Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 22 April – Thursday, 24 April 2025
Monday, 28 April 2025
Thursday, 1 May – Friday, 2 May 2025
Monday, 13 October – Thursday, 16 October 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	Yeboah Augustine
NMC PIN:	19J0519O
Part(s) of the register:	Registered Nurse - Adult Nursing RNA – (14 October 2019)
Relevant Location:	Warwickshire
Type of case:	Misconduct
Panel members:	Mandy Rayani (Chair, Registrant member) Sarah Morgan (Registrant member) Sabrina Sheikh (Lay member)
Legal Assessor:	Simon Walsh
Hearings Coordinator:	Ibe Amogbe (22 – 24 April 2025, 28 April 2025, and 1 – 2 May 2025) Nicola Nicolaou (13 – 16 October 2025)
Nursing and Midwifery Council:	Represented by Brittany Buckell, Case Presenter (22 – 24 April 2025, 28 April 2025, and 1 – 2 May 2025) Iwona Boesche (13 – 16 October 2025)
Mr Augustine:	Not present and not represented at the hearing
Facts proved:	2, 3, 4, 8a, 8b, 8c, 9b (in relation to 8b and 8c only), 10a, 10b, 12c, and 15 (in respect of 22 July 2022 only)
Facts not proved:	1, 5a, 5b, 6, 7, 9a, 11, 12a, 12b, 13, 14a, 14b, and 16

Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Augustine was not in attendance and that the Notice of Hearing letter had been sent to Mr Augustine's registered email address by secure email on 24 March 2025.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mr Augustine

The panel next considered whether it should proceed in the absence of Mr Augustine. It had regard to Rule 21 and heard the submissions of Ms Buckell who invited the panel to continue in the absence of Mr Augustine. She submitted that Mr Augustine had voluntarily absented himself.

Ms Buckell referred the panel to correspondences between Mr Augustine and the NMC including an email dated 18 November 2024, which stated that:

> *'Due to* [PRIVATE], *I won't be able to attend the meetings as scheduled.'*

Ms Buckell also referred the panel to the NMC telephone note dated 10 April 2025, which stated:

> *'I asked to reaffirm if he was OK for us to proceed without him at the hearing, He confirmed it was fine.*
> *He said, I am just hoping for the best, but I wont be there'*

Ms Buckell submitted that the NMC has made all reasonable efforts to contact Mr Augustine and that there has been no application from him to adjourn the hearing, nor any indication that an adjournment would secure his future attendance. She further stated that some witnesses are available to give evidence and submitted that there is a strong public interest in resolving the matter without delay.

The panel sought further clarity from Ms Buckell as to what offers were provided to Mr Augustine to secure his attendance, and whether all options to facilitate his attendance were made available to him. Ms Buckell informed the panel that Mr Augustine was provided with all options such as a physical hearing, and virtual attendance, however, Mr Augustine declined to attend.

The panel accepted the advice of the legal assessor.

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

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

- Mr Augustine indicated in his telephone conversation with the NMC dated 10 April 2025 that he will not be participating in this hearing;
- Mr Augustine has voluntarily absented himself;
- No application for an adjournment has been made by Mr Augustine;
- Mr Augustine's health and wellbeing might be impacted if there are further delays;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Four witnesses are scheduled to give live evidence at this hearing;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Augustine in proceeding in his absence. Although the evidence upon which the NMC relies has been sent to him, he has made no formal response to the charges. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Augustine's decision to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge

That you, a registered nurse:

1. On or around 21 March 2023, administered an incorrect dose of medication, namely 2.5mg of Morphine instead of 5mg to Resident A as prescribed.

2. Responded to Colleague A's email sent on or around 21 March 2023 requesting an investigation meeting following the medication error in 1(a) above with, '*I will not be attending any meeting. You need a psychiatric assessment because you are sick in the head'* or words to that effect.

3. Your actions at charges 2 above were unprofessional and/or intended to undermine Colleague A.

4. Between 24 November 2022 and 21 March 2023 made comments on one or more Accident and Incident forms, which were inappropriate and/or unprofessional.

5. On an unknown date:

    a. said to Colleague B, '*I have had enough of your bullshit*' or words to that effect and/or
    b. threw the handover book into Colleague B's lap.

6. Between 21 April 2021 and 31 March 2023, on one or more occasion, shouted at Colleague B.

7. Between 21 April 2021 and 31 March 2023, on one or more occasion swore at Colleague B.

8. On unknown dates, made one or more of the following comments in the staff communication book:

    a. 'think twice before you put my name here'; and/or
    b. 'if you don't know how to communicate on personal issues just learn and if it is arrogance, kill it' and/or

c. ‘I wonder how people got themselves into managerial position with this kind of poor communication skills. Even the Home manager does not write my name in the book when she wants to communicate with me. Because of arrogance and disrespect people behave anyhow. This NONSENSE MUST STOP. Augustine’

9. Your actions at charge 5-8 were:

    a. Threatening or intended to be threatening and/or
    b. Unprofessional

10. On or around 31 August 2021 without clinical justification:

    a. Grabbed Resident B’s arm/palm/wrist
    b. Took a pen out of Resident B’s hands and threw it across the room

11. On an unknown date in August 2022, delayed in administering end of life medication to Resident D in that you administered the medication approximately 10-20 minutes after you should have.

12. On 23 July 2022:

    a. Did not complete or ensure that the fluid balance intake chart was completed for Resident I as required.
    b. Did not complete or ensure that it was recorded on Resident H’s 24 hour repositioning record that Resident H had been repositioned as required.
    c. Did not complete or ensure that it was recorded on Resident B’s 24 hour repositioning record that Resident B had been repositioned as required.

13. Did not complete or ensure that the fluid balance chart was completed for Resident C on 23 August 2022 as required.

14. Did not complete or ensure that it was recorded on their 24 hour repositioning record that one or more of the following residents had been repositioned as required:

    a. Resident J on 20 July 2022
    b. Resident B on 31 July 2022

15. Did not complete or ensure the night touch point cleaning record was completed as required whilst you were on shift on 22 July 2022 and/or 22 August 2022.

16. Between 21 April 2021 and 31 March 2023, on at least one occasion, failed to provide adequate oral handovers.

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

Background

The NMC received a referral on 1 December 2022 from Colleague B, the Clinical Lead at [PRIVATE] ('the Home'), Care UK. The charges arose whilst Mr Augustine was employed as a registered nurse at the Home. Mr Augustine started working at the home in April 2021 and was the nurse in charge on night shifts. The allegations relate to incidents that were said to have occurred between 2021 and 2023.

It is alleged that on 31 August 2021, Mr Augustine grabbed Resident B's wrist and snatched a pen from her hand, which he then threw across the room with force. Witness 5, a colleague witnessing the incident, stated that the incident occurred during personal care, that Resident B appeared frightened, and that the pen left a visible mark on the wall. Witness 5 said that Resident B later told her that she had been hurt and did not want Mr Augustine to return to her room.

