

**Nursing and Midwifery Council
Fitness to Practise Committee**

Substantive Hearing
Monday, 27 January 2025 – Friday, 14 February 2025
Monday, 30 June 2025 – Thursday, 3 July 2025
Friday, 12 September 2025 – Monday, 22 September 2025

2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant: Marlene Pontes

NMC PIN 11D0660E

Part(s) of the register: Registered Nurse - Adult Nursing (February 2012)

Relevant Location: Somerset

Type of case: Misconduct

Panel members: Philip Sayce (Chair, Registrant member)
Melanie Lumbers (Registrant member)
Suzanna Jacoby (Lay member)

Legal Assessor: Christopher McKay (27 - 31 January 2025);
Nigel Mitchell (30 June 2025 – 3 July 2025);
Nigel Ingram (3 - 14 February 2025; 12 - 22
September 2025)

Hearings Coordinator: Petra Bernard (27 January 2025 – 14 February
2025); (12 - 22 September 2025)
Amira Ahmed (30 June 2025 – 3 July 2025)

**Nursing and Midwifery
Council:** Represented by Giedrius Kabasinskas, Case
Presenter; (27 January 2025 – 14 February 2025;
30 June 2025 – 3 July 2025)
Naa-Adjeley Barnor, Case Presenter (12 - 22
September 2025)

Ms Pontes: Present and represented by Michelle Stewart,
Thompsons Solicitors (27 January 2025);
Tope Adeyemi instructed by Thompsons Solicitors
(29 January 2025 – 14 February 2025; 30 June
2025 – 3 July 2025; 12 - 22 September 2025)

Facts proved:	1b, 1e(i), 1e(ii), 1e(iii), 1f, 1g, 2a, 2b, 2c, 2d, 2e(i), 2e(ii) and 2e(iii) and 2f
Facts not proved:	1a, 1c, 1d and 2g
Fitness to practise:	Impaired
Sanction:	Conditions of practice order (12 months)
Interim order:	Interim conditions of practice order (18 months)

Decision and reasons on application to adjourn the hearing (Day one)

At the outset of the hearing, Ms Stewart on your behalf, made an application to adjourn the hearing until Wednesday, 29 January 2025. She informed the panel that your representative, Ms Adeyemi (Counsel), had been admitted to hospital over the weekend and is not well enough to join the hearing today. She told the panel that Ms Adeyemi anticipates being able to join the hearing in-person on Wednesday 29 January at 9.30am.

Mr Kabasinkas on behalf of the Nursing and Midwifery Council (NMC) submitted that he remains neutral on the application.

The panel heard and accepted the advice of the legal assessor, who referred the panel to Rule 32 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ('the Rules'), which includes:

'32.

...

(2) A Practice Committee considering an allegation may, of its own motion or upon the application of a party, adjourn the proceedings at any stage, provided that -

(a) no injustice is caused to the parties; and

(b) the decision is made after hearing representations from the parties (where present) and taking advice from the legal assessor.

...

(4) In considering whether or not to grant a request for postponement or adjournment, the Chair or Practice Committee shall, amongst other matters, have regard to -

(a) the public interest in the expeditious disposal of the case;

- (b) the potential inconvenience caused to a party or any witnesses to be called by that party; and*
- (c) fairness to the registrant.'*

The panel had regard to the information before it. The panel noted that potential alternative arrangements to cover for your representative at this stage would not expedite the progress of the hearing, given the volume of documents needing to be read and complexity of this case. The panel was satisfied, based on the assurances given by Ms Stewart, that Ms Adeyemi would attend the hearing on Wednesday 29 January 2025.

The panel considered the inconvenience that may be caused to the witness who was due to attend the hearing today, if it decided to adjourn. However, the panel decided that there is a public interest in the expeditious disposal of the case and it would be fair and in the interests of justice to grant the application for an adjournment of this hearing.

The panel concluded that this hearing is adjourned until Wednesday, 29 January 2025 at 09.30.

Decision and reasons on application to amend the charge (Day three)

The panel heard an application made by Mr Kabasinkas to amend the wording of charges 1f and 2f. He made a further application to amend the numbering in the sub-particulars to Charge 2e, to mirror those in the sub-particulars in Charge 1e.

Mr Kabasinkas submitted that these proposed amendments would provide clarity and more accurately reflect the evidence.

“That you, a registered nurse and the registered Manager of [PRIVATE] (‘the Home’)

1. Did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in to the following incidents related to the health and wellbeing of residents or staff;

...

*f. An allegation of abuse **perpetrated** by Person 1 against Resident 7, made on 08/02/2020;*

...

2. Did not safely and effectively manage the Home in that you failed to notify or failed to ensure that the following incidents were notified to the Care Quality Commission ('the CQC') and/or appropriate Safeguarding referrals were made in a timely manner or at all;

...

e. Report that on 29 August 2020

h. i. a registered nurse caused/allowed a Care Supervisor to administer controlled drugs to a resident when it was not clinically indicated and/or

iv. ii. a registered nurse signed to say that they had witnessed the administration of the medication when they had not and/or

v. iii. Emergency care was required for Resident 6 due to them receiving medication when it was not clinically indicated

*f. An allegation of abuse **perpetrated** by Person 1 against Resident 7, made on 08/02/2020*

..."

Ms Adeyemi raised no objection to the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed.

The panel determined that it was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy of the charges.

Details of charges (as amended)

That you, a registered nurse and the registered Manager of [PRIVATE]
(‘the Home’)

1. Did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in to the following incidents related to the health and wellbeing of residents or staff;

- a. Resident 1’s fall on 06 December 2019;
- b. Report on 20/21 August 2020 that Resident 4 had a red hand print on their thigh;
- c. Report of a resident perpetrating sexual abuse upon another resident;
- d. Resident 5’s unwitnessed fall on 07 December 2019;
- e. Report that on 29 August 2020
 - i. a registered nurse caused/allowed a Care Supervisor to administer controlled drugs to a resident when it was not clinically indicated and/or
 - ii. a registered nurse signed to say that they had witnessed the administration of the medication when they had not and/or
 - iii. Emergency care was required for Resident 6 due to them receiving medication when it was not clinically indicated
- f. An allegation of abuse perpetrated by Person 1 against Resident 7, made on 08/02/2020.
- g. Allegation/s of bullying and/or sexual misconduct perpetrated by Person 2 against one or more staff members.

2. Did not safely and effectively manage the Home in that you failed to notify or failed to ensure that the following incidents were notified to the Care Quality Commission (‘the CQC’) and/or appropriate Safeguarding referrals were made in a timely manner or at all;

- a. Resident 1 ’s fall on 06 December 2019;
- b. Report on 20/21 August 2020 that Resident 4 had a red hand print on their thigh;
- c. Report of a resident perpetrating sexual abuse upon another resident;

- d. Resident 5's unwitnessed fall on 07 December 2019;
- e. Report that on 29 August 2020
 - i. a registered nurse caused/allowed a Care Supervisor to administer controlled drugs to a resident when it was not clinically indicated and/or
 - ii. a registered nurse signed to say that they had witnessed the administration of the medication when they had not and/or
 - iii. Emergency care was required for Resident 6 due to them receiving medication when it was not clinically indicated.
- f. An allegation of abuse perpetrated by Person 1 against Resident 7, made on 08/02/2020.
- g. Allegation/s of bullying and/or sexual misconduct perpetrated by Person 2 against one or more staff members.

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

Decision and reasons for recusal

Prior to hearing submissions on hearsay applications from Mr Kabasinkas and Ms Adeyemi, the panel Chair noted that he had observed in your final bundle, that you had studied at and obtained qualifications from the University of [PRIVATE]. The Chair stated that he is connected to [PRIVATE] as he tutors on a course you have studied, however clarified that it was not during the same timeframe. He confirmed that he did not know you.

Mr Kabasinkas referred to the case of *Porter v Magill* [2002] 2 AC 357 which sets out the test for potential tribunal bias.

You were asked whether you knew the Chair and you confirmed that you did not. Ms Adeyemi submitted that she had no concerns in this regard.

Mr Kabasinkas submitted that there is no suggestion that this panel would have actual bias and that there is no possibility for apparent bias. He submitted that he was content for the matter to rest.

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

The panel was content to continue with the hearing.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Adeyemi under Rule 31 to redact parts of the witness statements of Witness 1 and Witness 4 together with their corresponding exhibits as hearsay. She referred the panel to a document she prepared which specified the parts as follows:

“Witness 4’s witness statement: paragraph 25, refers to comments made by Colleagues 1, 2 and 3; Paragraph 85 comments on statements by Colleagues 4 and 5; Paragraph 93, comments on what Colleague 5 states; Witness 4’s meeting minutes with Colleague 6 on 8 February 2020, meeting with Person 1 on 24 February 2020, Statement from Colleague 2, email from Colleague 2 dated 25 February 2020; email from Colleague 3 dated 30 December 2019; Colleague 1’s: handwritten statement from dated 18 December 2019, communication to management dated 22 July 2020; and Witness 1’s witness statement: comments on what Colleague 5 states.”

In her submissions, Ms Adeyemi referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 Admin, which sets out the factors the panel should take into account when deciding whether or not to admit hearsay evidence.

Ms Adeyemi submitted that these above mentioned comments and references are hearsay and go to the heart of the charges.

