Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 27 November 2023 – Friday, 1 December 2023
Monday, 4 December 2023 – Friday, 8 December 2023
Monday, 11 December 2023 - Wednesday, 13 December 2023
Tuesday, 9 April 2024 – Friday, 12 April 2024
Monday, 15 April 2024 – Friday, 19 April 2024

Virtual Hearing

Name of Registrant:	**Antonio H Gutierrez**
NMC PIN:	02A2423O
Part(s) of the register:	Registered Nurse - Sub Part 1 RN1: Adult Nurse, Level 1 - 29 January 2002
Relevant Location:	Essex
Type of case:	Misconduct
Panel members:	Janet Fisher (Chair, Lay member) Frances Clarke (Registrant member) Louise Guss (Lay member)
Legal Assessor:	Lucia Whittle-Martin (27 November – 1 December 2023) Oliver Wise (4-13 December 2023, 9 – 19 April 2024)
Hearings Coordinator:	Margia Patwary (27 November – 13 December 2023, 9 -10 and 12 April 2024, 15 April 2024) Hamizah Sukiman (11 April 2024) Yewande Oluwalana (16-19 April 2024) Shela Begum (18 April 2024)
Nursing and Midwifery Council:	Represented by Anna Leathem, Case Presenter (27 November – 13 December 2023) Represented by Michael Smalley, Case Presenter (9 –19 April 2024)

Mr Gutierrez:	Intermittently present and represented throughout by Khaled Hussain-Dupré (27 November – 13 December 2023, 9-19 April 2024)
No case to answer:	Charge 1b), 1c), 1d), 1e), 2a)i), 3a) and 3b)
Facts proved by admission:	Charge 1a), 2a)ii, 2b) and 2c)
Facts proved:	Charge 2d)
Facts not proved:	Charge 1f) and 2e)
Fitness to practise:	Impaired
Sanction:	**Caution order (2 years)**

Details of charge (as amended)

That you, a registered nurse:

1) On 12 March 2020:

    a) Failed to document that Resident A had not eaten or drank well. **[PROVED BY ADMISSION]**

    b) Failed to ensure Resident A was offered food and drink more regularly. **[NO CASE TO ANSWER]**

    c) Failed to put in place enhanced monitoring of Resident A. **[NO CASE TO ANSWER]**

    d) Failed to check Resident A's catheter. **[NO CASE TO ANSWER]**

    e) Failed to complete an early warning score sheet for Resident A. **[NO CASE TO ANSWER]**

    f) Failed to handover or otherwise make colleagues aware that Resident A had not eaten or drank well on 12 March 2020. **[FACTS NOT PROVED]**

2) On 12 March 2020:

    a) Failed to communicate appropriately with Resident A's relatives when they called the Home for an update in that you:

        i) Advised them that Resident A had not eaten or drank much but it was not an emergency when you had not assessed Resident A sufficiently to make this comment. **[NO CASE TO ANSWER]**

ii) On 12 March 2020 and/or 13 March 2020, Did not arrange to call Resident A's relatives back and/or handover your conversation with Resident A's relatives to another nurse so that they could be kept updated on Resident A's condition. **[PROVED BY ADMISSION]**

On 13 March 2020:

b) Advised the GP that you carried out a urine sample which was positive for a UTI. **[PROVED BY ADMISSION]**

c) Incorrectly recorded that Resident A had a urine test completed and had a positive result for a UTI. **[PROVED BY ADMISSION]**

d) Your conduct at charge 2b) and/or 2c) was dishonest in that you were attempting to create a false impression that you had taken a urine sample and that it was positive for a UTI when you had not done so. **[FACTS FOUND PROVED]**

e) Failed to assess Resident A when you were advised by carers that he had left sided weakness. **[FACTS NOT PROVED]**

3) Your actions at charges 1 and/or 2(b), (c), (d) and (e):
   a) intentionally took an unreasonable risk with Resident A's safety and wellbeing. **[NO CASE TO ANSWER]**
   b) contributed to the death of Resident A. **[NO CASE TO ANSWER]**

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

Decision and reasons on application to amend the charge

Ms Leathem, on behalf of the Nursing and Midwifery Council (NMC), made an application under Rule 28 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004. Ms Leathem proposed that the amendments would provide clarity and more accurately reflect the evidence. She provided written submissions which stated:

1. *…*

   28.–(1) At any stage before making is findings of fact...the Fitness to Practise Committee, may amend–

   (a) the charge set out in the notice of hearing; or
   (b) the facts set out in the charge, on which the allegation is based,

   unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

   (2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on the issue.

2. *The proposed amendments are as follows:*

   2) ~~On 13 March 2020:~~ ***On 12 March 2020****:*

   a) Failed to communicate appropriately with Resident A's relatives when they called the Home for an update in that you:

   i) Advised them that Resident A had not eaten or drank much but it was not an emergency when you had not assessed Resident A sufficiently to make this comment.

ii) ***On 12 March 2020 and/or 13 March 2020****,* ***did*** *not arrange to call Resident A's relatives back and/or handover your conversation with Resident A's relatives to another nurse so that they could be kept updated on Resident A's condition.*

On 13 March 2020:

b) Advised the GP that you carried out a urine sample which was positive for a UTI, ~~when you had not done so~~.

c) ~~Inaccurately~~ ***Incorrectly*** *recorded that Resident A had a urine test completed and had a positive result for a UTI*

d) Your conduct at charge 2b) and 2c) was dishonest in that you were attempting to create a false impression that you had taken a urine sample and that it was positive for a UTI ***when you had not done so****.*

e) Failed to assess Resident A when you were advised by carers that he had left sided weakness.

*3) Your actions at charges 1 and/or 2****(b), (c), (d) and (e)****:*
*a) intentionally took an unreasonable risk with Resident A****'s*** *safety and wellbeing.*
b) contributed to the death of Resident A. [sic]

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

Charge 2(a)

3. *In respect of charge 2, the application to amend is made in the interests of clarity. The evidence of* [Witness 3] *is that the call between the Registrant and the relative of Resident A (whereby the Registrant is alleged to have advised that Resident A had not eaten or drank much) took place on 12 March 2020 and not 13 March 2020.*

4. *In respect of charge 2(a)(ii), it is submitted that this should be amended to 'on 12 March 2020 and/or 13 March 2020' to reflect the evidence that a call is alleged not to have been arranged between the relative's call on 12 March 2020 and the relative's follow up call on 13 March 2020. It follows that the allegation of failing to handover this conversation to another nurse must occur from 12 March 2020 given the call took place on this date into 13 March 2020 when* [Witness 2] *is said to have come on shift.*

Charge 2(c)

5. *It is submitted that 'inaccurately' should be replaced with 'incorrectly' as inaccurately presupposes the dishonest intent which is the nature of charge 2(d) and not charge 2(c).*

Charge 2(d)

6. *Similarly with charge 2(d), it is submitted that 'when you had not done so' should be removed from charge 2(b) and added on to charge 2(d) as the dishonest charge.*

Charge 3

7. *It is submitted that further specifying the exact charges in 3 ensures that the Registrant knows exactly what alleged conduct he is answering in respect of charges 3(a) and (b).*
8. *Charge 3 (a) is amended to rectify a grammatical error.'*

Mr Hussain-Dupré, on your behalf, did not oppose 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 interests 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. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

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

At the outset of the hearing, Ms Leathem made an application for her forthcoming hearsay application be held in private on the basis that there will be some reference to matters relating to Witness 3's [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Hussain-Dupré made no objections to the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in connection with matters relating to Witness 3's [PRIVATE] as and when such issues are raised in order to maintain the confidentiality of sensitive information.

Decision and reasons on application to admit hearsay evidence

Ms Leathem made an application under Rule 31 that the panel should allow Witness 3's witness statement into evidence. In her written submissions, she set out the evidence which was subject to the application:

1. *Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 is applicable:*

31.–(1) Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in the appropriate Court in that part of the United Kingdom in which the hearing takes place).

2. *The panel should consider also consider the principles in Thorneycroft v NMC [2014] EWHC 1565 (Admin), El Karout v NMC [2019] EWHC 28 (Admin) and NMC v Ogbonna [2010] EWCA Civ 1216.*

3. [Witness 3]*'s witness statement concerns charges 1 and 2 in the context of investigating the concerns at the local level. It is acknowledged that she is not a direct witness to anything and where she is the only witness, her evidence is hearsay. However, much of this is based on documentary evidence such as the interview minutes.*

4. *One of the factors that the panel will consider when deliberating on the application is whether anything contained in a statement that's hearsay, is sole and decisive to the charge.*

5. *It is acknowledged that some of her evidence, based on the exhibits, is sole and decisive. This is as follows:*
   i. *Paragraphs 9, 12, 20 and 28 refers to charge 1b*
   ii. *Paragraphs 9, 12 and 20 refers to charge 1d*
   iii. *Paragraphs 9, 12, 20 and 23 refers to charge 1e*

6. *The remaining paragraphs of her witness statement concern charges that are*

also supported by the evidence of [Witness 2] *or* [Witness 1] *and their exhibits. The panel will hear live evidence from them.* [Witness 3]*'s evidence on the other charges is not therefore sole and decisive.*

7. *In respect of charge 1(e),* [Witness 3]*'s evidence is based on an admission by the Registrant in interview (Exhibit KE9, page 23 Exhibit Bundle). It is submitted that documentary evidence such as this is less likely to cause unfairness to the registrant than, for example, hearsay in the form of reporting a conversation that one hears second hand.*

8. *It is submitted that efforts were made by the NMC to secure the attendance of* [Witness 3]. *The reason for* [Witness 3]*'s non-attendance is outlined in the hearsay bundle.* [PRIVATE]

9. [Witness 3] *is not a registered nurse and therefore is not duty bound under the NMC Code to cooperate with requests to act as a witness. Obtaining a witness summons from the High Court would have been the only means of forcing her attendance. This is of course a last resort and not taken lightly.* [PRIVATE].

