this undertaking, because you were not working at the time in order to do so. The panel therefore finds this charge not proved.

Charge 2d)

d) Did not disclose your undertakings to your agency and your employer whilst working in two settings via an agency as per undertaking 6.

This charge is found proved

In reaching this decision, the panel took account of all the relevant evidence.

The panel took account of Witness 4's witness statement evidence. It had regard to her email dated 9 July 2024 to the NMC, which includes:

> ***'Undertakings 5*** *- During the 3 shifts booked, James worked with 2 different Trusts - Our clients were not notified of the conditions and therefore has caused a risk to the registrant and patient safety*
>
> ***Undertaking 6 -*** *We were not informed of the order in place to ensure that this undertaking was met during his assignments with* [PRIVATE] *and our clients'*

The panel assessed Witness 4 to be a credible witness and it had no evidence before it to refute what she states.

In your oral evidence under cross-examination when taken to undertaking 6, you said that you understood that you worked in two settings after your undertakings were published and before your shifts were cancelled. The panel determined that on your own admission and on a factual basis, it finds this charge proved.

Charge 2e)

e) Worked on one or more occasion without the supervision of a Band 5 nurse as per undertaking 7.

This charge is found proved.

In reaching this decision, the panel took account of all the relevant evidence.

The panel took account of your oral evidence and accepted your evidence that you were working with a band 6 nurse and not on your own.

The panel took account of Witness 4's witness statement, which includes:

> *'Mr Langford would have worked the shifts without supervision prior to his NMC undertakings coming in force. However, as a standard, there would have been a nurse in charge on the wards during his assignments. But after the undertakings were put in place on 27 June 2024, Mr Langford worked unsupervised on 27 June 2024, 29 June 2024 and 28 July 2024* [sic – the panel determined that '*28 July 2024'* was a typographical error and should read 30 June 2024].*'*

The panel had regard to Witness 4's email dated 9 July 2024 to the NMC, which includes:

> ***'**We were not informed of the order in place to ensure that this undertaking was met during his assignments with* [PRIVATE] *and our clients'*

The panel was of the view that working with a band 6 nurse is not the same as being actively supervised by a band 5 nurse as was required. Further, the panel noted that Witness 4 does not confirm that supervision took place and there is no evidence to show that you were supervised by the band 6 nurse you worked with. The panel therefore finds this charge proved.

Panel remarks

In the initial substantive hearing in January 2025, allegations were put by your former representative Ms Bennett that there was a racial basis for the charges and that it was prejudiced against you. However, at this resumed hearing you represented yourself and have made the point that there was no racial element to the charges. The panel determined that these were only submissions made by Ms Bennett and no evidence was provided to support these claims. The panel would not wish it to be thought that you had raised unsupported allegations when you had not.

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.

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.

Submissions on misconduct and impairment

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

In relation to misconduct, Mr Kabasinskas referred to the following cases of: *Nandi v GMC* [2004] EWHC 2317 (Admin); *Holder v NMC* [2017] EWHC 1565 (Admin); *Schodlok v GMC* [2015] EWCA Civ 769, *GMC v Adeogba* [2016] EWCA Civ 162 (paragraph 20) and *Roylance.* He also referred the panel to the NMC guidance on Misconduct reference FTP-2a.

Mr Kabasinskas invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 2015' (the Code). He identified the following specific, relevant standards where, in the NMC's view your actions amounted to a breach of those standards: 19.4, 20.1, 20.4 and 23.3.

Mr Kabasinskas submitted that there is an implied duty on registrants to engage with a resolution of the matter and undertakings are a form of that resolution. He submitted that undertakings are different to a conditions of practice order. Upon acceptance the nurse must comply with the terms of an undertaking. He submitted that the breach of undertakings is a form of conduct that falls below the standards expected of a registered nurse and it is the NMC's position that it amounts to misconduct.

Mr Kabasinskas 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. He referred the panel to the cases

of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin)*, Cohen v GMC* [2008] EWHC 581 (Admin), *Amao v NMC* [2014] EWHC 147 (Admin) and *Pillai v GMC* [2015] EWHC 305 (Admin).

Mr Kabasinskas referred to the case of *Grant* and submitted that limbs a), b) and c) of Dame Janet Smith's test as set out in the Fifth Shipman Report are engaged in this case. He submitted that there are two actions which put patients at a risk of harm. Firstly, working in contravention when your practice is restricted and secondly not disclosing those restrictions to your employer and agency had put patients at a risk of harm. He submitted that not cooperating with the regulator about restrictions has brought the profession into disrepute.

In looking at the issue of insight, remediation and risk of repetition, Mr Kabasinskas referred the panel to the case of *Cohen* and the test set out within. He also referred to the case of *Amao* which differentiates between different types of insight and NMC guidance FTP-15.

