Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

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

Thursday 23 March 2023 – Friday 31 March 2023
Wednesday 6 September 2023 – Friday 8 September 2023
Tuesday 19 September 2023 – Friday 22 September 2023
Thursday 1 February 2024 – Friday 2 February 2024

Name of Registrant:	Josan Icot
NMC PIN	06G0312O
Part(s) of the register:	Sub Part 1 - Adult Nursing (Level 1) 26 July 2006
Relevant Location:	Sandwell
Type of case:	Misconduct
Panel members:	Louise Fox (Chair, lay member) Jane Jones (Registrant member) Isobel Leaviss (Lay member)
Legal Assessor:	Charles Parsley (28 – 29 March 2023) Robin Hay (6 – 8 and 19 – 22 September 2023) Paul Housego (1 – 2 February 2024)
Hearings Coordinator:	Petra Bernard (28 – 29 March 2023 and 10 – 22 September 2023) Anya Sharma (6 – 8 September 2023) Petra Bernard (1 – 2 February 2024)
Nursing and Midwifery Council:	Represented by Michael Smalley, Case Presenter (28 – 29 September 2023); Rakesh Sharma, Case Presenter (6 – 8 and 19 – 22 September 2023) Matthew Kewley, Case Presenter (1 – 2 February 2024)

Mrs Icot:	Present: 23 - 31 March 2023; 6 - 8 September 2023; and 19 - 22 September 2023 Via telephone: 1 – 2 February 2024; and represented by James Wilkinson, Unison
No case to answer:	Charge 1i(ii), 2e(ii)
Withdrawn:	Charge 1(f)
Facts proved by admission:	Charges 1a, 1c, 1d, 1e, 1i(i), 2e(i)
Facts found proved:	Charges 1b, 2f
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (9 months with review)**
Interim order:	**Conditions of practice (18 months)**

Details of charges (as read)

That you, a registered nurse:

1) On 28 July 2021 in relation to the unwitnessed fall suffered by Resident A:

a) Failed to call 999 immediately;

b) Failed to carry out an adequate assessment;

c) Failed to commence neurological observations;

d) Failed to ensure the resident's movements were minimised;

e) Failed to complete the Falls Observations record, alternatively

f) Failed to record details of any refusal of observations;

g) Failed to escalate the fall to the manager or suitable deputy;

h) Failed to handover details of the fall;

i) Failed to contemporaneously complete:

i) The event form

ii) The body map

2) On occasions on or after 28 July 2021:

a) Incorrectly claimed to have escalated the fall to the manager;

b) Your actions in charge 2) a) above were dishonest in that you knew you had

not escalated the fall as you claimed to have done.

c) Incorrectly claimed to have handed over the fall;

d) Your actions in charge 2) c) above were dishonest in that you knew you had

not handed over the fall as you claimed to have done.

e) Created retrospective documentation and records including:

i) The event form

ii) The body map

f) Your actions in charge 2) e) above were dishonest in that you intended to create a misleading impression that you carried out the necessary assessments and record creations contemporaneously when you had not.

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

Admitted Facts

At the outset of the hearing, through your representative Mr Wilkinson, you admitted charges 1a, 1c, 1d, 1e, 1i(i), and 2e(i).

The panel therefore found charges 1a, 1c, 1d, 1e, 1i(i), 2e(i) proved by way of your admissions.

Decision and reasons on application to admit the written evidence of Witness 4 under Rule 31 (Day two)

The panel heard an application made by Mr Smalley under Rule 31 to admit the written evidence of Witness 4. The witness had been scheduled to attend to give evidence virtually on 27 March 2023 and did not attend. Efforts were made to contact her by email and telephone on 27 March 2023 but there were no responses. Witness 4 was asked to attend to give evidence today at 9am, but she did not attend or send any communication to explain her non-attendance.

On Thursday 23 March 2023, the hearings coordinator emailed Witness 4 to enquire if she could give evidence on that day, as another witness was not available, and received a short reply stating only that she could not do so because she was at work. This was the last communication received from Witness 4.

Mr Smalley referred the panel to the exhibited NMC correspondence log bundle, which shows a chronology of communication between the NMC and Witness 4 in relation to

her attendance to give live evidence at this hearing today. In an NMC telephone note dated 8 March 2023, Witness 4 had confirmed that she would attend the hearing on 27 March 2023. He submitted that a number of further attempts were made to contact Witness 4 by the NMC Case Officer and the Hearing Coordinator by email and telephone on 27 March 2023, but to no avail.

When the witness could not be contacted on 27 March 2023, Mr Smalley reminded the panel of the witness' duty as a registered nurse to assist her regulator in its fitness to practise investigations. He stated that a letter would be sent to the witness reminding her of this and inviting her to attend on 28 March 2023. However, on 28 March 2023 Mr Smalley told the panel that late on the previous afternoon, the reviewing lawyer for the NMC had decided against sending such a letter because the witness had previously been cooperative and had told the NMC in February 2023 that she was five months' pregnant. Mr Smalley submitted that all reasonable steps had been taken to secure Witness 4's attendance.

Mr Smalley cited the case law of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) as important when considering a hearsay application and *El Karout v NMC* [2019] EWHC 28 (Admin). Mr Smalley made submissions in relation to the key factors identified in *Thorneycroft* and on that basis invited the panel to admit the evidence of Witness 4.

Mr Wilkinson objected to the application on the basis that it is unfair and prejudicial to you. He submitted that there are significant disputed issues with Witness 4's evidence, in particular the allegations around documentation, hand-over, escalation of the incident and related dishonesty allegations. He submitted that it is unfair that he is unable to cross-examine Witness 4 particularly given that she may not be an impartial witness as [PRIVATE] who was also involved in some of the events relating to the allegations.

Mr Wilkinson submitted that Witness 4's evidence is contested and therefore it would be unfair if you were unable to test her evidence. He submitted that if the panel were to admit Witness 4's evidence they should treat it with caution.
The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included reminding the panel that a

decision to admit evidence under Rule 31 is '*subject only to the requirements of relevance and fairness'*. He also referred to the cases of *Thorneycroft* and *El Karout* as relevant case law.

The panel gave the application in regard to Witness 4 careful consideration. The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 4 to that of allowing her written statement into evidence.

The panel noted the relevant principles in *Thorneycroft*:

"Paragraph [45] the relevant principles which emerge from the authorities are these:

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

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

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

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

demonstrably reliable, or alternatively that there will be some means of testing its reliability.

The panel went on to consider the following key factors set out in paragraph 56.

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

The panel determined that Witness 4's evidence appears to be decisive. The panel considered that her evidence is the sole direct evidence particularly in relation to the allegations of dishonesty in charge 2 regarding the hand-over and retrospectively creating records and documentation. Witness 4 was the only witness due to give oral evidence who was said to be present at the hand-over meeting linked to charges.

