Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting

27 – 28 February 2020

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

Name of registrant:	Mteto Morrison Njomi
NMC PIN:	00I1224O
Part(s) of the register:	Registered Nurse – Sub part 1 – Mental Health Nursing (1 October 2000) Registered Nurse – Sub part 1 - Adult Nursing (25 July 2014)
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Tim Skelton (Chair, Lay member) Catherine Lamb (Registrant member) James Hurden (Lay member)
Legal Assessor:	James Holdsworth
Panel Secretary:	Rob James
Facts proved:	1a, 1b, 1c, 2a, 3a, 3b, 3c, 3d, 4ai, 4aii, 4b, 5, 6a, 6b
Facts not proved:	2b, 4c
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim Order:	Interim suspension order (18 months)

Details of charge:

That you, a Registered Nurse:

1) On 6 June 2018:

   a) Failed to administer Sinemet to Resident A and/or ensure that such medication was administered;

   b) Inaccurately recorded that you had administered Sinemet to Resident A;

   c) Left Resident A's Sinemet medication in a pot on drug trolley;

2) On 21 July 2018:

   a) Failed to administer insulin to Resident B and / or ensure that insulin was administered;

   b) Failed to record the insulin administered / provided to Resident B;

3) Failed to administer Alendronic Acid to one, or more, resident's on:

   a) 6 July 2018;

   b) 13 July 2018;

   c) 30 July 2018;

   d) 13 August 2018

4) On the nightshift of 12 / 13 August 2018:

a) Failed to following instructions from a GP to monitor Resident C's:

i) blood sugar / BM;

ii) ketones;

b) Failed to carry out observations in relation to Resident C who had badly controlled diabetes;

c) Failed to record your actions / observations referred to at charges 4 (a) and / or 4 (b) above:

i) Accurately;

ii) At all;

5) Failed to disclose to United Response that you were subject to an interim conditions of practice order;

6) You conduct at charged 5 above was dishonest in that:

a) Knew that you were required to disclose the existence of the interim conditions of practice order to any prospective employer at the time of application;

b) Intended to conceal the existence of the interim conditions of practice order.

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

Decision on Service of Notice of meeting

The panel was informed at the start of this meeting that written notice of this meeting had been sent to Mr Njomi's registered address by recorded delivery and by first class post on 10 January 2020.

The panel accepted the advice of the legal assessor that the notice of this meeting had been sent in accordance with Rules 11A and 34 of the Nursing and Midwifery Fitness to Practise Rules (2004).

In the light of all of the information available, the panel was satisfied that Mr Njomi had been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the rules.

Background

On 6 June 2018, Mr Njomi had worked a nightshift at Oaken Holt Nursing home ("the Home"). A dayshift carer, Ms 1, found a pot of medication in the drug trolley that had been dispensed but not given to Resident A. Following identification of the resident, who confirmed they had not received their morning medication, the Medication Administration Record ('MAR') was checked and it was found that the medication had been signed as administered by Mr Njomi.

On 21 July 2018, Ms 2, the day nurse attended for duty and noted that a resident had not been administered her insulin. The resident had been due to receive 36 units of insulin, however there were only 18 units left of her prescription. Instead of giving her the 18 units and then arranging for a new prescription, it is alleged that Mr Njomi administered no insulin at all.

On 6 July 2019, 13 July 2018, 30 July 2018 and 13 August 2018 it is alleged that Mr Njomi failed to administer Alendronic Acid to a number of the residents.

On 12 August 2018, Resident C, who had health problems including poorly controlled diabetes and erratic blood sugar levels, was visited in the Home by an out of hours GP. The GP provided instructions that the resident's blood sugar and ketones were to be monitored overnight. Other instructions were also left which stated that the out of hours GP should be called again if the BM and ketones did not come down. Mr Njomi was present at the handover from the day staff while the doctor was present and while the doctor was giving specific instructions in relation to monitoring blood sugar levels and ketones. The following morning the residents own GP called for an update and it was found that Mr Njomi had not monitored or recorded the resident's blood sugar levels and ketones overnight.