It is also alleged that Mr Augustine failed to complete or ensure the completion of essential records, including food and fluid charts and repositioning records for

multiple residents. Mr Augustine allegedly expressed a belief that some of these records were unnecessary and refused to incorporate them into care plans, despite his responsibility to do so.

It is alleged that Mr Augustine did not respond promptly to calls from a carer to attend to Resident D, to administer end of life medication resulting in a delay of around 20 minutes. Family members of Resident D also raised concerns about the delay and the lack of communication at a critical time.

It was also alleged that on or around 21 March 2023, Mr Augustine administered a lower dose of morphine than prescribed without authorisation. It is claimed that Mr Augustine gave 2.5mg instead of the 5-10mg prescribed, based on his own view that the prescribed dose was too high. This was allegedly done without consulting a doctor or following proper procedures. The prescribing doctor later expressed surprise that Mr Augustine acted in this way and stated that any concerns should have been raised directly with him.

In addition, a number of staff raised concerns about Mr Augustine's alleged inappropriate remarks and behaviour in the workplace. It is alleged that he wrote unprofessional and personal comments in communication records, undermined colleagues, and made others feel uncomfortable or intimidated. Colleagues reported feeling stressed, anxious, or reluctant to work with him due to his behaviour.
As a result of the allegations, a local investigation was conducted by the Home, which resulted in a disciplinary hearing.

During the local investigations, it is alleged that Colleague A, the Home Manager at the time of the alleged incident, emailed Mr Augustine inviting him to a disciplinary hearing, to which he allegedly responded saying that she needed a psychiatric assessment.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Buckell under Rule 31 to admit the following into evidence as hearsay:

- Colleague A’s witness statement and exhibits
- Witness 4’s evidence referenced in Colleague A’s statements
- Resident B’s statements to Colleague A and Witness 5
- Meeting minutes dated:
    a. 6 January 2023
    b. 11 May 2023
    c. 19 June 2023

Ms Buckell referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). She submitted that this case laid out a series of factors to be considered in admitting hearsay evidence and to which she would make reference in her submissions.

In relation to the evidence of Colleague A, Ms Buckell submitted that this was not the sole or decisive evidence in relation to any charge. She noted that the evidence is supported by further documentation, including Mr Augustine’s own admissions, internal reports, and the supplementary statement of Witness 3, who is in attendance.

Ms Buckell further submitted that the NMC had taken reasonable steps to secure attendance. In respect of Colleague A, telephone notes documented in the hearsay bundle record her reasons for not attending.

Regarding the reference to Witness 4’s evidence Ms Buckell submitted that the incident in question is discussed by multiple witnesses, including Colleague A and Witness 3. In addressing the availability of Witness 4, Ms Buckell referred the panel to email correspondences dated 27 February 2025 and 9 April 2025.

With respect to the statements attributed to Resident B, Ms Buckell noted that these are reported consistently by Colleague A and Witness 5, the latter of whom is attending the hearing. She submitted that while Resident B is not giving live evidence, the Home Manager has advised that it would not be appropriate to ask her

to do so due to concerns for her wellbeing. In these circumstances, the NMC submits that the evidence is reliable and should be admitted.

In relation to the meeting minutes, Ms Buckell submitted that these documents form part of the local investigation process. They record Mr Augustine's responses to the allegations and demonstrate his opportunity to comment and engage with concerns at the time. She submitted that they are relevant and admissible as hearsay records of internal proceedings.

Having regard to the seriousness of the allegations against Mr Augustine, Ms Buckell submitted that they are serious in nature and, if found proved, may amount to misconduct. She acknowledged that an adverse finding could have a significant impact on Mr Augustine's nursing career, but submitted that this should not preclude the fair and proportionate use of hearsay evidence.

Ms Buckell submitted that Mr Augustine had been given advance notice of the NMC's intention to rely on hearsay evidence. She informed the panel that this was discussed with him by telephone on 10 April 2025. The hearsay bundle was also shared with him on the morning of the hearing dated 22 April 2025.

She concluded by submitting that the hearsay evidence is relevant, reliable, and admissible under Rule 31, and that it would be fair to admit it.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor also referred the panel to the principles derived from the judgement in the case of *Thorneycroft* which the panel should consider when determining whether it would be fair to admit the evidence.

The panel noted the paragraphs 45 and 56 of the judgement in the case of *Thorneycroft*:

‘45. For the purposes of this appeal, the relevant principles which emerge from the authorities are these:

1.1. *The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.*

1.2. *The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.*

1.3. *The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.*

1.4. *Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.*

In my judgment, unless the Panel is given the necessary information to put the application in its proper context, it will be impossible to perform this balancing exercise.

[…]

56…. The decision to admit the witness statements despite their absence required the Panel to perform careful balancing exercise. In my judgment, it was essential in the context of the present case for the Panel to take the following matters into account:

(i) *whether the statements were the sole or decisive evidence in support of the charges;*

(ii) *the nature and extent of the challenge to the contents of the statements;*

(iii) *whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*

(iv) *the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;*

(v) *whether there was a good reason for the non-attendance of the witnesses;*

(vi) *whether the Respondent had taken reasonable steps to secure their attendance; and*

(vii) *the fact that the Appellant did not have prior notice that the witness statements were to be read.'*

The panel considered each of the hearsay applications separately.

Colleague A's witness statement and exhibits

The panel first considered whether the NMC had provided a good and cogent reason for Colleague A's non-attendance. Her witness statement, signed and dated 21 November 2024, contained the usual rubric 'I am willing to attend a hearing and give evidence before a committee of the NMC if I am required to do so'.

The reality was, however, rather different. Although warned to the possibility of a hearing as long ago as 5 November 2024, Colleague A was chased about attendance in correspondence dated 25 February and 27 March 2025 and telephoned twice on 1 April 2025 (the calls were unanswered and voicemail messages left), little was heard from Colleague A leading the case coordinator to conclude Colleague A was avoiding contact with the NMC.

On 1 April 2025 the case coordinator received a message from Colleague A in which she said she had been told earlier that she was not needed to attend and her position now was that:

'*I'm not going to attend all right. And really, don't contact me again about this. I have got enough on with* [PRIVATE] *I'm sorry about that I hope it goes ahead okay alright*'

Two further telephone calls on 1 April 2025 and one call on 10 April 2025 were unsuccessful. Again, the NMC case coordinator concluded that Colleague A was avoiding contact with the NMC. The case coordinator wrote to Colleague A on 10 April 2025 to offer her supportive measures and reasonable adjustments in an effort to secure her attendance but nothing more has been heard from Colleague A.