She also submitted that there are parts of Witness 2's witness statement that are disputed and irrelevant to the allegations. She submitted that the veracity of what Colleagues 2, 3, 6 and 7 have stated cannot be tested as they have not been called to give evidence.

Ms Adeyemi submitted that there is some information that could cast doubt on their credibility in respect of the allegations, and suggested that they each have a vested interest in maintaining their position regarding the information presented within the documents before the panel, which could not be tested.

Ms Adeyemi submitted that there has been no good reason why these individuals have not been called as witnesses and it is not acceptable that the NMC have not called these witnesses. She submitted that the hearsay evidence contained in these documents is not reliable and it would not be fair to admit them into evidence.

Ms Adeyemi invited the panel to not allow the hearsay evidence.

Mr Kabasinkas in his submissions referred the panel to NMC guidance DMA-6 on Evidence and the case of *El Karout v NMC* [2019] EWHC 28 (Admin). He submitted that all of the evidence is relevant and relate to each of the specific charges.

In relation to Witness 2's witness statement and comments in the corresponding documentation, Mr Kabasinkas submitted that they are common documents from a business undertaking an investigation. He submitted that all of these documents have been served some time ago allowing sufficient time to respond, and indeed you have responded to the allegations.

In relation to Witness 2's evidence, he submitted that it is not the sole and decisive evidence as Witness 3 and Witness 4 will also be giving live evidence. He submitted that you will have the opportunity to challenge the parts of the NMC's evidence you disagree with.

Mr Kabasinkas submitted that it would be fair and relevant for these documents to be admitted. In relation to the seriousness he submitted that the allegations are serious

and relate to a failure to investigate and report incidents related to the health and wellbeing of residents or staff.

Mr Kabasinkas invited the panel to admit the hearsay evidence.

The panel heard and accepted the advice of the legal assessor, which included references to Rule 31 and the cases of *Bonhoeffer v General Medical Council* [2011] EWHC 1585 (Admin), *Thorneycroft* and *El Karout*.

The panel considered each item of evidence in determining whether it is relevant and fair to admit it as hearsay evidence. The panel considered whether the nature of the charges and the paragraphs specified by Ms Adeyemi constituted hearsay evidence. The panel reminded itself of the stem of each of the charges which relate to the alleged failure to investigate or ensure an adequate investigation was undertaken (charge 1) and the alleged failure to ensure that incidents were notified to the Care Quality Commission (CQC) (charge 2).

The evidence which Ms Adeyemi objected to being admitted was hearsay but was being relied on by the NMC as evidence of the fact that complaints were made to you. The NMC are not relying on the precise wording of the complaints being true. Because of the limited reliance by the NMC on the hearsay evidence and the fact that it was not the sole and decisive evidence in support of the charges, the panel decided to admit the hearsay evidence relied on by the NMC. It was not unfair to you to do so. You would be able to give evidence yourself about anything the complainants had said to you which differed from their written complaints. The panel could give the hearsay evidence the weight it considered appropriate in due course when considering whether the charges had been proved or not.

The panel noted that you do not dispute the fact that complaints were made, even though you may dispute the precise terms of the complaints. The panel also noted that the objections to this evidence were being made at a very late stage. There had been ample opportunity prior to the commencement of this hearing to raise these issues with the NMC, for example, in the Case Management Form (CMF) or other correspondence.

Decision and reasons on application to admit evidence (Day five)

The panel heard an application made by Mr Kabasinskas under Rule 31 to not allow parts of your 'stage 1 registrant's bundle' into evidence at this stage. He provided the panel with a written schedule summarising his submissions and objections, as follows:

1. **Performance Review from Agency Cover 24/7 Ltd dated 11 July 2021 (pages 92 – 120);** This refers to your performance post 14 June 2021, which relates to employment after the period in question and therefore it is not relevant to the stage one of these proceedings.
2. **Letter from Agency Cover 24/7 Ltd dated 4 November 2021 (pages 121 – 123);** It contains hearsay by the author (Mr 1) and the source of the hearsay is not clear.
3. **Agency Cover 24/7 Ltd checklist dated 10 November 2021 (last updated on 25 June 2021) (pages 124 – 125) and Agency Cover 24/7 Ltd checklist dated 16 July 2021.**
4. **Email correspondence between you and the CQC regarding your application to cancel your registration as a manager (pages 192 – 206).**
5. **Email dated 30 November 2020 regarding your application to Newcross Healthcare.**

Documents listed as 3, 4 and 5 above are not relevant to stage one of these proceedings.

6. **The Home's Annual Audit dated 31 July and 1 August 2019 (pages 174 – 178).** The document contains online reviews, hearsay and the authors cannot be identified.
7. **Correspondence between you and the Home regarding the investigation, disciplinary process and your suspension dated 8 October 2020 and 12**

October 2020 pages 207 – 209, 211 – 235). In your correspondence you challenge the disciplinary process using employment law. He submitted that whether the disciplinary process was fair or unfair was a matter for an employment tribunal to determine. He therefore submitted that these documents, with the exception of your email dated 12 October 2020, are not relevant.

8. **Your completed Reflective Accounts Form last updated on 27 January 2018 (page 340).** This document pre-dates the employment period at the material time, therefore it is not relevant to stage one of these proceedings.

9. **Testimonials and character references from various individuals.** They do not comment on your performance at the material time and therefore are not relevant to stage one of these proceedings.

In conclusion, Mr Kabasinkas submitted that in relation to the evidence being '*relevant and fair*' under Rule 31, his objections related more to relevance. He referred the panel to the case of *Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin) in relation to the admissibility of hearsay evidence in regulatory proceedings. He submitted that you raise contextual factors that are not relevant to this stage of proceedings, however may be relevant to later stages.

Ms Adeyemi submitted that it is fair and relevant to allow the above listed documents 1 - 9 taken from your 'stage 1 registrant's bundle' into evidence at this stage of proceedings. She submitted that there is nothing within the 'stage 1 registrant's bundle' that would have any adverse impact on the proceedings, be detrimental for the panel to see nor would it be prejudicial to the NMC in any particular way.

In relation to points 1, 2 and 3, Ms Adeyemi submitted that the author Mr 1 will be attending the hearing at stage 2 in order to give live evidence in due course. She submitted that he can be asked questions regarding the concerns raised. She further submitted that the checklist provides evidence of your compliance, willingness and diligence in the area of concern and it is supportive evidence of that.

In relation to point 4, she submitted that it is evidence to show that you know how to report matters and had done so in relation to your contacting the CQC, which she submitted is contrary to the picture that is being painted of you. She submitted that the CQC letter is supportive of the fact that at every step of the way you always endeavour to do things properly.

In relation to point 5, Ms Adeyemi submitted that contrary to what had been said to you regarding the provision of a simple reference to a prospective employer (Newcross Healthcare), the Home went against that and appear to have gone on to provide further information. She submitted that you are not heavily relying on this document however it does provide context and perspective.

In relation to the Home's Annual Audit in point 6, Ms Adeyemi submitted that it is relevant and fair for the panel to take into account at this stage. She submitted that the online reviews go to credibility. She submitted that the panel will bear in mind that they are online reviews and the nature of such reviews is that you do not always get significant details as to the individuals concerned. She submitted positive reviews have commented on your abilities as a manager at the Home. She submitted that it is highly relevant to the panel's considerations at this stage.

Ms Adeyemi acknowledged that the documents in point 7 contain correspondence between you and your employer (the Home) and the NMC's concern that it is an employment matter. However, she submitted that it is inevitable that in regulatory proceedings there is some overlap in regards to matters of employment. She submitted that the purpose of these documents is to correct the impression the NMC witnesses have created when they explicitly reference the fact that you simply did not attend your disciplinary hearing and that they had to rearrange it a number of times. She submitted that this document is to support the fact that there were some issues around that and the panel may be mindful of some of your responses at the time. She submitted that the email is supportive evidence to put forward your perspective and show the context at that time.

In relation to the references, testimonials and character references from various individuals referred to in point 8, she submitted that they relate to the charges brought

against you, and none of them concern your clinical competence; rather they are all about your character. She submitted that the charges concern your ability to manage a home safely and effectively, therefore they speak to your ability and credibility. She submitted that they are highly relevant to those considerations at this stage (facts).

In relation to your reflective account in point 9, Ms Adeyemi submitted that it is relevant bearing in mind the nature of the charges and it makes a point about your attitude. However, she submitted that it is not strongly opposed to include it at this stage.

In conclusion, Ms Adeyemi submitted that, with the exception of the reflective account in point 9, everything else that the NMC seeks to object to, she strongly opposes the objections. She invited the panel to allow the documents into evidence, in order for you to be in a position to fully put your points across and try, to the extent that you can, rebut the allegations.

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 panel considered each of the documents separately as listed in points 1 – 9 above.

In relation to point 1, the panel considered that the performance review is evidence of you working in a professional and transparent manner, as well as your passion for direct care. The panel was of the view that it is a contemporary document to show how you work and was written at the time from a referrer. The panel determined that it is fair and relevant to both stage one and two of these proceedings and decided to allow it into evidence at this stage.