- FTP-15a: Can the concern be addressed?,

Mr Kabasinskas submitted that the misconduct in charge 2 is much harder to address as the failure to comply with undertakings contains elements of failure to act. He submitted that whilst your position is that it was an unintentional breach the panel may find that it was deliberate and therefore serious. He submitted that a failure to act is particularly serious as you entered into an undertaking with your regulator and failed to notify the agency.

- FTP-15b: Has the concern been addressed?

Referring to the guidance Mr Kabasinskas submitted that insight on the part of a nurse is crucially important. He referred to your early reflections and submitted that it is limited. He submitted that it contains deflection of blame to the agency and others. He submitted that there is no reflection on the impact of your misconduct on the profession.

In relation to your written reflective piece provided today he submitted that, comparing these two documents your insight remains unchanged.

- FTP-15c: Is it highly unlikely that the conduct will be repeated?

Mr Kabasinskas submitted that your insight is developing and that insufficient steps have been taken by you to address the concerns identified, therefore your conduct is likely to be repeated.

He submitted that a point the panel may wish to consider is whether your behaviour arose in unique circumstances to suggest that the risk of repetition in the future is reduced, he submitted that it is the NMC's position that these were not unique circumstances.

In relation to public protection, Mr Kabasinskas submitted that your misconduct has not been addressed. therefore the risk of repetition remains. He submitted that there is a risk to the health, safety, wellbeing of a public therefore a finding of impairment on public protection grounds is necessary.

In relation to public interest, he submitted that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and wellbeing of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession.

He submitted that due to the nature of the profession it is expected that registrants will engage with their regulator and comply with any restrictions imposed upon them. He submitted that public confidence in the profession would be diminished if a nurse who has breached an undertaking was not found to be impaired. He submitted that a finding of impairment on your practice on public interest grounds in this case is required.

You told the panel that you honestly and sincerely did not mean to breach the undertakings and that it was unintentional. You said that if you knew what you know now you would have done things differently. You said that this has cost you a lot. You

have reflected and although you unintentionally breached the undertakings it does not mean your competence in practice is impaired.

You told the panel that nurses are not trained in fitness to practise proceedings and understanding the legalities and effect of what undertakings actually mean. You said that you have reflected on how you would handle things differently were it to happen again.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included the cases of: *Grant, Roylance, Nandi* and NMC guidance FTP-2a and DMA-1.

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 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:

> ***19.4*** *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*
>
> ***Promote professionalism and trust***
> *You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.*
>
> ***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*

23.3 *tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that this is serious professional misconduct. You received a clear letter from your regulator whose overarching objective is to protect the public. The letter contained precise details about what you had to do, when it had to be done by and there was no ambiguity in the letter. The panel determined that you voluntarily agreed to the undertakings and failed to adhere to and cooperate with your regulator's decision, which is serious misconduct, especially bearing in mind that you were being investigated for clinical misconduct against Resident A at the time.

The panel found that your actions did fall seriously short of the conduct and 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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

The panel determined that you had undertakings put in place by your regulator acting to manage the risk it had identified in your practice. Failing to comply with your regulator and failing to adhere to the undertakings put patients at unwarranted risk of harm.

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

The panel determined that your past failure to cooperate with your regulator has brought the nursing 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 medical profession;...'

The panel determined that by not complying with the undertakings you agreed to with your regulator, you breached a fundamental tenet of the nursing profession, namely failing to adhere to the NMC Code of Conduct and cooperating with your regulator.

The panel finds that patients were put at risk of harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to a breach of regulations extremely serious.

The panel considered the following factors set out in the case of *Cohen:*

- Is the behaviour easily remediable?

The panel determined that your misconduct is remediable.

- Has it already been remedied?

The panel determined that you knew on 28 May 2024 details of the undertakings that would involve restrictions of your practice and that you needed to inform your employer. The panel determined that this has not been addressed in your reflective pieces. You stated that the breach was unintentional but you have not shown any insight on how you could have acted differently, given that you knew they were coming into force a month

before they were published. The panel accept your lack of intention but consider that you were reckless towards your obligations arising from the undertakings. You have not shown sufficient understanding of how you needed to ensure that the undertakings were complied with on time.

- Is it highly unlikely to be repeated?

Regarding insight, the panel determined that this had developed over the course of this hearing but that you still appeared to lack an understanding of the seriousness of the breach of undertakings or how the breach could have been avoided. The panel was therefore not satisfied that this would not happen again in the future.

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 have taken steps to strengthen your practice. The panel took into account the training you have undertaken and the reflective pieces written by you. However, the panel determined that your reflections lack the full insight required to show your understanding of the gravity and implications of breaching your undertakings.