The panel agree with the case coordinator's assessment in the telephone call note dated 10 April 2025 that Colleague A is deliberately avoiding contact with the NMC and do not find this to be a good or cogent reason for her non-attendance.

The panel noted the guidance in *Thorneycroft* that the absence of a good and cogent reason for non-attendance does not automatically result in the exclusion of hearsay evidence and went on to consider the substance of Colleague A's evidence.

Colleague A was the home manager at the Home at the time of the various matters referred to in the charge. The panel noted that Colleague A herself witnessed none of the disputed matters but recounted what she had been told by other people. The panel further noted that these other people were expected to come themselves to give direct evidence. The panel determined that it would not be fair in the circumstances, to admit evidence about simply what Colleague A was told.

Colleague A also offered evidence about Mr Augustine's record keeping. This evidence was generic. As the charges faced by Mr Augustine refer to specific dates and to specific residents the panel determined that it would not be fair to admit generic evidence about record keeping standards when it would not be possible to ask the witness if she could be referring to a date or resident specified in the charge.

Colleague A also offered direct evidence about her personal interactions with Mr Augustine but the panel noted that were no charges that related directly to this.

In conclusion, the panel determined it would be unfair to admit hearsay evidence from Colleague A and rejected the application.

Witness 4's evidence referenced in Colleague A's statement

The panel found that the application to admit hearsay evidence from Witness 4 was unusual in that there was no statement from her. With the help of Ms Buckell, the panel identified the evidence in issue as being comments made by Witness 4 to Colleague A (as recorded in paragraph 33 of Colleague A's statement). In essence these were that Witness 4 had *'called'* Mr Augustine three times on an unidentified day to administer end-of-life medication to Resident D and that there had been a 20-minute delay in the administration of the medication which Mr Augustine explained as being because he was busy.

An examination of the reasons for Witness 4's non-attendance quickly identified why there was no statement from her. She had repeatedly refused to sign the draft statement prepared for her by the NMC (presumably this statement was drafted in line with the comments reported by Colleague A). It had been explained to Witness 4 in writing by the case coordinator that:

> '*We need your signed statement to be part of the evidence for the hearing in this case*.'

A chasing email from the case coordinator on 9 April 2025 elicited the following response from Witness 4 the next day:

> '*I want to let you know that I have thought about this and I don't want to carry on. I don't feel that it is fair what that family did to Mr Augustine. He's a genuine man hardworking and honest. He hasn't done nothing wrong* [sic] […] *I don't want to feel that my presence in this it will damage his future and also to lose his pin number.* […] *He's a good guy*'

The panel considered this provided a good and cogent reason for Witness 4's non-attendance: she clearly no longer supports the NMC's case. The panel determined

this clearly weighed against admission of her hearsay evidence rather than in favour of its admission. It would be manifestly unfair to admit hearsay evidence that appears to have been subsequently specifically rejected by a witness.

The application in respect of Witness 4 was refused.

Minutes of Meetings

The NMC applied to admit as hearsay evidence the minutes from three different meetings. An application to admit evidence as hearsay is an application to admit such evidence as to the truth of its contents and not simply, for example, to show that someone was present at a meeting. The panel looked at each meeting separately.

In all three cases, the meeting minutes dated 6 January 2023, 11 May 2023, and 19 June 2023, had witnesses in attendance. The NMC has not attempted to take witness statements from, or indeed to call, any of the witnesses present at these meetings. The explanation was that the NMC did not think it was necessary. The panel did not find this to be a good reason for non-attendance.

The panel recognised that when minutes of formal meetings are signed by a registrant as being a true record of what happened, it may be excessive to call witnesses to prove their accuracy.

In respect of the meeting held on 3 November 2022, the minutes were signed electronically by two out of three attendees but not until 6 January 2023. These minutes have not been signed by Mr Augustine and there is no evidence that they were ever offered to him for comment or approval. The minutes of the meetings held on 11 May 2023, and 19 June 2023, were not signed by any of the attendees or Mr Augustine and there is no evidence that they were ever offered to him for comment or approval.

In addition, the panel noted that Mr Augustine has previously complained that meeting minutes (albeit not specifically these minutes) taken during formal Home meetings were either inaccurate or incomplete.

In all the circumstances the panel considered it would not be fair to admit these meeting minutes as evidence of the truth of their contents and the application to do so was refused.

Resident B's statements to Witness 5

The panel has considered the application to admit hearsay evidence from Resident B in relation to Charge 10. Ms Buckell applied to admit statements made by Resident B to Witness 5, on 31 August 2021, which are as follows:

> *'The* [registrant] *has hurt me'*
> *'I am scared'*
> *'I don't want the* [registrant] *in my room'*
> *'I want more females visiting me'*

The panel is satisfied that there is a good and cogent reason for Resident B not to attend to give evidence. In particular, her age and physical frailty render her attendance impractical.

The panel notes that the hearsay evidence is not the sole or decisive evidence in relation to Charge 10. The evidence of Resident B serves to support the direct evidence provided by Witness 5.

In light of the above, the panel is satisfied that it is fair to admit the hearsay evidence of Resident B.

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 Ms Buckell on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mr Augustine. Although Mr Augustine did not attend this hearing, and did not provide any formal response to the charges, he did, at earlier stages of this case, provide detailed written submissions in respect of regulatory concerns that mirror the charges the panel are dealing with. The NMC included these informal submissions in the exhibits bundle for this hearing and the panel have therefore carefully considered them and given them appropriate weight.

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 something occurred as alleged.

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

- Colleague B: Clinical Lead at the Home at the time of the alleged incidents.
- Witness 3: Deputy Manager employed by Care UK at the time of the alleged incidents.
- Witness 5: Care Assistant at the Home at the time of the alleged incidents.
- Witness 6: Registered Nurse who conducted the disciplinary

investigation at the time of the alleged incidents.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC along with Mr Augustine's informal submissions.

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

Charge 1

1) On or around 21 March 2023, administered an incorrect dose of medication, namely 2.5mg of Morphine instead of 5mg to Resident A as prescribed.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 3, as well as the written submissions from Mr Augustine to the NMC dated 4 December 2023. The panel also had regard to the documentary evidence exhibited, which included the Medicine Management Policy.

The panel noted the following from Mr Augustine's submissions:

> *'I felt the 5mg was too lethal and hence I made a best decision to give 2.5mg instead of the prescribed 5mg. The timing was not appropriate for me to discuss my concerns with out of Hours GP. I gave the medication at 7:20am and my shift ends at 8:00am. Moreover, the issue of pain cannot be delayed and hence I made a best interest decision and the 2.5mg of Morphine was enough to control the resident's pain from 7:20 until her death at 3:40pm.*'

The panel was satisfied, based on the evidence before it, that Mr Augustine administered 2.5mg of Morphine.

The panel, however, found no evidence before it to indicate that 5mg was the prescribed dose for Resident A.