Mr Njomi was placed on an Interim Conditions of Practice Order on 2 November 2018. On 1 December 2018, he commenced full time employment with nursing agency, United Response, as an HCA. A review hearing for the Interim conditions of practice order was to be held on 2 May 2019. In preparation for the review hearing, Mr Njomi's current nominated employer was contacted and it was found that he had not notified them of the ICOPO or of his dismissal from the Home. It is said that Mr Njomi's conduct was dishonest.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case. It also heard and accepted the advice of the legal assessor.

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 the facts will be proved if the panel was satisfied that it was more likely than not that the incidents occurred as alleged.

The panel considered each charge and made the following findings:

Charge 1:

1) On 6 June 2018:

a) Failed to administer Sinemet to Resident A and/or ensure that such medication was administered;

b) Inaccurately recorded that you had administered Sinemet to Resident A;

c) Left Resident A's Sinemet medication in a pot on drug trolley;

These charges are found proved.

In considering this charge, the panel had regard to the evidence of Ms 1. In her NMC witness statement she said:

> *"When I went to the medication trolley. I found a pot with either two or three tablets in it. I knew that these were the 0730 tablets for Resident A. She was the only resident in there who got these tablets in the morning.*
>
> *I checked her MARR sheet and saw that the initials "NM" were on the sheet at the 0730 tablets, so he had signed to say that he had given them.*
>
> *At that time [Resident A] was able to say if she had the tablets. I spoke to her and she said that she hadn't had them that morning. I knew that this was a mistake that had been made and that I had to tell the manager about it. I went to the manager with the tablets and told her what I had found."*

The panel took account of the MAR chart as included in the NMC bundle. The evidence of Ms 1 was that she had found two or three Sinemat tablets in a pot. She realised that these were for Resident A because Resident A was the only resident in the Home who had been prescribed this medication. The panel also noted that Ms 1 asked Resident A if she had taken her morning tablets and she confirmed she had not. Despite the fact

that these tablets had not been administered, Mr Njomi nevertheless signed the MAR chart as if they had been given.

The panel noted the evidence of Ms 1 and in particular, that she had brought this failure to the attention of her manager on 6 June 2018. The panel had sight of a record of a supervision meeting between Mr Njomi and Ms 3 on 13 June 2018 in which this failure was discussed. The panel determined that this meeting occurred as a result of Ms 1 referring this incident to her manager which, in the panel's view, increased the reliability of her evidence.

The panel also took account of the witness statement of Ms 3, the Deputy Manager of the Home, who recalled Mr Njomi stating during an investigatory meeting that he could not remember if he administered the medication or not. The panel also took account of the fact that Mr Njomi seemed to dispute this allegation in a fact finding meeting that took place on 17 August 2018.

The panel was of the view that the evidence of Ms 1 was more convincing than Mr Njomi's replies given during the investigatory meeting. The panel therefore found the charges proved.

Charge 2a:

2) On 21 July 2018:

a) Failed to administer insulin to Resident B and / or ensure that insulin was administered;

This charge is found proved.

The panel had regard to the evidence of Ms 2. In her witness statement she said:

"The first incident referred to on the list happened on 21 July 2018. I was on duty and had taken over from Morrison. One of the residents in the Home, Resident B, was diabetic and got 36 units of insulin in the morning. She had only 18 units of insulin left. Instead of giving her that 18 units and then arranging for me to get her a new prescription in the morning, Morrison had not given her anything. When I started duty, I gave her 18 units initially and then arranged for a new prescription to be collected.

In my opinion it was better to give her the 18 units straight away and then give the rest as it was available. It would have been 'under dosing' but in my professional opinion that would have been better than giving her nothing."

The panel noted the handwritten note also completed by Ms 2 and was of the view it was consistent with the evidence in her NMC statement.

The panel also had regard to the investigatory meeting notes of the investigatory meeting on 17 August 2018 in which Mr Njomi appeared to suggest that the medication had been administered but not recorded.

The panel took account of the fact that the MAR chart for Resident B, as included in the NMC bundle, suggested that Mr Njomi administered insulin to Resident B on days leading up to 21 July 2018 and those following but not on the day in question. The MAR chart also confirms that Ms 2 administered 18 units of insulin which is consistent with her witness statement.

