Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Wednesday, 3 April 2024

Virtual Hearing

Name of Registrant:	**Dora Margaret Pasirayi**
NMC PIN:	98E0136E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nurse (Level 1) October 2001
Relevant Location:	Essex and Tendring
Type of case:	Misconduct
Panel members:	Adrian Ward (Chair member) Kathryn Elizabeth Smith (Registrant member) Michael Glickman (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Monowara Begum
Nursing and Midwifery Council:	Poppy Cleary
Miss Pasirayi:	Present and represented by Zahra Ahmed, instructed by the Royal College of Nursing (RCN)
Order being reviewed:	Suspension order (6 months)
Fitness to practise:	Not Impaired
Outcome:	**Order to lapse upon expiry in accordance with Article 30 (1), namely 13 May 2024**

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

At the outset of the hearing, Ms Ahmed, on your behalf, made a request that this hearing be held partly in private [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Cleary, on behalf of the Nursing and Midwifery Council (NMC), indicated that she supported 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 hear parts of this hearing in private [PRIVATE].

Decision and reasons on review of the substantive order

The panel decided to make no order and allow the current order to lapse on its expiry.

The current order will expire at the end of 13 May 2024 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the first review of a substantive suspension order originally imposed for a period of 6 months by a Fitness to Practise Committee panel on 13 October 2023.

The current order is due to expire at the end of 13 May 2024.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

'That you, a registered nurse:

1. On 17/18 July 2020:

a. …
b. Having witnessed Colleague A be physically abusive to Patient A, failed to intervene and/or escalate.
c. …
d. Failed to report:
i. …
ii. physical abuse;
iii. …

2. Subsequent to the events set out at charge 1, created an inaccurate statement in that you omitted to record the verbal and/or physical abuse of Patient A and/or Patient A's inappropriate seclusion.

3. Your actions at charges 1d and 2 were dishonest in that you were seeking to conceal the abuse Patient A had suffered and/or Patient A's inappropriate seclusion.

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

The original panel determined the following with regard to impairment:

'The panel determined that all four limbs of the Grant test are engaged.

The panel considered Mr Shurey's submissions, along with the reference to relevant case law, namely, that the panel should not make a determination of impairment on the basis alone of the dishonesty charges being contested.

The panel carefully considered the breaches of the Code and the charges found proved.

The panel had regard to the evidence in this case and it found that Patient A was put at risk of unwarranted physical and emotional harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel accepted that it was a one-off incident but it was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to a failure to act to prevent and escalate the physical assault of a patient by a colleague, compounded by subsequent dishonesty in failing to report and record the assault, as extremely serious.

The panel was of the view that although you have admitted the charges relating to failing to intervene or escalate matters when Patient A was subject to physical abuse and thereafter not reporting the incident or creating an accurate record, you have shown only limited insight to what happened as to how would you have done things differently, how you would approach similar circumstances in the future. The panel found that your responses during your evidence failed to demonstrate sufficient insight into the impact of the assault on Patient A and appeared to be more focused on the unfairness of you being labelled as dishonest.

The panel has accepted the submission of Mr Shurey on your behalf that the fact that you have not admitted the dishonesty charge does not preclude the panel from finding that you have gained full insight. The panel has considered all the evidence when determining whether you have gained full insight and the risk of repetition of your misconduct, including Mr Shurey's submissions to take account of your previous good character and the evidence that this was a one-off incident, and that the dishonesty charge is not the primary matter charged.

The panel considered whether you have taken steps to strengthen your practice. Whilst the panel acknowledged the challenges you faced in

securing employment due to practice restrictions, it is pertinent to note that the panel had a very limited number of training certificates and no clear evidence of professional development following the incident. As such, the panel was of the view that you have not been able to demonstrate that he you have strengthened your practise.

On this basis and given your limited level of insight into the matters in charges found proved, the panel decided that there is a risk of repetition and that a finding of impairment is necessary on the grounds of public protection.