The panel noted that Witness 3 made reference in her oral evidence to a directive that 5-10mg of Morphine could be administered. However, the panel has not seen any documentary evidence to support the existence of such a directive, for example, a MAR chart, prescription sheet, or other written instruction.

It considered that even if such a directive to administer 5-10mg could be interpreted as equivalent to a prescription for 5mg, the panel does not consider that the administration of 2.5mg constituted an incorrect dose.

The panel took into account that Mr Augustine provided a clear and reasonable explanation for his decision to administer 2.5mg, which it found credible and consistent.

The panel also noted that Mr Augustine's explanation was supported by the Medication Management Policy, which allows for professional discretion in administration. The policy states:

> *'5.4 Procedure for the administration of prescribed medication*
>
> […]
>
> *12. Where appropriate, colleagues must administer or withhold in the context of the resident's condition.'*

The panel therefore accepted that Mr Augustine's decision to administer 2.5mg was made in accordance with his professional judgement, taking into account Resident A's condition and comfort at that time.

For these reasons, the panel concluded that this charge is not proved.

Charge 2

2) Responded to Colleague A's email sent on or around 21 March 2023 requesting an investigation meeting following the medication error in 1(a) above with, 'I will not be attending any meeting. You need a psychiatric assessment because you are sick in the head' or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence provided, including the email correspondence dated 23 March 2023 between Mr Augustine and Colleague A.

The panel noted that in this email, Mr Augustine wrote:

> *'I will not attend any meeting. You need a psychiatrist assessment because you are sick in the head.'*

The panel was satisfied that the alleged communication occurred as described, and therefore found this charge proved.

Charge 3

3) Your actions at charges 2 above were unprofessional and/or intended to undermine Colleague A.

This charge is found proved (in that the actions were unprofessional but not intended to undermine).

The panel considered the email dated 23 March 2023, which formed the basis of Charge 2.

The panel found that the language used by Mr Augustine was completely unnecessary and wholly unprofessional. The panel considered that no one should

expect to receive an email of this nature in a workplace setting, and that such communication falls far below the standards expected of a registered nurse.

The panel then carefully considered whether Mr Augustine's email was intended to undermine Colleague A. However, in the absence of any further evidence to demonstrate intent, the panel was unable to conclude that Mr Augustine deliberately sought to undermine Colleague A.

Accordingly, the panel found that Mr Augustine's conduct was unprofessional, but it was not satisfied that his actions were intended to undermine Colleague A. This charge is therefore found proved.

Charge 4

4) Between 24 November 2022 and 21 March 2023 made comments on one or more Accident and Incident forms, which were inappropriate and/or unprofessional.

This charge is found proved.

In reaching its decision, the panel took into account the Accident and Incident Forms presented by the NMC and the oral evidence of the witnesses.

The panel considered the following examples of entries made by Mr Augustine on Accident and Incident Forms:

Accident and Incident Form entry dated 24 November 2022

> *'*[…] *It was reported but instead the Home Manager* [Colleague A] *went to her defence with a falsified information from her GP Ptractice* [sic]. *She did not give the details of the GP she spoke with for Verification of her defence. Instaed* [sic] *of Medication competency for the Clinical Lead, she was defended.*

It was the same issue with syringe Driver where the Clinical Lead [Colleague B] *left a Needle in two residents and the Home Manager* [Colleague A], *Regional Director went to her defence. I have been through series of Harrasment* [sic] *(Suspensions and Discipliary* [sic] *Process). I am currently going through another Discipliary* [sic] *process for JUST an OMISSION in Documentation despite working with an Agency on that particular night. I am going through all these issues (Suspension, Discipliary* [sic] *Process) mainly because I am BLACK whiles the WHITE will always be Defended.*

When I raised Concerns on Racism, the Home Manager [Colleague A] *said "RUBBISH" to me. She said it repeatedly 3X every time Racism was mentioned. As part of my Discipliary* [sic] *Process, one of the allegation is saying "BULLSHIT" once to a colleague. The Home Manager who is expected to know better using inappropriate words 3X needs to be Sanctioned'*

Accident and Incident Form entry dated 9 December 2022:

'[…] *Resident G is not the only victim as even staff feels the stress. The Manager has been very inefficient and ineffective as picked up by Care UK and CQC inspectors who indicated an improvement requied* [sic] *in Leadership.*

[…]

The Manager has been very inefficient as these issues keeps recurring but does not go through Disciplinary Process for ABUSING Residents but will be the First to put other staff through for just an OMISSION in Documentation. INJUSTICE INDEED'

Accident and Incident Form entry dated 17 March 2023:

'[…] *Out of Gross disrespect for the Nursing Team, the* [...] *was influenced to make a decision to transfer the Resident to the Nursing Unit. The resident was not fit for Hoisting and without any form of assessment by the* […] *the*

Resident was hoisted and injured him. Out of ARROGANCE, they were in a hurry to transfer the resident with no SENSE of care and PATIENCE. The […] *has always surrounded* [...] *self with INCOMPETENT people influencing her Decisions. The* [...] *is NOT CAPABLE of making any MEANINGFUL DECISION and SHE MUST GO WITH IMMEDIATE EFFECT'*

Accident and Incident Form entry dated 21 March 2023:

'[…] *A Starting Dose of Morphine 5mg is a Leathal* [sic] *Dose rather than Therapeutic.* […] *Only inexperience* [sic] *people will query my judgement. Why is it that the Doctor doesnt want any other Clinician to be involved. Trying to make a Case out of Nothing to stay Relevant* […]*'*

The panel found that, while it was not inappropriate in itself for Mr Augustine to complete Accident and Incident Forms, the language and tone used in several of these entries were wholly unprofessional and inappropriate. The panel considered that the forms had been used improperly as a means to raise concerns about colleagues and management, rather than for their intended purpose of recording clinical or operational incidents.

The panel noted that Mr Augustine did not provide any explanation as to why he wrote such entries in the Accident and Incident Forms.

The panel accepted the consistent and credible evidence of Witness 3 and Colleague B, who explained the correct complaints and grievance procedures that should be used to raise such concerns. The panel was satisfied that there were alternative and appropriate ways available to Mr Augustine, and that the Accident and Incident Forms were not the correct route to do so.

Accordingly, the panel concluded that Mr Augustine's comments were inappropriate and unprofessional, and therefore found charge 4 proved.

Charges 5a and 5b

5) On an unknown date:
    a) Said to Colleague B, '*I have had enough of your bullshit*' or words to that effect and/or
    b) Threw the handover book into Colleague B's lap.

These charges are found NOT proved.

The only evidence presented in support of this charge came from Colleague B. Colleague B stated that the incident had been witnessed by other people, one of whom she mentioned by name. Colleague B indicated that statements had been submitted to the Home, but these were not included in the evidence before the panel.

