Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
4 – 7 May 2021
13 – 14 September 2021

Nursing and Midwifery Council
Virtual Hearing

Name of registrant:	**Antenio Porte**
NMC PIN:	03L0930O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing 24 December 2003
Area of registered address:	Carlisle
Type of case:	Misconduct
Panel members:	Gail Mortimer (Chair, Lay member) Jonathan Coombes (Registrant member) Jayanti Durai (Lay member)
Legal Assessor:	Tracy Ayling
Panel Secretary:	Xenia Menzl
Nursing and Midwifery Council:	Represented by Beverley Da Costa, Case Presenter
Mr Porte:	Not present and not represented in absence
Facts proved:	1a), b), 2a), b), 3a) b), c), d), e), 4a), b), c), e) 5a), b), c), 6a), b), c), 7
Facts not proved:	4d), 8
Fitness to practise:	Impaired
Sanction:	Conditions of Practice Order (12 months)
Interim order:	Interim Conditions of Practice Order (18 Months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Porte was not in attendance and that the Notice of Hearing letter had been sent to Mr Porte's registered e-mail address on 25 March 2021.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and the fact that this hearing was going to be held virtually and, amongst other things, information about Mr Porte's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Ms Da Costa, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr Porte has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Porte

The panel next considered whether it should proceed in the absence of Mr Porte. It had regard to Rule 21 and heard the submissions of Ms Da Costa who invited the panel to continue in the absence of Mr Porte. She submitted that Mr Porte had voluntarily absented himself.

Ms Da Costa submitted that Mr Porte had disengaged with the NMC and was no longer represented. However, Ms Da Costa referred the panel to an e-mail from Mr Porte to the Panel Secretary, dated 4 May 2021 at 8.18am stating:

'*I would like to inform you that I will not be attending.*'

In reply to a further e-mail from the Panel Secretary Mr Porte replied on 4 May 2021 at 9:28am:

'*Yes. I am happy for the panel to proceed in my absence.*'

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 .

The panel has decided to proceed in the absence of Mr Porte. In reaching this decision, the panel has considered the submissions of Ms Da Costa, the e-mails from Mr Porte to the Panel Secretary, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Porte;
- Mr Porte has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A number of witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employers and the clients who need their services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and

- There is a strong public interest in the expeditious disposal of the case.

The panel acknowledged that there is some disadvantage to Mr Porte in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered e-mail address, he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, it can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Porte's decisions to absent himself from the hearing, waive his right to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Porte. The panel will draw no adverse inference from his absence in its findings of fact.

Details of charge

That you, a registered nurse:

1) On 07 April 2019, following a fall by Resident A:

    a) Failed to carry out any physical examination on Resident A **[Proved]**
    b) Failed to seek medical advice for Resident A **[Proved]**

2) On 07 April 2019, following a fall by Resident B:

    a) Failed to carry out any physical examination on Resident B **[Proved]**
    b) Failed to seek medical advice for Resident B **[Proved]**

3) On 07 April 2019, following a fall by Resident A, failed to complete;

    a) An accident form **[Proved]**
    b) A falls log **[Proved]**
    c) A body map **[Proved]**
    d) A 24 hour observation sheet **[Proved]**
    e) A safeguarding log **[Proved]**

4) On 07 April 2019, following a fall by Resident B, failed to complete;

    a) An accident form **[Proved]**
    b) A falls log **[Proved]**
    c) A body map **[Proved]**
    d) A 24 hour observation sheet **[Not Proved]**
    e) A safeguarding log **[Proved]**

5) On 07 April 2019, following a fall by Resident A, failed to;

    a) Report the fall to the Home Manager and/or the Deputy Manager **[Proved]**
    b) Report the fall to Safeguarding **[Proved]**
    c) Inform Resident A's family **[Proved]**

6) On 07 April 2019, following a fall by Resident B, failed to;

    a) Report the fall to the Home Manager and/or the Deputy Manager **[Proved]**
    b) Report the fall to Safeguarding **[Proved]**
    c) Inform Resident B's family **[Proved]**

7) On 07 April 2019, following the falls of Residents A and B, instructed colleagues A, B, C and D to keep the incident to themselves. **[Proved]**

8) Your actions in charge 7 above were dishonest as you knew the incident should be documented and reported by the means listed in charges 3 to 6 above. **[Not Proved]**

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

Background

The charges arose whilst Mr Porte was the nurse in charge on duty on the day shift on 7 April 2019 on the memory care unit at Kingston Court Care Home (the Home). The Home has the capacity to take 74 residents in total across three floors. Each floor is classed as a unit. The memory care unit is on the top floor. Also on duty on that unit were healthcare assistants (HCA) Colleague A, Colleague B, Colleague C, and Colleague D.

The allegations arose from an incident in the dining room at lunchtime on the memory care unit, when Resident B pulled Resident A's chair backwards, causing them both to fall to the floor. The emergency buzzer was activated and Mr Porte went into the dining room. It is alleged that Mr Porte did not carry out physical checks or take observations of Residents A and B and that he did not seek medical advice.

The Home's policy was that, following a resident's fall, the following documentation should be completed: an Accident form; a falls log; a body map; a 24 hour observation sheet and a safeguarding log. It is alleged that Mr Porte did not complete any of this documentation.

In addition, it is alleged that Mr Porte failed to report to the Home Manager, Deputy Manager, Safeguarding, or Resident A and Resident B's families that Resident A and Resident B had fallen on 7 April 2019. This was against the Home's policies. The incident was reported to the Home Manager by one of the healthcare assistants the following day. Safeguarding and the residents' families were subsequently contacted.

All four healthcare assistants who were present at or shortly after the residents' fall reported in their internal statements that Mr Porte made a comment to the effect of telling them to keep the incident to themselves. It is suggested by the NMC that by using these words, Mr Porte was attempting to cover up that the residents had fallen.