10. *Plainly, hearsay evidence is not as useful to the panel as live witness evidence. However, it is submitted that the NMC have made efforts to secure the attendance of this witness. This is material that's properly recorded in a witness statement, is signed, dated and contains a statement of truth. It was made in contemplation of NMC proceedings, paragraph 1 states as such.*

11. *Therefore, it's not simply just material that someone has taken a note of or someone has put in an email. It is submitted that it is serious quality evidence that she has checked and signed and that should give the panel some comfort.*

12. *Whilst her evidence cannot be challenged, it is submitted that much of her evidence is based on documentary evidence in any event. She does not have first hand knowledge and her evidence goes to what is outlined within those documents which the panel have from her exhibits. The panel should therefore admit the evidence and give it appropriate weight as necessary.*

13. *The NMC's application is for the whole of* [Witness 3]*'s statement to be admitted into evidence as hearsay. However, if the panel is not prepared to admit the paragraphs referred to where they are sole and decisive, the application would be to admit the witness statement into evidence, save for those paragraphs.*

14. *The panel have the discretion to admit the evidence subject to relevance and fairness. If admitted, the secondary stage is to consider what weight should be attached.*

Mr Hussain-Dupré, responded to those submissions and provided written submissions which stated:

1. *Applying the test in Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin), there follow submissions on limbs 2, 4, 5 in relation to adducing the witness statement of* [Witness 3] *as hearsay.*

Limb 2 - the nature and extent of the challenge to the contents and statements

2. *The panel has already heard submissions on the contents of the witness statement of* [Witness 3], *that as one of the local investigators,* [Witness 3] *collected various evidence but had no firsthand experience of the complained of incident, nor was she even on site. Any conclusions that she draws as to the Registrant's acts or omissions must be on the basis of an evaluation of her findings.*

3. *In turn,* [Witness 3]*'s findings were at least in part reliant on elements of* [Witness 1]'s *earlier investigation.*

4. *The way in which* [Witness 3]*'s witness statement has been drafted makes it impossible to discern the points at which she is talking about her own knowledge of the policies and procedures of the home, versus ones where she is taking her investigatory findings and applying them to the policies and procedures to arrive at what the Registrant did not do, but ought to have done and vice versa. The lack of opportunity to cross examine* [Witness 3] *results in unfairness to the Registrant as it becomes impossible to interrogate how she arrived and her conclusions and whether there is any sound basis for her opinions, or indeed upon what information they are based.*

5. *As noted in the NMC's submissions, [Witness 3]'s evidence is sole and decisive at paras 9, 12, 20, 23, and 28.*

6. *Where the redactions of* [Witness 3]'s *evidence have not been agreed or accepted by the panel, as set out above, it becomes impossible for the Registrant to challenge whether they do indeed derive from the findings of the investigation.*

Limb 4 - seriousness of the charges

7. *Clearly when viewed in the context of Charge 3, the allegations against the Registrant are serious and subject to the panel's findings could result in a strike order as a sanction.*

Limb 5 - reasonable explanation

8. *Whilst the Registrant is sympathetic to* [Witness 3]'s *present medical condition,*

it is noted that her opening gambit when called by the NMC was that she refused to give evidence unless compelled. Once the NMC explained that she would be compelled she then [PRIVATE].

9. [PRIVATE].

Exhibits and further hearsay

10. *Should the panel reject the Council's application, the Registrant offers no objection to the exhibits KE1 - KE 15 inclusive being adduced as hearsay.*

11. *The Registrant requests that the Safeguarding Adults Form [Exhibits, p355] be excluded on the basis that there is a significant factual error contained within it and also that it was completed by a member of staff who was involved in the complained of incident and who is not called as a witness.*

12. *It therefore follows that even without* [Witness 3]*'s statement, the panel has before it the necessary evidence upon which to base its determination of the facts as alleged, without any risk of unfairness to the Registrant.'*

Both counsel supplemented their written submissions orally to the panel.

The panel accepted the advice of the legal assessor. She referred the panel to the Rules and to the principles established in case law, principally the cases of *Thorneycroft v NMC [2014] EWHC 1565 (Admin), R (Bonhoeffer) V GMC [2011] EWHC 1585 (Admin)* and *NMC v Ogbonna* [2010] EWCA Civ 1216.

The panel gave consideration to the factors set out in the case of *Thorneycroft*.

The panel determined that there was a good reason for the absence of Witness 3. The panel accepted the evidence provided by the witness in respect of her health which

stated that her health would be put at risk if she was forced to give evidence in this hearing.

The panel also determined that the NMC had made reasonable efforts to secure Witness 3's attendance by offering a variety of support, but without success. The panel accepted that, [PRIVATE], it would be unreasonable to expect the NMC to apply for a witness summons. The evidence the NMC wish to adduce is a signed and dated witness statement written for use in these proceedings and stating that it is true to the best of the witness's knowledge and belief and that on the 5 January 2022, when it was signed, she was willing to attend and give evidence.

Neither the NMC, nor you, have suggested that there is a risk of fabrication, or that the notice given of this application was insufficient.

In considering the seriousness of the charges, the panel determined that the charges are serious and could have a severe impact on your career if found proved. The panel also noted that you wish to extensively challenge Witness 3's evidence and there is a risk of unfairness if you are deprived of the opportunity to challenge that evidence, particularly in cross examination. The witness was an investigatory officer and exhibits a large number of documents, gathered as part of her investigation and you have clearly stated that you do not challenge the admissibility of those documents.
The panel considered the contents of the witness statement. The panel noted that there were already some agreed redactions to Witness 3's statement and that the NMC are not seeking to admit as evidence those parts of the statement. In relation to proposed redactions which are not agreed, the onus will be on the NMC case presenter to justify adducing them in evidence after the evidence of the live witnesses has been heard. Until that stage in the evidence, the redactions which are not agreed should be excluded in Witness 3's written statement before the panel.

In the light of the exhibits and the witness statements of Witness 1 and Witness 2, the panel determined that Witness 3's written statement was not the sole and decisive evidence on any charge.

On the basis set out above, the panel came to the view that it would be fair to accept into evidence the hearsay evidence of Witness 3's written statement and exhibits.

The parties agreed that the safeguarding report should not go into evidence.

Process to be adopted in relation to disputed redactions in Witness 1's statement

Both representatives had made written representations about the statements of Witness 1 and Witness 3, addressing the admissibility of their content. Having determined the position in respect of Witness 3, the panel invited submissions on how to proceed in respect of Witness 1's statement.

Both representatives made oral submissions.

Ms Leathem submitted that the panel should adopt a process of making a determination in respect of each contested redaction proposed by Mr Hussain-Dupré before the witness is called to give evidence. The panel should hear detailed submissions on each disputed aspect and give a reasoned decision as to whether the text should be admitted or excluded from Witness 1's written statement. Her written submissions addressed your objections on admissibility and stated:

1. *The starting point is Rule 31 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004. In essence, evidence is admissible if it is relevant and fair: 31.–(1) Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in the appropriate Court in*

that part of the United Kingdom in which the hearing takes place).

2. *It is submitted on behalf of the NMC that both the statements of* [Witness 3] *and* [Witness 1] *in the format of the NMC agreed redactions are relevant and admissible statements. These are preliminary observations and not conclusions.*

3. *The Panel are the ultimate arbiters of fact and it is submitted that the statements of both witnesses are not going to affect that. The conclusions of the investigation have already been redacted which is what Enemuwe says. It is accepted that where the material is plainly a finding, it should be redacted so as not to influence the Panel as arbiters of fact.*

4. *It is submitted that much of what is said by both* [Witness 3] *and* [Witness 1] *is recounting what was told to them as part of the investigation, not of itself a finding or conclusion of the investigation. For example, at paragraph 24 of* [Witness 3]*'s statement, "The Nurse said during their interview that they did not document their conversation with the family as they were too busy". This is information from the interview itself and told directly to* [Witness 3]. *It is not a finding of the investigation, merely a narrative of what the Registrant said in interview as part of the local investigation.*

5. *It is submitted that it is not uncommon for panels to receive statements from investigating officers who provide such a narrative particularly where the points are already within the exhibits. It is submitted that it is therefore less likely to be prejudicial to the Registrant.*

6. *Furthermore, it is respectfully submitted that the proposed redactions on behalf of the Registrant are inconsistent. The following examples are provided from* [Witness 3]*'s witness statement:*

   Paragraph 21: "During this interview the Nurse also admitted to making up the

urine results."

Paragraph 29: "During interview on 14 April 2020, the Nurse admitted that they had completed the note but only said it as a positive result to get a better result from the GP for the family as they felt pressure from them."

7. *It is not suggested by the Registrant that the first example should be redacted. It is proposed, however, that the second example should be redacted. It is submitted that in both these examples, the witness is recounting what was said in interview by the Registrant. There is no material difference between the two sentences save for the content of what is admitted. It is submitted that this inconsistency detracts from the submission that the evidence is a finding of a previous decision maker where both of the highlighted examples are materially the same.*

8. *In respect of the formal outcome of the internal investigation, it is submitted that the panel have not in fact seen the outcome. The outcome of the investigation was redacted prior to the panel receiving the bundles. Whilst it is acknowledged that the Bupa Investigation Summary references 'Findings', it is submitted that what follows is again information extracted from interviews or documents.*

9. *In respect of comments of how the nurse should have acted in the circumstances, the Registrant's position is understood to be that this presupposes a finding that the nurse has acted in a certain way. It is submitted that matters that fall under the opinion of a witness may sometimes be relevant to the panel's consideration on the facts, but any previous findings in relation to the evidence would not be.*

10. [Witness 2] *is a nurse within the Home and would be aware of the policies and procedures, thereby in a position to comment on what conduct is expected. It remains a matter for the panel, as arbiters of fact, to consider whether or not the conduct occurred and would be assisted as to whether or not the Registrant can*

be said to have failed in any of his duties as a nurse by any evidence on what is expected of a nurse at the Home. The evidence is therefore plainly relevant.

11. *In relation to* [Witness 1]*'s comments in respect of the cause of death certificate and acting on the UTI sooner (paragraphs 26, 27 and 28), it is submitted that she is entitled to comment on the alleged care provided to the Resident alongside his cause of death as a registered nurse herself. Whether or not she is experienced enough to provide such comments is not to be considered at this stage. However, what is submitted is that these comments cannot be regarded as findings of the investigation or indeed an opinion tainted by the findings of the investigation when an allegation of contributing to the Resident's death was never an allegation considered as part of the Home's investigation.*

12. *Finally, if the panel considers it is relevant and fair for the matters to be included, the appropriate weight to be attached to such evidence can be decided by the panel in due course.*

Mr Hussain-Dupré invited the panel to exclude the contested redactions and to permit Ms Leathem to seek to ask questions on those matters subject to your right to object. In his written submission on the admissibility of the content of the statement he stated:

1. *This is an application to exclude evidence on the basis that it constitutes the findings of previous decision makers, on issues which are before the panel in the instant proceedings.*

2. *The application is made under Rule 31 of The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004, which states:*

   31.—(1) Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such

evidence would be admissible in civil proceedings (in the appropriate Court in that part of the United Kingdom in which the hearing takes place).

3. *The Registrant relies on the application of Enemuwe v Nursing and Midwifery Council [2015] EWHC 2081 (Admin), specifically at paras 82-84:*

   82. Although the Committee clearly conducted this whole hearing with the utmost care, and although they clearly demonstrated a capacity to discriminate between the various charges, some of which were found proved and others not proved, there must be a risk here that in some way they allowed themselves to be influenced, even if only peripherally, by their knowledge that all the allegations had earlier been upheld by Ms 2.

   83. What they should in fact have done was decline to admit any evidence by any means of the outcome of the supervisory investigation, and they should have treated the findings and decision of Ms 2 as completely irrelevant and excluded from their consideration by operation of rule 31(1).
   …

4. [Witness 1] *and* [Witness 3] *conducted separate stages of the local investigation. The panel has, unfortunately, had sight of the formal outcome of those proceedings in the Exhibits bundle. It is understood that the NMC agrees that these should in any case be redacted.*

5. *Neither witness was present at the time of the complained of incidents. Although* [Witness 1] *was the manager of the home, at the material time she was on holiday. The understanding and narrative given by each witnesses is therefore wholly derived from evidence gathered during the local investigation.*

6. *It is accepted that both witnesses are able to provide evidence to the panel as to the generic policies and procedures of the Home or BUPA as the employer. They*

may also give evidence as to how the investigations were conducted and what evidence was collected from a procedural perspective. However, it is argued that they should not be permitted to put before the panel as evidence matters which are in fact a composite, reliant on the knowledge gained through the investigation set in the general context of policy and procedure. In various passages of their statements, the commentary provided by both witnesses can only make sense if the maker of the statement has weighed up evidence which they received during the local investigation and made determinations on what did or did not happen, what the Registrant did or did not do, whether any other colleague bore any responsibility and how this ultimately affects the culpability of the Registrant. The effect is to introduce their findings by the back door.