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

The panel noted Mr Wilkinson's submissions and your written response to the charges and concluded that there are a number of significant contested issues within Witness 4's evidence. The panel determined that the nature and extent of the challenge to Witness 4's evidence was substantial.

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

The panel noted Mr Wilkinson's submission that he suggested Witness 4 may not be an impartial witness, [PRIVATE] In addition, the panel noted that her husband was also her line manager at the time of the events.

The panel kept in mind the legal assessor's advice and was also of the view that it may be reasonable to have a suspicion of a slant in her evidence to your possible detriment. The panel recognised that a cautious approach was required and that it was important in this context to test the reliability of Witness 4's evidence in order to be fair to you.

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

The panel considered the charges that you face are serious particularly due to the dishonesty element in the charges. The panel noted the NMC's sanction bid of a striking-off order. The panel determined that adverse findings would have a significant impact on your career.

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

No reason let alone a good reason has been provided by the NMC for the non-attendance of Witness 4.

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

The NMC wrote to Witness 4 on 22 February 2023 requesting her attendance at the hearing on 27 March 2023. On 8 March 2023, Witness 4 confirmed her attendance as requested. However, she did not attend. Efforts were made to contact her by email and telephone on 27 March 2023 but there was no response. Witness 4 was asked to attend to give evidence today at 9am, but she did not attend or send any communication to explain her non-attendance.

The panel considered that there were further steps that could have been taken. Witness 4 had been communicating with the NMC up until 23 March 2023 when she stated that she was at work and at that point she did not indicate any reason for being unable to attend on 27 March 2023. The panel considered that further attempts could have been made, for example: to request a short adjournment during the time allocated for this hearing to continue trying to contact her and establish the reason for her non-attendance or contacting her employer to ascertain whether she was currently at work.

In addition, the panel considered it would be reasonable, as she is a registered nurse, to remind her of her obligations to cooperate with her regulator.

> *(vii) the fact that the Appellant did not have prior notice that the witness statement was to be read*."

The panel noted that the application was made today and you did not have prior notice. Mr Wilkinson has submitted that this is unfair to you. The panel determined this could potentially put you at a disadvantage.

In conclusion, the panel determined that Witness 4's evidence is highly relevant. The panel considered that all the key factors in *Thorneycroft* are engaged and led to the conclusion that it would be unfair to you to allow Witness 4's written evidence to be admitted.

In these circumstances the panel refused the application.

Decision and reasons for the panel's request for further investigations (Day 4)

Mr Smalley informed that panel that a further email was sent at 6pm yesterday by the hearings coordinator but Witness 4 has still not responded to emails regarding her attendance to give oral evidence at this hearing.

During the course of reading and hearing evidence the panel had noted Witness 6's central role in the chronology and events which form the basis of your referral.

It noted that:

- Witness 6 was the lead registered nurse and deputy manager/clinical lead within the Home at the relevant time
- At the time of the events Witness 6 was deputising for the manager (Witness 3) who was on holiday
- There was evidence that Witness 6 was present at the shift handover on the

morning of 28 July 2021

- There was evidence in the daily record that Witness 6 had examined Resident A during the relevant period
- [PRIVATE]
- Witness 6 had provided a written statement to the local investigation which was contained within the bundle and his account of events appears to differ materially from yours
- Witness 6 is referred to frequently by other witnesses as the source of much of the material relied upon by the NMC relevant to the charges but was not asked to provide a statement to the NMC

The panel was mindful of the guidance derived from the case of *Jozi* that it should be proactive in the public interest in upholding the overarching objectives of the NMC and when considering whether it should request that further investigation be undertaken with a view to securing relevant evidence. The panel also took note of the NMC guidance DMA-5 *'When should a panel direct further investigation?'*

The panel asked Mr Smalley to explain why the NMC had not sought to call Witness 6 as a witness in this hearing.

In responding Mr Smalley stated that he would be making reference to matters relating to Witness 6 which would be appropriate to be dealt with in private pursuant to Rule 19(3).

Mr Wilkinson raised no objections.

The panel accepted the advice of the legal assessor and agreed to the relevant parts of Mr Smalley's submissions being held in private.

Mr Smalley told the panel that the NMC had initially considered calling Witness 6 as he was an important witness. However, the NMC had understood that the Home were considering referring Witness 6 to the NMC in relation to another matter and decided not to call him. When it was later established that he was no longer going to be referred,

the reviewing lawyer at the NMC decided not to call him as a witness even though the investigation into this case was still ongoing.

Mr Smalley conceded that there had been a failure on the part of the NMC and a *"missed opportunity"* to call Witness 6 to give evidence. Mr Smalley submitted that further investigation would necessarily result in an adjournment of the hearing. He told the panel that the NMC still considered there to be sufficient evidence to support the charges as a whole and in particular a case to answer in relation to dishonesty which is a serious aspect of the case. The NMC considered that it would be disproportionate to pursue further investigations in view of the public interest in the expeditious disposal of this case.

Mr Wilkinson submitted that he supports Mr Smalley's submission to proceed with the hearing. He felt that it would be unfair to you and disproportionate to adjourn this hearing in order to call Witness 6 as a witness. He told the panel that it would adversely impact your wellbeing as it is unknown how long an adjournment would take, given that it has already taken two years to get to this point in proceedings. Further, he submitted that the passage of time in the intervening period may impact your and the witnesses' recollection of events. He indicated that he would be making no case to answer submissions on your behalf in relation to some of the charges but that the remainder of the case could and should proceed on the basis of the evidence before the panel without further delay.

The panel heard and accepted the advice of the legal assessor. He referred to the cases of *Professional Standards Authority for Health* and *Social Care v Nursing and Midwifery Council and Jozi* [2015] EWHC 764 (Admin) and *Ruscillo v CRHCP, GMC* [2004] EWCA Civ 1356 as providing guidance as to when panels should request additional evidence.

He also referred to Rule 32 which sets out the matters to be considered regarding adjournments:

32.

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

(a) no injustice is caused to the parties; and
(b) the decision is made after hearing representations from the parties (where present) and taking advice from the legal assessor.

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

(a) the public interest in the expeditious disposal of the case;
(b) the potential inconvenience caused to a party or any witnesses to be called by that party; and
(c) fairness to the registrant.

The panel had regard to the following points in the NMC guidance DMA-5 *'When should a panel direct further investigation?'.*

There are a number of reasons why a panel may direct us to carry out further investigations. These include:

- *New information has come to light that neither we nor the nurse, midwife or nursing associate have seen, which could undermine our case, support our case, or support the case of the nurse, midwife or nursing associate*.
- *The information currently before a panel is obviously incomplete or does not cover all the areas of concern. One example of this could be missing pages from patient notes, or from some other important document.*
- *Further information is essential to clarify or expand on evidence already obtained*
- ...