Mr Porte's Admissions to the Facts

At the outset of the hearing, Ms Da Costa referred the panel to an e-mail sent by Mr Porte's former representative, dated 5 May 2020, which had Mr Porte's Case Management From (CMF) attached. The e-mail stated:

> '*Please find attached completed CMF. I have highlighted our response as I was unable to print the form and tick the boxe*s.*'*

Ms Da Costa submitted that Mr Porte made full admissions to charges 1a), b), 2a), b), 3a) b), c), d), e), 4a), b), c), d), e), 5a), b), c), 6a), b), c). She submitted that these admissions were also confirmed in the local investigation interview. She therefore invited the panel to find these charges admitted by Mr Porte in accordance with Rule 24.

Mr Porte denied allegations 7 and 8.

The panel considered Ms Da Costa's submissions. However, it was of the view that whilst Mr Porte admitted to elements of the charges in the local interview he was not at that stage aware of the charges drafted by the NMC. The panel was cautious in its approach as Mr Porte was neither attending the hearing nor was he represented in his absence. Whilst the panel acknowledged that the e-mail dated 5 May 2020 was sent by Mr Porte's representative at the time, it had no information as to why Mr Porte was no longer represented by them. It was also noted that the CMF was incomplete and that Mr Porte had not been copied into the e-mail to which it had been attached.

The panel instructed the Panel Secretary to e-mail Mr Porte regarding this issue, since he had replied to her earlier emails on 4 May 2021. Mr Porte replied on 5 May 2021 at 3.51am, stating:

> '*I apologise for the late reply. However, my memory of that incident is no longer clear as it has been a couple of years [PRIVATE]. If that is what I agreed with with* [sic] *my representative at that time then all I can say is yes I confirm to the denial of said charges.*'

Ms Da Costa submitted that this reply was equivocal and that it was a matter for the panel to determine whether it considered this e-mail as confirmation that Mr Porte admitted the charges.

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

The panel agreed with Ms Da Costa and determined that Mr Porte's e-mail was equivocal. It therefore concluded that, in the interests of fairness, it would disregard the admissions made by Mr Porte's former representative on his behalf on the CMF. The panel therefore determined that it would consider all the charges individually.

Decision and reasons on application to admit written the statement of Ms 6 into evidence

The panel heard an application made by Ms Da Costa under Rule 31 to allow the written statement of Ms 6 into evidence. Ms 6 had not been called to give evidence at this hearing. This had been agreed between Mr Porte and his representative whilst he was still being represented. On this basis Ms Da Costa advanced the argument that there was no lack of fairness to Mr Porte in allowing Ms 6's written statement into evidence.

The panel gave the application in regard to Ms 6 serious consideration. The panel noted that Ms 6's statement had been prepared in anticipation of being used in these

proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by her.

The panel considered whether Mr Porte would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Ms 6 to that of a written statement.

The panel considered that as Mr Porte had been provided with a copy of Ms 6's statement and, as the panel had already determined that Mr Porte had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Ms 6 and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Ms 6, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Da Costa on behalf of the NMC and the written documentation provided by Mr Porte.

The panel has drawn no adverse inference from the non-attendance of Mr Porte.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will

be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Mr 1: Registered Mental Health Nurse, Deputy Manager at Kingston Court Care Home at the time of the incident.
- Colleague A: Healthcare Assistant at Kingston Court Care Home.
- Colleague B Healthcare Assistant at Kingston Court Care Home.
- Colleague C Healthcare Assistant at Kingston Court Care Home.
- Colleague D Carer at Kingston Court Care Home at the time of the incident.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC and Mr Porte.

The panel considered the evidence of the witnesses and made the following conclusions:

Mr 1: The panel considered the evidence of Mr 1 to be credible. Mr 1 was not a direct witness to the events, however, he was in charge of the investigation of the incidents and was able to speak to the policies and procedures of the Home. The panel found that Mr 1 did his best to assist the panel and

answered questions to the best of his ability. He gave an honest and measured view of the accounts given by the HCAs and the incident. The panel found that he was thoughtful, straightforward, and objective in his answers. Mr 1 admitted variations and was fair and balanced toward Mr Porte. The panel found Mr 1 to be a reliable witness.

Colleague A The panel considered Colleague A to be the only direct witness to the falls. The panel found Colleague A's evidence to be, at times, subjective which gave the impression that Colleague A was unable to separate her personal views of Mr Porte from an objective assessment of the situation. Colleague A's view of Mr Porte was quite contrary to the other witnesses who had given evidence. Further, the panel found that upon questioning inconsistencies in her evidence became clear. The panel therefore found that Colleague A was less reliable in her evidence than the other witnesses.

Colleague B: The panel considered the evidence of Colleague B to be credible. Colleague B was not a direct witness to the falls, however, she had worked with Mr Porte the most. The panel found that Colleague B's insight into the individual residents at the home was very helpful. The panel found Colleague B to be open, fair and balanced. Her answers were consistent and un-ambivalent. The panel was of the view that she could elaborate on her answers during panel questions and was able to explain why perceptions of different situations might have occurred. The panel also noted that Colleague B trained other staff in manual handling, which added to her experience and perspective in relation to falls.

Colleague C: Colleague C was not a direct witness to the fall. The panel found that Colleague C seemed to be led by the panel which made the actual events unclear and highlighted inconsistencies between her written and oral evidence. However, the panel found that Colleague C did give a positive

picture of Mr Porte's overall nursing. The panel was of the view that Colleague C was less reliable than other witnesses.

Colleague D: Colleague D was not a direct witness to the fall and her evidence was very limited. The panel found that Colleague D did not remember much of the detail of the day and was open about her memory issues. The panel found her positive review of Mr Porte's nursing care, outside the incident, helpful. The panel was of the view that Colleague D did her best to assist the panel. However, due to her poor recollection of the events and inconsistencies in her evidence the panel felt that Colleague D's evidence was not particularly reliable.