7. *In respect of the findings and outcomes in previous investigations, at para 83 of Enemuwe, Holman J stated that the panel should: 'decline to admit any evidence by any means of the outcome of the supervisory investigation' and it is argued that weight should be attached to 'by any means'.*

8. *The NMC is calling* [Witness 2], *who was a colleague of the Registrant and who was on shift on 13 March 2020 and involved in the incident. The NMC has not called […], the Deputy Manager of the Home, who was on shift on both 12 and 13 March 2020 and also, according to* [Witness 2], *involved in administering care to Resident A. Both gave evidence to the local investigation.*

9. *The evidence of* [Witness 3] *and* [Witness 1] *is problematic in that it presupposes the Registrant's actions and the Registrant being responsible for certain acts or omissions as charged. This can only be based on the findings of the investigation. Whether the Registrant failed to do something relies on there being an obligation for them to do such a thing in the first place. These are matters which the panel must determine and are fundamentally the same questions which were addressed by* [Witness 3] *and* [Witness 1] *in the local investigation.*

10. *Matters are further compounded as* [Witness 3] *is not available to give live evidence and the NMC intends to make a hearsay application in relation to her evidence. Such an application must inevitably be opposed on the basis of further unfairness, should* [Witness 3]*'s witness statement be allowed to stand, without any opportunity to cross examine her.*

11. *Per para 82 of Enemuwe if there is a peripheral risk that the panel, even taking the utmost care, may be influenced by knowledge of the findings of the local investigation then such evidence ought definitely to be excluded. That risk must be elevated if there is a possibility that the evidence of two witnesses strays into the territory of previous findings.*

12. *Accordingly the panel is invited to exclude any relevant sections of the witness statements.*

13. *In respect of the investigatory report, under the heading 'Findings' the Registrant accepts the redactions proposed by the NMC on the basis that the portions which remain are a summary of the investigation and not interspersed with commentary from* [Witness 3].

The legal assessor referred the panel to Rule 31(1). He emphasised the requirements of relevance and fairness when the panel was considering whether to admit evidence. He advised that evidence is generally of higher quality if it derives from the witnesses' own knowledge rather than information they have received.

The legal assessor referred the panel to Rule 22(3)(a), which provides for witnesses to give evidence by examination-in-chief before cross-examination. There is no provision in the Rules for evidence to be given by witness statements, although it was generally convenient to use witness statements where admissibility is in issue. In the case of Witness 1, he advised that there were strong considerations against the panel poring over contentious passages in her witness statement before she gave evidence. Those

contentious passages would be given undue attention if they were not to be admitted. However, there was a benefit in not interrupting constantly a witness during her evidence. The panel should consider the written submissions by both parties, together with their oral submissions, before concluding which approach was preferable.

The panel accepted the legal assessor's advice.

The issue arises at this stage in relation to only Witness 1, as Witness 2's witness statement is not proposed to be further redacted. The panel decided it would be fair and effective to deal with the matters of admissibility as Witness 1 gives her evidence. The panel had read Witness 1's unredacted witness statement. The panel was conscious that it should not be focusing on material which might have to be excluded on the basis that it would be unfair for the NMC to rely upon it.

The panel noted that Witness 1 was giving her evidence from several different perspectives as the Home Manager of the Home, a registered nurse who had been asked to comment on Resident A's hospital records and an investigator who conducted interviews with the registrant and his colleagues. There was a lack of clarity about her evidence and there were already elements of the statement that it was agreed should be redacted. Mr Hussain-Dupré explained that he needed to understand in which capacity the comments are made in order to argue their admissibility and inadmissibility. The panel considered the witness statement and decided that this was reasonable and that this exercise could not be practically done on paper. The panel recognised that this may complicate matters for the NMC in presenting its evidence as there may be objections to some of the supplementary questions asked by Ms Leathem. However, this approach was fairer and more effective than going through Witness 1's statement, sentence by sentence for the contested redactions to be decided upon which would be inappropriate and impractical.

The approach which the panel has decided to take accords with the prescribed process for oral evidence set out in Rule 22(3)a of the NMC Rules which states:

22. *(3) Witnesses –*

(a) shall first be examined by the party calling them;

(b) subject to rule 23(4) and (5), may then be cross examined by the opposing party;

(c) may then be re-examined by the party calling them; and

(d) may then be questioned by the Committee.

On the basis set out above, it was the panel's view that it should deal with admissibility of the contested redactions during Witness 1's oral evidence rather than as a preliminary issue. Further, the panel decided this would be the most appropriate way of determining what is required under Rule 31(1) and the requirements of relevance and fairness.

Decision and reasons on application for hearing to be held in private (Witness 1)

Ms Leathem made an application for the adjournment application to be held in private on the basis there will be references made to Witness 1's [PRIVATE]. She submitted that any public interest in these parts of the case being aired in public session is outweighed by the need to protect her privacy in this respect. This application was made pursuant to Rule 19 of the NMC (Fitness to Practise) Rules 2004, as amended ("the Rules").

Mr Hussain-Dupré made no objections.

The panel accepted the legal assessor's advice.

Having heard that there may be references to Witness 1's [PRIVATE], the panel determined to hold part of the adjournment application which dealt with those circumstances in private.

Reasons for adjournment

Witness 1 was not available to give evidence during the remainder of the hearing listed in December 2023. The application to adjourn the hearing to a date convenient to the panel and Mr Hussain-Dupré was unopposed. The panel decided to grant the adjournment in order to ensure that Witness 1 could give evidence, as her evidence constituted a significant element of the NMC's case.

Resumed hearing

Mr Gutierrez was not present when the hearing resumed on 9 April 2024. Mr Hussain-Dupré submitted that Mr Gutierrez was content for the hearing to continue in his absence. This course was supported by Mr Smalley, who had taken over as the NMC case presenter. The panel decided that there was no good reason for an adjournment and that the hearing should proceed. However, it transpired that Witness 1 was not available on that day. Accordingly, the panel adjourned the hearing to 10 April 2024 when Witness 1 gave evidence.

Charges admitted

The following charges were admitted:

Charge 1a, 2a(ii), 2b and 2c. On 11 April 2024, the panel checked with Mr Hussain-Dupré that these charges were admitted, which he confirmed. Accordingly, these charges were found proved.

Decision and reasons on application of no case to answer

After Mr Smalley had closed the NMC's case, the panel considered an application from Mr Hussain-Dupré that there was no case to answer in respect of charges 1(b), 1(c),

1(d), 1(e) and 1(f), as well as charges 2(a)(i), 2(e), 3(a) and 3(b). This application was made under Rule 24(7).

Mr Hussain-Dupré provided the panel with written submissions, which included the following:

12. *It is accepted that Resident A entered the Home* [PRIVATE]*.* [Witness 1] *also explained that there would have been a specific care plan for a resident with a long term catheter, however, this was also not put before the panel. It is submitted that the panel cannot therefore place any weight on what may or may not have been contained in those documents.*

13. [Witness 1] *also confirmed that during her investigation she did not uncover any evidence of any staff member having a concern about Resident A's condition, until* [Ms 1] *notified the Registrant and* [Witness 2] *of the left sided weakness at around 17:00 on 13 March 2020. While* [Witness 1] *noted that discussions about residents may have been noted in a care risk meeting document, this has also not been produced in evidence. As the local witness statement of* [Mr 1] *and the NMC witness statement and live evidence of* [Witness 2] *omit any mention of concerns, the panel is invited to conclude that there is no evidence that any concerns arose, were raised or discussed either on 12 or 13 March.*

14. *It is submitted that the local investigation was predicated on the fact that there must have been a blatant and obvious concern on 12 March, however, there is insufficient or vague evidence to prove that point, as was accepted by* [Witness 1] *in her evidence.*

15. *It is argued that while* [Witness 3]'s *evidence is relevant to some of the charges, the evidence given by* [Witness 1]*, particularly in regard to whether or not there should have been a concern on 12 March is more definitive in that she was cross*

examined and then answered questions from the panel revealing specific information which is relevant to this issue.

16. *The panel has not received any expert medical evidence to indicate a likely period of deterioration, or when symptoms might have been obvious.*

17. *In the absence of the transcript covering the full cross examination of* [Witness 2] *and questions from the panel, it is submitted that her live evidence was as follows:*
    a. *That she was allocated to looking after the residents upstairs, while the Registrant was stationed downstairs on the smaller unit so that he could also do administration;*
    b. *She had observed that Resident A was eating and drinking less and discussed this with care staff, but the situation was perfectly normal for Resident A and this did not cause her to have any concerns;*
    c. *She did not recall anything that she was told by the Registrant, or any discussions that were had, in relation to Resident A, except that no urine test had been carried out while she was on annual leave;*
    d. *She spoke to Resident A's [relative] and told her that she had no knowledge of Resident A's eating or drinking, but accepted that she did actually have knowledge of both. As a result of the call she cannot recall raising any issue with the Registrant, but she did check Resident A's vitals and they were normal and she therefore had no concerns;*
    e. *She had decided to carry out a urine test but could not obtain a sample due to issues with Resident A's catheter bag, which she changed. Even though she had direct interaction, she did not notice anything abnormal. She failed to actually obtain the requisite sample, despite returning later to check Resident A's vitals when his* [relative] *came to the home and was angry;*
    f. *She intended to call the GP once she had taken the urine sample, but did not;*

g. *She made no record until 19:05;*
h. *She only 'thought' that the Registrant had done a urine test, but she did not ask him about it or any results;*
i. *When the left side weakness was reported to her, both she and the Registrant checked on Resident A and confirmed the weakness and did therefore assess him, but that the Registrant was already waiting for a callback from the GP surgery. When the callback came through, the Registrant called 999 as instructed.*
j. *That it was normal to check with the GP whether an end of life patient with a DNR in place should be sent to hospital, particularly during the Covid-19 pandemic;*
k. *That during part of the day,* [Mr 1] *was present when she was giving Resident A his medication and a drink, but that she did not discuss any concerns with* [Mr 1]*;*
l. *That staff had been told by* [Witness 1]*, the Home Manager, to only record fluid output and not fluid intake*.

In relation to Charge 1b), Mr Hussain-Dupré outlined in his written submissions:

26. It is submitted that there is insufficient evidence to prove that the Registrant had a positive obligation to offer food and drink more regularly, therefore failure is not made out.