- *Whether the evidence is important to an issue it has to decide.*

The panel determined that without evidence from Witness 4 or Witness 6 the information before it is incomplete and does not cover all areas of the concern. Witness 6 was involved in the handover and could potentially address the allegations regarding escalation to the manager and documentation being retrospectively completed which are the basis of the dishonesty charges. The panel consider it essential to seek the evidence of Witness 6 because of his central role in critical aspects of the allegations you are facing, when it has not been provided with evidence from any other direct witnesses to some of these events. The panel's enquiry has established that Witness 6 could have been called as a witness by the NMC to give relevant evidence.

The panel considered overall fairness of the proceedings. When considering whether or not to direct further investigation, as well as your right to a fair hearing, the panel also considered that this includes fairness to the people involved in the events the case is about including Resident A and his family.

The panel recognises that the request for further investigation will result in an adjournment and it had regard to the provisions of Rule 32. The panel noted Mr Wilkinson's submission regarding the effect the lapse of time since the events may have on the recollection of the parties, however it determined that this can be mitigated by the NMC adducing contemporaneous records.

Without hearing live evidence from Witness 6 or Witness 4 the panel considered it would not be able to determine the facts fairly in relation to the disputed charges. The panel noted Mr Wilkinson's submissions about the impact an adjournment may have on you and it balanced this with the need to protect the public and the wider public interest. Although regrettable, and it being an unsatisfactory situation that Witness 6 was not called as a witness by the NMC before the hearing began, the panel decided that due to the significant gaps in the evidence regarding important issues it needs to decide that it is in the interests of justice to request further investigation before proceeding with the hearing.

The panel concluded that requiring that the relevant evidence is placed before it would not cause injustice to the parties but ensure that the case is properly presented.

Accordingly, the panel makes the following directions:

- The NMC should take the appropriate steps necessary with a view to securing the evidence of Witness 6
- The NMC should obtain and provide the staffing rotas for the Home on 28, 29 and 30 July 2021
- The NMC to continue trying to secure Witness 4 to either seek her attendance at the resumed hearing or establish the reason for her non-attendance
- The NMC to list the resumed hearing as expeditiously as possible

On Friday 31 March 2023, the hearing was adjourned with panel directions.

The split hearing resumed on Wednesday 6 September – Friday 8 September 2023 and Tuesday 19 September to Friday 22 September 2023.

Submissions on application of no case to answer

Mr Sharma confirmed that charge 1(f) was effectively withdrawn as it had been charged in the alternative to charge 1(e) which you had admitted at the outset of the hearing.

The panel considered an application from Mr Wilkinson that there is no case to answer in respect of charges 1(i)(ii), 2(c), 2(d) and 2(e)(ii). This application was made under Rule 24(7).

Mr Sharma opposed the application and made submissions that there was evidence to support each of these charges.

The panel took account of the submissions made by both parties and legal advice.

In reaching its decision, the panel has made an initial assessment of all the evidence adduced by the NMC .The panel was solely considering whether there was a real prospect that the facts alleged could be proved.

The panel was aware that in reaching its decision it must take the evidence currently before it at its highest. Further, if in regard to any allegation there is no evidence capable of satisfying the panel, or if the evidence is tenuous in that it is inconsistent, inherently weak or otherwise unreliable, then the submission succeeds.

Charge 1(i)(ii) – No Case to Answer

The NMC relied upon evidence from Witness 4 who said that she had found the body map that you had completed in Resident A's care plan on 4 August 2021 but that she had not found it there when she had checked the care plan on the 30 July and 2 August. The panel found the evidence to be tenuous. Witness 4's account that she did not find the document does not make it more likely than not that you failed to complete it contemporaneously. The panel decided that even taken at its highest, it could not be proved that you had failed to contemporaneously complete the body map.

The panel therefore found there to be no case to answer.

Charge 2e(ii) – No Case to Answer.

The panel had sight of the completed body map for Resident A. The matter the panel had to consider was whether there was evidence that this had been created retrospectively. The NMC's evidence is that of Witness 4 outlined above in Charge 1(i)(ii) that she looked for the body map and could not find it on the 30th July and 2nd of August and found only it on the 4th August. The panel decided, as under Charge 1(i)(ii) the evidence to be tenuous. Witness 4's account that she did not find the document does not make it more likely than not that you created it retrospectively. The panel decided that even taking the evidence at its highest, it could not be proved that you had created the body map retrospectively.

The panel therefore found there to be no case to answer.

Charge 2(c) – Proceeding

This charge is linked to charge 1(h), that you failed to hand over details of the fall, which you have denied.

The NMC relies on evidence from Witness 4 and Witness 6. Both witnesses say that you claimed to have handed over details of the fall at the handover on 28th July and both say that they were sure that you did not mention it. Witness 4 also gave evidence that you had subsequently admitted to her that you had not done so.

There were before the panel various documents in which you recorded details of the fall (including your 28 July 2021 handover notes, Resident A's care plan and Record of Daily Life) and that these could constitute handing over details of the fall. However, the evidence from Witness 4 and Witness 6 was that nurses at the Home relied upon the verbal handover and that nurses did not have time to check through the notes for all 30 residents at the start of the shift.

The panel decided that there was sufficient evidence upon which the charge 1h) could be proved, namely that you had failed to handover details of the fall, as they both said you had not done so verbally. The panel decided that it therefore followed that there was sufficient evidence upon which this charge (2c) could be proved namely that you had incorrectly claimed to have handed over the fall.

Charge 2(d) – Proceeding

This dishonesty charge relates to charge 2(c). The panel decided that in the event that you did not hand over details of the fall but nevertheless claimed to have done so, it would follow that there is evidence relating to dishonesty which calls for explanation.

Background

The charges arose whilst you were employed as a registered nurse by Trinity House (the Home). During the relevant time, you were the nurse in charge during a night shift at Trinity House (the Home) on 27-28 July 2021. At 6:45am on 28 July 2021, Resident A was found on the floor in his room by two carers. The carers fetched you and you checked Resident A for injuries but did not undertake clinical observations. Resident A reported that he was fine and was taken to the lounge to have his breakfast.

Resident A's care plans stated that as he was on anticoagulant medication, he was a higher risk of bruising and bleeding and 999 should be called in the event of a fall. Additionally, the Home's Post Falls Protocol should be followed which included completing a neurological observations chart and falls observation record.

It is alleged that you failed to follow Resident A's care plan in that you did not call 999 or follow the Post Falls Protocol. Further, you failed to mention the incident at handover on 28 July 2021.