In reaching its decision on the disputed charges, the panel took into account all the evidence adduced in this case including the oral and written evidence of Mr 1, Colleague A, Colleague B, Colleague C and Colleague D. It also considered the Mr 1's notes of his meetings with Colleague A, Colleague B, Colleague C and Colleague D, Resident A's clinical record, Resident B's clinical record, the Accident and Incident reporting Policy of the Home, the Safeguarding Adults policy of the home as well as the handover sheets of 7 and 8 April 2019, the daily diary of 6 to 8 April 2019, an extract from the communication book and several internal statements.

Charge 1a)

1) On 07 April 2019, following a fall by Resident A:
    a) Failed to carry out any physical examination on Resident A

This charge is found proved.

The panel noted that in his investigatory interview with Mr 1, Mr Porte stated:

'*I asked if she was ok, she said 'fine' then I helped her get up into the chair. After*

that I monitored her, she started walking around. When she was in the lounge, I tried to check her BP.'

When asked why he tried to take Resident A's blood pressure he said;

'*Just to make sure. To follow routine procedure. She refused the paracetamol and kept moving round. I did not check on Resident A I already had experience of trying to check her BP but she Keeps* [sic] *on resisting.*'

Mr Porte also replied to Mr 1's question if he did a visual look to check for bruises '*Yes*'.

The panel noted that Colleague A stated in her handwritten statement, which she had completed contemporaneously:

'*the nurse on duty, he didn't really check them both over properly considering I explained to him what happened, and I told him that Resident A had banged her head on the wheel of a residents wheelchair.*'

Further, Colleague C, in her meeting with Mr 1 when asked the question if Mr Porte had checked the residents replied '*No*'. She further stated:

'*I would expect the nurse to check them over, I'd expect him to get down on the floor and physically check the residents over. He just stood there*.'

The panel took into account Mr 1's oral evidence in which he stated that Mr Porte did know the protocol in a situation like this. The panel also noted that, in the investigatory interview with Mr 1, Mr Porte admitted to his shortcomings in dealing with the incident and was open in response to the questions asked. He explained to Mr 1 that on that afternoon he was '*emotionally and mentally distressed*' and had experienced mental blocks and lapses.

The panel also noted Colleague B's oral evidence and her first-hand knowledge of Resident A's behaviour. Colleague B explained to the panel that Resident A has dementia and can be difficult to handle at times. Resident A can react violently to anyone touching

her and can often lash out and in so doing injure herself. Mr 1 confirmed that Resident A could be vocal and uncooperative.

The panel concluded that Mr Porte did conduct a visual observation of Patient A's physical state. However, the panel was of the view that from the witness statements it was clear that a physical examination of Resident A had not been carried out. The panel acknowledged that Resident A might have been difficult to handle and the fall had happened in a dining room with other residents present. The panel considered that this could have been the reason that Mr Porte decided to conduct a visual observation. However, the panel was of the view that it is more likely than not that Mr Porte did not carry out a physically examination of Resident A after her fall.

The panel was therefore satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident A, Mr Porte failed to carry out any physical examination on Resident A.

Charge 1b)

1) On 07 April 2019, following a fall by Resident A:
    b) Failed to seek medical advice for Resident A

This charge is found proved.

The panel noted that Mr Porte in his investigation meeting with Mr 1 stated:

> '*I asked if she was ok, she said 'fine' then I helped her get up into the chair. After that I monitored her, she started walking around.*'

In their written reports of the incident Colleague C stated that the residents where '*shocked*' but not '*distressed*' and Colleague B stated that the residents seemed '*ok*' and there was no '*sign of injury's* [sic] *or blood or anything*'.

The panel concluded that Mr Porte had checked Resident A visually and his observations after the fall did not warrant him seeking medical advice for Resident A.

The panel was therefore satisfied that on the balance of probabilities it was more likely than not that on 7 April 2019, following a fall by Resident A, Mr Porte failed to seek medical advice for Resident A.

Charge 2 a)

2) On 07 April 2019, following a fall by Resident B:
    a) Failed to carry out any physical examination on Resident B

This charge is found proved.

The panel reminded itself of its findings with regard to charge 1a).

The panel noted that in his investigatory meeting with Mr 1, Mr Porte stated:

'[I] *checked her physical appearance, assessed her vital signs, her pulse, checked how she was looking, so I said she would be ok.*'

[…]

[Mr 1] *Did you do anything else?*

[Mr Porte] *Bruises, I checked her for bruises when she was in the chair.*

[Mr 1] *You did a visual look to check for bruises?*

[Mr Porte] *Yes*

[…]

[Mr Porte] […] *After a few minutes she was walking around.*

[Mr 1] *so both were now in the lounge, seated what next?*

[Mr Porte] *I was observing. She was wandering around as usual. I asked her if she wanted paracetamol, she said no, she'd had enough this morning. We just kept observations on Resident B. If she had stopped walking round then I would have seen she wasn't right, but she was walking around as usual.*'

The panel concluded, for the same reasons as stated above in charge 1a) that Mr Porte did not carry out a physical check on Resident B.

The panel was therefore satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident B, Mr Porte failed to carry out any physical examination on Resident B.

Charge 2b)

2) On 07 April 2019, following a fall by Resident B:
    b) Failed to seek medical advice for Resident B

This charge is found proved.

The panel reminded itself of its findings with regards to charge 1b). The panel concluded, that for the same reasons as stated above, Mr Porte had conducted a visual observation on Resident B but his observations after the fall did not warrant him seeking medical advice for Resident B.

The panel was therefore satisfied that on the balance of probabilities it was more likely than not that on 7 April 2019, following a fall by Resident B, Mr Porte failed to seek medical advice for Resident B.

Charge 3a)

3) On 07 April 2019, following a fall by Resident A, failed to complete;
    a) An accident form

This charge is found proved.

The panel took into account Mr 1's oral evidence in which he stated that Mr Porte knew the protocol to be followed, following a residents fall. Mr 1 stated: '*it was the first occasion that the registrant hadn't done what he would normally do*'.