In relation to point 2, the panel noted that it contains hearsay evidence from Mr 1. When questioned by the panel, Ms Adeyemi confirmed that Mr 1 would be attending the hearing to give evidence at stage one. The panel determined to allow it at this stage of the proceedings, however, was of the view that it may be more widely relevant

to stage 2, if applicable. The panel determined that it would decide the weight to attach to it once all the oral evidence has been heard.

In relation to point 3, the panel determined that they are not relevant to stage 1. The panel was of the view that they refer to dates beyond those specified in the charges. The panel determined that it may be more widely relevant to stage 2, if applicable. The panel determined that it would decide the weight to attach to them once all of the oral evidence has been heard.

In relation to point 4, the panel determined that the correspondence with the CQC may be relevant as evidence at this stage. The panel was of the view that the point it raises is not in dispute. Rather, it shows evidence of you taking the initiative to do things correctly. The panel decided to allow it into evidence at this stage, however determined that it will give it due weight once all of the oral evidence has been heard.

In relation to point 5, the panel was of the view that the charge is not about whether reasonable adjustments were made, rather, it is about you doing what you said you would do. The panel determined to allow it for stage 1 and stage 2.

In relation to point 6, the panel determined that the online reviews speak to how well the Home was run, as well as your character. The panel was of the view that you were not the only person responsible for patient's experience of the Home. The panel decided to allow it into evidence at this stage, however will give it due weight once all of the oral evidence has been heard.

In relation to point 7, the panel determined to allow these documents into evidence at this stage. The panel was of the view that it is relevant to whether the disciplinary policy and process was adhered to and therefore fair to allow it, balancing the NMC evidence before it.

In relation to point 8, the panel determined that it is relevant and fair to allow the testimonials and character references into evidence at this stage. The panel was of the view that, having had sight of the NMC bundle, there is a lot in relation to your

character. The panel determined that these documents give insight into a different side of your character as well as into the way you work more generally.

In relation to point 9, the panel determined to allow your reflective account into this stage of the proceedings. The panel was of the view that, balancing the concern raised by Mr Kabasinskas, that the dates to which it refers are outside of the material time of the charges, it would give it due weight once all of the oral evidence has been heard.

In these circumstances, the panel determined that the documents were relevant and that it would be fair to accept them into evidence. The panel was mindful that this would be hearsay evidence, and that it would consider what weight it deemed appropriate to give to the evidence when it reached the stage at which it would evaluate all the evidence heard during the proceedings.

Background

The charges arose whilst you were employed as a Home Manager by [PRIVATE] (the Home). The Home is a 90-bed dementia and nursing care home.

The NMC received a referral on 24 November 2020 from Witness 3, Quality and Compliance Manager at Notaro Homes Limited (the Company), regarding concerns related to issues with your leadership linked to patient safety.

It is alleged that you did not safely and effectively manage the Home, in that you failed to investigate or failed to ensure that an adequate investigation was undertaken into incidents that were related to the health and wellbeing of residents or staff. The incidents included:

- An alleged resident's fall on 6 December 2019,
- An alleged failure to report on 20/21 August 2020 that Resident 4 had a red handprint on their thigh,
- An alleged failure to report a resident perpetrating sexual abuse upon another resident;
- Resident 5's alleged unwitnessed fall on 7 December 2019,
- An alleged failure to report that:

- on 29 August 2020 a registered nurse allegedly caused/allowed a Care Supervisor to administer controlled drugs to Resident 6 when it was not clinically indicated,
- this registered nurse allegedly signed to say that they had witnessed the administration of the medication to Resident 6 when they had not and/or,
- Emergency care was required for Resident 6 due to them allegedly receiving medication when it was not clinically indicated.
- An allegation of abuse perpetrated by Person 1 against Resident 7, made on 8 February 2020.
- Allegation/s of bullying and/or sexual misconduct perpetrated by Person 2 against one or more staff members.

It is also alleged that you did not safely and effectively manage the Home in that you allegedly failed to notify or failed to ensure that the alleged incidents (mentioned above) were notified to the CQC and/or appropriate Safeguarding referrals were made in a timely manner or at all.

You have not practised as a registered nurse since 5 January 2022.

Decision and reasons on facts

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

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

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

- Witness 1: Deputy Manager of the Home, at the time of the concerns

- Witness 2: Registered Nurse and Clinical Lead of the Home, at the time of the concerns

- Witness 3: Quality and Compliance Manager of the Home, at the time of the concerns

- Witness 4: Registered Manager of Aspen Court Care Home (Home 2), at the time of the concerns

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. It considered all of the witness and documentary evidence provided by both the NMC and you.

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

Charge 1

‘That you, a registered nurse and the registered Manager of [PRIVATE] (‘the Home’)

1. Did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in to the following incidents related to the health and wellbeing of residents or staff;’

The panel noted that it had evidence from Witness 3 and 4 that it was your duty as the care home manager to ensure that an adequate investigation had been undertaken. Additionally Witness 3 and 4 confirmed that you would ultimately be responsible for reviewing all incident reports. The panel noted your evidence where you said you had implemented a system to record incidents. The panel determined that you acknowledged that recording incidents was part of your duties as the care home manager.

The panel considered the job description in relation to your role as the registered Home Manager which stated:

“12. To ensure Safeguarding Policies are adhered to, to protect and safeguard vulnerable people”

The panel determined that in order to adhere to this part of the job description the registered Home Manager would have to ensure that all untoward incidents were adequately investigated. You completed the Care Quality Commission (CQC)/ registration regulations and standards and the manager induction programme where you confirmed your knowledge of the relevant policies and procedures.

The panel then went on to consider the evidence and whether you properly discharged those duties in relation to each of the sub charges in charge 1.

Charge 1a

‘That you, a registered nurse and the registered Manager of [PRIVATE] (‘the Home’)

1. Did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in to the following incidents related to the health and wellbeing of residents or staff;

a. Resident 1’s fall on 06 December 2019’

This charge is found NOT proved.

In reaching this decision, the panel took into account the NMC guidance on delegation and accountability which stated:

“you take reasonable steps to monitor the outcome of the delegated task.”

The panel also took account of the NMC Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in particular section 11 which is titled:

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

The panel took account of sub section 11.3 of the Code which states:

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

The panel noted the witness statement of Witness 4 who stated that:

“The night nurse had been contacted at 06:00, and had called 111, who said to take Resident to hospital when it opened at 08:00 (the hospital is next door to the home). When [Witness 2] came on duty, he was made aware of this, but hadn't done anything. It was not until the late morning that the gentleman was taken to hospital.

...

Resident was also given blood thinning medication by a care supervisor, who had not been made aware by [Witness 2] not to give them this. That is [Witness 2's] actions, but Marleen was aware of this and didn't report anything.

...

The hospital complained about the length of time it took for the gentleman to go to hospital to be looked over. Marlene was aware and had not reported it to anyone. That is a safeguarding when there has been a fall and the resident had not been taken to hospital until late in the day. It doesn't mean to say Marlene had to do the reporting, but she should have checked it was done, and she didn't.

...

...when I spoke to Marlene in her investigation meeting, she said she didn't know anything about it. Then she said she did, and that everyone phones her if there is a fall."

The panel accepted your evidence that you had made enquiries which shows that you had investigated this but there was no evidence before the panel whether or not this was an adequate investigation.

You explained in your evidence that Witness 2 was instructed to get Resident 1 to the hospital and so you investigated why he did not by interviewing the care supervisor, the handover nurse, Witness 2 and the staff member who was meant to take the service user to hospital. The panel noted that you also stated that you had filed the paperwork of the interview records on the staff files, but you no longer have access to them.

The panel determined that there was no conclusive evidence whether interview records existed within the staff files. The panel also noted that you stated that you had made requests for this. Therefore, the panel was unable to determine whether or not the investigation you performed was adequate enough to manage the Home safely and effectively. It concluded that charge 1a is found NOT proved.

Charge 1b

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

1. Did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in to the following incidents related to the health and wellbeing of residents or staff;

b. Report on 20/21 August 2020 that Resident 4 had a red hand print on their thigh'

This charge is found proved.

The panel reminded itself of the NMC Guidance on delegation and accountability and section 11 of the Code as detailed in charge 1a.

The panel noted that you said that you were informed of the incident by the nurse on duty whilst you were on holiday. The panel accepted your evidence that you trusted the nurse in charge's judgment about the cause of the red hand print which you say they reported to you as being due to the way that Resident 4 was laying in the bed.

Your evidence regarding an investigation was inconsistent. In written evidence you said it was not investigated and in oral evidence you said Witness 1 had investigated it but Witness 1 said she was not aware of the incident and did not investigate it.

You accepted that the cause of the red hand print was unknown. In your oral evidence you accepted the red hand print could have been caused by a slap, manual handling or pressure. You explained that you thought Witness 1 had completed the investigation. You stated that you didn't check but believed that if Witness 1 had said she had done it then then you trusted her. The panel found your evidence to be inconsistent with regard to this charge. The panel accepted Witness 1's evidence that she did not know about this incident as she was on maternity leave.

The panel noted that when asked about the incident by Witness 4, you stated that the Resident had got the hand print on their thigh from sleeping in that position. The investigation notes reflected this and stated:

“[Witness 4] – was it investigated?”

MP – No as ti was just what the nurses said.[sic]

The panel determined that, as the cause of the red hand print was unknown, a full investigation was required and as the registered manager the responsibility to investigate or to ensure an adequate investigation was undertaken ultimately fell to you.