The panel concluded that the evidence of Ms 2 is entirely credible and consistent with the contemporaneous entry in the MAR chart. It therefore found the charge proved on the balance of probabilities.

Charge 2b

2) On 21 July 2018:

a) Failed to record the insulin administered / provided to Resident B;

This charge is found NOT proved.

Having found that Mr Njomi did not administer the insulin or ensure that it was administered to Resident B on 21 July, the panel determined that it would follow that there was nothing for him to record. The panel therefore found the charge not proved.

Charge 3a

3) Failed to administer Alendronic Acid to one, or more, residents on:

a) 6 July 2018;

This charge is found proved.

The panel had regard to the diary entry as included in the NMC bundle. It considered that it is clear that a handwritten note was left asking Mr Njomi to "*do all alendronic acid tablets in coach house tomorrow morning*".

The panel had regard to the fact that Mr Njomi did not contest this allegation. In fact, it noted his comments when asked about the administration of alendronic acid tablets on the dates included in charge 3 during the investigatory meeting on 17 August 2018. At this time he responded, "*Yes I do but if I am in a hurry and it's not my regular shift I'm likely to make mistakes, if I'm rushing I only see drugs I'm routinely used to*." The panel considered this to be a partial admission.

Having taken the evidence into account, the panel found the charge proved.

Charge 3b

3) Failed to administer Alendronic Acid to one, or more, resident's on:

b) 13 July 2018;

This charge is found proved.

The panel took account of the entry in the diary entry dated 13 July 2018 in which Mr Njomi was asked to give the relevant residents at the Home their alendronic acid tablets which had been due the day before and had not been administered by Mr Njomi.

The panel also took account of Mr Njomi's comments during the investigative interview on 17 August 2018 in relation to the mistakes he might make when administering this medication which he was not familiar with.

The panel took account of the notes from the disciplinary hearing that took place on 5 September 2018. In particular Mr Njomi's comment:

> *"I actually owned up to the error on 13th [July 2018]. I put my hands up and I agree. I have learned from it. Normally on my shift I do not give mediation on this day. I do not usually give weekly medication."*

The panel considered that this amounted to a partial admission in relation to 13 July 2018. Taking into account Mr Njomi's comment along with the other documentary evidence, the panel found the charge proved.

Charge 3c

3) Failed to administer Alendronic Acid to one, or more, resident's on:

c) 30 July 2018;

This charge is found proved.

The panel had regard to the witness statement of Ms 2. In relation to the administering of the alendronic acid on 30 July 2018 she stated:

> *"The next point mentioned on the list is about Morrison not giving residents their alendronic acid on 30 July 2018. Alendronic acid was prepared for several of the residents in the Home. There were different sides to the Home, one residential and one nursing. The one side got their alendronic acid on the Thursday and the other side on the Monday.*
>
> *Morrison usually worked on the nursing side, and if he was covering the residential side he was not used to it, so he would forget to give the alendronic acid.*
>
> *That should really not have happened because the alendronic acid is shown on the individual residents' MARR sheets. Morrison should have been checking these when he was giving their medication. It was even more important that he check the MARR sheets if he was not familiar with the unit, or the residents' medication."*

The panel also took account of the evidence of Ms 3 in relation to the alendronic acid on the above date. She stated:

> *"Morrison had failed to give this to three of the residents on the morning of 30 July….The nurse on the day shift each time had discovered that the MARR sheet had not been marked up by Morrison to say that the medication had been given."*

The panel had in evidence before it, the relevant MAR chart which clearly indicates that the alendronic acid was not administered to three residents.

The panel had regard to the diary entry on 30 July from Ms 1 who asked another member of staff to administer the alendronic acid as Mr Njomi "*did not give it on Monday*".

Taking into account the MAR chart along with the evidence of Ms 2 and Ms 3, the panel found the charge proved.

Charge 3d

3) Failed to administer Alendronic Acid to one, or more, residents on:

d) 13 August 2018

This charge is found proved.