The panel noted Mr Porte's comments in the investigation meeting with Mr 1:

> '[Mr 1] *So, to go back now, you have both ladies on the floor in the dining room, you have assisted both ladies off the floor, you've done some visual observations of the residents. What do you do next?*
> [Mr Porte] *Record everything. Yeah I admit, I apologise I had some lapses there was things that happened in the afternoon, when I went to start on the notes, another residents Daughter came in and started talking about her father.*
> [Mr 1] *Let's not go into* [that resident] *just now. So you're saying you started recording stuff?*
> [Mr Porte] *That's what I'm going to do.*
> [Mr 1] *So that's what you were going to do, did you do that?*
> [Mr Porte]*: I have like a mental block, I don't know if I do it or not, so that's one thing.*'

The panel did not find any evidence showing that Mr Porte completed an accident form for this incident. The panel therefore concluded, that due to the absence of such a form it is more likely than not that Mr Porte failed to complete an accident form on that occasion.

The panel is therefore satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident A, Mr Porte failed to complete an accident form.

Charge 3b)

> 3) On 07 April 2019, following a fall by Resident A, failed to complete;
> b) A falls log

This charge is found proved.

The panel reminded itself of its findings with regard to charge 3a).

The panel did not find any evidence showing that Mr Porte completed a falls log for this incident. The panel therefore concluded, that due to the absence of a falls log it is more likely than not that Mr Porte failed to complete a falls log on that occasion.

The panel is therefore satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident A, Mr Porte failed to complete a falls log.

Charge 3c)

3) On 07 April 2019, following a fall by Resident A, failed to complete;
    c) A body map

This charge is found proved.

The panel noted that in the investigation meeting with Mr 1, Mr Porte when asked if he had done a body map for Resident A replied '*I did not*'

The panel is therefore satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident A, Mr Porte failed to complete a body map.

Charge 3d)

3) On 07 April 2019, following a fall by Resident A, failed to complete;
    d) A 24 hour observation sheet

This charge is found proved.

The panel reminded itself of its findings with regard to charge 3a) and 3b).

The panel did not find any evidence showing that Mr Porte completed a 24 hour observation sheet for this incident. The panel therefore concluded, that due to the absence of a 24 hour observation sheet it is more likely than not that Mr Porte failed to complete in a 24 hour observation sheet on that occasion.

The panel is therefore satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident A, Mr Porte failed to complete a 24 hour observation sheet.

Charge 3e)

3) On 07 April 2019, following a fall by Resident A, failed to complete;
    e) A safeguarding log

This charge is found proved.

The panel reminded itself of its findings with regard to charge 3a), 3b) and 3d).
The panel noted that Mr Porte in his investigation interview replied to the question if he had informed the safeguarding team that '*It's Sunday and usually, you just record it, then on Monday you…*'

However, when questioned if he had recorded it in the diary to inform the safeguarding team on Monday Mr Porte stated:

'*It's not. Like I said, I really have my lapses. I forget a lot of things.*'

The panel did not find any evidence showing that Mr Porte completed a safeguarding log for this incident or made any notes of the fall in the daily diary. The panel therefore concluded, that due to the absence of a safeguarding log it is more likely than not that Mr Porte failed to complete a safeguarding log on that occasion.

The panel is therefore satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident A, Mr Porte failed to complete a safeguarding log.

Charge 4a)

4) On 07 April 2019, following a fall by Resident B, failed to complete;
    a) An accident form

This charge is found proved.

The panel reminded itself of its findings with regard to charges 3 a), b) c) and e).

For the same reasons as already stated above the panel is satisfied that on 7 April 2019, following a fall by Resident B, Mr Porte failed to complete an accident form.

Charge 4b)

4) On 07 April 2019, following a fall by Resident B, failed to complete;
    b) A falls log

This charge is found proved.

The panel reminded itself of its findings with regard to charges 3 a), b) c), e) and 4a).

For the same reasons as already stated above the panel is satisfied that on 7 April 2019, following a fall by Resident B, Mr Porte failed to complete a falls log.

Charge 4c)

4) On 07 April 2019, following a fall by Resident B, failed to complete;
    c) A body map

This charge is found proved.

The panel noted Mr Porte's reply to Mr 1's question in the investigation meeting asking if he completed a body map for Resident B. Mr Porte stated:

'*I did not do a body map. When I checked I didn't see anything so..'*

The panel is therefore satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident B, Mr Porte failed to complete a falls log.

Charge 4d)

4) On 07 April 2019, following a fall by Resident B, failed to complete;
    d) A 24 hour observation sheet

This charge is found NOT proved.

The panel noted Mr Porte's reply to Mr 1's question in the investigation meeting asking if he completed a 24 hour observation for Resident B. Mr Porte stated:

'*I think I have a 24 hours, I think*'

The panel also noted that there was a 24 hour observational post-falls check form for Resident B regarding a fall that occurred at 7.55am on the morning of the 7 April 2019. Mr Porte had completed those parts of the form for which he had responsibility. The panel noted that the sheet records observations at 8.10, 8.25, 8.55, 9.55, 11.55, 13.55 and 19.55.

The panel noted that Resident B seems to have experienced two falls on the 7 April 2019. However, it noted that the charge does not specify that Mr Porte failed to complete a 24 hour observation sheet for the second occasion.

The panel was therefore not satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident B, Mr Porte failed to complete a 24 hour observation sheet

Charge 4e)

4) On 07 April 2019, following a fall by Resident A, failed to complete;
    e) A safeguarding log

This charge is found proved.

The panel reminded itself of its findings with regard to charges 3 a), b) c), e), 4a) b) and c).

For the same reasons as already stated above the panel is satisfied that on 7 April 2019, following a fall by Resident B, Mr Porte failed to complete a safeguarding log.

Charge 5a)

5) On 07 April 2019, following a fall by Resident A, failed to;
    a) Report the fall to the Home Manager and/or the Deputy Manager

This charge is found proved.