The panel noted that in the investigation meeting you accepted that you did not investigate this matter. The panel determined that the conclusion drawn by the nurse who made an initial report to you was not the result of an adequate investigation and a fuller investigation was required in order to adequately assess the cause of the hand print.

Witnesses 3 and 4 both explained in their witness statements that no safeguarding was carried out and that ‘*nothing*’ was done by you.

The panel therefore found this charge proved.

Charge 1c

‘That you, a registered nurse and the registered Manager of [PRIVATE] (‘the Home’)

1. Did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in to the following incidents related to the health and wellbeing of residents or staff;

c. Report of a resident perpetrating sexual abuse upon another resident;’

This charge is found NOT proved.

The panel reminded itself of the NMC Guidance on delegation and accountability and section 11 of the Code as detailed above in charge 1a.

The panel had sight of the incident report made on 1 March 2020 that detailed the incident and included steps to minimise the risk of repetition. The panel noted the email from Witness 2 which addressed the incident and the movement of Resident 2 to the dementia section of the Home. The panel also noted that this email referred the recipient to you solely in relation to financial matters regarding Resident 2's care. The panel was of the view that the incident report contains sufficient information through which it could be established that the untoward incident had occurred and was therefore sufficient for that purpose. It was also apparent to the panel that actions were taken to minimise the reoccurrence and ensure the family were informed and involved in the decisions made for Resident 2 who lacked capacity at the time of the initial report.

The panel therefore found this charge NOT proved.

Charge 1d

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

1. Did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in to the following incidents related to the health and wellbeing of residents or staff;

d. Resident 5's unwitnessed fall on 07 December 2019;'

This charge is found NOT proved.

The panel reminded itself of the NMC Guidance on delegation and accountability and Section 11 of the Code as detailed above in charge 1a.

In reaching this decision, the panel noted your evidence in which you explained that you accept you failed to investigate the incident in a timely manner and that you were not made aware of it. In your witness statement you stated:

'I accept that I failed to investigate this incident in a timely manner, however this was because staff did not report the incident to me at the time that it occurred.'

The panel accepted your evidence that you opened an investigation in April 2020 once you were made aware of it and that disciplinary proceedings against Witness 2 were initiated at this time.

The panel had sight of the record of the fall within the care plan documentation for Resident 5 which was completed by Witness 2, which the panel noted would not have raised an alert to you. The panel accepted your evidence that as this incident was not recorded on an incident form you would not have been made aware through the reporting system in place at the Home. This was not your error. The panel determined that in the absence of the documentation detailing the investigation it could not determine whether or not your investigation was adequate. However the panel noted you had, before the meeting in October 2020, instigated disciplinary proceedings against Witness 2 which included your concerns about how they had managed this incident. The panel therefore concluded that, on balance you had investigated this incident and taken action as a result of that investigation.

The panel therefore found this charge NOT proved.

Charge 1e

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

1. Did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in to the following incidents related to the health and wellbeing of residents or staff;

e. Report that on 29 August 2020

- i. a registered nurse caused/allowed a Care Supervisor to administer controlled drugs to a resident when it was not clinically indicated and/or*
- ii. a registered nurse signed to say that they had witnessed the administration of the medication when they had not and/or*
- iii. Emergency care was required for Resident 6 due to them receiving medication when it was not clinically indicated.*

This charge is found proved.

The panel reminded itself of the NMC Guidance on delegation and accountability and Section 11 of the Code as detailed above in charge 1a.

The panel first considered each sub charge separately and concluded that each of the aspects of 1e(i), 1e(ii) and 1e(iii) individually merited a full and adequate investigation. The panel found that you did not ensure that the investigation was adequate. Controlled drugs were given to Resident 6 by a single carer. This medication was then counter signed by a nurse who did not witness the administration. Evidence shows that two hours and twenty minutes after medication was signed for Resident 6 aspirated and an ambulance was called. An email was sent from the nurse in charge to you close to the time of the incident. It described that Resident 6 was sleepy and unable to wave to his family at the barbecue. In light of Witness 2's denial that he was involved in the incident and the fact that actual harm was suffered by Resident 6 the panel determined that this incident would have clearly necessitated further investigation. The panel found this charge proved in its entirety for the following reasons.

You stated in your witness statement that you deny that you failed to investigate this incident as you were on annual leave at the time and Witness 1 and Witness 2 were in charge of the Home in your absence. In your witness statement you stated:

'On my return, [Witness 1] was conducting the investigation and she concluded the case whilst I worked on implementing group supervisions to all medication trained staff, implemented a near miss report form and met with staff as to implement better practices and avoid a possible similar case.'

However, the panel accepted the evidence of Witness 1 where she said:

"When I spoke to Marlene about this, she said she would take steps, and that she would be handling it and speaking to [Witness 2] about it. I did not investigate this incident, as Marlene said she would look into it. It was around the same time she was gathering information about [Witness 2] following the whistleblowing. So, it was my understanding and reassurance that Marlene was dealing with it. This was also dealt with as part of [Witness 2's] disciplinary."

The panel noted that there is no evidence that you looked at the adequacy of the investigation. In relation to this it took into account Witness 4's witness statement which stated:

'Marlene had raised in her disciplinary actions regarding [Witness 2] that he had authorised a member of staff to give a resident Lorazepam. He denied that. What we found had actually happened is that there was a barbeque on the day, and the nurse in charge of unit [Colleague 5] had said that supervisor [Colleague 4] could give Lorazepam, and [Witness 2] denies that he said he had instructed anybody to do that. We couldn't find any evidence that he had said that. Senior [Colleague 4] gave Lorazepam and the nurse in charge didn't witness this, and signed for it later to say it was given. The resident then became sleepy, aspirated, and medics needed to come. Marlene said that [Witness 2] needed to be disciplined.'

There should have been records of meetings with all parties involved. In her minutes ... [You] said she only spoke with [Witness 2], not [Colleague 5] or [Colleague 4], and she wanted [Witness 2] disciplined. We couldn't find evidence that he told [Colleague 4] to give the medication. If that was the case then why did the registered nurse sign for something that somebody else authorised? For

PRN (medications on an as required basis) medications you would need to witness it before signing.'

The panel determined that your investigation was insufficient and as the registered manager you had a duty to ensure an adequate investigation was completed either by yourself or by someone else given the seriousness of this incident which included significant failures in medication management, appropriate patient care and the consequences for Resident 6.

The panel therefore found this charge proved in its entirety.

Charge 1f

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

1. Did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in to the following incidents related to the health and wellbeing of residents or staff;

f. An allegation of abuse perpetrated by Person 1 against Resident 7, made on 08/02/2020.'

This charge is found proved.

The panel reminded itself of the NMC Guidance on delegation and accountability and Section 11 of the Code as detailed above in charge 1a.

In reaching this decision, the panel noted the brief investigation report dated 4 March 2020 which states that the investigation relating to the incident in this charge began on 20 February 2020. The panel was of the view that this report was inadequate and you were responsible for ensuring the investigation was conducted to an adequate level.

The panel noted that you are named as the investigator although you have denied being so. The panel further noted your signature on the investigation report.

The panel noted your account of your role during live evidence in which you said:

"I can only act on the information I've been given. I did take action and interviewed Person 1 and contacted Peninsula (Human Resources Company) who said you can't legally suspend Person 1."

The panel noted your contradictory evidence as you stated in your witness statement that:

'I accept that I failed to investigate this incident in a timely manner, however this was because staff did not report the incident to me at the time that it occurred. As soon as I become aware of the case, I did take actions as I explain below. As soon as I was made aware of the incident on 22/02/2020 I took actions and I allocated [Colleague 7] to carry out the investigation and I followed actions based on her findings from the investigation completed. I accept that I did not carry this out myself and I completely relied on the reports from another colleague.'

The panel also noted the Investigation Report was started on 20 February 2020 but in your witness statement you state that you were not made aware of the incident until 22 February 2020.

The panel in finding this charge proved also considered Witness 4's witness statement, which included:

'There was an allegation made by staff that Person 1 had physically abused a resident. Marlene was told about it and did not carry out any investigation or suspend Person 1. The allegation was that he was very aggressive, forcefully moving the resident and staff were concerned of physical abuse to the resident. It had been reported to Marleen [sic] and nothing was done. I'm sure I said this to her in her meeting minutes.'

Anything that is gross misconduct, and abuse is, we would need to suspend the person, do an investigation and notify safeguarding straight away. Safeguarding would then get back to us, normally the same day, and say let us know what you have done about it, what has been happening and the outcome. At the end of the outcome, when we have done the investigation, we would then report it to the CQC because we would then have an outcome from the safeguarding team and what has been done about it. If someone is badly hurt we would notify the CQC straight away. Nothing was done in this case. She said she had investigated it but the allegation was not validated, despite there being witness accounts and bruising. The person had evidence that something happened to them, and she said she had investigated. I did write in a letter she had done some sort of investigation, but she hadn't done anything. There were witnesses to say it happened, people had seen it happen, but she said her investigation showed it wasn't validated, but there was no evidence of anything.'

The panel determined that you did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in relation to the incident in this charge. The panel noted that your Investigation Report dated 4 March 2020, some weeks after the incident was reported to you. The panel noted that you did not follow procedure by suspending Person 1 when the incident was raised to you and your conclusions did not take into account the evidence supplied by witnesses to the abuse nor the physical bruising that Resident 7 sustained.