The panel took account of the witness statement of Ms 3. She stated:

> *"…He also failed to give it to three residents on the morning of 13 August too. The nurse on the day shift each time had discovered that the MARR sheet had not been marked up by Morrison to say that the medication had not been given."*

The panel also took account of a handwritten statement completed by Ms 4 on 13 August 2018 which stated:

> *"Today 13.08.18 during morning medication round I have discovered that alendronic acid 70mg tb hasn't been given for all residents in nursing ___ by night nurse Morrison Njomi.*
>
> *I have left message for night nurse [Ms 5] to give the alendronic acid 70mg next day in the morning for Resident F, Resident E, Resident G, Resident D."*

In her witness statement Ms 4 commented:

"The other thing that happened that same morning was that I noticed that Morrison had not given some of the residents their alendronic acid. This is medication for bones that some of the residents are given every Monday morning.

I noticed that Morrison had not signed the MARR sheets for the medication and so I counted the tablets to check if he had not given it or just not signed. I realised that he had not given the medication and so left a message for the nurse on duty that night to give it the next morning."

The MAR charts in relation to three residents indicate that the alendronic acid had not been administered to those residents.

The panel determined that the evidence that Mr Njomi did not administer alendronic acid on 13 August 2018 to one or more residents was credible and consistent. It found the charge proved.

Charge 4a

4) On the nightshift of 12 / 13 August 2018:

d) Failed to following instructions from a GP to monitor Resident C's:

iii) blood sugar / BM;

iv) ketones;

This charge is found proved.

The panel took account of the witness statements of both Dr 6 and Dr 7.

In his statement Dr 6 stated:

"On the evening of 12 August 2018 I was working in my capacity as an out of hours GP when I attended the Oaken Holt Care Home in Witney. I attended to see a female resident. She was a diabetic lady who had very badly controlled diabetes with blood levels that were eratic.

Having examined the resident and noted her BM, she was given a further four units of Novorapid (Insulin). I then gave her instructions that the resident was to be monitored and that if her BM didn't go down, out of hours was to be called back.

In the medical notes I have noted that she should not be given sugary drinks, and that her BM and ketones should be monitored. I left instructions that if her BM was not under 24, or of her ketones were more than 3, out of hours should be called back.

I cannot recall which nurse or nurses were present at the time and I cannot recall who I gave that instruction to.

The lady in question was a very unstable diabetic at this time. It was essential that her blood sugar was monitored as there was a real risk of her developing Diabetic Ketoacidosis. I am now aware her blood sugar was not monitored throughout the night after I left around 8:15, until 8:00am the following morning."

Dr 7 phoned the Home regarding Resident C the next morning. She was informed that blood sugar readings had not been taken as instructed by Dr 6. In her witness statement she said:

"This was a source of concern to me as the nightshift nursing team appeared to have failed to follow important instructions from the out of hours GP. The nurse to whom I was speaking did not appear to comprehend my concerns and so I asked

to speak with the line manager. My understanding is that the nurse I spoke with at the time was not the same nurse who is subject to this investigation."

The panel noted the statement of Ms 8, who was employed at the Home as the day Nurse. In relation to Dr 6's instruction, she stated that:

"The doctor's instructions were very clear to me that her blood sugar was to be monitored. I am sure that Morrison was also chatting to the doctor while I was still in the room too."

I think the doctor must have told Morrison about monitoring her blood sugar. He had also said he would call back to make sure her blood was OK. I also said to Morrison to make sure he did it."

The panel also had regard to the consultation notes as included in the NMC bundle. It was clear that Mr Njomi had been instructed to monitor Resident C's blood sugar and ketones.

The panel noted Mr Njomi's comments in relation to this allegation during the fact finding meeting on 17 August 2018. He stated:

"The doctor asked me to give 4 units. Nothing else was specified."

During the investigation, Mr Njomi also stated that Resident C was asleep and that he knew that her blood sugar levels would be tested in the morning. He further said that he did not want to disrupt the resident during the night.

The panel was of the view that Dr 6's instructions were very clear to Mr Njomi. As the nurse on shift on the night in question, he had a duty to follow the instructions given by the doctor and did not do this. It is apparent that Ms 8 understood the importance of Dr 6's instruction and reminded Mr Njomi of his responsibilities, but Mr Njomi, for reasons

unclear to the panel, did not undertake the instruction to monitor either Resident C's blood pressure or ketones during the night shift. The panel therefore found the charge proved.