It is alleged that it was not until handover on the morning of 30 July 2021 that you mentioned Resident A had suffered a fall two days earlier and had a red mark on his elbow. Another registered nurse, Witness 6, subsequently called 999 and Resident A was taken to hospital where he later died on 10 September 2021.

On 30 July 2021, you completed the Event form regarding Resident A's unwitnessed fall which was found by Witness 4 in Resident A's care plan on 2 August 2021. On 4 August 2021 a body map chart was also found in Resident A's care plans. Allegedly, neither of the forms were in Resident A's care plans on 30 July 2021 suggesting that you did not complete the forms until days after the incident.

The NMC allege that you created retrospective documents and records to create a misleading impression that you carried out the necessary assessments and record creations contemporaneously when you had not and that in doing so your actions were

dishonest. The NMC also allege that you incorrectly and dishonestly claimed to have escalated and handed over the fall.

An internal disciplinary investigation was carried out.

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

Decision and reasons on disputed facts

In reaching its decisions on the disputed facts, the panel considered all the oral and documentary evidence together with the submissions made by Mr Smalley and subsequently by Mr Sharma and those made by Mr Wilkinson.

The panel accepted the advice of the legal assessor.

Admitted Facts

At the outset of the hearing, through your representative Mr Wilkinson, you admitted to charges 1a, 1c, 1d, 1e, 1i(i), and 2e(i).

The panel therefore finds charges 1a, 1c, 1d, 1e, 1i(i), 2e(i) proved in their entirety, by way of your admissions.

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 and subsequently Mr Sharma on behalf of the NMC, Mr Wilkinson on your behalf, and those made by you.

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

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

- Witness 1: Regional Manager at Rehability UK, Dorset and internal investigator, at the relevant time
- Witness 2: Night Shift Carer at the Home, at the relevant time
- Witness 3: Registered Manager at the Home, at the relevant time
- Witness 4: Acting Deputy Manager at the Home, at the relevant time
- Witness 6: RGN and Clinical Lead at the Home, at the relevant time

The panel also heard evidence from you.

It was agreed by both parties that the witness statement of Witness 5 was accepted and could be read into the record.

Witness 1's evidence (Day 1)

Witness 1 confirmed the contents of his witness statement. As the internal investigator he was not a direct witness to any of the events.

When questioned by Mr Smalley he said that he did not think you had performed an adequate assessment by just *"checking him over"*. By not providing observations and not following the Home's falls management policy and Post Falls Protocol, your assessment was inadequate. You did not follow the required procedures, of which you confirmed to him you had been aware. If Resident A had refused to have observations

taken, it should have been documented by you in the nursing notes, handover notes and also verbally in the handover.

Mr Wilkinson asked Witness 1 whether the *'missed opportunities'* referred to in his witness statement and his report in relation to Resident A's fall may have been caused by some systemic issues. Witness 1 said that by '*missed opportunities'* he had meant what had occurred on 28 July 2021 for example, 999 not being called; entries on the body map not being made contemporaneously; and that it then took so long, 48 hours, for Resident A's injury to be noticed and reported. He was asked whether it was possible that Resident A had had another fall after 28th July 2021. Witness 1 said *"I can't guess".*

When asked whether he was aware of any issues between you and other colleagues, Witness 1 he said he had not been made aware.

The panel questioned Witness 1 as to who reported the incident to him and he confirmed that it was Witness 4. He told the panel that he could not remember when Witness 4 telephoned him but he recalled that she had said that Resident A had had an incident and had been admitted to hospital. He said that he was told the event form was found on the 2 August 2021.

Witness 1 said that he was sent some documentation on 3 or 4 August 2021 by Witness 6 and then at a later date was asked by the Group's Operational Manager to conduct an investigation. He said that he understood that the body map and event form should be handed to the manager and then stored in the office.

Witness 1 was asked by the panel whether he had asked you during the investigation whether you had written your notes retrospectively. He said he had not.

When taken to the event form, Witness 1 agreed that you had recorded that Resident A had refused observations and said however, it should have been corroborated by recording and signing this on a falls observation record.

When shown your entry on the record of daily life for Resident A and your entry at 06:45, Resident A's care plan and the handover sheet for 28 July 2021, Witness 1 conceded there may have been more records that he was not made aware of when he wrote his report and accepted that your record was a form of handover about Resident A's fall. Witness 1 confirmed he had seen the handover sheet in which redness of the elbow had been recorded.

Witness 2's evidence (Day 2)

Witness 2 confirmed the contents of her witness statement. She said that after Resident A was found on the floor, she wrote in the resident's care notes details of what had happened. Witness 2 explained to the panel that the carers wrote their notes in a separate book for each resident which was different from the nursing notes.

She said that you asked Resident A whether they were in pain and they said they were not. Witness 2 recalled you put a plaster on their head because it was bleeding. Witness 2 was asked if she heard you ask Resident A if she could take their observations, for example blood pressure and temperature. Witness 2 said she did not hear this, however she may have been out of the room at that time or it the observations may have been taken later. Witness 2 was asked if she remembered whether you completed a body map and she said she did not remember. Witness 2 said that Resident A would sometimes refuse to take their medication, have help with washing, drinks or to have their blood pressure taken.

When asked by Mr Wilkinson how busy the shift was around the time Resident A was found on the floor, Witness 2 said the shift was busy. When asked about who was present at morning handovers, she said nightshift carers would not attend

Witness 3's evidence (Day 2)

Witness 3 confirmed the contents of his witness statement. He said that the first time he heard of the incident that occurred on 28 July 2021 was on 30 July 2021 whilst on holiday when you sent him a message via WhatsApp.

Mr Wilkinson put to Witness 3 that it is your position that you did provide a handover to Witness 6 and he responded that he could not be sure without looking at the notes. When shown your notes on the handover sheet which included the phrase *'found sitting on the floor',* Witness 3 agreed that this was evidence of a handover of the unwitnessed fall.

Mr Wilkinson asked Witness 3 how he came to the conclusion that you did not follow proper protocol at the time. Witness 3 stated that it was common practice and in the Home protocol that a nurse should call an ambulance for anyone who is on blood thinner medication and who has a witnessed or unwitnessed fall.

Witness 3 when asked to whom you should have escalated the fall, if he were away, said that you should have escalated it to Witness 6.

Witness 3 when asked if it was possible that you tried to reach him by phone on 28 July 2021 said he had not received any calls or any missed calls from you on either his personal or work phones which were with him the whole time he was on holiday. He said phone reception was poor in that area and that you may have tried unsuccessfully. However, in reply to Mr Smalley, he did confirm that he received your WhatsApp message with the event form on 30 July 2021 whilst on holiday.

In response to panel questions about Witness 6 and Witness 4 having the same surname, Witness 3 confirmed that they were [PRIVATE]. Witness 3 said he had raised this with the organisation as he had inherited the issue. He said that Witness 6 managed the carers and was Witness 4's direct line manager.