The panel therefore found this charge proved.

Charge 1g

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

- 1. Did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was*

undertaken in to the following incidents related to the health and wellbeing of residents or staff;

g. Allegation/s of bullying and/or sexual misconduct perpetrated by Person 2 against one or more staff members.'

This charge is found proved.

The panel reminded itself of the NMC Guidance on delegation and accountability and Section 11 of the Code as detailed above in charge 1a.

The panel determined that as the registered Home Manager you should have ensured that an adequate investigation was carried out in relation to this charge.

The panel noted that in your live evidence you stated that you were neutral about the matter, although you conceded that it probably was not a good enough investigation and you accepted that you probably should have dealt with it in a different way. You said that you sought Person 2's views and that there is a record of this within the handwritten notes. You said that Person 2 denied the allegation and that it came down to his version of events versus the complainants. You said that they all came from different cultures. You said that you continued to support the complainant afterwards and would ask them "*is everything fine now*". You said that you would have suspended Person 2 had you had management support. Further, you said that Peninsula (HR) advised you that it would have been unfair to suspend Person 2. You also stated that this was the first time you had ever dealt with staff issues.

The panel noted that there were three other female members of staff who all raised concerns about the same male carer (Person 2). All staff reported their concerns and two of them then resigned from their posts. You acknowledged that one staff member was shaking and tearful when she reported the allegations to you. At an exit interview when talking about Person 2 the words "*bullied, intimidated and humiliated*" were used.

The panel in reaching its decision took account of the fact that Witness 4 in her live evidence stated that Colleague 2 had not been listened to and she also stated that there should have been a more in-depth investigation. She stated:

“...he should have been suspended and investigated and then disciplinary action taken and then informed CQC”. [sic]

The panel found that you did not safely and effectively manage the Home in that you failed to investigate or failed to ensure that an adequate investigation was undertaken in relation to the incidents in this charge. It therefore found this charge proved.

Charge 2a

‘That you, a registered nurse and the registered Manager of [PRIVATE] (‘the Home’)

2. Did not safely and effectively manage the Home in that you failed to notify or failed to ensure that the following incidents were notified to the Care Quality Commission (‘the CQC’) and/or appropriate Safeguarding referrals were made in a timely manner or at all;

a. Resident 1 ’s fall on 06 December 2019;’

This charge is found proved.

In reaching this decision, the panel noted Witness 3’s witness statement which stated

“... A safeguarding referral to CQC wasn’t raised between [Witness 2] and Marlene who had joint responsibility.

...

I said it would ultimately be Marlene’s responsibility because she was the Registered Manager. She was registered under the Health and Social Care Act,

which means she's liable for everything. She is ultimately responsible, but [Witness 2] could have done it. She didn't make sure that it had got done. Both are responsible but she was ultimately responsible because of her registration."

The panel took account of your live evidence in which you explained that you thought Witness 2 had informed safeguarding and/or CQC about the fall but you conceded that you had not checked whether Witness 2 had informed safeguarding. The panel noted that you conceded that this incident had met the threshold to making a notification to safeguarding.

The panel accepted Witness 2's evidence that, as he was not the clinical lead at the time, it was not his responsibility to inform safeguarding of Resident 1's fall on 6 December 2019 and ultimately that responsibility lay with you.

The panel has had sight of the residents' care records which documents actual harm to Resident 1 and it determined that this met the threshold for a safeguarding referral. You admitted that you failed to check this had been done and therefore the panel determined that you had failed to ensure that this incident was notified to the CQC and/or appropriate safeguarding referrals were in a timely manner. It therefore found this charge proved.

Charge 2b

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

2. Did not safely and effectively manage the Home in that you failed to notify or failed to ensure that the following incidents were notified to the Care Quality Commission ('the CQC') and/or appropriate Safeguarding referrals were made in a timely manner or at all;

b. Report on 20/21 August 2020 that Resident 4 had a red hand print on their thigh;'

This charge is found proved.

In reaching its decision, the panel noted that you stated in your live evidence that the incident on 20/21 August 2020 with Resident 4 was a safeguarding matter and should have been reported although not necessarily to CQC. The panel determined that this incident met the threshold for a referral to safeguarding and CQC. You said that you were reassured by Witness 1 that a referral to CQC was made and that she was very thorough in her investigation. Witness 3 stated that there had been no safeguarding or CQC referral and it would have been your responsibility to ensure that the notifications were done but nothing was done.

Witness 1 in her live evidence said she did not investigate or make any referrals as she was on maternity leave during that time but that she did do it in November retrospectively. The panel determined that it prefers the evidence of Witness 3 which aligned with contemporaneous documentation. Therefore, the panel found this charge proved.

Charge 2c

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

2. Did not safely and effectively manage the Home in that you failed to notify or failed to ensure that the following incidents were notified to the Care Quality Commission ('the CQC') and/or appropriate Safeguarding referrals were made in a timely manner or at all;

c. Report of a resident perpetrating sexual abuse upon another resident;'

This charge is found proved.

The panel noted your evidence in relation to this charge. You explained that you had assumed that Witness 2 had copied and pasted his findings to the appropriate

notification tool and had made the appropriate safeguarding referrals and only found out this was not done on 5 October 2020. The panel took account of Witness 2's evidence that he disputes your claim and said that this was your responsibility at the time and not his.

The panel had sight of the Home's policy of the need to notify any safeguarding or CQC referrals within a 72 hour time frame. It determined that as the registered Manager of the Home, it was your responsibility to ensure that this incident was notified to the CQC and that the appropriate safeguarding referrals were made in a timely manner and that this was not done. It therefore found this charge proved.

Charge 2d

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

2. Did not safely and effectively manage the Home in that you failed to notify or failed to ensure that the following incidents were notified to the Care Quality Commission ('the CQC') and/or appropriate Safeguarding referrals were made in a timely manner or at all;

d. Resident 5's unwitnessed fall on 07 December 2019;'

This charge is found proved.

The panel in reaching its decision took into account Witness 4's live evidence in which she explained:

"Nobody was made aware of anything, it should have reported to CQC and safeguarding. If she wasn't aware of the incident at the time and then found out, she should have reported it. Nothing was done until 9 months later."

The panel also noted Witness 3's live evidence in which they explained that

no safeguarding or CQC notification was raised, and it should have been done in relation to this incident.

The panel determined that as the registered Manager of the Home it was your responsibility to ensure that this incident was notified to the CQC and that the appropriate safeguarding referrals were made in a timely manner and that this was not done. It therefore found this charge proved.

Charge 2e

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

2. Did not safely and effectively manage the Home in that you failed to notify or failed to ensure that the following incidents were notified to the Care Quality Commission ('the CQC') and/or appropriate Safeguarding referrals were made in a timely manner or at all;

e. Report that on 29 August 2020

i. a registered nurse caused/allowed a Care Supervisor to administer controlled drugs to a resident when it was not clinically indicated and/or

ii. a registered nurse signed to say that they had witnessed the administration of the medication when they had not and/or

iii. Emergency care was required for Resident 6 due to them receiving medication when it was not clinically indicated.'

This charge is found proved.

The panel first considered each sub charge separately and concluded that each of the aspects of 2e(i), 2e(ii) and 2e(iii) would warrant the CQC being notified and a safeguarding referral being made in a timely manner.

The panel in reaching its decision took into account Witness 4's statement which stated:

'The main issue was, firstly, harm had come to the resident – they were sleepy and aspirated, and this makes it a safeguarding. If anybody aspirates we would automatically inform safeguarding. If someone has aspirated they are over sedated, which is clearly a safeguarding. CQC would need to be informed as well safeguarding as serious harm has come to the resident [sic]. This was not reported. Again, it comes back to Marlene not reporting to safeguarding and the CQC. They had to call 999, which makes it a safeguarding.'

It was a Saturday - Marlene doesn't need to physically do the reporting herself, but she has to make sure it is done. If on Monday when she came in it hadn't been done, she should have made sure it was then done. If the manager is not present there should be systems in place so staff know what to do.

Marlene was aware of the incident, she knew about it as she asked for the statements from [Colleague 5] and [Colleague 4]. She raised lots of things for [Witness 2] for a disciplinary, this was one of them, so she was aware of it but she hadn't notified anybody at this point – CQC or safeguarding. In her investigation meeting Marlene said that she was aware of the incident and she'd spoken with [Witness 2]. When I said it was a medication error, you needed to inform CQC, she said she was going to speak with the nurses involved but then she was suspended.'

You said that having delegated the reporting to a senior member of staff you were confident that the CQC notification matrix was made by Witness 1 on 23 September 2020. The panel noted that this was a month after the incident and that although you were not present on the day of the incident, you should have ensured that the notifications were made as soon as you were aware of it.

The panel accepted Witness 4's statement and the fact that a CQC referral should have been done as well as safeguarding as serious harm had come to Resident 6.

The panel determined that as the registered Manager of the Home it was your responsibility to ensure that these incidents were notified to the CQC and that the appropriate safeguarding referrals were made in a timely manner and that this was not done. It therefore found this charge proved in its entirety.