In relation to public protection, for all the reasons given above, the panel was of the view that a risk of repetition remains. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 considered that patients, their families and members of the public trust nurses to be able to provide safe, kind and effective care at all times. It considered that your misconduct was at odds with the public's expectation of how nurses should conduct themselves. The panel considered that confidence in the profession and in the

NMC as a regulator would be undermined if a finding of impairment were not made in the circumstances, in order to mark the seriousness of the conduct in this case. The panel therefore 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, on public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of three months without a review. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

The panel was aware that in the initial Notice of Hearing dated 28 February 2025, the NMC had advised you that it would seek the imposition of a suspension order with review if it found your fitness to practise currently impaired. Mr Kabasinskas, having taken further instructions, informed the panel that the sanction sought by the NMC is that of a suspension order of six months duration with review.

Mr Kabasinskas submitted that the following aggravating factors are applicable in this case:

- It was a reckless breach and you showed a cavalier attitude towards your obligations to the profession
- Your conduct put patients at a risk of harm

With respect to the mitigating factors, Mr Kabasinskas submitted:

- Your developing insight
- Your personal mitigation

Mr Kabasinskas submitted that to both take no action or impose a caution order would be wholly inappropriate, as the misconduct is not at the lower end of the spectrum, it would not reflect the seriousness of the misconduct, nor would it protect the public or maintain public confidence in the profession or the NMC as regulator. Referring to SAN-3c, he submitted that a conditions of practice order would be inappropriate as conditions are used to address clinical concerns and there are no clinical concerns in this case. Therefore no workable conditions that can be formulated in the circumstances of this case.

Mr Kabasinskas referred the panel to guidance SAN-3d on suspension orders. He submitted that, placing the seriousness somewhere in the middle of the scale, a suspension order is the most appropriate order to address the misconduct in this case. He submitted that a suspension order for a period of six months with a review is necessary in view of your developing insight.

Mr Kabasinskas referred the panel to SAN-3e on striking-off orders and SAN-2 'Cases involving deliberate breach of an interim order, substantive order or an undertaking'. He also referred to the case of *Ford v Owen and Financial Conduct Authority* [2018] (UKUT) 358 TCC which states **'***Reckless behaviour is capable of being characterised as a lack of integrity'*. He submitted that a breach of a restrictive measure in an undertaking may call into question whether the person should remain on the register. However, he submitted that it is the NMC's position that your conduct, whilst it is serious, is not fundamentally incompatible with continued registration.

The panel also bore in mind your submissions. You provided the panel with written submissions on sanction and referred to them in outline in your oral submissions.

You told the panel that you understand that you did breach the undertakings and have learned throughout this process over the past 18 months and you have not been working with this restriction placed on you. You said that you accept that your total omission on not fully understanding undertakings was reckless, however no harm was caused.

You said that you uphold the NMC regulation very seriously and the NMC Code is something you have always embedded in your practice. You said that this investigation has taught you a lot and you would look to support nurses out there to do the right thing and educate them on the NMC regulations.

The panel accepted the advice of the legal assessor.

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:

- Lack of personal responsibility regarding the undertakings

The panel was confident that, in its view your reckless approach to the commencement date of the undertakings was due to your naivety of their importance and underlying rationale rather than a cavalier attitude.

The panel also took into account the following mitigating features:

- Your genuine remorse and developing insight into your failings

The panel has considered the [PRIVATE] that you have provided. Whilst it could not be considered to be a mitigating factor, as there was no evidence of this at the time of the allegations, nonetheless, the panel has taken it into account as personal mitigation.

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, 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 in breaching undertakings 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;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *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 is of the view that there are no practical or workable conditions that could be formulated, given there are no clinical failings to be addressed in this case. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

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

The panel was satisfied that the misconduct in this case was not fundamentally incompatible with remaining on the register.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it and mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order for a period of three months without a review, would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However this is outweighed by the public interest in this case.

The panel considered that this order is 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.

Your submissions at the sanction stage demonstrated further reflection and insight into your misconduct. You stated:

> *'I fully acknowledge that I breached the undertakings imposed on me following the previous NMC decision. I take full responsibility for failing to inform my agency employer as required. Once I realised my mistake after two shifts on two different units over that weekend (28th and 29th June, 2024) and was notified by my agency on the Monday morning, 1st July, 2024 , I immediately ceased working and notified the other agency, YourNurse, that I had not work for over a year by giving a copy of my undertakings. Furthermore, every potential jobs I applied for employment, my undertakings were disclosed right from application stage. I understand completely that patient safety and public protection are central to the NMC's role.'*

The panel had regard to the NMC guidance 'Directing reviews at substantive order' Reference SAN-6. It was of the view that in light of all of the facts, the surrounding circumstances and your reflections, a review would serve no useful purpose and was therefore unnecessary.

The panel determined that a suspension order for a period of three months without a review was appropriate in this case to mark the seriousness of the misconduct.

This will be confirmed to you in writing.

Interim order

As the suspension 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 suspension sanction takes effect.

The panel accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Kabasinskas. He submitted an interim suspension order for a period of 18 months was necessary to cover any potential period of appeal. He submitted that the application is necessary on the grounds of public protection and in the public interest.

You made no submissions in respect of this application.

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 its determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any potential period of appeal.

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

That concludes this determination.