Witness 3 was asked by the panel about his comments to the coroner suggesting some of the documentation was written retrospectively and how he knew this. Witness 3 explained that he was relying on Witness 6 who had reported to him that there was no event form handover available on 28 July 2021. Witness 3 said the event form was only sent to him on 30 July 2021 when Resident A had already been admitted to hospital.

Summary of witness 4 (Day 8)

Witness 4 confirmed the contents of her witness statement. Her evidence was that she had been present at the handover you gave on 28 July 2021 and that you had 'not mentioned the fall'. She told the panel that she was sure about this and said that the first she heard about it was on 30 July 2021. When shown your 28 July 2021 handover sheet, Witness 4 said that she had not previously seen this document. She said that they were not usually given to or reviewed by the incoming shift staff. They were put in a file. Nurses at the Home relied on the verbal handover.

Witness 4 said that nurses should be familiar with the care plans of the residents at the Home and that nurses should refer to each resident's care plans throughout the shift.

Witness 4 explained that it was standard practice at the Home to complete an event form as soon as practicable after an incident occurred. Once completed, it should be passed to management in order for them to update the risk IT system and inform Head Office.

When it was put to her that the record keeping system at the Home at the time had been a bit confusing, Witness 4 agreed.

Witness 6's evidence (Day 7)

Witness 6 confirmed the contents of his witness statement. He confirmed he was the Clinical lead nurse at the time of the incidents. Witness 6 said nothing was mentioned about Resident A having had a fall in the handover on 28 July 2021 and the first he became aware of this was at the handover on 30 July 2021. Witness 6 explained that the handover is verbal and although it is good practice to read the handover sheets he did not do this and instead took his own notes at handovers.

When asked where he had looked for evidence that Resident A had had a fall as part of the internal investigation Witness 6 said he could not recall which documents he checked but just that he could not find any evidence.

Witness 6 told the panel that Resident A was known for making *'complaints and false allegations'* of having falls.

Witness 6 explained that it was some time since the events took place and there were a number of things he could not recall including if he was the only other nurse present at the handover that day, or if Witness 4 was at the handover. Witness 6 confirmed that he was [PRIVATE] to Witness 4.

Charge 1b

That you, a registered nurse:

1) On 28 July 2021 in relation to the unwitnessed fall suffered by Resident A:

    b) Failed to carry out an adequate assessment;

This charge is found proved.

The panel accepted that you did ask Resident A if they were in pain but it determined that you only carried out a very limited examination of Resident A while they were on the floor. The panel determined that you could not have performed an adequate body check as you explained that you had only rolled up Resident A's pyjama sleeves and checked his scalp. You also admitted that you had not asked the carers about where Resident A was found or whether they had been moved which would be part of an adequate assessment. It also considered your evidence in which you stated that Resident A refused to have their vital observations taken. You explained in your evidence that you did not ask Resident A again as you did not want to disturb them while eating breakfast. However, the panel determined that you made insufficient efforts to take Resident A's vital observations and you confirmed in evidence that you did not complete basic checks for concussion. The panel took into consideration you have admitted charges 1c, 1d and 1e, that you failed to commence neurological observations, failed to ensure Resident A's movements were minimised and failed to complete the Falls Observations record. The panel determined that these would all contribute to an adequate assessment following Resident A's unwitnessed fall.

The panel took account of Witness 2's witness statement, which says:

> *'Throughout the shift I witnessed Josan come and check on resident A regularly. However, I do not recall her taking Resident A's observations (blood pressure etc.) at the time of the incident or thereafter and I did not witness her write any notes in Resident A's care notes.'*

The Home's Post Falls Protocol states that '*If a resident's fall was unwitnessed...a full assessment must be completed'*. It goes on to list the need to complete vital signs observations, neurological observations and a physical examination. The document states *'assume that if a fall was unwitnessed, the patient may have hit their head and undertake neurological observations...'.* The panel determined that, as the nurse in charge, you had a duty to undertake an adequate assessment and failed to do so.

The panel therefore finds this charge proved.

Charge 1g

That you, a registered nurse:

On 28 July 2021 in relation to the unwitnessed fall suffered by Resident A:

g) Failed to escalate the fall to the manager or suitable deputy;

This charge is found not proved.

Mr Sharma's said that as Witness 3, who was the Home manager, was on annual leave on 28 July 2021 either the deputy manager (Witness 4) or the clinical lead (Witness 6) could be considered a suitable deputy. This was supported by Witness 6 in his oral evidence.

Witness 4 gave evidence that she was present at the handover on 28 July 2021 and that you had not mentioned the fall. You gave evidence that Witness 4 was not present. Witness 6 told the panel that he could not recall if Witness 4 was present. Therefore, the

panel did not rely on the evidence of Witness 4 as it could not be satisfied that she was present at the handover.

Witness 6 said in his witness statement *'on this day [30 July 2021], nothing was mentioned regarding Resident A and that they had a fall. This was not mentioned on any of the handovers in the morning of 28 or 29 July 2021'.* However, the panel found Witness 6's answers to questions were often vague and his recall seemed poor in relation to some of the events at the time of the incident and decided it could not rely on this part of his evidence.

The panel saw your handwritten notes of the incident on your handover sheet, the care plan and the record of daily life. You were clear in your evidence that you read out your handover sheet notes at the handover, specifically *'28th found sitting on the floor, near [their] bed unwitnessed fall 6:45am, redness on Lt elbow, no other injury [sic] informed'.* The panel found your evidence in this regard to be persuasive.

The panel decided that whilst you did not treat the unwitnessed fall with the seriousness that it warranted, it determined that you did escalate the event to Witness 6 during the handover on the morning of 28 July 2021, which was approximately an hour after Resident A was discovered on the floor.

The panel determined that by verbally reporting the incident to Witness 6 at the handover, in the circumstances this amounted to escalation. Witness 6 was the clinical lead for the Home and was also the nurse in charge of the incoming day shift on 28 July 2021, he was a suitable deputy.

The panel therefore finds this charge not proved.

Charge 1h

That you, a registered nurse:

On 28 July 2021 in relation to the unwitnessed fall suffered by Resident A:

h) Failed to handover details of the fall;

This charge is found not proved.

As outlined in the panel's reasons for finding Charge 1(g) not proved, the panel accepted your evidence that at the handover on 28 July 2021 you read out what you had written on your handover sheet: *'28th found sitting on the floor, near [their] bed unwitnessed fall 6:45am, redness on Lt elbow, no other injury [son] informed'.* The panel determined that this was providing details of the fall. Further, the NMC's position was that reading these comments would amount to a verbal handover.