Charge 4b

4) On the nightshift of 12 / 13 August 2018:

b) Failed to carry out observations in relation to Resident C who had badly controlled diabetes;

This charge is found proved.

The panel had regard to the statement of Dr 6. It was apparent that Mr Njomi had a duty to observe Resident C following Dr 6's instruction.

The panel noted that Mr Njomi was the only Registered Nurse on shift on the night in question. It noted the rota that confirmed this.

Dr 7 had called to find out what the results of the blood sugar readings were. In her statement she said:

> "*Having carried out my review of the record, I contacted Oaken Holt to learn what the blood sugar readings had been and what they were now. I was advised by the member of staff who answered that this had not been done."*

Ms 3. In her witness statement said:

> *"On the morning of 13 August 2018 however, another issue arose and it was as a result of this that an investigation was opened. That morning, a telephone call was received from a local GP by the manager. In that call she had said that*

Morrrison had failed to follow the instructions of an out of hours GP about monitoring the Blood Sugar levels of a diabetic resident."

In the fact finding interview on 17 August 2018, Mr Morrison denied that he had been asked by Dr 6 to make observations on Resident C and commented that he was "*only given instruction to let Resident C's own GP know and give four units of Novorapid* insulin."

The panel considered the evidence of Dr 6, Dr 7 and Ms 3 was credible and consistent. It found the charge proved on the balance of probabilities.

Charge 4c

4) On the nightshift of 12 / 13 August 2018:

c) Failed to record your actions / observations referred to at charges 4 (a) and / or 4 (b) above:

i) Accurately;

ii) At all;

This charge is found NOT proved.

The panel had regard to its findings at charges 4a and 4b. Having found that Mr Njomi did not follow the instruction of Dr 6 and did not carry out observations of Resident C during the night in question, the panel determined that it would not be logical for Mr Njomi to have recorded something he did not do. The panel therefore found the charge not proved.

Charge 5

5) Failed to disclose to United Response that you were subject to an interim conditions of practice order;

This charge is found proved.

The panel had regard to the interim conditions of practice order that was imposed on 2 November 2018. It noted, in particular, condition 9(c) which states that Mr Njomi must inform "any prospective employer (at the time of application)" that he was the subject of an NMC interim conditions of practice order. The order was widely drawn to include any employer.

The panel took account of Mr Njomi's application to United Response for the role of "support worker" dated 15 November 2018, 13 days after the interim conditions were imposed at a hearing when Mr Njomi was present and represented. On the application form, Mr Njomi stated that "*I am now a retired nurse*". Mr Njomi did not, at any stage, mention the interim conditions of practice order that had been imposed.

The panel had regard to the fact that Mr Njomi attended the interim order hearing and was represented.

Mr Njomi's employment by United Response was discovered by the NMC in preparation for the first review of the interim conditions of practice order.

The panel had regard to the witness statement of Mr 9. He said:

> *"When Morrison was interviewed he did not tell me that he had any conditions of practice imposed by the NMC. It didn't come up in the interview, but I wasn't interviewing him for a nursing post.*
>
> *He did not make any mention of any issues with any previous employers either.*
>
> *With the particular clients he was being recruited to support, he would have known that he was expected to dispense medication for them. "*

The panel considered it had no reason to doubt the credibility of Mr 9's statement. It is apparent that an interim conditions of practice order had been made in relation to Mr Njomi, that he was aware of it and yet failed to disclose it to United Response. Although Mr Njomi was not taking on a registered nursing role, he was applying for a role in healthcare which would require him to administer medication. The panel was aware that the interim conditions of practice order was drawn up to address concerns about several areas of Mr Njomi's nursing practice including medication administration. The panel therefore found the charge proved.

Charge 6

6) You conduct at charged 5 above was dishonest in that:

a) Knew that you were required to disclose the existence of the interim conditions of practice order to any prospective employer at the time of application;

b) Intended to conceal the existence of the interim conditions of practice order.

This charge is found proved.

The panel accepted the advice of the legal assessor who, in addressing the panel in relation to the issue of dishonesty, referred to the case of Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67:

> *"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief*

as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards dishonest".