The panel noted Mr 1 written witness statement:

> '[Ms 6, Home Manager] *informed me that* [Colleague A]*, Care Assistant, told her about the incident on* [7] *April.* [Ms 6] *told me that the incident had not been reported by* [Mr Porte] *as it should have been and asked me to carry out an investigation*.'

The panel found that this was confirmed in Mr 1's oral evidence.

The panel noted therefore that Mr Porte did not inform either Mr 1, the Deputy Manager at the time of the incident, or Ms 6, who was the Manager of the Home at the time.

The panel was therefore satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident A, Mr Porte failed to report the fall to the Home Manager and/or Deputy Manager.

Charge 5b)

5) On 07 April 2019, following a fall by Resident A, failed to;
    b) Report the fall to Safeguarding

This charge is found proved.

The panel reminded itself of its findings with regard to charge 3e) and that Mr Porte did not complete a safeguarding log regarding the fall.

The panel reminded itself that Mr Porte stated that the 7 April 2019 was a '*Sunday and usually, you just record it, then on Monday you…*

The panel noted that Mr 1 confirmed in this oral evidence that in such a case you would fill in the safeguarding form, note the incident in the patient notes or log it in the daily diary in order to inform the registered nurse on duty the following Monday to report the fall to safeguarding.

However, the panel did not find any evidence showing that Mr Porte did fill in a safeguarding log for this incident or made any notes of the fall in the daily diary or patient notes. The panel therefore concluded, that due to the absence of these Mr Porte failed to report the fall to safeguarding.

The panel was therefore satisfied that on the balance of probabilities on 7 April, following a fall by Resident A, Mr Porte failed to report the fall to safeguarding.

Charge 5c)

5) On 07 April 2019, following a fall by Resident A, failed to;
    c) Inform Resident A's family

This charge is found proved.

The panel noted that in response to Mr 1's question in the investigation meeting asking him if he had informed Resident A's family that she had had a fall, Mr Porte replied '*No*'.

The panel was therefore satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident A, Mr Porte failed to inform Resident A's family.

Charge 6a)

6) On 07 April 2019, following a fall by Resident B, failed to;
    b) Report the fall to the Home Manager and/or the Deputy Manager

This charge is found proved.

The panel reminded itself of its findings with regard to charge 5a).

For the same reasons as already stated above the panel was satisfied that on the balance of probabilities on 7 April 2019, following a fall by Resident A, Mr Porte failed to report the fall to the Home Manager and/or Deputy Manager.

Charge 6b)

6) On 07 April 2019, following a fall by Resident B, failed to;
    b) Report the fall to Safeguarding

This charge is found proved.

The panel reminded itself of its findings with regard to charge 5a).

For the same reasons as stated above the panel was satisfied that on the balance of probabilities on 7 April, following a fall by Resident B, Mr Porte failed to report the fall to safeguarding.

Charge 6 c)

6) On 07 April 2019, following a fall by Resident B, failed to;
    c) Inform Resident B's family

This charge is found proved.

The panel reminded itself of its findings with regard to charge 5c).

For the same reasons as stated above the panel was satisfied that on the balance of probabilities on 7 April, following a fall by Resident B, Mr Porte failed to report the fall to Resident B's family.

Charge 7

7) On 07 April 2019, following the falls of Residents A and B, instructed colleagues A, B, C and D to keep the incident to themselves.

This charge is found proved.

In reaching this decision, the panel took into account the oral and written evidence of Mr 1, Colleague A, Colleague B, Colleague C and Colleague D. It also considered the Mr 1's notes of his meetings with Colleague A, Colleague B, Colleague C and Colleague D.

The panel noted the different recollections of the witnesses as to what Mr Porte is alleged to have said.

Colleague A stated that Mr Porte said '*that we should keep it all between ourselves*', she further stated that Mr Porte tapped her on the shoulder later on and said words to the effect '*is that ok*' which left her '*gobsmacked*' and made her '*feel sick*'. Colleague A confirmed this in her oral evidence.

Colleague B stated that Mr Porte said '*what happens on the unit stays on the unit*' or words to that effect. She further states '*I assume that he meant that we should not gossip about it with staff members working on other floors of the Home. I do not believe that* [Mr Porte] *would have meant that we should not report the fall as it was his responsibility to report the fall*'. Colleague B confirmed this in her oral evidence. She stated that there was a lot of gossiping between staff and that her assumption regarding that point therefore seemed logical.

Colleague C stated that Mr Porte said '*Are we happy to keep this to ourselves?*'. Colleague C stated that she '*did feel a bit sick and did not feel happy about that*.'

Colleague D stated in her initial statement to Mr 1 following the incident that '*he* [Mr Porte] *said – what goes on up here stays up here, whatever that meant.*' In her statement to the NMC Colleague D stated that Mr Porte said '*what happens up here stays up here*' which she stated she took to mean not to report that Resident A and Resident B had fallen.

The panel noted that in the investigation meeting with Mr 1, Mr Porte first denied that he had said words to that effect and then stated '*I don't know, I cannot remember that I say that I say those kind of things, I'm not sure.*'

The panel noted that two witnesses state Mr Porte stated to '*keep it to themselves*' and two stated he asked to '*keep it on the floor'*. The panel concluded that instructions with

words to that effect had been given to the witnesses Colleague A, Colleague B, Colleague C, and Colleague D; however, each of them interpreted Mr Porte's words differently. The panel took into account Colleague B's oral evidence in which she stated that gossiping was a regular occurrence in the home and staff had been told not to gossip so as to avoid creating rumours. The panel concluded that all four witnesses corroborated in some form or another that Mr Porter said something along the lines of keeping it to themselves or keeping it on the floor. However, the panel also noted that none of the witnesses, despite their differences in interpreting Mr Porte's words, asked him to clarify what he meant. The panel therefore did not consider this charge with regards to the meaning of Mr Porte's words.

The panel was of therefore satisfied that on the balance of probabilities on 07 April 2019, following the falls of Residents A and B, Mr Porter instructed colleagues A, B, C and D to keep the incident to themselves.