The panel determined that you did hand over details of the fall to the incoming day staff and therefore it finds this charge not proved.

Charge 2a

That you, a registered nurse:

On occasions on or after 28 July 2021:

2a) Incorrectly claimed to have escalated the fall to the manager;

The panel finds this charge not proved.

Having found Charge 1g not proved, it follows that this charge falls away.

Charge 2b

That you, a registered nurse:

On occasions on or after 28 July 2021:

2b) Your actions in charge 2) a) above were dishonest in that you knew you had not escalated the fall as you claimed to have done.

The panel finds this charge not proved.

Having found Charge 2a not proved, it follows that this charge falls away.

Charge 2c

That you, a registered nurse:

On occasions on or after 28 July 2021:

2c) Incorrectly claimed to have handed over the fall;

The panel finds this charge not proved.

Having found Charge 1h not proved, it follows that this charge falls away.

Charge 2d

That you, a registered nurse:

On occasions on or after 28 July 2021:

2d) Your actions in charge 2) c) above were dishonest in that you knew you had not handed over the fall as you claimed to have done.

The panel finds this charge not proved.

Having found Charge 2c not proved, it follows that this charge falls away.

Charge 2f

That you, a registered nurse:

On occasions on or after 28 July 2021:

2f) Your actions in charge 2) e) above were dishonest in that you intended to create a misleading impression that you carried out the necessary assessments and record creations contemporaneously when you had not.

The panel finds this charge proved.

The NMC's case is that you signed the Event form to indicate that you had contacted Witness 3 on 28 July 2021 and made him aware of the unwitnessed fall, when you had not done so. The NMC also allege that you had signed the Event form as having been completed on 28 July 2021 when you had not done so in order to mislead others that you had completed those tasks on the day of the event. Therefore, the panel considered these two issues separately.

The panel considered your oral evidence about your attempt to contact Witness 3 who was on annual leave at the time. It noted that on the event form you signed to say that you had contacted him and made him aware on 28 July 2021 at 09:00, however you later stated in evidence, that you tried to telephone him but were not able to reach him or leave a message. You did not attempt to contact him again until you sent him a WhatsApp message on 30 July 2021 which he confirmed he did receive. You accepted in your evidence that you had not made him aware on 28 July 2021, however you had ticked '*yes'* on the Event form to say you had done so. This was therefore an incorrect entry on the Event form and you were not able to explain why you had done this.

You admitted that you had created the Event form retrospectively (Charges 1(i) and 2(e)(i)). You told the panel that you completed the Event form on 30 July 2021 after having been told that Resident A had been admitted to hospital.

The panel concluded that it was more likely than not that you intended to create a misleading impression in the Event form that on 28 July 2021 you had made Witness 3 aware of the incident when in fact you did not do so until 30 July 2021.

You admitted that you completed the Event form retrospectively on 30 July 2021. You explained that you had signed and dated section 16 of the form under the heading *'Form Completed* by' as *'28.7.21'* and *'08.30am'* because that was the date of the event (the unwitnessed fall). You said that you had misunderstood how to complete the form. The panel heard evidence from other witnesses that this section should reflect the date the Event form was completed and not the date of the event being recorded which you had already recorded in section 2 where you had written *'28.7.21'* and *'6:45am'*. The

panel found your explanation that you were unaware of how to complete the form, implausible. It concluded that as an experienced nurse you would understand the importance of completing the form in a timely way and recording accurately when the form was completed.

Your entry in the daily records for Resident A on 28 July 2021 at 07:00 stated *'event form done*'. However, you have since admitted that you did not complete the Event form until 30 July 2021. The panel concluded it was more likely than not that when you found out Resident A had been admitted to hospital on 30 July 2021, you realised that you should have completed the necessary assessments and records contemporaneously and you therefore intended to give the misleading impression that you had completed the Event form on 28 July 2021.

In evidence you stated that you did not tell anyone that you had completed the event form or filed it in the care plan. The panel determined that it needed to be handed in to the manager in order for it to be uploaded onto the Radar healthcare risk register system. It determined that had you been transparent you would have done this rather than putting it into the care plan and then not telling anyone you had completed it.

The panel determined that it is more likely than not that you intended to give a misleading impression that you completed and signed the Event form on 28 July 2021. The panel decided that ordinary members of the public would consider this to be dishonest.

The panel therefore finds this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

There was an application by both parties that the panel should first hear submissions in regard to misconduct and then having reached its decision in regard to misconduct it should, if misconduct were found, consider the question of fitness to practise. The panel agreed with this approach.

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

Mr Sharma provided the panel with written submissions and made brief oral submissions on misconduct.

Mr Sharma submitted that the panel should find that the facts found proved amount to misconduct. He referred to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) and to the specific paragraphs where, in his submission, your actions amounted to breaches of those standards, namely: 1.2, 3, 4, 6, 10.1, 13.1, 17.1 and 20.2. He also referred to the case of *Nandi v GMC* [2004] EWHC 2317 (Admin):

‘The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners’.

He submitted that the nature and circumstances of the charges which were admitted and those found proved amount both individually and collectively to serious professional misconduct.

Mr Wilkinson provided the panel with written submissions. The panel confirmed with Mr Wilkinson that it is his position to remain neutral on the question of misconduct and that the decision on misconduct is to be left entirely to the panel. He confirmed he had no further submissions on misconduct.

The panel accepted the advice of the legal assessor.

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 determined that your actions did fall significantly short of the standards expected of a registered nurse, and amounted to breaches of the Code. Specifically:

1.2 make sure you deliver the fundamentals of care effectively

3 Make sure that people’s physical, social and psychological needs are assessed and responded to

4 Act in the best interests of people at all times

6 Always practise in line with the best available evidence

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.1 complete 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 records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required [in relation to Charge 1a]
20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.2 act with honesty and integrity at all times...

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel finds that Charges 1a, 1b, 1c, 1d and 1e which have been found proved amount to misconduct. The panel determined that these were very serious failings and you did not follow the required protocols and care plan. It determined that your actions fell significantly short of what would be expected of a nurse in your position. Further, there were multiple failings identified in Charges 1a – 1e and your actions posed a significant risk of harm to Resident A. The panel determined that fellow nurses would find your actions to be deplorable.

In relation to Charge 1(i)(i), the panel determined that failing to contemporaneously complete the event form may not always be so serious as to amount to misconduct, however, in the context of your other failings, did so.

In relation to Charge 2(e)(i), the panel determined that to have retrospectively completed the event form may not be always so serious as to amount to misconduct as long as it was made clear that it was a retrospective record. However, you did not make this clear on the event form, which created an incorrect record of what actions had been

taken and when, and therefore it is serious and amounts to misconduct.