The panel did not see any other documentary evidence in relation to this incident, for example an escalation email to a manager or reports to the Home. The panel also found Colleague B's evidence of the incident to be vague and lacking specificity. The panel noted that Colleague B's general attitude towards Mr Augustine was negative. In her statement she said:

> *'I have been working for 24 years, and I have never met anyone like him before. I didn't have this experience before where I felt scared to go into work. I think he is dangerous because he doesn't take direction from anyone. I felt sorry for the residents and other staff members who ever came into contact with the registrant because of his aggressive behaviour. The registrant's behaviour is very unprofessional, and he shouldn't be allowed to practise as nurse.'*

The panel considered that these allegations were particularly serious and required cogent evidence, in line with the legal principle in *Braganza v BP Shipping* [2015] UKSC 17. The panel was not satisfied that Colleague B's evidence met this standard. In the absence of other evidence, the panel concluded that there was insufficient evidence to prove that Mr Augustine said the words alleged or threw the handover book into Colleague B's lap.

Accordingly, the panel found charge 5 not proved.

Charge 6

6) Between 21 April 2021 and 31 March 2023, on one or more occasion, shouted at Colleague B.

This charge is found NOT proved.

The only evidence presented in support of this charge came from Colleague B.

When asked in oral evidence, how often Mr Augustine shouted at her, Colleague B stated *"regularly",* but was unable to explain what she meant by regularly, or provide any specific examples.

The panel considered the reliability of Colleague B's evidence and found the same concerns as identified in relation to Charge 5. In the absence of corroborating evidence or specific examples, the panel was not satisfied that the allegation had been proved.

Accordingly, the panel found charge 6 not proved.

Charge 7

7) Between 21 April 2021 and 31 March 2023, on one or more occasion, swore at Colleague B.

This charge is found NOT proved.

The panel took into account Mr Augustine's written submissions sent to the NMC via email on 29 January 2023, which stated:

'I did swear at [Colleague B] *of which I regret.'*

The panel considered that although Mr Augustine stated in his written submissions that he swore at Colleague B, this was not a response to the charge in question. The panel noted that Mr Augustine did not attend this hearing to give evidence or be subject to cross examination.

The panel took into account Colleague B's oral evidence but considered that she was unable to provide detail as to what Mr Augustine had said to her, despite being asked several times by the panel. She could not specify what was said, when it was said, or where it occurred.

The panel determined that there was insufficient evidence before it provided by the NMC to find this charge proved on the balance of probabilities. As such, the panel found charge 7 not proved.

Charges 8a, 8b, and 8c

8) On unknown dates, made one or more of the following comments in the staff communication book:
   a) 'think twice before you put my name here'; and/or
   b) 'if you don't know how to communicate on personal issues just learn and if it is arrogance, kill it' and/or
   c) 'I wonder how people got themselves into managerial position with this kind of poor communication skills. Even the Home manager does not write my name in the book when she wants to communicate with me. Because of arrogance and disrespect people behave anyhow. This NONSENCE MUST STOP. Augustine'

These charges are found proved.

In reaching its decision, the panel took into account the entries in the staff communication book which shows the above comments made, and signed for, by Mr Augustine.

The panel therefore found charges 8a, 8b, and 8c proved.

Charge 9a

9) Your actions at charge 5-8 were:
    a) Threatening or intended to be threatening and/or

This charge is found NOT proved

As the panel found charges 5, 6, and 7 not proved, it did not consider these charges when deliberating on charge 9. The panel only considered charges 8a, 8b, and 8c in its deliberations of charges 9a and 9b.

In relation to Charges 8a, 8b, and 8c, the panel considered that Mr Augustine's words were not threatening nor was there any intent to be threatening. The panel noted Mr Augustine's explanation that his comments were a response to a colleague mentioning his name in the staff communication book. The panel found Mr Augustine's explanation credible and concluded that the words used were not threatening or intended to be threatening.

The panel therefore found this charge not proved.

Charge 9b

9) Your actions at charge 5-8 were:
    b) Unprofessional

This charge is found proved (in relation to charge 8b and 8c only).

Regarding charge 8a, the panel considered that Mr Augustine was asking colleagues not to name him in the staff communication book, and that Mr Augustine's use of words was clumsy, but not unprofessional.

The panel found that some of the language used in the staff communication book, in particular for entries relating to charges 8b and 8c, was unprofessional. Although

there was no evidence of intent to threaten, the panel considered the language, tone, and use of capitals to be unprofessional and not consistent with expected workplace behaviour.

Accordingly, the panel found charge 9b proved in respect of charges 8b and 8c only.

Charge 10a

10. On or around 31 August 2021 without clinical justification:

    a. Grabbed Resident B's arm/palm/wrist

This charge is found proved.

In reaching its decision, the panel took into account Witness 5's statement:

> *'*[…] *Resident B was laying down in bed and the registrant grabbed Resident B's arm.* […] *The registrant completed the care needs for Resident B and then left the room.* […] *I spoke to Resident B once the registrant left and Resident B said, "the registrant has hurt me, and I am scared."'*

This is supported by Witness 5's oral evidence when she said that she *"saw how Augustine still just grab her arm".*

The panel acknowledged that Witness 5 also gave a demonstration as to how Mr Augustine grabbed Resident B's arm during her oral evidence. The panel considered Witness 5 to be a credible and reliable witness.

The panel also took into account Mr Augustine's written submissions which stated:

> *'*[…] *it was alleged I twisted a resident wrist during personal care. I went into the resident's room with a carer and yet the carer didn't see any act neither did the resident made any reaction on the night of the incident.* […]*'*

The panel considered that grabbing a resident's arm/palm/wrist would require clinical justification, such as there being an emergency. However, there is no evidence of any clinical justification for Mr Augustine to grab Resident B's arm/palm/wrist.

The panel therefore found this charge proved on the balance of probabilities.

Charge 10b

10. On or around 31 August 2021 without clinical justification:

    b. Took a pen out of Resident B's hands and threw it across the room

This charge is found proved.

In reaching its decision, the panel took into account Witness 5's statement:

> *'*[…] *From what I can recall the situation wasn't gentle, it was like in frustration the registrant grabbed* [Resident B's] *palm. The registrant with one of his hands grabbed the palm and with the other hand pulled the pen out of Resident B's hand, then threw it towards the wall. The wall had a mark on it where the registrant threw the pen, the pen was thrown with great force. U[pm seeing this incident, I basically froze, I couldn't believe what had happened. I saw that Resident B was scared when the pen was thrown at the wall. She didn't say anything but was scared. Resident B was quite* [sic] *the whole time and was upset when we were cleaning/changing her. Resident B didn't react and didn't move. I could see that Resident B was not being her normal self.* […]*'*

This is supported by Witness 5's oral evidence when she said that Resident B was *"always fidgeting in her hand with some little things* […] *just to keep herself occupied and still keeping her mind working."* Witness 5 also said that Mr Augustine *"grab her arm just really with the force, grab the pen and throw it on the wall"*. Witness 5 recalled how she saw the pen *"flow through my face"*. The panel found Witness 5 to be a credible and reliable witness.