The panel had regard to the fact that Mr Njomi was in attendance at the interim order hearing and was legally represented. The interim conditions were clear in that he needed to disclose them to "any prospective employer". Mr Njomi completed the application to United Response just 13 days following the interim conditions becoming effective. If Mr Njomi had any reservations about the need to disclose the interim conditions, he would have been aware that he could have asked either his representative at the Royal College of Nursing (RCN) or the NMC Case Officer. The panel had not been provided with anything that led it to be believe that Mr Njomi had taken this line of enquiry.

The evidence of Mr 9 was clear. Mr Njomi had not mentioned that he was under interim conditions of practice at any point; either on the application form for the role of "support worker" or during the interview. It was clear that Mr Njomi had not been open about the restrictions on his practice and had sought to keep their existence from United Response.

The panel next went on to consider if a right thinking member of the public would consider Mr Njomi's actions to be dishonest. It concluded that any person would expect Mr Njomi to be open about the restrictions on his practice and that, despite the fact that he was not applying for a nursing role, he should have been honest with United Response and informed them of his interim conditions of practice order, particularly as the role applied for involved management and administration of medication to patients.

The panel therefore found Mr Njomi's actions to be dishonest and found the charge proved.

Decision on misconduct

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) ("the Code").

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that Mr Njomi's action, which involved various drug administration errors, observation errors, failure to follow the instruction of a doctor and dishonesty by failing to disclose the existence of an interim order, did fall significantly short of the standards expected of a registered nurse, and that his actions amounted to breaches of the Code. Specifically:

> ***Practise Effectively***
>
> *You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.*
>
> ***Preserve Safety***
>
> *You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put*

patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.
13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care.

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

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, treating people fairly and without discrimination, bullying or harassment

23 Cooperate with all investigations and audits
This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.
To achieve this, you must:
23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that although Mr Njomi admitted

some of his failings, he had demonstrated something of a careless approach to medication administration and observations that put patients at risk. Mr Njomi had also failed to follow clinical instructions from a doctor concerning an unstable diabetic patient thereby putting the patient at risk of serious harm. Although an isolated medication error may not have been deemed misconduct, when looking at his failings in the round, he put several residents at risk of harm over several weeks despite having supervision at the time. Furthermore he failed to inform a prospective employer of an interim conditions of practice order which would be considered to be deplorable by fellow nurses and fell seriously short of the conduct and standards expected of a nurse.

The panel concluded that Mr Njomi's actions amounted to misconduct.

Decision on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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 judgement 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.

Mrs Justice Cox went on to say in Paragraph 76:

> I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for

panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

> Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
>
> a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
>
> b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
>
> c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
>
> d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.

The panel finds that Mr Njomi's failings engaged all four limbs of the Grant judgment. His clinical failings put the residents at the Home at unwarranted risk of harm and also brought the profession into disrepute. His failure to inform his employer of the interim conditions of practice order that was imposed 13 days before his application for a health care position was dishonest and, along with the clinical misconduct, breached fundamental tenets of the nursing profession.

The panel was of the view that Mr Njomi's clinical failings were remediable. However, it noted that he had been offered help and guidance to improve his nursing practice by management at the Home but despite this support, had failed to address his clinical

shortcomings. The panel considered that this showed a lack of insight and a disregard for the effect that his failings may have on the residents at the Home or the colleagues that worked alongside him. The errors made by Mr Njomi mainly consisted of basic fundamentals of nursing care that needed to be done to ensure that the residents at the Home were cared for safely. Mr Njomi failed in his duties.

The panel also took account of Mr Njomi's failure to disclose the interim conditions of practice order. He knew that he had to disclose the order to any prospective employer but decided to deceive the prospective employer and undermine the interim conditions. Mr Njomi was aware of the concerns that related to his medication administration but chose not to make a prospective employer aware of this when knowing that his role would include medicine management.

The panel had regard to Mr Njomi's comments during the internal investigation into his clinical shortcomings and noted that the excuses given demonstrated no remorse and a casual non-caring attitude to his failings.

The panel is of the view that there is a risk of repetition based on Mr Njomi's lack of insight or remediation and failure to understand the seriousness of his failings. The panel therefore decided 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/protect the wider public interest, which 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 determined that, in this case, a finding of impairment on public interest grounds was also required. It was of the view that a member of the public would be concerned if the NMC, as the regulator of nursing, considered that Mr Njomi's misconduct, which involved both clinical failings and attitudinal issues, was not marked.