27. Further, it is in evidence and [Witness 1] *confirmed that Resident A was already being offered snacks outside normal meal times, that the family had brought in extra snacks and this was part of the care plan for the generalised weight and nutrition issues, resulting in Resident A being mentioned in the weight, nutrition and hydration section of the handover form.*

In relation to Charge 1c), the written submissions outlined:

28. *It is submitted that there is insufficient evidence to prove that the Registrant had a positive obligation to put enhanced monitoring in place on the basis that there were no concerns on 12 March.*

In relation to Charge 1d), Mr Hussain-Dupré outlined in his written submissions:

29. *The NMC has failed to produce any evidence which demonstrates that the Registrant did not check Resident A's catheter on 12 March 2020. The Registrant's own entry in the patient daily record suggests that the catheter was checked and there are no witnesses who can attest to the contrary - as confirmed by* [Witness 1]*'s evidence. This charge falls under Limb 1 of* Galbraith *and accordingly there is no case to answer.*

In relation to Charge 1e), Mr Hussain-Dupré outlined in his written submissions:

30. *It is submitted that there is insufficient evidence to prove that the Registrant had a positive obligation to complete an early warning score sheet.*

31. [Witness 1] *confirmed that the EWS was designed to help nurses crystallise any initial concerns so that they can identify the actual issues with a resident. She was clear that if there was no concern, then an EWS would not normally be completed.*

In relation to Charge 1f), Mr Hussain-Dupré outlined in his written submissions:

32. *It is submitted that there is insufficient evidence to prove that the Registrant had a positive obligation to hand over additional information about Resident A's eating and drinking, beyond the measures which were already in place.*

33. *It was* [Witness 2]*'s evidence that through her discussions with the carers, staff were aware of the issues with Resident A and that his pattern of eating and*

drinking was, according to [Witness 2]*, still normal. This was supported by* [Witness 1] *who said that Resident A often refused food and could be very particular about what he ate.*

34. *The handover sheet for 12 March 2020 confirms that the Registrant had marked Resident A in the section regarding general weight, nutrition and hydration concerns and [Witness 1] gave evidence that this was the appropriate place to document ongoing concerns, and that detailed concerns, if there were any, would be included in the resident's daily record.*

On Charge 2a(i), Mr Hussain-Dupré outlined in his written submissions:

35. *It is submitted that there is insufficient evidence to prove that the Registrant did not possess or obtain enough information to determine that the situation was not an emergency and that the Registrant did in fact make an entry in the daily patient record, which indicates vitals were taken and that there was no concern.*

36. *It was* [Witness 1]*'s evidence that the reduced intake of food and drink was not an emergency and that the Registrant's comment to the relative did therefore accurately reflect Resident A's condition.*

In relation to Charge 2e), Mr Hussain-Dupré outlined in his written submissions:

37. *It was* [Witness 2]*'s evidence that both she and the Registrant went into Resident A's room and checked for the left side weakness which they confirmed. The Registrant then relayed this to the GP and subsequently called 999 as instructed.*

38. *In her witness statement to the local investigation,* [Ms 1]*, the HCA confirms that she notified both the Registrant and* [Witness 2] *of the left side weakness at around 17:00 and that both went into Resident A's room.*

39. *It was* [Witness 1]*'s evidence that it was within the scope of the Registrant's experience and responsibilities to make a clinical judgement as to whether Resident A was indeed suffering from left side weakness, indicating a stroke, and that such a decision would constitute an assessment in those circumstances, with no further enquiry necessary.*

40. *Although* [Witness 1] *gave evidence that she would have called 999 immediately, she also confirmed that the usual process in relation to hospital referral for end of life residents was that the Home staff would call the GP who would then decide. Further, on questions from the panel, that there was no specific provision in the end of life care plan for different eventualities - that it was a blanket refusal of hospital treatment.* [Witness1] *noted that* [Dr 1] *was not the Home's usual GP.* [Witness 1] *also confirmed that in end of life care, a GP would often determine that a resident should not be admitted to hospital for further care and remain in the Home in the interests of dignity and comfort.*

In relation to Charge 3a), Mr Hussain-Dupré outlined in his written submissions:

41. *In dealing with the question of sufficiency of evidence, the panel is invited to consider the NMC's charging guidance (reference INV-4).*

42. *In hearing the Rule 28 application to amend the charges, the Case Presenter for the NMC made clear that her instructions were that this charge remain prefaced with 'intentionally'. The Legal Assessor clarified, for the record, that while the charging guidance INV-4 described an allegation of recklessness, the construction of the Charge 3(b) goes much further and alleges a state of mind where the Registrant deliberately pursued a course of action, intending the outcome. Solely for the purposes of this charge, it is submitted that the 'intentionally' element has the effect of prefacing each of Charges 1 and/or 2(b), (c), (d) and (e) with 'deliberately'. Accordingly the burden lies with the NMC to provide adequate evidence of such a state of mind.*

43. *Relying on the principles in Soni and Maclellan, and without anticipating the Registrant's evidence, the NMC's case relies on notes and summaries of interviews with the Registrant, collected as part of the local investigation. It is submitted that, even if as in* Galbraith*, this was taken at its highest, it remains insufficient to prove the requisite state of mind alleged in this charge, particularly that he pursued a deliberate course of action intending that Resident A would die or at least suffer serious harm.*

44. *Further or alternatively it is submitted that there is insufficient evidence to prove that Charges 2(b) and 2(c) presented a risk to Resident A's safety and wellbeing. On Charge 2(b) the result was that Resident A would normally be attended by a GP, but was in fact attended by paramedics. It is submitted that whether or not there was dishonesty as alleged in Charge 2(d) had no direct consequences to safety and wellbeing as Resident A was in fact transferred to hospital, or that otherwise he would have been seen by the GP.*

45. *Charge 2(e) is rebutted as set out above and therefore its relevance to Charge 3a is similarly refuted.*

In relation to Charge 3b), Mr Hussain-Dupré outlined in his written submissions:

46. *Under the first limb of* Galbraith*, the NMC has failed to produce the necessary expert medical evidence as to causation. It is argued that contribution is an extension to causation and that the two are inextricably linked. Certainly there has been no established causal timeline in relation to the Registrant's alleged acts or omissions and Resident A's death on 22 March 2020.*

47. *While the NMC has made clear that [Witness 1] is not being advanced as an expert witness, for the sake of clarity, it is submitted that in any case, she is not qualified to comment on cause of death or contribution in line with the principle established in* R v Clarke [2013] EWCA Crim 162 *at para 77, that cause of death*

should be reserved to a Home Office registered pathologist, with a higher medical qualification such as the Diploma of Medical Jurisprudence:

“Secondly, we think that the judge was entitled to rule that Professor Freemont did not have the expertise to give an opinion on the cause of death looking at the matter overall. The professor is distinguished in the field of osteoarticular pathology. He specialises in the process of fracture and the generalised disorders of bone known as metabolic bone disease. But he has never conducted a postmortem when there is a suspicion that the cause of death is murder. Such post-mortems are reserved to Home Office pathologists precisely because they have higher qualifications such as the Diploma of Medical Jurisprudence and the experience of assisting with the post-mortems in suspected murder cases. In this very case the first post-mortem by Dr Cvijan had been abandoned because he suspected foul play and the post-mortem had been carried out by Dr Kolar, a Home Office pathologist. Professor Freemont did not have the experience or expertise to consider all the possible causes of death apart from the fractures to the ribs in the way that Dr Kolar could in order to come to his overall conclusion that the cause of death was best regarded as "multiple injuries", where the likely mechanism for the multiple injuries was heavy punches or kicks.”

48. *Although* Clarke *is an authority in criminal law, it is submitted that the seriousness of Charge 3a and Charge 3b in combination, in the way explored by the first Legal Assessor with the previous Case Presenter on record, is such that there is an elevated level of seriousness and that the most rigorous standard should be applied when considering the evidence and determining whether this particular charge can be found proven.*

49. *The panel is respectfully reminded that whether or not the Registrant should or should not have called 999 sooner, or should have directly called 999 is not alleged in the charges and only has a bearing on Charge 3(b) if the panel*

determines that there is evidence which points to the delay contributing to Resident A's death. It is argued that on the evidence no such connection can be made.

50. *Resident A entered the Home as an end of life patient and died in hospital over nine days after being admitted on 13 March 2020. [Witness 1] pointed to inconsistencies with the hospital records, some suggesting that he was improving, others that he remained in a similar condition as on admission. As per* Clarke*, cause of death is an exclusionary process and it is respectfully submitted that the panel is not in a position, nor has it received any evidence, which would allow it to exclude other factors which may have led, either in part or in whole, to Resident A's death. Even on the balance of probabilities, there is insufficient evidence which can point to a role, if any, that the Registrant played in Resident A's death.*

In his oral submissions, in relation to Charge 3(a), Mr Hussain-Dupré drew the panel's attention to the legal advice received on Day 4 of the proceedings, which outlined NMC Guidance on '*Investigating what caused the death or serious harm of a patient (causation)*' (reference: INV-4) and how the charge is intended to read.

He also invited the panel to prefer the evidence of Witness 1 over Witness 3, as she has been subject to cross-examination in these proceedings. He submitted that she has given clear evidence which undermines Witness 3's evidence.

With regard to Charge 3(b), Mr Hussain-Dupré submitted that contribution and causation are inextricably linked. He further submitted that, even if there were multiple contributors to an incident, the NMC would need to prove the causation, and each contributor needs to be proven on the evidence.

Mr Smalley outlined the legal basis for this application, and he drew the panel's attention to both Rule 24(7), as well as the second element outlined in the case of

Galbraith. He provided the panel with an evidence matrix from the NMC setting out the evidence it wishes to rely on for each charge.

With regard to the phrase ‘contributed’, Mr Smalley submitted that the NMC has charged Mr Gutierrez with contributing to Resident A’s death, rather than causing it. He further submitted that there were a number of causes to Resident A’s death, and he submitted that the NMC does not need to prove each cause. He submitted that the failure of care surrounding Resident A’s UTI and/or stroke was one of the causes, and it is the NMC’s case that causation means the effect of the failures of care was more than merely negligible. Mr Smalley submitted that, in this case as a whole, there is a prima facie case as to the clinical failure of care concerning Resident A’s UTI and/or stroke being one of the causes of Resident A’s death.

Mr Smalley submitted that Mr Gutierrez would have been aware of the risks posed to Resident A through clinical failures surrounding UTI and/or stroke care. He further submitted that it is not the NMC’s case Mr Gutierrez intended the outcome, but that he intentionally took the risk in that case. He submitted that this intention can be inferred from acts, as outlined in the evidence, as well as the knowledge expected of Mr Gutierrez around the clinical care required in handling a UTI and/or stroke.

The panel took account of the submissions made and accepted the advice of the legal assessor. He referred to *Galbraith*. He advised that the allegation of failure required proof of a breach of duty. He advised that the allegation that a registrant caused the death of a resident was very serious; it required cogent evidence to establish it, and that such evidence would normally need to be given by an expert medical practitioner.

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

Mr Hussain-Dupré made a general point in respect of Charge 1 that the failures particularised in that charge all depended upon the registrant having breached a duty in respect of Resident A. He submitted that nothing in the evidence received by the panel demonstrated that Mr Gutierrez had a duty to act as set out in charges 1(b)-(f), sub charge 1(a) already having been proved by admission.

The panel considered the evidence before it and the obligations upon all registered nurses to prioritise people in their care and practise effectively and safely, as set out in the NMC Code.

In relation to Charge 1b), the panel considered the documentary evidence from 12 March 2020, which is the primary evidence of the condition of Resident A on that date. The NMC evidence matrix refers to the evidence of Witness 3 and the notes of the clinical walk round. Witness 3 gives her opinion of the steps that the registrant should have taken, with the benefit of hindsight, but is not able to comment on Resident A's usual condition and the changes in that condition that she believes would have raised a concern and therefore a duty to act. The clinical walk round document mentions Resident A is *'poorly monitor closely'* but covers a full week of care and the entry is undated.