Charge 8

8) Your actions in charge 7 above were dishonest as you knew the incident should be documented and reported by the means listed in charges 3 to 6 above.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and written evidence of Mr 1, Colleague A, Colleague B, Colleague C and Colleague D. It also considered Mr 1's notes of his meetings with Colleague A, Colleague B, Colleague C and Colleague D and Mr Porte.

The panel noted that Mr 1 and Colleague B, Colleague C and Colleague D all agreed that Mr Porte was a good, caring and conscientious nurse, attesting to his previous good character. Mr 1 and Colleague B especially stated that Mr Porte's behaviour on the 7 of April 2019 was out of character and not in keeping with his usual professional practice.

The panel noted that Colleague A's statement and oral evidence, in her opinion of Mr Porte, did not align with that of her colleagues. However, the panel was of the view that her evidence was less objective than that of her colleagues.

The panel noted that Mr 1 stated that Mr Porte, when questioned, knew all the procedures and protocols he had to follow after a resident had had fall. This was the only incident when Mr Porte had not followed these.

The panel noted Mr Porte's statement in the investigation meeting and concluded that he did not try to maintain a position stating that the falls did not occur or that Colleague s A, B, C and D's account of the falls were exaggerated. He was honest in his admissions. The panel acknowledged that Mr Porte made early and open admissions to the mistakes he made and that he did apologise for his failings.

The panel noted that Mr Porte had said he had been '*distracted*' by the relative of another resident following the incident when he went to start on the notes.

The panel also reminded itself of its findings with regard to charge 7. The panel has already determined that Colleague A, B, C and D all interpreted Mr Porte's remark differently. The panel noted that none of them challenged Mr Porte as to what he meant or commented on his remark at the time. The panel considered this to be unusual as at least two of them stated later that they were shocked by his statement. Further, the panel noted that there is conflicting evidence of the colleagues as to whether or not they discussed Mr Porte's instruction between themselves after he had left the room.

The panel concluded that Mr Porte's actions are those of a normal person, who somehow made a mistake for reasons unknown. He was forthcoming during the investigation interview and did not try to hide his failings in any way and admitted his mistakes. Being objective and judging by the standards of ordinary people the panel was of the view that

Mr Porte's motives in instructing his colleagues to keep the incident to themselves were not dishonest.

The panel was therefore not satisfied that on the balance of probabilities Mr Porte's actions in charge 7 above were dishonest as he knew the incident should be documented and reported by the means listed in charges 3 to 6 above.

Decision to adjourn the hearing

Before making her submission on misconduct and impairment Ms Da Costa provided the panel with further evidence to support her submissions. The evidence contained e-mails, dated October 2019, between the NMC and Mr Porte's last known employer raising similar concerns to the facts found proved by the panel. Ms Da Costa submitted that this information is important in order for the panel to make an informed decision with regard to misconduct and impairment. However, Ms Da Costa was not able to confirm to the panel whether this information was placed before Mr Porte prior to this hearing.

The panel noted that Mr Porte has had some recent engagement with the NMC and these proceedings.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel reviewed the additional evidence and was of the view that it is evidence that is relevant to its consideration of Mr Porte's current impairment. However, the panel was conscious that Mr Porte may not have seen the additional evidence and has therefore not had an opportunity to comment on the evidence.

The panel was of the view that, although Mr Porte had chosen not to attend this hearing, it is not clear that he was aware at the time of making that decision to absent himself and not make representations, that these e-mails, which might well impact on his future nursing practice, would be put before the panel.

The panel determined that it is a basic principle of fairness that Mr Porte has notice of this evidence and is given the opportunity to factor this into any submissions Mr Porte might choose to present to the panel.

The panel heard and accepted the advice of the legal assessor who referred it to Rule 32 of the Rules and its power to adjourn a hearing if it found it necessary.

The panel considered the time of day and stage of the proceedings and was of the view that it was not possible to offer Mr Porte the opportunity to respond to this matter this afternoon. It therefore considered whether to adjourn the hearing until the new evidence has been presented to Mr Porte and he has been given a reasonable time to respond.

The panel considered three factors in its decision. First the panel considered the potential inconvenience an adjournment would cause. The panel has heard from all witnesses as to facts, the NMC has closed their case with regards to facts and the panel has already determined the facts of the case. It was therefore of the view that there is no inconvenience caused by adjourning the hearing.

Next the panel considered the public interest in the expeditious disposal of this case. The panel noted that the NMC had been in possession of the emails since October 2019 and has only chosen to present this evidence to the panel at this stage. However, it was not clear whether the evidence had been presented to Mr Porte. The panel was therefore of the view that the fairness to Mr Porte outweighs the public interest in the expeditious disposal of this case.

The panel therefore determined that it is fair and necessary to adjourn the hearing to allow enough time for the NMC to inform Mr Porte of the additional evidence and for him to make any submissions in response to it.

Application for an interim conditions of practice order

The panel, having indicated that it had made the decision to adjourn in accordance with Rule 32, invited Ms Da Costa to make submissions with regard to an interim order.

Ms Da Costa submitted that an interim order is necessary at this stage given the findings of facts and the charges found proved by the panel and in relation to the additional information put before the panel. She submitted that there is a real risk of harm to the public and that restricting Mr Porte's practice is necessary to protect the public.

Ms Da Costa submitted that an interim conditions of practice order is appropriate in this case. She suggested that Mr Porte should be under supervision and that he should not be the nurse in charge of a shift.

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

Decision and reasons on interim order

The panel took account of the submissions made by Ms Da Costa.

The panel concluded that, based on the information before it, there is no evidence that would suggest that there is a real risk of significant harm to the public should an interim order not be made. The panel was mindful that the charges found proved related to one single incident on one single occasion, there was no patient harm and no dishonesty. The panel also considered the new information placed before it by Ms Da Costa. However, the panel noted that these concerns were raised by Mr Porte's former employer in October 2019 and that these concerns have not warranted the NMC to seek an interim order in the

almost two years since the e-mails. The panel was of the view that the new information does not alter the risk to the public in any way and was satisfied that there is no evidence before it to suggest that Mr Porte currently poses a significant risk to the public.