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

Determination on sanction:

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Njomi off the register. The effect of this order is that the NMC register will show that he has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case. The panel accepted the advice of the legal assessor. 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 Sanctions Guidance ("SG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel considered the following to be aggravating factors in the case:

- Mr Njomi put vulnerable patients in his care at risk on more than one occasion;
- Mr Njomi failed to respond to training opportunities despite being given management support to address his shortcomings;
- Mr Njomi was found to have acted dishonesty;
- Mr Njomi demonstrated no evidence of insight, remorse or remediation.

The panel was of the view that there were no mitigating factors in the case.

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

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to*

practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that Mr Njomi's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

Mr Njomi has demonstrated an inability to comply with conditions previously imposed on him which in itself makes a conditions of practice order inappropriate.

Furthermore, the panel had regard to the fact that Mr Njomi stated on his application form to United Response that he had retired from being a Registered Nurse.

For these reasons, it concluded that there were no workable or appropriate conditions that could be made.

The panel concluded that the placing of conditions on Mr Njomi's registration would not adequately address the seriousness of this case, particularly the aspect of dishonesty, and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG indicates that a suspension order would be appropriate where (but not limited to):

- a single instance of misconduct but where a lesser sanction is not sufficient
- no evidence of harmful deep-seated personality or attitudinal problems

- no evidence of repetition of behaviour since the incident
- the Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour

The panel viewed this case against the totality of its timeline. What began in mid 2018 were some simple errors in the management and administration of medication. Mr Njomi was offered help, support and training to rectify these shortcomings. These failings could and should have been easily addressed without the involvement of the NMC had Mr Njomi accepted that there was an issue with his nursing practice.

The seriousness of Mr Njomi's failings, however, increased. By failing to act on a doctor's reasonable and rational requirement for a vulnerable resident to be properly monitored throughout the night, he demonstrated a total disregard for the safety of that resident.

When these failings were no longer able to be addressed at a local level, the concerns were raised to the NMC and led to Mr Njomi appearing before the investigating committee.

Any professional, who is responsible for reflecting on and developing their own practice, should and would have acknowledged that there must have been an issue with how they work for matters to have arrived at this juncture. Indeed, it appeared that Mr Njomi had acknowledged this issue to a panel of this regulator who imposed the interim conditions of practice order.

However, it is apparent that this expression of insight into the failing in his practice was not genuine. Within 13 days of the Investigating Committee imposing the interim conditions of practice order, Mr Njomi had applied for a post that he knew involved the management and administration of medication to patients, in a non-regulated role. He acted dishonestly by concealing the failings of his practice from his new employers to

gain employment, when any responsible healthcare professional should have put the safety of potential patients first, not their own self interest.

It is the view of the panel that Mr Njomi's actions represent a clear attitudinal issue. His unsafe and poor nursing practice has been highlighted to him by colleagues, managers, union representatives and this regulator's independent panel members. Yet rather than accept there must be an issue, Mr Njomi concealed his failings and applied for a new job, in a non-regulated role, where these failings could again impact on the safety and wellbeing of patients.

The panel therefore concluded that a suspension order was not appropriate in this case.

The panel therefore concluded that a striking off order would be the only appropriate sanction. It had regard to the SG which indicates that a striking off order would be appropriate when what the nurse has done is fundamentally incompatible with being a registered professional and may include the following:

- Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?
- Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?
- Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?

Mr Njomi's attitude is considered by the panel to be fundamentally incompatible with the attitudes and behaviours expected of a Registered Nurse, who must at all times seek to protect patients from risks of harm including those posed by their own nursing abilities. This attitude is not, in the panel's view, remediable. If it were, it would have been remediated at a far earlier stage than these proceedings. The panel considered that all three tests as set out above are met.

For these reasons, the panel considered that this order was necessary to protect the public and mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

Determination on Interim Order

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension 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. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim order will be replaced by the striking-off order 28 days after Mr Njomi is sent the decision of this hearing in writing.

That concludes this determination.

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