The panel considered the oral evidence of Witness 1 who was clear that Resident A was already being offered snacks outside normal mealtimes, that the family had brought in extra snacks, and this was part of the care plan for the generalised weight and nutrition issues experienced by Resident A.

The panel noted Resident A's Food Intake Diary dated 12 March 2020 which states that he ate a breakfast of porridge and later a chocolate bar, half a packet of crisps and a strawberry mousse.

The panel therefore considered that there was insufficient evidence in the NMC case to establish that the condition of Resident A on 12 March 2020 gave rise to a duty, or a

positive obligation, on the registrant to ensure Resident A was offered food and drink more regularly, that is, as an additional step over and above the existing care plan. The panel determined that, in the absence of evidence showing a significant change in Resident A's condition on 12 March 2020, there is insufficient evidence to indicate there is a case to answer.

In respect of Charge 1c), the panel again considered the documentary evidence from the 12 March 2020, which is the primary evidence of the condition of Resident A on that date. The NMC evidence matrix refers to the evidence of Witness 3, Witness 1 and the notes of the clinical walk round. Witness 3 gives her opinion of the steps that the registrant should have taken, with the benefit of hindsight, but is not able to comment on Resident A's usual condition and the changes in that condition that she believes would have raised a concern and therefore a duty to act. The clinical walk round document mentions Resident A is '*poorly monitor closely'* but covers a full week of care and the entry is undated.

The statement of Witness 1 sets out that *'signs of deterioration'* should be acted upon, but in her oral evidence Witness 1 accepted that the significant sign of deterioration was the left sided weakness, which did not occur until 13 March 2020. The panel heard that Resident A was receiving end of life care and had a care plan for the generalised weight and nutrition issues he experienced. Witness 1 stated that his eating and drinking normally fluctuated and this would be expected for someone in his condition. The panel therefore considered that there was insufficient evidence in the NMC case to establish that the condition of Resident A on 12 March 2020 gave rise to a duty, or a positive obligation, on the registrant to ensure Resident A was subject to enhanced monitoring, that is, as an additional step over and above the existing care plan.

The panel determined that, in the absence of evidence showing a significant change in Resident A's condition on 12 March 2020, there is insufficient evidence to indicate there is a case to answer.

In relation to Charge 1d), the panel again considered the documentary evidence from 12 March 2020. The panel considered the documentation before it confirms that Mr Gutierrez did check the catheter. Accordingly, the panel determined that there is no case to answer in respect of this charge.

In relation to Charge 1e), the panel again considered the documentary evidence from 12 March 2020, which is the primary evidence of the condition of Resident A on that date. The NMC evidence matrix refers to the evidence of Witness 3, the notes of the clinical walk round and the notes of an investigation meeting between Witness 3 and the registrant dated 14 April 2020. Witness 3 gives her opinion of the steps that the registrant should have taken, with the benefit of hindsight, but is not able to comment on Resident A's usual condition and the changes in that condition that she believes would have raised a concern and therefore a duty to act. The clinical walk round document mentions Resident A is *'poorly monitor closely'* but covers a full week of care and the entry is undated. The notes of the meeting of 14 April 2020 confirm that no early warning score sheet was completed but don't assist the panel with the changes in Resident A's condition that would have given rise to a duty to complete one.

The panel therefore considered that there was insufficient evidence in the NMC case to establish that the condition of Resident A on 12 March 2020 gave rise to a duty, or a positive obligation, on the registrant to complete an early warning score sheet. The panel determined that, in the absence of evidence showing a significant change in Resident A's condition on 12 March 2020, there is insufficient evidence to indicate there is a case to answer.

On Charge 1f), the panel considered that there is no documentation indicating that a handover was completed on 12 March 2020. The duty to document or otherwise make colleagues aware of Resident A's condition is not purely based upon a significant change in his condition. The registrant has already admitted that he failed to document Resident A not having eaten or drank well. This absence was considered alongside the

Disciplinary Hearing notes dated 1 May 2020, on Mr Gutierrez's response to questions concerning a handover:

> *'AW…did you put your resident on the handover? Did you write that he needed to be monitored overnight?*
>
> *AG: No I was preoccupied'*

The panel determined that, whilst it has not yet determined the weight of this evidence, there is sufficient evidence to indicate there is a case to answer in respect.

In relation to Charge 2a)i), the panel considered Witness 3's witness statement, as well as the Investigation Meeting notes, dated 14 April 2020. The panel noted that the information before it indicated that Mr Gutierrez assessed Resident A at 15:10, and the telephone call from the resident's family member was received later in the evening, at around 19:00. The panel considered that, according to Witness 3's witness statement, Mr Gutierrez appeared to have informed Resident A's family member that Resident A had not eaten or drank much, but it was not an emergency, according to his assessment. The panel was unable to determine what further assessment was expected of Mr Gutierrez at that stage, and consequently, the panel was unable to identify evidence supporting the *'insufficiency'* element of this charge. Accordingly, the panel determined that there is no case to answer in respect of this charge.

With regard to Charge 2e), the panel considered Witness 2's evidence and witness statement, which indicated that there is no written documentation of Mr Gutierrez's assessment. This implies that there may well have been no assessment made by Mr Gutierrez, in circumstances when, as there is evidence he had been informed by carers of Resident A's left sided weakness, he should have made such an assessment.

The panel determined that, whilst it has not yet determined the weight of this evidence, there is sufficient evidence to indicate there is a case to answer.

Charges 3a) and 3b) are both very serious charges. Charge 3a) alleges Mr Gutierrez intentionally took an unreasonable risk with Resident A's safety and wellbeing. Charge 3b) alleges that his actions contributed to Resident A's death.

The NMC guidance on 'Investigating what caused the death or serious harm of a patient (causation)' is engaged. The guidance states:

> *'For this reason we'll only focus on whether the nurse, midwife or nursing associate's clinical failings caused the death or serious injury of a patient if it's clear that the nurse… deliberately chose to take an unreasonable risk with the safety of patient or service users in their care.'*

It follows from this guidance that charge 3a) should be interpreted as an allegation Mr Gutierrez was taking a deliberate risk.

In relation to Charge 3a), the panel considered that the evidence available before it indicated some inaction from Mr Gutierrez with respect to the matters raised in the charges. The panel gave careful consideration to Witness 1's evidence. The panel had no material before it from which a panel could properly infer any intention on Mr Gutierrez's part to take an intentional risk with Resident A's safety and wellbeing. On the contrary, the admitted allegations at charge 2b) and 2c) that he advised the GP of a positive UTI test is consistent with seeking help for Resident A from the GP rather than taking a risk with Resident A's safety. Accordingly, the panel determined that there is no case to answer in respect of this charge.

In relation to Charge 3b), the panel considered paragraphs 26 and 27 of Witness 1's witness statement, which detailed Resident A's death. Witness 1 is a qualified nurse, who was employed at the same home as Mr Gutierrez. The panel determined that Witness 1 was not an expert witness, qualified to give evidence as to the causes of death of Resident A.

There was evidence before the panel which indicated that Resident A suffered from a UTI on 13 March 2020. The death certificate identified a UTI as one of the causes of death on 22 March 2020, along with the use of a long term catheter. Other significant conditions contributing to the death are listed as cerebrovascular disease and dementia.

If a panel were to find that Mr Gutierrez's actions had caused or contributed to Resident A's death it would have been necessary for it to be provided with cogent expert evidence upon which it could rely. This would have to be given by a competent doctor who had given full consideration to Mr Gutierrez's actions and their impact, along with any other relevant circumstances, on Resident A. No such evidence was provided to the panel.

This hearing commenced in November 2023. There had been no preliminary meeting under Rule 18. By the time the hearing was adjourned on 7 December 2023, the issues in relation to causation and the problems in relation to Witness 1's giving evidence of causation had been clearly identified. No steps were taken to adduce expert evidence by either party before the hearing resumed four months later on 9 April 2024. There would be no point now in directing the NMC to seek expert evidence in relation to this allegation, given that the NMC had plenty of opportunity to do so before.

Accordingly, the evidence before the panel does not support that any of the actions in charges 1, 2b), 2c), 2d) and 2e) contributed to Resident A's death and there is no case to answer in respect of charge 3b).

Supplementary reasons pursuant to Mr Smalley's request

The panel had handed down its determination on the application of no case to answer on 12 April 2024. On the next hearing day, 15 April 2024, Mr Smalley, who was not the case presenter during the first part of the hearing in November/December 2023, invited

the panel to expand on its reasons in respect of charge 3b). He queried whether the panel had not followed NMC Guidance in relation to its responsibility to ask the NMC to obtain further evidence, if the panel is concerned that there are gaps in the evidence which will prevent it from properly performing its function.

The legal assessor advised that the panel had a discretion to take this course, in line with the general rule in civil proceedings explained in *English v Emery Reinhold & Strick* [2002] EWCA Civ 605.

In dealing with the point raised by Mr Smalley, it is necessary to go back to the early stages of the hearing. The question of whether the NMC should seek additional expert evidence was raised as a live issue before the panel on 28 November 2023. Mr Hussain-Dupré raised the issue as to whether Witness 1 could properly be considered an expert for these purposes and the legal assessor also queried this point. The hearing was adjourned to enable a senior NMC lawyer to be contacted by Ms Leathem, the then case presenter. That review took place. The panel's understanding was that, having considered their position and the available evidence, the NMC did not propose to seek additional expert evidence. Only when that review had taken place did the panel proceed with the case.

This issue was then aired in the hearing, as the extract from the transcript from 30 November 2023 shows. The electronic transcript contains many imperfections and has been corrected below to what the panel believes was said.

> *"Anna Leathem (Case Presenter): The grammatical change, yes, that's the only proposed amendment I have taken full instructions or on both 3A and B and that my instructions are that they remain as they are.*
>
> *Lucia Whittle-Martin (Legal Assessor): Yes, thank you. So in those circumstances, but then before we set sail on the basis of the allegation as drafted, I think I have a duty to seek absolute clarity on what it is that the NMC*

are alleging, so that the registrant understands what it is that he has to meet. So starting then with charge 3B that perhaps speaks for itself. It's alleging is, is it not that the registrant has caused at least in part, Resident A's death, and can I just ask you to confirm for the record that the NMC are content in that regard, that they're in a position to call evidence from a witness? Who has suitable expertise to deal with that issue?

Anna Leathem: Yes, the NMC are satisfied that there is sufficient evidence. To support a contribution to death.

Lucia Whittle-Martin: Thank you and I appreciate some of these points may be visited, revisited by Mr Hussain-Dupré at a later stage, but I just wanted to check that these points have been thought through, before we go any further as well."

The NMC's case remained open during the long adjournment between 7 December 2023 and 9 April 2024 and additional evidence could have been obtained to fill any gaps in their case.

On the resumption of the case on 9 April 2024, Mr Smalley confirmed that Witness 1 was not to be presented as an expert witness by the NMC.

Following a submission of no case to answer, the panel decided that there was no material before it from which a panel could properly conclude that Mr Gutierrez intentionally took an unreasonable risk with Resident A's safety and wellbeing (Charge 3a)).