Charge 2f

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

2. Did not safely and effectively manage the Home in that you failed to notify or failed to ensure that the following incidents were notified to the Care Quality Commission ('the CQC') and/or appropriate Safeguarding referrals were made in a timely manner or at all;

f. An allegation of abuse perpetrated by Person 1 against Resident 7, made on 08/02/2020.'

This charge is found proved.

In reaching its decision the panel determined that this incident did meet the threshold to notify CQC and Safeguarding. It also determined that you had the ultimate responsibility as the registered Home Manager, and you failed to ensure that this incident was notified to CQC and Safeguarding. The panel noted that in the brief investigation report that has your name on dated 4 March 2020 has no mention of notifying CQC and Safeguarding.

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

'...There was no safeguarding referral made. Even if she had done an investigation and there was nothing there, she still should have reported it

because it was an allegation of physical abuse - especially when there were witnesses and bruising. A full investigation should have been done as we are there to protect people.

...

The reason Person 1 should have been suspended is that if you are doing an investigation, people need to feel free to report what they have seen. They may feel intimidated or bullied working in the person's presence. Also, for the resident's sake. There had been an allegation of abuse and Person 1 had been allowed to continue to work within the care home – that is not keeping anyone safe.'

The panel also took account of your witness statement in which you explained:

'After the investigation was finalised, I was informed that all proceedings were completed. I was working with a very high workload at this time, and I did not specifically ask to see the safeguarding and CQC reports and assumed from [Witness 1's] report that "all proceedings were completed" that this included Safeguarding and CQC notification was completed as she had been doing those reports for a couple of months by now.'

The panel determined that there clearly was a duty and ultimate responsibility on you to make the notifications to CQC and safeguarding. It noted that you have said you assumed this would have been done by other colleagues. The panel noted that you accept that you did not ask to see the reports to CQC and safeguarding and therefore could not have ensured that they were undertaken. Therefore, the panel found this charge proved.

Charge 2g

'That you, a registered nurse and the registered Manager of [PRIVATE] ('the Home')

2. Did not safely and effectively manage the Home in that you failed to notify or failed to ensure that the following incidents were notified to the Care Quality Commission ('the CQC') and/or appropriate Safeguarding referrals were made in a timely manner or at all;

g. Allegation/s of bullying and/or sexual misconduct perpetrated by Person 2 against one or more staff members.'

This charge is found NOT proved.

In reaching this decision, the panel found that there was no positive evidence that you were under a duty to report alleged abuse between staff members to CQC and/or Safeguarding. The panel therefore found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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

You gave evidence under oath.

Ms Adeyemi asked you a series of questions in relation to each of the charges found proved, on what you would do differently now and your reflection on the impact your actions had on the residents concerned, their families, the Home, your colleagues and the wider nursing profession.

You outlined to the panel your nursing qualifications and healthcare career history to date. You spoke of the passion and fulfilment you derive from working in the healthcare sector.

Ms Adeyemi submitted that aside from the referral from the Home in this case, there has been no prior concerns raised of any kind which relate to your nursing practice.

Charge 1b

You said that you had failed because you trusted staff to complete the tasks you asked of them, however you recognise that you should have reviewed the full investigation reports and contacted the safeguarding team and make the appropriate referrals.

In relation to the impact your behaviour had on Resident 4 and their family, you said that you put yourself in their shoes; that Resident 4 would have felt disrespected, disempowered, unable to protect themselves and their family would feel guilt and grief over having admitted them to the Home and would lose trust in the service.

Charge 1e(i), 1e(ii), 1e(iii)

You said that you would concentrate on implementing tools to avoid similar situations occurring in future, for example: supervision to avoid near misses with medication; always make sure to prioritise safeguarding; check documentation and speak to the safeguarding team; ensure the adequacy of any investigation; delegate tasks where necessary and always check that they have been completed to the required standard.

In relation to the impact on Resident 6 you said that they would have felt worthless, scared, and disempowered; you described it as the worse feelings someone could have. In terms of the impact of your actions on your colleagues, you said that they would have felt that you have not done enough, that nothing would be sorted and this could result with them feeling unsafe. You said a culture of lack of trust would develop, as well as a negative impact on the Home's reputation in terms of professionalism and recruitment.

Charge 1f

You said that you would make sure to monitor the investigation process more closely. You failed to check if the investigation was fully completed and whether the safeguarding was done as required. You reiterated that you went on the trust of colleagues and that you should have challenged more and explored more options. You said that going forward you would speak less and write more so as to make sure everything is documented.

In terms of the impact of your actions on Resident 7 and their family, you said that they would have felt frustrated, disempowered, guilty, lack of trust, hope and dignity. You said it was serious and that your colleagues would lose trust in you.

You said that bullying and sexual misconduct are very serious allegations and you should have asked for support and involved safeguarding earlier for that support. You said that you feel you have failed and should have challenged the team more and made sure the service had the right support, that you should have dedicated more time to doing things properly, rather than go off your gut feeling.

You said the impact of your conduct on the nursing profession is not good at all. If the service is not fulfilling the need it would impact its reputation and lead to a lack of confidence in the service.

Charge 1g

You said that in future you would defer to your senior management and ask for advice. Further you would have spoken to the person concerned and got safeguarding support involved earlier. In relation to the staff member concerned who was subject to Person 2's sexual misconduct, you said that they would have felt a lack of trust and felt disempowered.

Charge 2a, 2b, 2c, 2d, 2e(i), 2e(ii), 2e(iii), 2f

In relation to notifying CQC and safeguarding you again said that bullying and sexual misconduct are very serious allegations and you should have involved safeguarding earlier for support. You went on to say that your failure to notify CQC is of the utmost importance and the duty of candour applies. You said that although you created a tool to support you to do this, it is about going back to actually check the information in the report and see what you had delegated to be done was completed.

You spoke of the risks in not properly notifying CQC and doing referrals. You said that you could learn and improve the service by following their guidance and protocols. You said your aim was to encourage professionals to do well, but you did not know at the time to share good practice. You had tried to cover all bases with the huge workload you had. You said that you should have prioritised yourself and obtained management support in order to be in a better position to provide a better service to residents.

Ms Adeyemi asked you about your time management and how you organise tasks appropriately. You said your mistake was that you did not prioritise your own time, did not delegate and just did more hours to support the staff. You said however there were often no one there to support you. You said you failed to challenge and put yourself under so much [PRIVATE], however going forward you would challenge more.

Ms Adeyemi asked you what you thought the impact of your conduct would have on public confidence in nurses. You said it would not be good at all and that it would cause a lack of trust and confidence in the services they provide.

Ms Adeyemi asked you about the [PRIVATE] of the job and the level of [PRIVATE] you were under at the time, noting that it was reported by some of your former colleagues that you were tearful at times and [PRIVATE]. You disclosed that [PRIVATE] during the period of time you worked at the Home which they were aware of. You said [PRIVATE]. In terms of your personal coping methods you said that it is better to stop and not undertake more tasks than you are able to do that are not manageable.

Ms Adeyemi asked you about the series of 'Continuing Professional Development (CPD) In Adult Nursing' courses you undertook in 2024. You said that you completed the courses when you were unemployed in order to stay updated and maintain your professional learning. You said you wanted to believe that you could become a nurse again. Ms Adeyemi also took the panel through the details of the numerous training courses you have undertaken, which included safeguarding and complaints handling. You explained that these courses were very short and you printed the certificates on the same day and this was the reason the dates of the course appeared to be clustered around particular dates.

Ms Adeyemi submitted that in relation to misconduct, you accept the panel's decision on the facts and you are grateful for its detailed consideration given to your case. She submitted that your conduct did fall short of what is expected of a registered nurse and is regrettable, however it is not so serious to amount to misconduct.

Ms Adeyemi gave no submissions in respect of the breaches of the 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 2015' (the Code) identified by the NMC.

Ms Adeyemi referred the panel to the NMC guidance on seriousness of misconduct as well as to relevant case law, which included : *Roylance v General Medical Council*_(No 2) [2000] 1 A.C. 311; *Nandi v General Medical Council* [2004] EWHC 2317 (Admin); *GMC v Meadow* [2006] EWCA Civ; and *Remedy v GMC* [2010] EWHC 1245 (Admin).

In relation to impairment, Ms Adeyemi submitted that you have been open, straightforward and candid in saying you did not read the policies. She submitted that you are very knowledgeable and keen, however got side tracked due to [PRIVATE].

She referred the panel to a recent positive reference relating to your time as a team leader in another home. She further submitted that you have received consistent exceptional feedback and that you are remorseful about not doing better.

Ms Adeyemi submitted that in all the circumstances your fitness to practise is not currently impaired.

Ms Barnor invited the panel to take the view that the facts found proved do amount to misconduct. She referred the panel to 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 2015' (the Code) and identified the specific sections, where your actions amounted to misconduct, as follows: 1.2; 3.4; 8.5; 8.6; 11.2; 11.3; 16.4; 17.1; 17.2; 17.3; 20.1; 20.8; and 25.1.

Ms Barnor submitted that there has been a consistent theme in your case of shifting blame or minimising responsibility. She submitted that the panel heard evidence from you that you had not read the Home's safeguarding and reporting policies to CQC, however you recognised that you ought to have familiarised yourself with the relevant policies.