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

In this regard, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case, where you did not act to protect a vulnerable patient from physical abuse nor record accurately or escalate the matter. It therefore also finds your fitness to practise impaired on public interest grounds.

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

The original panel determined the following with regard to sanction:

'...The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind that your failings in

this case, were not related to your clinical practice. The panel took into account the SG, in particular:

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

The panel took into account the factors outlined in the SG for imposing a conditions of practice order. It was of the view that workable conditions could theoretically be formulated despite the nature of the charges in this case, if you had demonstrated better insight into your failings. However, noting that you were the nurse in charge, and you failed to act having witnessed an assault namely, striking and kicking a vulnerable patient and thereafter did not report or document the behaviour. The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;and*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *…*

Having considered that the panel's findings did not fully satisfy the SG relating to a suspension order, the panel went on to consider whether a striking-off order would be proportionate. The panel determined that the regulatory concerns in this case do raise fundamental questions regarding your duty to protect vulnerable patients. However, it took into consideration that the misconduct related to a single incident. The panel determined that public confidence in the nursing profession could be upheld by way of a sanction less than a striking off order given that this was a serious but single incident, set against a long unblemished career as a nurse, supported by some testimonials, and you were the witness to physical abuse rather than the perpetrator. Although you did not promptly report the actual physical abuse you witnessed, you did make early admissions.

The panel decided that a striking off order was not the only order available to protect patients, members of the public, or maintain professional standards.

The panel noted that you were the nurse in charge of shift with a responsibility to ensure patient safety. It determined that your responses during your oral evidence did not adequately demonstrate your insight into the wider impact of your failure to take action regarding the assault of Patient A and your focus appeared to be more on the perceived fairness of being labelled as dishonest. However, the panel concluded, having carefully considered the guidance in relation to suspension and striking off orders, that the misconduct in this case was not fundamentally incompatible with remaining on the register. In the panel's judgement, this order would provide you with an opportunity for further reflection and to foster the development of further insight.

The panel was of the view that an informed member of the public would be satisfied that this was a reasonable and proportionate sanction in the circumstances. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

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

Decision and reasons on current impairment

This panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle, your training certificates, reflective piece and testimonials from colleagues. It has taken account of the submissions made by Ms Cleary on behalf of the NMC.

Ms Cleary took the panel through the background of the case.

Ms Cleary submitted that the previous panel recommended that a future panel would be assisted by:

- Testimonials and references from any paid or voluntary work
- Reflection on the misconduct
- Whether there has been engagement and attendance at this hearing

Ms Cleary referred the panel to your bundle and submitted that you had engaged with the NMC process and provided information relevant to the recommendations of the previous panel. She reviewed your reflective piece which considers the incident that took place in

2020 and your understanding of your duties under the Code of Conduct. She outlined to the panel that you have reflected on the allegation of dishonesty and shown insight into your failings. She further referred the panel to the training certificates in your bundle and the testimonials from your colleagues.

The panel also had regard to your oral evidence which you gave under affirmation, as well as submissions from Ms Ahmed.

Ms Ahmed referred you to your reflective piece dated 27 March 2024. She outlined that in your reflective piece you offered an apology and further reflection on how your actions were found to be serious enough to constitute misconduct, which can affect public confidence in the professions. When asked why this was important, you stated that you apologised so that the public will have confidence and be reassured that their families and relatives are being looked after properly by nurses.

When asked about insight, you said that you have now come to realise what went wrong and what you could have done differently. You said that you now understand and accept why the previous panel found your conduct dishonest. You stated that you have undertaken training courses which are most relevant to the charges found proved, such as record keeping, Prevention and Management of Violence and Aggression (PMVA) and the Duty of Care. You stated that you have learnt that it is important to produce accurate documentation so if an incident arises again, you will have correct information to rely on. You stated that in the future if you are asked to provide a statement, you will take your time to reflect and record everything accurately. You explained that you had provided your statement following the incident in a state of panic and that your mind had gone blank.