When considering whether Mr Gutierrez's actions contributed to Resident A's death, the panel did not accept Witness 1's opinion evidence as expert evidence and found no evidence on which a panel could rely to find that Mr Gutierrez contributed to Resident A's death (Charge 3b)).

In the panel's judgment, it would have been very unfair to Mr Gutierrez if before ruling on the application of no case to answer, it had directed that the NMC seek evidence from a competent doctor when the matter had been raised, as set out above, in November 2023. It would have caused significant extra expense and delay, in a case which is now more than four years since the events in question. It may well have been the case that a competent doctor would not have been able to provide an opinion which supported the NMC case.

Moreover, the panel's finding that there was no case to answer in respect of charge 3a), the charge that Mr Gutierrez intentionally took an unreasonable risk, meant that, assuming the NMC would follow its own guidance, the NMC would not seek to adduce this expert evidence.

As explained above under the reasoning in relation to charge 3a), the NMC guidance on 'Investigating what caused the death or serious harm of a patient (causation)' states:

> *'For this reason we'll only focus on whether the nurse, midwife or nursing associate's clinical failings caused the death or serious injury of a patient if it's clear that the nurse… deliberately chose to take an unreasonable risk with the safety of patient or service users in their care.'*

Consequently, it appeared to the panel that Mr Smalley was right to concede during discussions, that the question of whether the panel should have invited the NMC to apply for an adjournment to seek expert evidence was academic, because the NMC would not have sought such evidence in the light of the panel's finding no case to answer in relation to charge 3a).

Decision and reasons on application to amend the charge

On 15 April 2024, the panel heard an application made by Mr Smalley, on behalf of the Nursing and Midwifery Council (NMC), to amend charge 2d). He submitted that the

charge would be better expressed if it was made clear that the panel was asked to consider Mr Gutierrez's conduct at charge 2b) and 2c) both cumulatively and alternatively. He therefore invited the panel to consider the following amendment:

> *"Your conduct at charge 2b)* ***and/or*** *2c) was dishonest in that you were attempting to create a false impression that you had taken a urine sample and that it was positive for a UTI when you had not done so."*

Mr Hussain-Dupré opposed the application and submitted that it is ultimately up to the panel to decide whether to allow the amendment. However, he conceded that he would not have approached the presentation of Mr Gutierrez's case in a different way if this amendment had been made earlier in the hearing.

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 an amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to Mr Gutierrez and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Background

Mr Gutierrez is a registered nurse, whose name was first entered in the NMC register on 29 January 2002. He was referred to the NMC on 18 September 2020. At the time of the concerns raised, he was working as the unit manager and head of care at the Home). He had been employed at the Home in various roles since 2003.

The charges all concern one resident within the home, namely Resident A and the care he is alleged to have received shortly before his admission to hospital on 13 March 2020. Resident A originally came to the Home for end of life care. He had a history of Parkinson's, Urinary Tract Infections ('UTIs') and was at risk of falls. He was admitted to the Home with a catheter, which meant he was at increased risk of UTIs.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Smalley on behalf of the NMC and by Mr Hussain-Dupré on Mr Gutierrez's 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: Home Manager and a registered nurse.
- Witness 2: Registered nurse at the Home.

The panel read the statement of Witness 3 who was the local investigating officer and the regional support manager for Bupa. Witness 3 was not a registered nurse.

The panel also heard evidence from Mr Gutierrez under oath.

Before making any findings on the facts, the panel accepted the advice of the legal assessor. He advised the panel that the civil standard of proof applied, but that cogent evidence was required if the panel was to find dishonesty.

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

Charge 1f)

That you, a registered nurse:

1) On 12 March 2020:

f) Failed to handover or otherwise make colleagues aware that Resident A had not eaten or drank well on 12 March 2020.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence from Witnesses 1, 2 and 3, Resident A's Daily Notes, Food Intake Diary, Fluid Intake Diary, The Handover Document for 12 March 2020 and also Mr Gutierrez's evidence.

The panel considered the evidence before it and found the Handover sheet had Resident A listed in the box *'weight loss/poor nutritional intake/dehydration'* and the panel noted that the document had been seen and signed by the registered nurse on the night shift. The panel noted that Mr Gutierrez did not have any new concerns regarding Resident A's eating or drinking to those that had already been documented in Resident A's care plan and for which his end of life care plan stated he would need prompting for meals and medications. The panel had sight of Resident A's Daily Notes, Food Intake Diary, and Fluid Intake Diary where the carers had recorded the details of Resident A's eating and drinking. Mr Gutierrez recorded his observations of Resident A in the Handover Document. The panel considered Witness 2's evidence but found that

she was not present on 12 March 2020. The panel concluded that there was no evidence presented by the NMC that something new had happened that raised more concern and therefore required an additional level of handover.

The panel also considered Witness 3's statement and her opinions regarding Mr Gutierrez's actions. It determined that her opinions were based on the view of Resident A's presentation on 12 March 2020 as being out of the ordinary. The panel heard evidence from Witness 1 and Witness 2, both of whom knew the resident and were actively involved in his care. They were both clear that Resident A had longstanding issues with eating and drinking; this was addressed within his care plan and was part of his normal presentation. The panel preferred the evidence of Witness 1, Witness 2 and Mr Gutierrez in this respect.

In the panel's opinion, the concessions made by Mr Gutierrez in the course of the local investigation reflected his readiness to accept blame, in hindsight, and are not to be regarded as conclusive, in the light of the other evidence referred to above.

The panel therefore determined that Mr Gutierrez had done what was necessary regarding Resident A and this charge is found not proved.

Charge 2d)

That you, a registered nurse:

2) On 12 March 2020:

d) Your conduct at charge 2b) and/or 2c) was dishonest in that you were attempting to create a false impression that you had taken a urine sample and that it was positive for a UTI when you had not done so.

This charge is found proved.

In reaching this decision, the panel took into account Mr Gutierrez's evidence.

Mr Gutierrez admitted to charges 2b) and 2c) early on in the proceedings. He admitted in his evidence that no urine test had been done. The panel determined that he knew it was not true that Resident A had tested positive for a UTI when he called the GP surgery, and he knew that it was not true when he wrote this information on the handover note. The panel found that as a registered nurse he should have acted with integrity by not providing to another healthcare professional or recording on contemporaneous records, false information claiming that something had happened, when it had not.

The panel took into account the contextual factors at the time of the incident. Mr Gutierrez said that Resident A's relative was in the office when he was making the call to the GP surgery, and he felt under pressure to do something. He panicked and felt he had to do "*something more clinical*". He said that he felt intimidated by the relative.

The panel also considered Mr Hussein-Dupré's written submissions:

> '*In his evidence in chief the Registrant asserted that if he had called after 17:00, the GP would not have come out, and that if there were concerns an ambulance would need to have been called. It is submitted that this runs counter to the objectives of end of life care in the Home. The Registrant also explained that 13 March was a Friday and a day when the regular GP should normally have come to the home, but because of the Covid-19 pandemic had not attended. It is submitted that this provides additional context to the difficulties in getting a GP to see a resident'*.

The panel had regard to Mr Gutierrez's admission in oral evidence that giving false information in this way was dishonest. The panel considered the objective test which it is required to consider as to whether Mr Gutierrez's actions were dishonest by the standards of ordinary and decent people. The panel concluded that his actions in

relation to both 2b) and 2c) were dishonest, but at the lower end of the spectrum for dishonesty. It considered that the purpose of his dishonest actions was to get Resident A medical assistance from a GP in difficult circumstances during a pandemic.

The panel therefore concluded that this charge is found proved.

Charge 2e)

That you, a registered nurse:

2) On 12 March 2020:

e) Failed to assess Resident A when you were advised by carers that he had left sided weakness.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence and Mr Gutierrez's evidence.

The panel considered that Mr Gutierrez had been made aware of Resident A's left side weakness by carers at approximately 17:00. When Mr Gutierrez was alerted, he and Witness 2 both went to Resident A's room, and he did a brief physical assessment of Resident A and saw that his left arm was weak. Witness 2, in oral evidence, said that she could not remember whether Mr Gutierrez checked Resident A whilst she was briefly in the room and mentioned that she left the room to continue her medication round. The GP had already been contacted about Resident A in respect of another issue before Mr Gutierrez went to Resident A's room and he was at that time awaiting a call back from the surgery.

The panel also considered the daily notes and noted that Witness 2 had documented the events on Mr Gutierrez's behalf, and he agreed that he should have documented

his assessment himself. Mr Gutierrez did not ignore the carers' concern and did complete a basic assessment from which he concluded that Resident A needed medical advice from the GP. Further steps could have been taken; however, to characterise this as a failure to assess would not be correct.

In Mr Gutierrez's statement,

> *'At around 17:00 the care staff reported general left side weakness in Resident A. I happened to be near the door of Resident A's room and* [Witness 2] *was in the opposite room. We both went into the room at the same time to assess the weakness. I raised Resident A's left arm to confirm the weakness. We checked the baseline observations, which were normal, and confirmed left side weakness.* [Witness 2] *and I talked about the observations. In my view at the time I immediately thought it was a stroke. I said to* [Witness 2] *that we would wait for the GP to call back.*

The panel found that Mr Gutierrez made concessions and was frank when giving evidence. The panel believed his account of the events. In his statement he said that the daily notes were written by Witness 2,

> *'While I was updating the handover sheet,* [Witness 2] *offered to make the entries on the daily patient record, which she did at 19:05. This included everything from the shift and should have included that we had assessed the left side weakness. She did mention some things that I had done. I do not know why she did not document the assessment for the weakness. At 20:20 she finalised the recording, including that Resident A had been attended by paramedics, even though she was not involved…'*

The panel therefore determined that this charge is found 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. Before hearing submissions, the panel suggested that it would be appropriate to hear submissions only on misconduct in the first instance and then hand down a determination on misconduct, before considering any evidence and submissions in relation to impairment. The reason for taking this course was to inform the panel's decision on the admissibility of a disputed document. The panel's suggestion was agreed by Mr Smalley and Mr Hussein-Dupré.

Submissions on misconduct

Mr Smalley invited the panel to take the view that the facts found proved amount to misconduct.

Mr Smalley submitted that the facts found proved fall under three areas: communication with either colleagues or with family members, record keeping, and honesty and integrity. Mr Smalley said that these three areas are key elements of good and safe nursing practice. He identified the specific, relevant standards of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) as being 5.5, 8.2, 8.6, 10.1, 10.3, 20.1 and 20.2. He submitted that all the charges found proved amounted to misconduct.

Mr Hussain-Dupré submitted that the misconduct in Mr Gutierrez's case would need to be serious to meet the threshold. He submitted the following in respect of the charges found proved. Charge 1a) was identified as a minor concern and that there was documentary evidence in respect of handover and Resident A's care plan. In respect of charge 2aii) as a registered nurse, it was less than ideal for Mr Gutierrez not to arrange to call the relatives back or to handover the conversation to another nurse. However, Witness 2 was able to speak to Resident A's relative and no impact was caused in the absence of Mr Gutierrez letting her know. This was not serious enough to amount to misconduct.