The panel is aware that the threshold for an interim order to be imposed solely on the grounds that it is in the public interest is high. In the circumstances of this case the panel concluded that the high threshold has not been met. The panel has therefore decided that it is not necessary in all the circumstances to impose an interim order.

The NMC may ask for this decision to be reviewed if any new evidence becomes available that may be relevant to Mr Porte's case.

That concludes this determination.

Resuming Hearing 13 – 14 September 2021

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Porte was not in attendance and that the Notice of Hearing letter had been sent to Mr Porte's registered e-mail address on 26 July 2021.

The panel took into account that the Notice of Hearing provided details of resuming dates of the hearing and the fact that this hearing was going to be held virtually and, amongst other things, information about Mr Porte's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Ms Da Costa, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr Porte has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Porte

The panel next considered whether it should proceed in the absence of Mr Porte. The panel had regard to Rule 21 and heard the submissions of Ms Da Costa who invited the panel to continue in the absence of Mr Porte. She submitted that Mr Porte had voluntarily absented himself.

Ms Da Costa reminded the panel that Mr Porte did not attend during the last sitting of the hearing in May 2021. She reminded the panel of its decision to proceed in his absence on that occasion.

Ms Da Costa referred the panel to an email sent by Mr Porte, dated 6 September 2021, which states:

> '*I will not be attending the hearing and I am happy for you to proceed in my absence. Thank you.*'

The panel accepted the advice of the legal assessor.

The panel has decided to proceed in the absence of Mr Porte. In reaching this decision, the panel has considered the submissions of Ms Da Costa, the communication from Mr Porte, and the advice of the legal assessor. It has had particular regard to any relevant case law and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Porte;
- Mr Porte has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure his attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Porte.

Decision on Misconduct and Impairment

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 Mr Porte's 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, Mr Porte's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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.'*

Ms Da Costa invited the panel to take the view that 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) in making its decision.

Ms Da Costa identified the relevant standards where registrant's actions amounted to misconduct. She submitted that Mr Porte failed to work cooperatively, failed to share information to identify possible risks, did not report the incidents himself and failed to keep clear and relevant records of the incidents. She submitted that Mr Porte was clearly expected to carry out observations on Resident A and B, however, failed to do so.

Ms Da Costa acknowledged that no significant harm came to the patients as a result of Mr Porte's actions and omissions. However, he did instruct others to keep the incident to themselves and did not report the incidents himself. Ms Da Costa invited the panel to find that Mr Porte's actions and omissions amount to misconduct.

Submissions on impairment

Ms Da Costa moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and uphold proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Da Costa submitted that the misconduct can be remedied if sufficiently addressed to ensure that it is not repeated. However, she submitted that but for his consent for the panel to proceed in his absence, Mr Porte has not engaged in the NMC process; he has not submitted a reflective piece, nor any testimonial or references or provided the panel with evidence of any additional training he has undertaken.

Further, Ms Da Costa referred the panel to the email exchange that Mr Porte's subsequent employers provided. In particular she referred the panel to the following statement, dated 4 October 2019, which states that Mr Porte has failed to act upon concerns that arose with residents and that harm was only prevented due to other staff stepping in.

Ms Da Costa submitted that this further evidence demonstrates that it is reasonable to take the view that there is a real risk of repetition.

Ms Da Costa informed the panel that Mr Porte has not been working as a registered nurse since 20 October 2019. She submitted that there is no further information regarding his nursing practice or work. She stated that this raises the question as to whether Mr Porte has remediated his actions and omissions. She submitted that there is no evidence before the panel that Mr Porte has remediated his misconduct.

Ms Da Costa therefore invited the panel to find that Mr Porte is currently impaired as a result of his misconduct. She submitted that such a finding is necessary to protect the public and that it is also otherwise in the public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mr Porte's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Porte's actions amounted to a breach of the Code. Specifically:

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.6 share information to identify and reduce risk

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

The panel considered Charges 1 and 2 individually, but came to the same conclusion. The panel was of the view that it was a fine balance in judgement whether or not to carry out a physical examination on vulnerable patients with dementia, one of whom was known to behave aggressively, on occasions, when touched. The panel noted that such an examination could have distressed the residents further. The panel was of the view that whilst this may have not been ideal, it was a matter within the judgement of the clinical professional at the time. The panel concluded that these two charges did not amount to serious misconduct.

Regarding Charges 3 a), b) c), d), e) and 4a), b), c), and e) the panel was of the view that not completing the necessary records in these cases an accident form, a falls log, a body map, a 24 hour observation sheet in case of Resident A and a safeguarding log, is a serious omission, particularly considering the vulnerability of Residents A and B. The panel is of the view that it is the duty of a registered nurse to inform colleagues and other clinical practitioners of any incidents that occurred during their shift. The panel is of the view that not completing the required records was a serious omission; it deprived colleagues, who were responsible for the care of the residents following the incidents, of important information. Not having this information may have affected the judgement of Mr Porte's colleagues regarding the wellbeing of the residents and could have eventually led to serious harm to the residents. The panel was therefore of the view that the failure to complete the required records appropriately amounted to misconduct.

The panel then considered charges 5 a), b) c) and 6 a), b) and c) individually. It was of the view that there were policies and procedures in place at the Home for such incidents. The panel was of the view that it is a registered nurse's duty to follow these procedures, even if the nurse was of the view that the incident was minor. The panel was particularly concerned that Mr Porte did not inform the resident's families regarding the incidents. The panel was of the view that Mr Porte was the professional in charge and that it was his duty to follow these procedures and policies and that these omissions therefore amount to serious misconduct.

Lastly the panel considered charge 7. The panel had already decided that Mr Porte's statement had the potential to be interpreted in different ways. It was of the view that whilst it found that Mr Porte did make that statement in some form it was not serious enough to amount to serious misconduct.