The panel considered that taking the pen out of Resident B's hand and throwing it across the room would require clinical justification. However, there is no evidence before the panel of any clinical justification to take the pen from Resident B's hand and throw it across the room.

The panel therefore found this charge proved on the balance of probabilities.

Charge 11

11. On an unknown date in August 2022, delayed in administering end of life medication to Resident D in that you administered the medication approximately 10-20 minutes after you should have.

This charge is found NOT proved.

In reaching its decision, the panel took into account Colleague B's email to Colleague A dated 30 August 2022 which stated:

> *'*[…] *The family expressed concerns to me on Sunday about the nurse and his general attitude and manner* […] *They said that he took a while to come to see them* […]*'*

This email did not address the concerns within the charge, namely that Mr Augustine administered the end-of-life medication 10-20 minutes after he should have. The panel considered that there was insufficient evidence before it to find this charge proved.

The panel therefore found this charge not proved.

Charge 12a

12. On 23 July 2022:

a. Did not complete or ensure that the fluid balance intake chart was completed for Resident I as required.

This charge is found NOT proved.

In reaching its decision, the panel took into account Resident I's fluid balance intake chart which was undated but signed on 23 July 2022. The panel also had sight of the duty rota which indicates that Mr Augustine was working on the night shift of 22/23 July 2022, but not 23/24 July 2022.

Witness 6, in her oral evidence, was unable to clarify the date of the fluid balance intake chart and was not aware if Mr Augustine was working the night shift of 23/24 July 2022.

The panel expected there to be two fluid balance intake charts for the night shift of 22/23 July 2022. So far as Mr Augustine's night shift was concerned, one would cover the period 20:00 to 00:00 on 22 July 2022, and the other 00:00 to 08:00 on 23 July 2022. However, the panel had sight of one chart which was undated and shows a first entry being made at 08:45.

The panel considered that the NMC had not provided sufficient evidence to find this charge proved on the balance of probabilities.

The panel therefore found this charge not proved.

Charge 12b

12. On 23 July 2022:

b. Did not complete or ensure that it was recorded on Resident H's 24 hour repositioning record that Resident H had been repositioned as required.

This charge is found NOT proved.

In reaching its decision, the panel took into account Witness 6's oral evidence when she was asked how Mr Augustine would have known the frequency with which to reposition Resident H. Witness 6 responded *"because it would be in his care plan".*

The panel noted that it did not have sight of Resident H's care plan which Witness 6 said would have the detail of the frequency of repositioning for Resident H. The panel therefore considered that the NMC has not provided sufficient evidence of the frequency with which repositioning was required to find this charge proved.

The panel therefore found this charge not proved.

Charge 12c

12. On 23 July 2022:

    c. Did not complete or ensure that it was recorded on Resident B's 24 hour repositioning record that Resident B had been repositioned as required.

This charge is found proved.

In reaching its decision, the panel took into account Resident B's 24-hour repositioning record which states that Resident B should be repositioned every four hours.

The panel noted that the repositioning chart is empty for the period of 00:00 to 07:00 on 23 July 2022. It therefore considered that no entries were made during this part of Mr Augustine's shift.

The panel therefore found this charge proved.

Charge 13

13. Did not complete or ensure that the fluid balance chart was completed for Resident C on 23 August 2022 as required.

This charge is found NOT proved.

In reaching its decision, the panel took into account Resident C's fluid balance chart dated 23 August 2022, which commenced at 08:30.

The panel noted that no entries were made on the fluid balance chart after 14:18 on 23 August 2022. The panel had sight of the duty rota which shows that Mr Augustine commenced his shift at 20:00 on 23 August 2022. The panel considered that as the fluid balance chart was incomplete on the shift preceding Mr Augustine's shift, it is difficult to determine what the requirement was in regard to completing the chart.

The panel therefore found this charge not proved on the balance of probabilities.

Charge 14a

14. Did not complete or ensure that it was recorded on their 24 hour repositioning record that one or more of the following residents had been repositioned as required:

a. Resident J on 20 July 2022

This charge is found NOT proved.

In reaching its decision, the panel took into account Resident J's 24-hour repositioning record which states that Resident J should be repositioned every four hours.

The panel considered that, with the exception of one entry at 09:15, there is no evidence before it that Resident J was repositioned at a time that needed to be recorded on the form. The panel considered that if there is no evidence before it to suggest that Resident J was repositioned, it cannot criticise Mr Augustine for not recording that Resident J was repositioned.

The panel noted that when asked in oral evidence to explain the charts and what they showed, Witness 6 was confused and said, *"I can't actually say I've got an answer for that one".*

The panel therefore found this charge not proved on the balance of probabilities.

Charge 14b

14. Did not complete or ensure that it was recorded on their 24 hour repositioning record that one or more of the following residents had been repositioned as required:

b. Resident B on 31 July 2022

This charge is found NOT proved.

In reaching its decision, the panel took into account Resident B's 24-hour repositioning record and noted that it did not state the frequency that Resident B should be repositioned.

The panel considered that during part of the period that Mr Augustine was on duty, from 00:00 to 08:00, Resident B's 24-hour repositioning record had not been completed. The panel considered that it is not evident what the frequency of Resident B's positioning was, and therefore, Mr Augustine cannot be criticised for not completing or ensuring that the 24-hour repositioning record was completed.

The panel therefore found this charge not proved on the balance of probabilities.

Charge 15

15. Did not complete or ensure the night touch point cleaning record was completed as required whilst you were on shift on 22 July 2022 and/or 22 August 2022.

This charge is found proved (in relation to 22 July 2022 only).

In reaching its decision, the panel took into account the night touch point cleaning record dated 22 July 2022. The panel noted that entries were not completed on the chart for 19:00, 02:00, or 06:00 and therefore determined that Mr Augustine did not complete or ensure the night touch point cleaning record was completed as required whilst he was on shift on 22 July 2022.

The panel also took into account the night touch point cleaning record dated 22 August 2022 and noted that the record is completely empty for the entire week. The panel considered that it was unclear whether the record was still required.

The panel took into account Witness 6's oral evidence when she said *"I've got two copies here, so I don't know why they were put in. But on the 22nd it's got that Augustine was working on the 22nd. So as far as I would see is, they've called this as a reflection that on the 22nd nothing was done* […] *I would say they've looked at it, seen for the shift that Augustine was on, he's not filled anything in so they've pulled this as a demonstration that there's nothing being recorded. They would obviously have put another one in place for the rest of the week to come through."*

The panel understood from Witness 6 that there were two night touch point cleaning records, but that the panel only had sight of one record and therefore could not be satisfied that it had the complete set of records before it to determine whether or not Mr Augustine completed or ensured the record was completed as required whilst he was on shift on 22 August 2022.