Ms Barnor submitted that asking or assuming that the actions had been completed without assuring yourself that they had been, does not absolve you of your personal responsibility as the CQC Registered Manager of the Home, to properly investigate incidents, to ensure that the investigations had been completed, to promptly make notifications to the CQC or safeguarding or ensure that those notifications had in fact been completed. The Home was a facility with a high level of risk and therefore there is a need for someone accountable and to be held accountable and responsible for ensuring that the obligations governing the care of the service users are fulfilled. She further submitted that you failed to ensure these obligations were carried out effectively even though you stated that you had concerns about the practice of one of the nurses you delegated the task to.

Ms Barnor submitted that your actions, or rather your omissions in this case, fell far short of what would have been proper in the circumstances. Your failures in this case exposed residents and staff to very serious consequences. The Home is primarily a

dementia nursing home and it also houses end of life residents. Your failure to ensure that the investigations were properly conducted and reported to the relevant authorities exposed the residents to risk of serious harm and in other instances to potential further abuse, which was also very serious.

In relation to the inappropriate administration of medication to a vulnerable resident and allegations of bullying and or sexual misconduct by Person 1 against colleagues, Ms Barnor submitted these are very serious. She submitted that the misconduct found would be regarded as deplorable by other practitioners.

In relation to impairment, Ms Barnor submitted that the panel should have regard to protection of the public and to the wider public interest. This included the need to declare and maintain proper standards and of conduct and behaviour and to maintain public confidence in the profession and in the NMC as regulator. 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 Barnor submitted that the first three limbs of the 'test' in the case of *Grant* are satisfied by your past conduct. She submitted that it is clear on the evidence before the panel, that both residents and staff were put at risk of harm as a result of your misconduct. She submitted that if the panel were to find that your failures amount to serious misconduct and that they breached the Code, it stands to reason that the fundamental tenets of the profession would also have been breached, which are prioritisation of people, effective practice, preservation, safety and the promotion of professionalism and trust.

Ms Barnor submitted that the panel should find that as a consequence of your failings, members of the public would be alarmed to hear that, a registered home manager, who was a nurse, did not properly investigate or report to the relevant authorities incidents of potential abuse and/or harm relating to residents and staff, would be entitled to think less favourably of the profession.

In relation to insight, she submitted that the panel may find that your actions or omissions were underpinned by an attitudinal issue, and that your attitudinal issue was one of deflecting responsibility onto others, by relying on their work without verifying it

for yourself independently.

Referring to your extensive curriculum vitae (CV), numerous courses undertaken and training certificates provided, Ms Barnor commended you for your commitment and work done over the last few years. However, she submitted that the majority of the learning undertaken is largely irrelevant to the misconduct in this case. She submitted that it may be concluded that the training you have undertaken is insufficient to appropriately address the level of misconduct in this case. She further submitted that you have not worked as a registered manager since you left the Home, nor have you worked as a registered nurse for some time and therefore you have been unable to apply any of the learning undertaken in practice.

Ms Barnor referred to the following factors set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin):

- Is the behaviour easily remediable?
- Has it already been remedied?
- Is it highly unlikely to be repeated?

Ms Barnor submitted that the first three limbs of the 'test' in the case of Grant are met.

Ms Barnor submitted that it is the NMC's position that this is so serious that it has such a detrimental impact on public confidence in not only the profession, but the NMC as a regulator. She submitted that this case involves fundamental breaches of the absolute requirement to safeguard vulnerable residents, many of whom cannot speak for themselves and rely on the leadership in their homes to protect them, therefore it should be marked with a finding of current impairment.

Ms Barnor submitted that the likelihood of the conduct being repeated is of concern. She submitted that at this stage and in the future, there is sufficient evidence for a finding of current impairment. She invited the panel to make a finding that your fitness to practise is currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Cohen v GMC*; *Calhaem v GMC* [2007] EWHC 2606 Admin); *Roylance v General Medical Council*; *Nandi v General Medical Council*; and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* 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.*’

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:

‘3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

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

8.6 share information to identify and reduce risk

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

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

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

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

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

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'

The panel was aware of the guidance given in FTP-2a that not all breaches of the Code or issues with practice will be a matter of regulatory concern.

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 your failings were serious incidents which occurred over a period of time involving a number of people. This included colleagues who relied on you, as their manager, to follow correct procedures and vulnerable residents, some of whom suffered from dementia, were non-verbal and/or at the end of their life.

The panel found that your actions both jointly and separately did fall seriously short of conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 3 March 2025, 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 open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or

determination show that his/her/ fitness to practise is impaired in the sense that S/He:

- a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d)'*

The panel determined that parts a) b) and c) of the above 'test' to be engaged.

The panel found that residents and colleagues were put at risk and were caused actual physical harm as a result of your inability to understand and prioritise what your role and responsibilities were as the Home Manager. This included your failure to look at the Home's policies including safeguarding issues. The panel noted your role, as manager of the Home, included ensuring policies and procedures relating to safeguarding were followed, and determined that this would not have been possible for you to do having failed to read them. The panel was of the view that your failings were serious and your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered the context of your senior role at the Home at the time. The panel understood that it was a Home that was not doing too well in terms of its standing with other medical professionals within the community, however these difficulties were known to you having worked there previously. The Home was going to be challenging yet you went ahead and accepted the senior position as the Registered Manager at the Home. The panel was of the view that you recognised the issues within the Home as

you chose to spend time developing your own audit tools, rather than prioritise more urgent tasks within the Home.

Regarding insight, the panel acknowledged that you are remorseful and have sought to demonstrate an understanding of how your actions put residents and colleagues at risk of harm as well as gaining an understanding of your failings and how these impacted negatively on the reputation of the nursing profession. The panel noted your assertion you would not wish to undertake a management role in the future, the panel reminded itself that the role of a nurse inherently requires management and leadership skills. The panel considered that in order for a finding of no impairment to your fitness to practise, it would need to be satisfied that your failings had been sufficiently remedied and addressed in order for you to practise kindly, safely and professionally. The panel determined that although you gave some examples where you have challenged and reported on poor practice, it was not yet satisfied that you could adequately explain what you would do differently in situations similar to the matters found proved.

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 sufficient steps to strengthen your practice. The panel took into account the numerous courses you have undertaken, the training certificates and reflective piece you have provided. However, the panel was not satisfied of your ability to prioritise and carry out your duties, or show an understanding of what your management role and responsibilities were, in order to ensure patient safety and the safety of others in the future. The panel took account of the courses and assessments you have since undertaken. The panel was of the view that your responses to their questions about how you would apply the lessons learned from the courses you have undertaken into your practice were vague and you were not able to articulate to the panel's satisfaction how you would apply your learning in practice to a particular scenario in order to sufficiently reassure it that you would not make the same mistakes again.

The panel took account of your reflective statement, which includes:

'I will continue to keep myself updated with any training needs, research for best evidence practice and follow company's policies. I will strive to start doing a daily diary of my daily practice, be even better at recording issues that I found and report them. If I feel I am struggling with my caseload I will report and seek for advice.'

The panel was of the view that you recognise the value of training. It has taken account of your intention and commitment to change your practice, however what is missing is evidence of your ability to apply what you have learned into practice.

The panel therefore determined that there is a risk of repetition of your misconduct. The panel therefore concluded that, in these circumstances, a finding of impairment is necessary on the ground 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 proper professional standards for members of those professions.

The panel had regard to the serious nature of your misconduct and determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case, particularly as this misconduct involved a series of failings relating to numerous incidents of physical and sexual harm to patients over a period of time. The panel were particularly concerned that that a number of the residents were vulnerable.

The panel was of the view that a fully informed member of the public, aware of the proven charges in this case, would be very concerned if you were permitted to practise as a registered nurse without restrictions. For this reason, the panel determined that a finding of current impairment on public interest grounds was also required. It determined that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold the proper professional standards for members of the nursing profession.

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

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. It took account of all the submissions of Ms Barnor and those of Ms Adeyemi. The panel received no further evidence from anyone at this stage.

The panel accepted the advice of the legal assessor.

Submissions on sanction

The panel was aware that in the initial Notice of Hearing dated 2 December 2024, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired. Ms Barnor, having taken further instructions, informed the panel that the sanction sought by the NMC remains unchanged.

Ms Barnor submitted that the following aggravating factors are applicable in this case:

- Risk of serious patient harm and actual patient harm was suffered

- Your misconduct was repeated over a significant period of time
- There has been limited insight demonstrated by you
- You were in a position of responsibility as the registered home manager at the time the incidents took place

With respect to the mitigating factors, Ms Barnor submitted:

- There is evidence to suggest that you were perhaps not provided with the necessary support from the Home at the time
- Some incidents took place during the COVID-19 pandemic
- You have engaged with the NMC throughout its proceedings
- You have undertaken training since the incidents occurred
- You have worked as a registered nurse since the incidents (although not recently)

Ms Barnor 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, they would not reflect the seriousness of the misconduct, nor would they protect the public or maintain public confidence in the profession or the NMC as regulator. She submitted that a conditions of practice order would be inappropriate, as noted in the panel's findings, that although your misconduct is capable of being remedied given the lack of insight displayed by you in the five years since the concerns were raised, patients would be put in danger either directly or indirectly, were a conditions of practice order be imposed. She further submitted that the issues in this case demonstrate a general incompetence, which SAN-3c guidance states make conditions of practice inappropriate.