The panel found that Mr Porte's actions in charges 3, 4, 5 and 6 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, Mr Porte'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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, they must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) […]

The panel finds that residents were put at a real risk of harm as a result of Mr Porte's misconduct. Mr Porte's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that it had little evidence before it to show that Mr Porte has sufficient insight into his failings. Although, in his interview with Mr 1, Mr Porte did apologise for his failures that day, the panel noted that he has not produced a reflective piece for these proceedings or acknowledged the impact his failings could have had on Residents A and B. The panel therefore concluded that Mr Porte has very limited insight into his failings.

The panel was satisfied that the misconduct in this case is capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Porte has remedied his practice. The panel again noted that Mr Porte has not

provided the panel with any evidence that he has taken steps to remediate his misconduct. The panel further noted the email from Mr Porte's most recent employer, dated 4 October 2019, which stated that:

> '*There have been a number of incidents whereby Antonio has not reacted as quickly or as effectively as we would expect from a qualified nurse. Staff report that they have found residents seen by Antonio, poorly, with a high fever for example, or sores. And Antonio has not acted upon the concerns.*
>
> *Our staff have intervened and no harm has been caused to the resident as interventions were immediately carried out.*
>
> *His position is under review because he is under probation still and we are not confident that he will perform to the standard expected following completion of his probation*.'

The panel was of the view that this is evidence that Mr Porte has not remedied his misconduct two years after the original incident and that there is a high risk of repetition of the misconduct found. The panel noted that, according to the employer, whilst no harm had been caused to the residents, this was only prevented due to the timely intervention of other colleagues. The panel was therefore of the view that Mr Porte is liable to repeat matters of the kind found proved.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Porte's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of twelve months. The effect of this order is that Mr Porte's entry on the NMC register will show that he is subject to a conditions of practice order and anyone who enquires about his registration will be informed of this order.

Submissions on sanction

Ms Da Costa submitted that the misconduct found was too serious to take no further action or impose a caution order. She submitted that these sanctions would not protect the public nor would they address the public interest in this case. She submitted that Mr Porte lacks insight into his failings and that therefore there is a potential risk of harm to patients should he be able to practise unrestricted.

Ms Da Costa submitted that this was Mr Porte's first regulatory concern and it was a single incident that occurred on one single shift. She submitted that the issues identified by the panel predominantly relate to clinical issues and record keeping. Ms Da Costa therefore submitted that a conditions of practice order would be a suitable sanction in this case. She submitted that such an order, with suitable conditions, could manage Mr Porte's remediation.

Ms Da Costa invited the panel to impose a conditions of practice order for a period of twelve months.

Decision and reasons on sanction

Having found Mr Porte's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate. Although not intended to be punitive in its effect, any sanction may have such consequences. The panel had careful regard to the Sanctions Guidance (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:

- Lack of insight; and
- Potential real risk of harm to two vulnerable residents;

The panel also took into account the following mitigating features:

- One single incident on one single shift;
- No disciplinary or previous regulatory findings against Mr Porte; and
- Some evidence of Mr Porte going through a stressful period at the time of the incident.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Porte's 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 Mr Porte's

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 a conditions of practice order on Mr Porte'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, 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;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

The panel had regard to the fact that evidence was presented, at the fact finding stage of these proceedings, that Mr Porte was a caring nurse and that the incidents at the time of the misconduct seemed out of character. However, at the impairment stage of the proceedings evidence was presented to the panel, from his employer in 2019, indicating that there was a real risk of harm to patients in the future if Mr Porte was allowed to continue unrestricted practice. Balancing all of these factors the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that it was in the public interest that, with appropriate safeguards, Mr Porte should be allowed to practise as a nurse.

The panel considered a suspension order but determined that given the reasons above such a sanction would be disproportionate.

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.

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

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

1. You must work with your line manager, supervisor, mentor or deputy to create a personal development plan (PDP). Your PDP must address the concerns about record keeping and communicating effectively with relevant parties. You must:
    a) Send your NMC case officer a copy of your PDP within a month of starting employment.
    b) Meet with your line manager, supervisor, mentor or deputy at least every week for the first six weeks of your employment, and thereafter at times agreed with your line manager, to discuss your progress towards achieving the aims set out in your PDP.
    c) Send your case officer a report from your line manager, supervisor, mentor or deputy 4 weeks before the review hearing. This report must show your progress towards achieving the aims set out in your PDP.

2. 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.

3. 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.

4. You must immediately give a copy of these conditions to:
    a) Any organisation or person 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.
    e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

5. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

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

The period of this order is for twelve months.

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

Any future panel reviewing this case would be assisted by:

- Mr Porte's attendance, in person or remotely, at the review hearing;
- A detailed reflective piece in a recognised format (such as Gibbs' Reflective Cycle) as evidence of Mr Porte's insight into his failings;
- References/Testimonials from any work undertaken, whether paid or voluntary;
- Evidence of any steps Mr Porte has taken with regards to training and education to keep his clinical skills up to date and maintain professional development; and
- Any other evidence Mr Porte deems would be helpful to a future committee.

This will be confirmed to Mr Porte in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Da Costa. She submitted that an interim order is necessary to protect the public for the reasons identified by the panel earlier in their determination until the substantive conditions of practice order comes into effect. She therefore invited the panel to impose an interim conditions of practice order for a period of 18 months to cover the 28 day appeal period and any period of appeal.

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, so as to maintain public confidence in the profession and its regulatory process. In reaching a decision to impose an interim order the panel had regard to facts found proved, to the risk which it had identified of potential harm to patients and the reasons set out in its decision for the substantive order. The panel took account of the impact, financial and professional, an interim order will have on Mr Porte.

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 detailed in the substantive order. The period of that order is 18 months, to allow for the time which may elapse before an appeal may be heard.

The panel is satisfied that this order, for this period, is appropriate and proportionate in the circumstances of Mr Porte's case.

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 the decision of this hearing in writing is send to Mr Porte.