The panel therefore found charge 15 proved in relation to the night touch point cleaning record on 22 July 2022 only.

Charge 16

16. Between 21 April 2021 and 31 March 2023, on at least one occasion, failed to provide adequate oral handovers.

This charge is found NOT proved.

In reaching its decision, the panel first considered what it understood an adequate handover to be. It considered that an adequate handover is one that ensures that enough information regarding each resident is handed over to the oncoming shift to enable them to look after the residents safely.

The panel then went on to determine whether evidence had been provided in regard to Mr Augustine's handovers.

The panel took into account Witness 3's oral evidence when she said *"he would just come in, sit down and he would go through each resident. It would be, they've been okay, no concerns. just for every resident.* […] *He didn't really inform us of any infections or if a resident had been feeling unwell or if they'd had a fall or anything like that. They were very basic handovers."*

The panel also took into account Mr Augustine's written submission which stated:

> *'Handover is a summary of what happened during a shift.* […] *During the day, Residents are engaged in a lot of activities, family visit, multi-disciplinary reviews/assessment, GP visits, change in Residents condition, residents going out, etc. At night, it is usually routine unless a change in resident's condition or care plan and comparing intake and output for residents being monitored. I don't know what details were missing in my handovers* […]*'*

The panel considered that in the absence of any specific examples provided of information that Mr Augustine failed to hand over, it was unable to determine whether or not Mr Augustine failed to provide adequate handovers.

The panel therefore found this charge not proved on the balance of probabilities.

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 Mr Augustine's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

Ms Boesche, on behalf of the NMC, invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Boesche identified the specific, relevant standards where Mr Augustine's actions amounted to misconduct. She submitted that Mr Augustine's conduct, as detailed in the charges, fell significantly short of the standards expected of a registered nurse. She submitted that the areas of concern identified relate to unprofessional behaviour, inadequate record keeping, and action which caused harm to a resident.

Ms Boesche submitted that Mr Augustine's actions found proved by the panel are so serious as to amount to misconduct.

Submissions on impairment

Ms Boesche moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Boesche submitted that limbs a, b, and c of the test referred to in *Grant* are engaged in this case. She submitted that Mr Augustine's action of grabbing a resident's wrist and throwing a pen across the room caused the resident harm and distress. She further submitted that Mr Augustine's actions of inadequate record keeping further exposed residents to risk of harm in the event of other members of staff not having sufficient information regarding the residents. Ms Boesche submitted that Mr Augustine's actions breached fundamental tenets of the nursing profession and brought the profession into disrepute.

Ms Boesche submitted that Mr Augustine has not provided evidence of any meaningful insight into his actions, and has not demonstrated any strengthening of his practice. Ms Boesche therefore submitted that a finding of impairment is necessary on the ground of public protection.

Ms Boesche submitted that a finding of current impairment is also necessary on the ground of public interest to declare and uphold proper standards of conduct and behaviour.

The panel accepted the advice of the legal assessor who referred the panel to the cases of *Nandi v GMC* [2004] EWHC 2317 (Admin), *Mallon v GMC* [2007] CSIH 17, *Holton v GMC* [2006] EWHC 2960 (Admin), *Meadow v GMC* [2007] QB 462, and *Cohen v GMC* [2008] EWHC 581 (Admin).

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 Mr Augustine's actions amounted to a breach of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.1** treat people with kindness, respect and compassion*
> ***1.2** make sure you deliver the fundamentals of care effectively*
> ***1.5** respect and uphold people's human rights*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> ***2.6** recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***8 Work cooperatively***
> *To achieve this, you must:*
> ***8.2** maintain effective communication with colleagues*
>
> ***9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues***
> *To achieve this, you must:*
> ***9.3** deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
> *To achieve this, you must:*
> ***10.1** complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

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*

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

20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each charge individually when determining whether Mr Augustine's actions amounted to misconduct.

Regarding charges 2 & 3, and 4, the panel first noted that charge 3 is a consequence of Mr Augustine's actions set out in charge 2. The panel considered that Mr Augustine's behaviour at charges 2 and 4 would be considered deplorable by another registered nurse and that his unprofessionalism was so serious as to amount to misconduct. The panel considered that the language used in charge 2, and the fact that it was targeted at a specific individual, Colleague A, was disrespectful, accusatory, and likely to cause serious upset. In charge 4, the panel considered that the following words represented a significant departure from the standards expected of a registered nurse and therefore amounted to misconduct:

'[…] *It was reported but instead the Home Manager* [Colleague A] *went to her defence with a falsified information from her GP Ptractice* [sic]. *She did not give the details of the GP she spoke with for Verification of her defence. Instaed* [sic] *of Medication competency for the Clinical Lead, she was defended.*

It was the same issue with syringe Driver where the Clinical Lead [Colleague B] *left a Needle in two residents and the Home Manager* [Colleague A], *Regional Director went to her defence. I have been through series of*

Harrasment [sic] *(Suspensions and Discipliary* [sic] *Process). I am currently going through another Discipliary* [sic] *process for JUST an OMISSION in Documentation despite working with an Agency on that particular night. I am going through all these issues (Suspension, Discipliary* [sic] *Process) mainly because I am BLACK whiles the WHITE will always be Defended.*

When I raised Concerns on Racism, the Home Manager [Colleague A] *said "RUBBISH" to me. She said it repeatedly 3X every time Racism was mentioned. As part of my Discipliary* [sic] *Process, one of the allegation is saying "BULLSHIT" once to a colleague. The Home Manager who is expected to know better using inappropriate words 3X needs to be Sanctioned'*

Whilst the panel acknowledged that Mr Augustine may have had legitimate concerns about his treatment in the workplace, the use of the Accident and Incidents Form, which could be viewed by others, was wholly inappropriate and unprofessional such that it amounted to misconduct.

Regarding charges 8a, 8b, and 8c, the panel considered that Mr Augustine demonstrated poor and unprofessional communication with his colleagues, but that the unprofessionalism was not so serious as to amount to misconduct. The panel considered that these were general comments written in a communication book designed for all staff to use. The comments in the communication book made by Mr Augustine were in response to colleagues writing comments to him. The panel considered that Mr Augustine's comments were not targeting individuals or intending to be threatening, and therefore considered that this did not amount to misconduct.

Regarding charge 9b, the panel considered that Mr Augustine's comments at charges 8b and 8c were unprofessional, but, as referenced above, were not so serious as to amount to misconduct.

Regarding charges 10a, and 10b, the panel considered that Mr Augustine's actions would be considered deplorable by another registered nurse. The panel noted that Mr Augustine's conduct, in grabbing Resident B's arm/palm/wrist, and throwing a pen across the room with force, caused a vulnerable resident, who was more than a

hundred years old, physical and psychological harm. This represented a serious departure from the standards expected of a registered nurse and therefore amounted to misconduct.