Ms Barnor submitted that a suspension order would again be inappropriate. She referred to SAN-3d and submitted that additional time away from practice will not achieve a different outcome. She submitted that the misconduct in this case is fundamentally incompatible with ongoing registration.

Ms Barnor submitted that the proportionate and appropriate sanction is that of a striking-off order. She submitted that the misconduct in this case raises fundamental questions about your professionalism and relate to the fundamental tenets of nursing. She submitted that to allow you to remain on the register would undermine public confidence in the profession and the NMC as regulator.

Before making submissions on sanction, Ms Adeyemi informed the panel that you wish to convey your apologies once again and you are mindful and regretful of the resources and time that have been used up to consider this matter.

Ms Adeyemi reminded the panel that the purpose of sanction is not to punish but to focus on the overriding objective which is public protection. She submitted that any sanction should be proportionate to meet that aim and needs to go no further than needed to meet this objective.

Ms Adeyemi submitted that she agrees with Ms Barnor's submissions on the aggravating and mitigating features in this case, as it assists the panel in determining what is proportionate. She submitted that the picture described of you by the NMC as a potentially dangerous practitioner that would harm patients is completely incorrect and not reflected in the evidence. She submitted that you have made mistakes and found things difficult, however you have demonstrated an attitude of care and kindness towards members of the public, patients and people that you have looked after. She submitted this is in complete contradiction to what the NMC seek to put forward as your practice and state of mind in terms of aggravating features.

Ms Adeyemi submitted that it is fully accepted that your actions had the potential to cause serious harm, and there were a number of different problems in relation to your conduct which had the potential to reflect poorly on the profession, especially given the

context of it being a care home.

In terms of mitigation, she submitted that the panel are entitled to take into account that the Home environment was very challenging. She submitted that there has been no repetition of the misconduct in this case, you have expressed remorse for what occurred and demonstrated some insight and proactively sought to remediate the deficiencies in your practice. She submitted that there is a complete lack of evidence of malice. She submitted that it is relevant that you are of good character with no previous regulatory history, and that your good character is supported by positive testimonial evidence.

Ms Adeyemi addressed the panel first on a striking-off order. She submitted that removal from the register would be wholly disproportionate and is not necessary. She reminded the panel of the overriding objective to protect the public, uphold standards and to maintain public confidence and that the panel must act proportionately. She submitted that there are other sanctions available to the panel without permanently removing you from the register.

Ms Adeyemi submitted that it is not accepted that the deficiencies relating to your practice concerning leadership can be said to have a link to clinical competence, which has never been challenged at the fact stage.

In relation to a suspension order, Ms Adeyemi submitted that it is not needed to address the risk that arises in this case or even to mark the misconduct. She submitted that the value of a suspension is when a registrant poses a danger, and there is no evidence that if you worked you would cause danger.

Turning to a conditions of practice order, Ms Adeyemi submitted that you would abide by any conditions the panel sees fit to impose. She submitted that the panel may wish to consider the following conditions:

- That you undertake a further period of reflection and be supervised for a period of time, so an assessment can be made as to whether you are able to apply

what you have learnt in practice.

- Supervision could also serve to provide a method of assessing whether you can prioritise and carry out duties properly

Ms Adeyemi submitted that a conditions of practice order for a period of three months would suffice to fulfil this purpose and would be proportionate.

Ms Adeyemi invited the panel to take into account your personal circumstances, that you have a passion for nursing, caring for people and learning. She submitted that this is the best job that you have ever had and it would be a great loss financially and emotionally if you were not able to practise for an extended period of time.

In terms of public confidence, she submitted that members of the public expect proportionate regulation and they would not be concerned if you were in a position to practise, albeit with some restrictions for a period of time, which would enable some sort of assessment as to how you were progressing.

Ms Adeyemi submitted that if given the opportunity, you would strive to care for people to the highest standard and leave no room for doubt as to your abilities in relation to all areas of your nursing practice, including leadership, clinical skills, attitude and organisation.

Ms Adeyemi invited the panel to impose a conditions of practice order for a period of three months.

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:

- Your insight into your failings in your role as a manager is not yet fully developed
- Your pattern of misconduct over a period of time
- Your misconduct put patients at risk of suffering harm and caused physical harm

The panel also took into account the following mitigating features:

- Your apologies and steps taken to address the concerns
- Your previous good character
- Your 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, the harm caused to residents and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel was of the view that the circumstances of this case do not meet the necessity test to impose a suspension order. The panel was of the view that its finding of impairment has marked the seriousness of this case and indicates the need for you to improve your practice. Further, to impose a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your

case, where there was as much a failure of management as a lack of action on your part. All facts found proved relate exclusively to your role as a manager and are not related to your direct patient care. Whilst risks to residents of serious harm were identified in the panel's findings, these are attributed to your failings as a Home Manager and not to your direct patient care.

In making this decision, the panel carefully considered the submissions of Ms Barnor in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of this case.

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

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

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

The panel had regard to the fact that these incidents happened some five years ago and that, other than these incidents, you have had an unblemished career of ten years

as a registered nurse. The panel was of the view that as well as maintaining confidence in the nursing profession and the NMC, and upholding proper professional standards, the public interest may include, with appropriate safeguards put in place, the return of an otherwise good and competent nurse to unrestricted practice. This would ensure at this time, and going into the future, that the public would remain protected and that the wider public interest, equally, would be reflected.

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

Further, the panel noted the oral evidence of Witness 4, who said:

'I would say clinically Marlene is an amazing nurse. She's very skilled. And she's somebody that if I was in hospital and I was needed to have clinical care, she would be very good at that, yes, she's very good.'

And

Witness 3's witness statement included: *'She was kind, caring, and a good nurse...'*

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

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

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.'

1. You must not be a manager in charge of a service.
2. You must ensure that you are supervised by a Registered Nurse any time you are working. Your supervision must consist of:
 - Working for one substantive employer that must not be an agency.
 - Working at all times on the same shift as, but not always directly observed by, another Registered Nurse.
 - Weekly meetings to discuss your clinical caseload.
3. You must not be the nurse in charge, and you must not be the most senior nurse on duty.
4. You must work with your line manager, mentor or supervisor to create a personal development plan (PDP). Your PDP must include:
 - Undertake face to face training on safeguarding, investigating safeguarding concerns and how to report them.
 - Confirmation that you have read the local safeguarding policies and procedures and reflective discussions on how you implement them.
 - Any safeguarding concerns you identify or that are reported to you and the actions you have taken in response to them.
 - Confirmation that you have read and understood the local complaints policy and procedures and an understanding of your role and responsibilities (as a registered nurse) within these.
 - Any complaints reported to you and the actions you have taken in response to them.
 - Undertake face to face training on management.
 - Reflective discussions about your management of patients and staff in your work as a Registered Nurse.
 - Reflection on working cooperatively with colleagues, showing an understanding of how to question and verify what has been reported to you. or what you have observed, rather than trusting what you assume or have been told.
 - Effective delegation and monitoring of work that you delegate.

5. You must:
 - Send your case officer a copy of your PDP within 14 days of starting employment.
 - Send your case officer a report from your line manager, mentor or supervisor every six months. This report must show your progress towards achieving the aims set out in your PDP.
6. You must engage with your line manager, mentor or supervisor on a frequent basis to ensure that you are making progress towards aims set out in your personal development plan (PDP), which include:
 - Meeting with your manager, mentor or supervisor at least every month to discuss your progress towards achieving the aims set out in your PDP.
7. You must keep the NMC informed about anywhere you are working by:
 - a. Telling your case officer within seven days of accepting or leaving any employment.
 - b. Giving your case officer your employer's contact details.
8. You must keep the NMC informed about anywhere you are studying by:
 - a. Telling your case officer within seven days of accepting any course of study.
 - b. Giving your case officer the name and contact details of the organisation offering that course of study.
9. You must immediately give a copy of these conditions to:
 - a. Any organisation or person you work for.
 - b. Any employers you apply to for work (at the time of application).
 - c. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

10. You must tell your case officer, within seven days of your becoming aware of:
- a. Any clinical incident you are involved in.
 - b. Any investigation started against you.
 - c. Any disciplinary proceedings taken against you. Seven calendar days is the expected timeframe.

11. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

- a. Any current or future employer.
- b. Any educational establishment.
- c. Any other person(s) involved in your retraining and/or supervision required by these conditions.

12. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from (delete as applicable) either:

- a. your line manager.
- b. mentor or supervisor.

The period of this order is for a period of twelve months.

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

Any future panel reviewing this case would be assisted by:

- Evidence of professional development, including documentary evidence of completion of the above mentioned courses, references and testimonials from a line manager or supervisor that detail your current work practices;
- Updated reflection on how you could address the failings identified in the future.

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the conditions of practice sanction takes effect. 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 Barnor. She submitted that an 18-months interim conditions of practice order is appropriate and proportionate in this case given the panel's determination on sanction.

Ms Adeyemi submitted that the interim conditions of practice order is not necessary. She submitted that in consideration of the broader issue, you have been able to practise unrestricted in the period following these events and able to regulate your own behaviour. She submitted that there is no value or need and it is disproportionate and unfair in the circumstances.

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be inconsistent with its earlier findings. The conditions for the interim order will be the same as those that are set out in the substantive order, for a period of 18 months on the basis that the appeal process, if commenced by you, might last for that period of time.

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

That concludes this determination.