Mr Hussain-Dupré submitted that in respect of the dishonesty charges this was at the lower end of the spectrum as identified by the panel and it was to facilitate help for Resident A. He said Resident A's care was not compromised. He referred the panel to *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and said that Mr Gutierrez's actions would not be regarded as deplorable by other nurses given the context of the circumstances at the time. He said that Mr Gutierrez accepts that there were failings, but this was a discrete matter that was not an ongoing course of behaviour. He submitted that a breach of professional duty must be serious enough to amount to misconduct.

The panel accepted the advice of the legal assessor who advised that a breach of professional duty must be serious if it is to amount to misconduct. He referred to *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Johnson and Maggs v Nursing and Midwifery Council* (No 2), [2013] EWHC 2140 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mr Gutierrez's actions did fall short of the standards expected of a registered nurse, and that the following elements of the Code were engaged:

> ***'5.5*** *share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand*
>
> ***8.2*** *maintain effective communication with colleagues*

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

8.6 *share information to identify and reduce risk*

10.1 *complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

10.3 *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

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

20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'*

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

The panel considered the facts found proved individually and identified in respect of charge 1a) that Mr Gutierrez had completed some relevant documentation and that in any event this information was readily available. It was primarily the duty of the carers to update Resident A's Food Intake Diary and Fluid Intake Diary records which they had done, in detail. Resident A's care plan existed and although the concern about Resident A's nutrition continued there was nothing new on 12 March 2020 that was of concern that required additional recording. Mr Gutierrez had completed the handover sheet and had made an entry on Resident A's daily notes. The panel found that although Mr Gutierrez's daily note could have been clearer, his failing was not serious enough to amount to misconduct.

In respect of charge 2aii) the panel was of the view that it would have been best practice for Mr Gutierrez to have contacted Resident A's relatives to update them following his conversation with them on 12 March 2020, and for that conversation to be recorded in the appropriate communication log. However, the conversation was straightforward in that there were no new concerns raised on 12 March 2020. It would also have been best practice for Mr Gutierrez to have handed over his conversation with the relatives to Witness 2 on 13 March 2020. However as stated above there were no new concerns raised at that stage. The panel determined that Mr Gutierrez's omission was not serious enough to amount to misconduct.

The panel determined that the untrue statements set out at charges 2b) and 2c), which the panel has found to be dishonest, constitute misconduct. The panel has borne in mind its previous finding that this dishonesty was at the lower end of the spectrum, but providing false clinical information to a healthcare professional and creating an intentionally incorrect record are sufficiently serious to be characterised as deplorable by nurses and the general public.

The panel therefore determined that Mr Gutierrez's actions at charges 2b), 2c) and 2d) amounted to misconduct.

Decisions and reasons on the application to admit unredacted witness statements and exhibit KE16

Before the panel moved on to consider current impairment, it heard submissions from Mr Smalley and Mr Hussain-Dupré on whether unredacted versions of Witness 2 and Witness 3's statements, and exhibit KE16 should be admitted into evidence.

Mr Smalley submitted that the contents of Witness 2 and Witness 3's statements go to previous disciplinary concerns that were raised against Mr Gutierrez in 2015 and that exhibit KE16 was a letter dated 4 November 2015 with the outcome of the disciplinary hearing.

Mr Smalley submitted that the concerns raised were similar to the circumstances in Mr Gutierrez's current case and indicate that this may not have been a one-off incident, and therefore this incident from 2015 was relevant to be considered by the panel. He referred the panel to the case of *Nicholas-Pillai v General Medical Council* [2009] EWHC 1048 (Admin). He submitted that the panel are entitled to take into account, at a stage in which they are determining whether fitness to practise is impaired, material other than the allegations that it has considered. He said that Mr Gutierrez's previous work history is something that is extremely relevant to the panel's determination and should therefore be considered.

Mr Hussain-Dupré submitted that it would be wholly prejudicial and unfair to Mr Gutierrez to admit this evidence at this stage of the proceedings. He submitted that the previous incident in 2015 would not be able to be discussed with Witness 2 and Witness 3 as they are not present at the hearing, that their evidence contained inconsistencies with exhibit KE16 and therefore to admit this evidence would in fact require a hearing within a hearing as to the details of the previous incident. Further, Mr Hussain-Dupré submitted that the author of the letter exhibited at KE16 was not present at this hearing and was someone entirely different to Witness 3. He submitted that the contents of KE16 are irrelevant to the only charges the panel found amounted to misconduct.

The panel accepted the advice of the legal assessor, who referred the panel to Rule 31 and the requirements of fairness and relevance.

In order for the panel to make a decision on the admissibility of the unredacted witness statements of Witness 2 and Witness 3, and also KE16, the panel decided it would have to review the documents.

The panel determined that the documents provided related to a previous concern that occurred in 2015 and resulted in Mr Gutierrez having a 12 month written warning, which was accepted. This alleged incident was not referred to the NMC at the time and was not charged as part of this current case. In the panel's judgement, the evidence was not

relevant to the only charges that amounted to misconduct, of which the main significance is Mr Gutierrez's dishonesty. It would be unfair to Mr Gutierrez if this evidence was admitted as the incident is not relevant to the current decision making process.

For these reasons, the panel decided not to admit either the unredacted witness statements of Witness 2 and Witness 3, or the letter dated 4 November 2015 into evidence.

Submissions on impairment

Following the panel's decision on misconduct, it moved on to consider whether, in all the circumstances, Mr Gutierrez's fitness to practise is currently impaired.

The panel heard evidence from Mr Gutierrez under oath. He put forward a further reflective piece and was cross-examined.

Mr Smalley addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. He referred to *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v GMC* [2007] EWHC 581 (Admin).

Mr Smalley said the panel will have to consider the *Grant* test and whether Mr Gutierrez has in the past and/or is liable in the future to act so as to put patients at unwarranted risk of harm, has in the past and/or is liable in the future to bring the profession into disrepute, has in the past and/or is liable in the future to breach one of the fundamental tenets of the profession, and has in the past and/or is liable in the future to act dishonestly. Mr Smalley submitted that all four limbs are engaged and that Mr Gutierrez in cross examination accepted that they were engaged.

Mr Smalley submitted that accurate record keeping in clinical records is of paramount importance to the safe care of patients and honesty is a fundamental tenet of the nursing profession. He submitted that if there is a risk of further dishonesty in clinical records, there is a risk of harm to patients. This is in breach of a fundamental tenet of the profession and therefore brings the profession into disrepute. Further, he submitted that the fourth limb on dishonesty is engaged as the panel found two dishonesty charges proven.

Mr Smalley submitted that impairment is a forward looking exercise and referred the panel to the case of *Cohen.* He said that the panel must consider whether a concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated. He submitted that dishonesty is identified by the NMC as a concern that is more difficult to put right and he referred the panel to the NMC's guidance on seriousness at FTP-3a which identified falsifying records as a concern that is more difficult to put right. Mr Smalley submitted that if the panel find that the dishonesty concern has not been remedied, then there is a risk of repetition, that if Mr Gutierrez was placed in a similar situation, that he could act dishonestly again, thereby placing patients at risk of harm. Mr Smalley invited the panel to find Mr Gutierrez impaired on grounds of public protection.

Mr Smalley submitted that accurate record keeping is of paramount importance to the safe care of patients and dishonest conduct in relation to clinical records is at the height of seriousness. Public confidence in the profession would be undermined if a finding of impairment on public interest grounds were not made.

Mr Hussain-Dupré provided written submissions, which included the following passage:

> *'19. It is submitted that the Registrant's conduct in respect of the dishonesty charges which have been found to constitute misconduct does amount to an isolated incident and is not indicative of a deep-seated attitudinal issue which*

cannot be remediated. No harm was suffered by Resident A in relation to the dishonesty and the Registrant did not stand to gain from his dishonesty. As the panel has already accepted, his actions were at least in part to secure medical care for Resident A, but those actions were clearly misguided and a lapse in judgement which cannot be justified. The Registrant has acknowledged this. However, impairment is a consideration of whether the Registrant is currently impaired, set against the backdrop of what happened earlier. It is therefore argued that per Grant, the Registrant would not pose a continuing risk to the public if he was allowed to resume practising.

20. In relation to public interest, it is submitted that a single incident lapse of judgement, over the course of a few hours, in an otherwise unblemished career is unlikely to diminish the public's trust in the regulator or in the profession, particularly as no harm was suffered as a result. The panel has determined that the dishonesty was at the lower end of the spectrum and it is submitted that this would also be a factor in how the public might perceive the transgression and how it reflects on the profession. Confidence in the NMC as a regulator is maintained through the panel's finding of misconduct and holding the Registrant to account by identifying the serious nature of his conduct, which remains a matter of record, even if the panel were to find that the Registrant is not currently impaired. The Registrant has placed particular emphasis in his evidence on upholding the values set out in the NMC Code and it is argued that the risk or likelihood of repetition is low (per Cohen). This is not part of a repeated pattern of behaviour which would suggest that the Registrant has a propensity to be dishonest, or a situation where the dishonesty somehow furthered his own interest.

21. In answer to the NMC's test as to whether the Registrant can practise kindly, safely and professionally, the panel has heard from the Registrant himself as to his general approach to nursing and prioritising patient care, so it must be assumed that he can practise kindly. It is argued that the very limited misconduct

at the lower end of the spectrum, which this case has been narrowed to, is such that the Registrant can also return to nursing and practise safely and professionally.'

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

'The question that will help decide whether a professional's fitness to practise is impaired is:
"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"
If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. At 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.'

At 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that where clinical records are not accurate and create a false impression patients would be put at unwarranted risk of harm. Mr Gutierrez's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was satisfied that confidence

in the nursing profession would be undermined if its regulator did not find these charges relating to dishonesty did not give rise to a finding of impairment.

Regarding insight, the panel considered that Mr Gutierrez had made admissions to the charges, fully engaged with his regulator and demonstrated an understanding of how his own actions at the time put Resident A at risk of harm and the impact it had on colleagues, the family of Resident A and the nursing profession. The panel had regard to Mr Gutierrez's reflection statement and his oral evidence that demonstrated what he would do differently in the future if a similar situation were to occur. It noted the 10 positive testimonials that attested to Mr Gutierrez's care as a registered nurse from colleagues who he had worked with in the Home and the relative of a former resident. The panel also considered that Mr Gutierrez has not been able to work in a healthcare setting since being dismissed from the Home but has actively sought guidance and mentorship from a Renal Practice Development Nurse Lead, who provided a reference. The nurse stated the following in a reference dated 12 November 2023:

> *'Antonio has actively sought guidance and mentorship from me, demonstrating a genuine desire to learn from his mistakes and grow as a practitioner. We have been having a weekly catch-up via video conference. He has engaged in regular reflective discussions, where he openly acknowledges the impact of his actions and expresses remorse for any harm caused. While I am aware of Antonio's previous misconduct, I firmly believe that individuals can learn from their mistakes and grow both personally and professionally. Antonio has taken responsibility for his actions and has actively sought opportunities for self-reflection and improvement he has regular reflective discussions.'*

The panel is aware that this is a forward-looking exercise and accordingly, it went on to consider whether Mr Gutierrez's misconduct was remediable and whether it had been remediated. The panel then considered the factors set out in the case of *Cohen.* It was satisfied that the misconduct in this case is capable of being addressed. It determined that this was an isolated incident at the start of the Covid-19 pandemic. Mr Gutierrez

was motivated by the difficulty at that time of obtaining GP care for a resident. This was the context of his providing false information to the receptionist at the GP surgery. His false record entry on a handover document arose at the end of the shift in relation to the same resident.