Regarding charge 12c, the panel considered that Mr Augustine's actions fell short of the standards expected of a registered nurse in that he failed to complete Resident B's 24-hour repositioning record. The panel considered that the failure to complete one resident record during one shift was a departure from the standards expected of a registered nurse, but not so serious as to amount to misconduct.

Regarding charge 15, the panel considered that Mr Augustine's actions fell short of the standards expected of a registered nurse in that he failed to complete the night touch point cleaning record. However, the panel considered that the failure to complete this administrative record, not linked to a specific resident's care, on one occasion was not so serious as to amount to misconduct.

Therefore, the panel considered that only Mr Augustine's actions at charges 2 & 3, 4, 10a, and 10b were so serious as to amount to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 February 2024, 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 make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*
>
> In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:
>
> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*

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

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

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

d) …

The panel considered charges relating to unprofessional language engaged limb b because members of the public and fellow professionals would not expect a registered nurse to communicate in such a way. In the absence of any evidence of insight or reflection, the panel considered that Mr Augustine was liable to treat colleagues in the same way in the future.

The panel considered that limb c was engaged in that Mr Augustine breached one of the fundamental tenets of the nursing profession, namely, the requirement in the Code to promote professionalism and trust.

In respect of charge 10, the panel noted that Resident B was caused physical and psychological harm by Mr Augustine when he grabbed her arm. The panel therefore found that this engaged limb a of the Shipman test. In the absence of any evidence of insight or reflection, the panel considered that Mr Augustine was liable to treat a resident in the same way in the future.

The panel also found that limb b was engaged in respect of charge 10 because members of the public would expect an elderly vulnerable resident to be treated safely and with dignity. Mr Augustine's actions were a clear breach of several fundamental tenets of the nursing profession, and limb c is therefore engaged.

Regarding insight, the panel considered that Mr Augustine has not demonstrated an understanding of the fact that actions caused harm to Resident B, nor has he demonstrated an understanding of why what he did was wrong, the seriousness of his misconduct, and how this impacted negatively on the reputation of the nursing profession.

The panel considered the factors set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and determined that the misconduct is capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Augustine has taken steps to

strengthen his practice. The panel considered that Mr Augustine has not provided any evidence to suggest that he is remorseful for his actions, or that he has any insight into his failings. The panel also considered that Mr Augustine has not provided any evidence to suggest that he has remedied the concerns in this case, or that he has taken steps to strengthen his practice. The panel therefore considered that there is a risk of repetition and subsequent risk of harm.

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 objective of the NMC is the protection of the public. This is achieved by the pursuit of the following objectives:

a) To protect, promote, and maintain the health, safety, and well-being of the public;
b) To promote and maintain public confidence in the nursing and midwifery professions;
c) To promote and maintain proper professional standards and conduct of those professions.

The panel determined that public confidence in the nursing profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Augustine's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months. The effect of this order is that the NMC register will show that Mr Augustine's registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Boesche submitted that taking no action, or imposing a caution order, would be inappropriate in view of the seriousness of this case.

Regarding a conditions of practice order, Ms Boesche submitted that this would also be inappropriate as this case concerns Mr Augustine's unprofessional behaviour and attitude. She submitted that no conditions could be formulated that would address the concerns in this case, adequately protect the public, or maintain public confidence in the nursing profession.

Ms Boesche submitted that a suspension order would be inappropriate in view of the seriousness of the case. She submitted that Mr Augustine's actions require removal from the register. She submitted that this was not a single instance of misconduct, but was misconduct that occurred over a period of time. Ms Boesche submitted that there is evidence of deep-seated personality and attitudinal concerns. She further submitted that Mr Augustine has not taken any steps to address the concerns, and has not demonstrated that he recognises the consequences of his actions.

Ms Boesche submitted that Mr Augustine's actions are incompatible with him remaining on the register. She submitted that in light of Mr Augustine's lack of remorse, reflection, and insight, a striking off order is the only appropriate and proportionate sanction to protect the public and maintain professional standards.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr Augustine's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne

in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Conduct which caused harm to Resident B
- Unprofessional communication occurred on a number of occasions
- Lack of insight into failings
- Lack of remorse and remediation

The panel did not identify any mitigating features in this case but recognised that Mr Augustine was not in attendance to present any mitigation.

As required by Article 29(3) of the Nursing and Midwifery Order, 2001 ('the Order'), the panel first considered, pursuant to Article 29(4), whether to undertake mediation or to take no further action. It considered that neither of these outcomes would be appropriate as neither would restrict Mr Augustine's practice. The public would therefore not be protected and the public interest would not be satisfied. The panel then moved on to consider the four available sanctions set out in Article 29(5) of the Order.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Augustine's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Augustine's 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 Mr Augustine's 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;*
- *…*
- *…*
- *…*
- *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 rejected Ms Boesche's submission that Mr Augustine's actions at charge 10 are a result of a deep-seated attitudinal problem. It took into account Witness 5's evidence which stated that this was out of character for Mr Augustine. Further, the panel noted that the incident outlined in charge 10 was an isolated incident. However, the panel considered that there are no identifiable areas of Mr Augustine's practice that are in need of assessment or retraining. The panel therefore considered that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case.

Furthermore, the panel concluded that the placing of conditions on Mr Augustine's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a 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 panel noted that the harm caused to Resident B was a single instance of misconduct which could be remedied. It noted that Mr Augustine demonstrated more than one instance of unprofessional communication with colleagues, however, the panel was satisfied that this was not fundamentally incompatible with Mr Augustine remaining on the register.

The panel went on to consider whether a striking-off order would be proportionate. The panel considered that given the fact that the incident of harm caused to Resident B was an isolated incident, to strike Mr Augustine off the register would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Augustine's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order may cause Mr Augustine. 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.

In making this decision, the panel carefully considered the submissions of Ms Boesche in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a striking off order is not the only sanction that will be sufficient to protect the public and maintain professional standards.

The panel determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may extend, or further extend the order, make an order falling within Article 29(5), or make a conditions of practice order.

Any future panel reviewing this case would be assisted by:

- An update regarding Mr Augustine's [PRIVATE]
- A reflective piece demonstrating insight into the matters found proved
- An indication as to whether Mr Augustine wishes to continue practising as a registered nurse
- Evidence of any relevant updated training
- Testimonials relating to current employment

This will be confirmed to Mr Augustine 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, or is otherwise in the public interest or in Mr Augustine's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Boesche. She submitted that an interim suspension order for a period of 18 months is necessary to allow time for any possible appeal.

The panel 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. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision on the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination on imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow time for any possible appeal.

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

That concludes this determination.