In relation to Charge 2(f), the panel concluded that this dishonesty was particularly serious as it occurred in a clinical context. It determined that you were not acting in the best interests of Resident A, rather that you acted in your own best interest in order to create a misleading impression that you carried out the necessary assessments and record creations contemporaneously when you had not done so.

The nursing team, patients and families rely upon the accuracy and timeliness of record keeping and the honesty of nurses. Any dishonesty in practise not only causes risk of harm or further harm but also seriously damages the reputation and trust placed in the profession. The panel determined that your conduct at 2(f) amounts to misconduct.

For these reasons, the panel concluded that your actions individually and collectively did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

The panel heard further evidence from you.

The panel was provided with written submissions and heard brief oral submissions on impairment by Mr Sharma and Mr Wilkinson.

The panel accepted the advice of the legal assessor.

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 *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) in reaching its decision. In paragraph 74, she said:

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

The panel had regard to the principles set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether you have provided evidence of insight, remorse and strengthened practice.

In relation to insight, although you did make some admissions and demonstrated some understanding in regard to some aspects of your misconduct, you have not been able to demonstrate sufficient insight into how your actions put Resident A at a risk of harm. You did not demonstrate that you understood the gravity of the situation or the significant risks posed to Resident A, in particular by not completing adequate assessments or calling 999. Nor did you satisfy the panel that you sufficiently appreciated the impact your misconduct could have on your colleagues, the Home and the public's trust in nurses.

Under cross-examination you expressed some degree of remorse however the panel was not satisfied about its adequacy. You did not appear to have reflected on the impact that your misconduct could have had on Resident A, their family, your colleagues and the nursing profession.

The panel considered whether you have strengthened your practice. In addition to your oral evidence, it took into account the training you have completed since the incident and your reflective statement. The training that you have undertaken was only that required for your current role and provided by your employer. This did not address the specific concerns apart from one online course on record keeping. The supervision notes also did not directly address the concerns outlined in the charges. In your evidence you said that you had not read anything independently or undertaken any training of your own volition specific to the charges. The panel could not be satisfied that you had read and understood the Falls policy or the record keeping policy of the home where you are now working. Also, you were vague about which other policies you had read.

You have worked as a registered nurse in your current post for about a year without concerns, however this has been under supervision. Moreover, the two references from your colleagues did not refer to the specific concerns set out in the charges.

For all the reasons above, the panel could not be satisfied that you have strengthened your practice in relation to the charges found proved.

In paragraph 76 of her judgment, 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 determined that limbs a, b, c and d were engaged by your misconduct.

Resident A was put at risk of significant harm as a result of your misconduct. Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel determined that you have developing but limited insight, have not yet strengthened your practice and therefore a real risk of repetition of your misconduct in relation to Charge 1 remains.

In addition, the panel found you had been dishonest, and that this dishonesty was serious. However, the panel decided that it was relatively narrow in scope, isolated in nature, did not suggest deep-seated attitudinal failings and therefore was capable of being remedied. Nevertheless, the panel found your insight in relation to the finding of dishonesty to be very limited and concluded that there remains a risk of repetition.

The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining

public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel was satisfied that, having regard to the nature of your misconduct, the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of current impairment were not made. A reasonable, informed member of the public would be very concerned if your fitness to practise were not found to be impaired.

For all the above reasons the panel determined that a finding of impairment on public interest grounds is also required.

The hearing was adjourned on Friday 22 September 2023 after the panel had received written submissions and brief oral submissions on sanction from both Mr Sharma and Mr Wilkinson and received legal advice. The hearing resumed on Thursday 1 February 2024.

The legal assessor for the last two days of these proceedings had read the papers and offered further legal advice below.

Sanction

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

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

The panel accepted the advice of the legal assessor who referred the panel to the relevant parts of following legal authorities and the principles therein regarding denial of

allegations, insight and sanctions and the relationship between contesting the charges and insight, including *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin); *Nicholas-Pillai v GMC [2009]* EWHC 1048 (Admin); *Amao v Nursing and Midwifery Council* [2014] EWHC 147 (Admin); *Motala v GMC* [2017] EWHC 2923 (Admin); *Yusuff v GMC* [2018] EWHC 13 (Admin); *GMC v Khetyar* [2018] EWHC 813 (Admin); *GMC v Awan* [2020] EWHC 1553 and *Dhoorah v Nursing and Midwifery Council* [2020] EWHC 3356 (Admin).

Submissions on sanction

The panel was aware that in the original Notice of Hearing, dated 21 February 2023, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practice currently impaired. During the course of the hearing, the NMC revised its proposal and submitted that a suspension order for a period of medium length (suggested 6 months) would reflect the seriousness of this case.

NMC submissions on sanction

Mr Sharma provided both full written submissions and brief oral submissions, which included the following:

> *'The panel will consider whether this matter could be dealt with by way of taking no further action, but it is submitted that this case is too serious to be addressed by this option. The NMC's main concerns if no action were to be taken would be the lack of protection afforded to patients and sending entirely the wrong message to both the public and fellow registered professionals. In our submission these are serious matters requiring a robust sanction.*
>
> *18. In considering whether a caution order would be appropriate, the panel will have to evaluate any insight shown by Mrs Icot. In our submission, the evidence before the panel falls far short of showing a fully developed insight. We also submit that the conduct found proved in this case is too serious to be dealt with by a caution order.*

19. We submit that a conditions of practice order is not appropriate. Whilst we accept all charges with the exception of 2 f) involve failings which could be remedied with further training and assessment, in our submission the Registrant did not lack the knowledge of what should have been done. It became clear in her evidence that the Registrant knew what she should have done but failed to do so.

20. In our submission charge 2f) demonstrate a concerning deep seated attitudinal problem. Creating a misleading impression that something had been done when in reality it had not is particularly serious in nursing practice. In our submission, for these reasons, it would not be possible to devise a package of conditions which would adequately protect the public and uphold standards. [**Note:** the Legal Assessor pointed out that this submission was not consistent with the panel's determination that there was no deep seated attitudinal issue, and Mr Kewley accepted that this was correct and withdrew that submission].

21. The NMC sanction guidance suggests a suspension order may be appropriate where there is a single incident and there are no underlying attitudinal concerns. Although the charges in this case stem from a single event, in our submission there are several distinct parts of the incident which give rise to the concerns. As we have noted above, in our submission there may also be attitudinal issues involved in this case.

22. Having taken account of the observations above, the panel may conclude that a suspension order would not be appropriate. We would invite the panel to take careful account of the period of practice without further incident together with the long period of safe practice before the incident and weigh this up along with any insight shown. If the panel consider the Registrant has started to develop insight, in our submission a suspension order may be appropriate. Only if the panel conclude that no or wholly insufficient insight has been evidenced should the panel move on to consider a striking off order.