The panel considered the NMC guidance at FTP-3a which deals with serious concerns which are more difficult to put right. In the present case, Mr Gutierrez had no personal interest or gain in the matters which gave rise to his misconduct. He was not seeking to cover up any mistake. There is no basis for the panel to conclude that he has any entrenched attitudinal problems.

Having heard Mr Gutierrez give evidence and be cross-examined both at the facts stage and at the impairment stage and after given full consideration to the circumstances of his misconduct, the panel concluded that Mr Gutierrez's behaviour was highly unlikely to be repeated.

The panel therefore determined that Mr Gutierrez is not impaired on public protection grounds.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. Mr Gutierrez has rightly expressed that the public have to be able to rely on nurses to uphold proper standards and trust in the profession. The public have to believe nurses have honesty and integrity. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case where Mr Gutierrez has been found to be dishonest.

It therefore finds Mr Gutierrez's fitness to practise impaired on the grounds of public interest only.

Sanction

The panel considered this case very carefully and decided to make a caution order for a period of two years. The effect of this order is that Mr Gutierrez's name on the NMC register will show that he is subject to a caution order and anyone who enquires about his registration will be informed of this order.

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

Submissions on sanction

Mr Smalley invited the panel to consider what sanction, if any, to impose on Mr Gutierrez as a result of its finding of current impairment on public interest grounds alone. He submitted that having considered the SG, the NMC's position is that the appropriate sanction in this case is one of a suspension order.

In the notice of hearing, dated 16 October 2023, the NMC informed Mr Gutierrez that it would be seeking a striking off order. However, Mr Smalley submitted that this is no longer the appropriate sanction, given the panel's findings on facts, on the level of dishonesty and the fact that impairment was found on public interest grounds alone.

Mr Smalley submitted that the public interest must be at the forefront of any decision on sanction and that includes protection of members of the public, maintenance of public confidence in the profession and the declaring and upholding proper standards of conduct and behaviour within the professions.

Mr Smalley submitted that in this case, given the panel's findings on impairment, the important aspects are firstly, maintaining public confidence in the profession that nurses are can be trusted, and secondly, the declaring and upholding of proper standards of conduct and behaviour within the profession, in that dishonest behaviour, particularly in the clinical setting, is unacceptable for a registered nurse. He submitted that any sanction imposed must do no more than what is necessary to meet that public interest and must be balanced against the registrants right to practice in his chosen career.

Mr Smalley invited the panel to consider aggravating and mitigating features of the case. He submitted that an aggravating feature in this case is that this was dishonesty in a clinical setting with the intent of giving an inaccurate picture of care that had been provided to Resident A and that the NMC says is that the height of seriousness in terms of dishonesty.

Mr Smalley acknowledged that there are significant mitigating features already identified by the panel in its finding of impairment. He highlighted that the incident occurred during the course of one shift, the panel has found that the dishonesty was at the lower end of the scale and that Mr Gutierrez has demonstrated insight into the dishonesty.

Mr Smalley invited the panel to assess the available sanctions in ascending order starting with the least severe and invited it to consider whether those sanctions would appropriately reflect the public interest of maintaining public confidence and declaring and upholding proper professional standards.

Mr Smalley submitted that a caution order would not be appropriate as it does not reflect the seriousness of dishonesty within the clinical setting. He further submitted that a conditions of practice order is clearly not appropriate in this case because the panel has not identified any ongoing clinical concerns and therefore no relevant or workable conditions could be formulated in this case.

Mr Smalley submitted that the NMC's position is that a suspension order is the appropriate sanction as not only would this reflect the seriousness of the dishonesty charges, but also recognizes the mitigating features present in this case. He further submitted that a suspension order would meet the public interest.

Mr Smalley submitted that a striking off order would be disproportionate.

Mr Hussain-Dupré provided written submissions in which he stated:

> *'1. The panel is undoubtedly aware of its obligation to consider sanctions in ascending order of severity and that the sanction applied should be proportionate.*
>
> *2. The panel has already identified that the Registrant is not impaired on the grounds of public protection and that his dishonesty is not a product of an entrenched attitudinal issue and that it can in fact be remediated.*
>
> *Mitigating factors*
> *3. This was an isolated incident in relation to a single patient.*
>
> *4. There was no personal gain or attempt to cover up the Registrant's actions.*
>
> *5. No harm was suffered by Resident A as a result of the Registrant's conduct.*
>
> *6. The panel identified that the dishonest conduct was at the lower end of the spectrum.*
>
> *7. The Registrant has demonstrated insight into his failings and their consequences for patients, families, the nursing profession and public confidence in both the profession and the regulator. The Registrant has expressed his remorse to the panel and also gave evidence of his deep desire to*

apologise to the family for his misconduct and how this might have affected them.

8. The misconduct is acknowledged to have taken place in difficult circumstances, during the Covid-19 pandemic.

9. Despite not being able to work, the Registrant has still taken steps to remediate his practice through mentorship, which the panel has already acknowledged.

10. The panel has determined that the Registrant is not impaired on public protection grounds and that, for the reasons set out in its earlier decision, there is a low risk of repetition.

11. The panel have already received various positive testimonials from former colleagues and from the Registrant's mentor.

12. There are no previous regulatory concerns.

No further action

13. Following the panel's finding of impairment on the public interest ground, it is accepted that a sanction of no further action would not adequately reflect the grounds for its decision, or satisfy the public that the misconduct has been taken seriously.

Caution order

14. The panel having only found impairment on the public interest ground, it is submitted that a caution order acknowledges that finding and confirms to the public that the misconduct in this case is not seen to be condoned or excused in any way by the regulator.

15. Having identified that the misconduct is remediable and there is low risk of repetition, a caution order has the effect of putting the Registrant on notice that

he must maintain the standards expected of nurses and that there is an ongoing expectation of such as a direct result of these fitness to practise proceedings.

16. It is argued that this is a proportionate sanction where the public protection ground is not engaged.

Conditions of practice

17. It is submitted that a conditions of practice order is unlikely to be focussed enough to address the misconduct which has been identified by the panel. However, it is accepted that conditions which include supervision may well mitigate any risk. It is argued that if the panel is minded to impose conditions, that these be the least restrictive possible, in the interests of proportionality, including only indirect supervision, to ensure that the Registrant is able to secure work as a nurse. It is submitted that particularly in the care home environment which the Registrant is accustomed to, staffing levels and ratios are often such that direct supervision makes it impossible for even the most accommodating potential employer to take on a nurse who requires direct supervision.

Suspension

18. The panel has already acknowledged that the Registrant has not been able to work for an extended period of time, approaching four years now, due to a related issue in respect of the Disclosure and Barring Service. It is argued that a suspension would therefore have a punitive effect and would be disproportionate in a case where there is a finding only on the public interest ground. Having not worked for over three years, the Registrant will have to complete his revalidation before returning to practice, so in any case, he will experience a further delay, which would only be compounded by a suspension. He will also need to go through a process to ensure that the DBS record is reviewed and updated, again, resulting in a delay before he can work in any nursing role.

Strike order

19. The panel has already noted throughout its findings both the context of the Registrant's conduct and the low risk of repetition. It is argued that for low level dishonesty, whilst the public might expect the regulator to acknowledge the seriousness by a finding of impairment, where a strong possibility of rehabilitation has been identified, there would also be an expectation of a second chance, so that nurses who are still have the capacity to practise kindly, safely and professionally are not excluded from the profession for a single lapse. It is therefore argued that a strike order would be a disproportionate sanction which does not reflect the findings of the panel in other aspects of this case.
20. The NMC has indicated that given the panel's findings on impairment, it will not be seeking a strike order.

CONCLUSION
21.Accordingly the panel is invited to issue a caution order for up to two years.'

Decision and reason on sanction

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

The panel took into account the following aggravating features:

- Matters of dishonesty which occurred within a clinical setting with the intent of giving an inaccurate picture of clinical presentation and care that had been provided to Resident A.

The panel also took into account the following mitigating features:

- This was an isolated incident in relation to a single resident in a single shift.
- No harm was suffered by Resident A as a result of Mr Gutierrez's conduct.
- The panel identified that the dishonest conduct was at the lower end of the spectrum. The dishonesty was not motivated by personal gain or an attempt to cover up his actions, instead it was motivated by his desire to obtain medical care for Resident A in difficult circumstances.
- Mr Gutierrez has demonstrated insight into his failings and their consequences for patients, families, the nursing profession and public confidence in both the profession and the regulator. He has expressed his remorse to the panel and also gave evidence of his deep desire to apologise to the family for his misconduct and how this might have affected them.
- The misconduct is acknowledged to have taken place in difficult circumstances, at the start of the Covid-19 pandemic.
- Despite not being able to work, Mr Gutierrez has still taken steps to remediate his practice through mentorship.
- The panel has determined that Mr Gutierrez is not impaired on public protection grounds and that, for the reasons set out in its earlier decision, there is a very low risk of repetition.
- The panel have already received 10 positive testimonials from former colleagues, a relative of a former resident and from Mr Gutierrez's mentor.

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

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 has taken into account that it has found Mr Gutierrez's fitness to practise impaired on public interest grounds alone. Further, it found that the dishonest conduct was at the lower end of the spectrum, there was no evidence of deep-seated personality or attitudinal problems and was not likely to be repeated.

Mr Gutierrez has shown insight into his conduct. He made admissions and apologised for his misconduct, showing evidence of genuine remorse. Mr Gutierrez has engaged with the NMC since referral. The panel has been told that there have been no regulatory findings in relation to Mr Gutierrez's practice either before or since this incident.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. It determined that a conditions of practice order was not the appropriate sanction in this case given that no clinical concerns have been established.

The panel concluded that no useful purpose would be served by a conditions of practice order. It is not necessary to protect the public and would not assist Mr Gutierrez's return to nursing practice.

The panel further considered whether a suspension order would be necessary to mark Mr Gutierrez's dishonest behaviour. In making this decision, the panel carefully considered the submissions of Mr Smalley in relation to the sanction that the NMC was seeking in this case. However, the panel considered that it has been over four years since the events occurred and during this period of time Mr Gutierrez has been subject to serious allegations which this panel has found were not based on reliable evidence. As explained by Mr Hussain-Dupré at paragraph 18 of his written submissions on sanction, the time taken to resolve these unsubstantiated allegations has resulted in Mr Gutierrez being prevented from practising as a nurse for four years. For that reason and because it would in any case be an inappropriate sanction in relation to the gravity of

the misconduct, the panel determined that to impose a further period of suspension would be plainly unjust.

The panel has decided that a caution order would adequately protect the public. Further, the panel concluded that it is in the public interest to support the return of a capable registered nurse back into the profession.

For the next two years, Mr Gutierrez's employer - or any prospective employer - will be on notice that his fitness to practise had been found to be impaired and that his practice is subject to this sanction. Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of two years would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered nurse.

At the end of this period the note on Mr Gutierrez's entry in the register will be removed. However, the NMC will keep a record of the panel's finding that his fitness to practise had been found impaired. If the NMC receives a further allegation that Mr Gutierrez's fitness to practise is impaired, the record of this panel's finding, and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to Mr Gutierrez in writing.

That concludes this determination.