When asked what you had learnt from your training in relation to duty to report after an incident takes place, you stated that you understand that it is important to report an incident, especially when it is related to safeguarding, and you would do so by informing the manager and following the safeguarding policies. You said that you learnt about the "*Five R's*" in safeguarding, which are to '*Recognise, Respond, Report, Record and Refer*', so if an incident took place, you would take action and follow the appropriate procedures.

You stated that you have learnt from the training you have undertaken and have an understanding of what you would do differently in the future, including ensuring that incidents are documented accurately and appropriate techniques are used if it is necessary to restrain a patient.

Ms Cleary asked what action you would take if you were to see a colleague abuse a patient. You responded that you would first tell the colleague to stop and then you would report it by completing an incident form and informing the manager. You further stated that you would raise it as a safeguarding concern which may include you contacting the local authorities, and if it is something serious that puts patients at risk you would contact the police.

When asked about previous incident and how you would deal with it differently regarding your own shock and panic, you stated that you would ask for more time to reflect and remember everything, and you would not write while in a state of panic and shock. You were then asked what you would do if you were to encounter an incident in which you were unsure of what action to take, to which you stated that you would contact your manager.

You told the panel that you had undertaken one day of mandatory training which included practical basic life support, moving and handling and safeguarding. You also stated that you undertook a further day of PMVA training. When asked about agency placements and whether you were briefed about policies and procedures, you stated that you are normally given an induction on policies and procedures when you are first employed in a new setting.

In her closing submissions, Ms Ahmed submitted that you have been qualified as a registered mental health nurse since 2001 and that the event that led to the regulatory concern is out of character. She drew the panel's attention to the testimonials from fellow mental health professionals which attest to your ability to work in a challenging environment with the most vulnerable sections of society. She submitted that you have never faced any complaints and have never been subject to any disciplinary or regulatory proceedings until this incident, which suggests that there are no underlying attitudinal issues. She submitted that you have shown insight, demonstrated understanding of the

reasons underlying the previous panel's determination on dishonesty and have properly reflected on the contents of the incident report form. She submitted that you acknowledge your shortcomings in your practice, and this is evident from your reflective piece. She submitted that you have admitted to your failings and acknowledge your shortcomings in fully reporting the extent of the incidents. She submitted that you have undertaken relevant training, and you hope to build on that if given the opportunity.

Ms Cleary reminded the panel that the burden of proof was on you but accepted that you had provided the material suggested by the previous panel and had continued to engage with the regulatory process.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired.

The panel noted that the original panel found that you had demonstrated a limited level of insight. At this hearing the panel determined that you have shown adequate insight into your failings. In your reflective piece you demonstrated an understanding of why what you did was wrong and how this impacted negatively on the reputation of the nursing profession. When questioned during the course of this hearing about how you would handle the situation differently in the future, you were able to provide sufficiently detailed answers.

In its consideration of whether you have taken steps to strengthen your practice, the panel took into account the relevant training you have undertaken, and the reflective piece written by you, dated 27 March 2024.

The original panel determined that you were liable to repeat matters of the kind found proved. Today's panel has had new information put before it which shows your insight, demonstrable remorse, and these steps taken to strengthen your practice, such as

relevant training certificates. The panel noted that this was a one-off incident and you have shown insight on how you would handle similar situations differently in the future. It further noted your colleagues' testimonials which speak to your honesty and good character. In light of this information, this panel determined that you are now not liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is not necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, the public interest has been met by your six month suspension and a finding of continuing impairment on public interest grounds is not required.

For these reasons, the panel finds that, although your practise was impaired at the time of the incidents, given all of the above, your fitness to practise is not currently impaired.

In accordance with Article 30(1), the substantive suspension order will lapse upon expiry, namely the end of 13 May 2024.

This will be confirmed to you in writing.

That concludes this determination.