23. The conclusion we reach is that a suspension order may be appropriate. The Registrant was responsible for serious professional misconduct including dishonesty however she has a long history of previous safe practice and has continued to practice without further incident or concern. Although the NMC do not consider the Registrant's insight to be fully developed, this is something she has started to develop and can be assessed again before a return to unrestricted practice.

The NMC therefore submit that the appropriate sanction is a suspension order of medium length (suggested 6 months) to reflect the seriousness of this case'.

Mr Wilkinson's submissions on sanction

Mr Wilkinson took the panel through all the available sanctions in ascending order and made submissions on whether they were appropriate and proportionate in your case.

He submitted that a conditions of practice order for 12 months would serve to ensure that you are accountable and undertake development, thus maintaining public protection. It would also serve the public interest by maintaining confidence in the profession as the NMC will be seen to uphold and promote proper standards of practice.

Mr Wilkinson submitted that should the panel agree to conditions of practice he requested that the panel set out conditions similar to those interim conditions already in place and contained in his written submissions.

Mr Wilkinson submitted that any sanction should balance your interests and right to practise, against the NMC's duty to protect the public and the wider public interest. He submitted that a conditions of practice order for a period of 12 months would be sufficient to address regulatory concerns identified. He further submitted that a suspension order would not be necessary nor proportionate in this matter.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Resident A was a vulnerable elderly person in a nursing home who was relying on you to provide effective care
- Your conduct put Resident A at risk of suffering significant harm by not acting appropriately
- Your limited insight into some of the failings particularly around the misleadingly dated retrospective documentation

The panel also took into account the following mitigating features:

- The dishonesty was relatively narrow in scope, was a single isolated incident and was not premeditated
- Evidence of some relevant reflections and training (albeit limited to mandatory training)
- You made a number admissions at the outset of the hearing.

The panel had regard to the Code and referred to the guidance SAN-2 ‘Considering sanctions for serious cases’.

The panel was of the view that Resident A was vulnerable but had already been transferred to hospital at the time you created misleading retrospective documentation and therefore was not put at further direct risk by your actions. It determined that your dishonest conduct was less serious as this was a one-off isolated incident and your action was opportunistic and/or spontaneous in nature. It had already determined, earlier in the hearing, that there were no concerns about you having a deep-seated

attitudinal problem. It further determined that there was no direct personal gain on your part, save that you were seeking to avoid the consequences of not recording matters contemporaneously and therefore acting in your own interests rather than those of Resident A and the Home. The panel also noted that you have been no previous regulatory concerns in relation to your practice and therefore considered your conduct to be on the less serious end of the spectrum of dishonesty.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and it would not provide public protection. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*

- *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 bore in mind that its decision on fitness to practise is forward looking, focusing on current fitness to practise and is not intended to be punitive.

The panel determined that it would be possible to formulate appropriate and practical conditions which should enable you to address the serious clinical failings highlighted in this case and would provide adequate public protection. The panel noted that although you had undertaken some training and reflections, this was insufficient to fully address the clinical failings.

The panel determined that the dishonesty charge found proved was also capable of being remediated, as stated earlier in the determination on impairment. The panel accepted that you would be willing to comply with conditions of practice and noted you have been working since November 2021 under interim conditions of practice without any concerns.

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

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order for a period of 9 months with a review. The panel concluded that 9 months would be sufficient for you to comply with the conditions of practice, strengthen your practice and to mark the seriousness of the misconduct.

The panel was of the view that to impose a suspension order would be disproportionate and it would not be in the public interest in the circumstances of your case.

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

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

1. You must keep the NMC informed about anywhere you are working by:
    a. Telling your case officer within seven days of accepting or leaving any employment.
    b. Giving your case officer your employer’s contact details.

2. You must keep the NMC informed about anywhere you are studying by:
    a. Telling your case officer within seven days of accepting any course of study.
    b. Giving your case officer the name and contact details of the organisation offering that course of study.

3. You must immediately give a copy of these conditions to:
    a. Any organisation you work for.
    b. Any agency you apply to or are registered with for work.
    c. Any employers you apply to for work (at the time of application).
    d. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

4. You must tell your NMC case officer, within seven days of your becoming aware of:
    - Any clinical incident you are involved in.

- Any investigation started against you
- Any disciplinary proceedings taken against you.

5. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   - Any current or future employer.
   - Any educational establishment.
   - Any other person(s) involved in your retraining and/or supervision required by these conditions.

6. You must limit yourself to one single employer organisation. This may be an agency provided your placement is for a period of three months or more and in only one place of work.

7. You must ensure that you are supervised by a registered nurse of the same band as you or above at any time you are working. Your supervision must consist of:

   - Working at all times while being directly supervised for a minimum of four weeks and until assessed as competent to work under indirect supervision. You must be assessed by your supervisor in the following areas of practice:
     (a) Effective management of patients who have had a witnessed or unwitnessed fall
     (b) Assessment and escalation of deteriorating patients
     (c) Record keeping
     (d) Working knowledge of all policies and procedures in your workplace

8. You must give a copy of this determination to your supervisor.

9. You must meet with your line manager or supervisor (or their nominated deputy) fortnightly to create and update your PDP (to include relevant

training) designed to address the concerns about the following areas of your practice:

(a) Effective management of patients who have had a witnessed or unwitnessed fall
(b) Assessment and escalation of deteriorating patients
(c) Record keeping
(d) Working knowledge of all policies and procedures in your workplace

10. You will send the NMC a report on your progress in completing the Personal Development Plan (PDP). This should be submitted at least seven days in advance of the next NMC hearing or meeting from either:
    - your line manager (who must be a registered nurse); or
    - supervisor.

11. You must send your NMC case officer, at least seven days before any review, evidence that you have successfully completed assessed training[1] in the following areas of practice:
    (a) Effective management of patients who have had a witnessed or unwitnessed fall
    (b) Assessment and escalation of deteriorating patients.

12. You must send a reflective piece using a recognised reflective model, at least seven days before any review addressing the following areas:
    - The impact of your failings on Resident A, your colleagues, your employer and the wider nursing profession
    - How you would act differently in a similar situation in the future, particularly in relation to management of patient falls and related documentation
    - How you have strengthened your practice since these incidents with reference to the charges found proved

[1] The aim is for an assessed course, for example, that is not only completed through attendance

- What you have learned from any relevant training you have undertaken
- The importance of honesty in nursing and in particular the relation to record keeping

The period of this conditions of practice order is for nine months with review.

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

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Kewley. He submitted that a 18 months interim conditions of practice order is appropriate and proportionate in this case given the panel's determination on sanction.

Mr Wilkinson submitted that the interim conditions of practice order should mirror the substantive order, otherwise raised no objection to the application.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the

facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

This will be confirmed to you in writing.

That concludes this determination.