Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 4 July 2022 – Thursday, 7 July 2022
Thursday, 1 – Friday, 2 December 2022

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

Name of registrant:	**Richard Anthony Jankowski**
NMC PIN:	85E0674E
Part(s) of the register:	Registered Nurse Mental Health Nursing – September 1989
Relevant Location:	Derbyshire
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair, Lay member) Anne Grauberg (Registrant member) Mary Golden (Lay member)
Legal Assessor:	Andrew Young
Hearings Coordinator:	Catherine Acevedo
Nursing and Midwifery Council:	Represented by Silas Lee, Case Presenter
Mr Jankowski:	Not present and not represented
Facts proved:	All charges
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order – 18 months

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

At the outset of the hearing, Mr Lee made a request that parts of this case be held in private on the basis that proper exploration of Mr Jankowski's case involves reference to his health. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Having heard that there may be reference to Mr Jankowski's health, the panel determined to hold those parts of the hearing in private.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Jankowski was not in attendance and that the Notice of Hearing letter had been sent to Mr Jankowski's registered email address on 1 June 2022.

Mr Lee, 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.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mr

Jankowski's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all of the information available, the panel was satisfied that Mr Jankowski 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 Jankowski

The panel next considered whether it should proceed in the absence of Mr Jankowski. It had regard to Rule 21 and heard the submissions of Mr Lee who invited the panel to continue in the absence of Mr Jankowski. He submitted that Mr Jankowski had voluntarily absented himself.

Mr Lee submitted that there had been no engagement at all by Mr Jankowski with the NMC in relation to these proceedings. Mr Jankowski's last contact with the NMC was a telephone call on 22 April 2020 and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion. Mr Lee provided the panel with a summary of the multiple attempts made by the NMC to engage Mr Jankowski.

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 Jankowski. In reaching this decision, the panel has considered the submissions of Mr Lee and the advice of the legal assessor. It has had particular regard to the factors set out in the decisions 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 Jankowski;
- Mr Jankowski has not engaged with the NMC since April 2020 and has not responded to any of the letters sent to him about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Five witnesses are due to attend the hearing remotely to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Jankowski in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email address, he has made no formal response to the allegations, although he did provide written representations between 2018 – April 2020. 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, this can be mitigated. The panel 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 Jankowski's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf, other than his written representations from 2018 – April 2020, already referred to.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Lee, on behalf of the NMC, to amend the wording of charge 6.

The proposed amendment was to include 'On 14 November 2018' to the beginning of charge 6. It was submitted by Mr Lee that the proposed amendment would provide clarity and more accurately reflect the evidence.

Original charge 6

> 'Inaccurately recorded that both you and colleague 1 had 'assisted [resident A] up as awake' and recorded colleague 1's initials against this inaccurate entry'.

Proposed charge 6

> **'On 14 November 2018,** inaccurately recorded that both you and colleague 1 had 'assisted [resident A] up as awake' and recorded colleague 1's initials against this inaccurate entry'.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Jankowski and no injustice would be caused to either party by the proposed amendment being allowed. It

was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered nurse,

1. On one or more occasions between June and November 2018,

    a. Directed colleague 1 and colleague 2 to carry out the 1am round on their own and then record their initials as well as yours on the resident room charts.
    b. Unnecessarily woke residents up and got them dressed before 6am.

2. When acting as set out at charge 1(a), you acted without integrity, in that you directed junior colleagues to behave dishonestly and create inaccurate records.

3. Moved resident(s) by yourself when it was unsafe and/or clinically inappropriate to do so on:

    a. 15/16 June 2018, in respect of resident C and/or one or more other resident(s).
    b. 13/14 November 2018, in respect of B and/or A.
    c. On one or more further occasions between June and November 2018.

4. On the nightshift of 13/14 November 2018,

    a. Did not document resident A's injury in her daily notes.
    b. Did not complete an entry in the accident book.
    c. Did not handover that resident A had suffered an injury.

5. Slept on duty and did not provide supervision or prioritise patient care on:

a. 15/16 June 2018,
b. 25/26 November 2018,
c. On further occasions between June and November 2018.

6. On 14 November 2018, inaccurately recorded that both you and colleague 1 had ‘assisted [resident A] up as awake’ and recorded colleague 1’s initials against this inaccurate entry.

7. Your conduct at charge 6 was dishonest in that:

    a. You knew you had moved resident A out of bed by yourself,
    b. You intended to mislead any subsequent reader of that entry into believing you and colleague 1 had moved resident A when this was not the case.

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

Decision and reasons on application to admit telephone evidence of Colleague 1

The panel heard an application made by Mr Lee under Rule 31 to allow Colleague 1 to give evidence via telephone. Colleague 1 indicated to the NMC that she was experiencing a high level of anxiety regarding possibly giving evidence. She also refers to an injury to her foot. Colleague 1 has said that she is willing to engage in the hearing but was concerned about attending the hearing virtually as she does not have a laptop or smartphone. Mr Lee asked the panel to allow Colleague 1 to give their evidence over the telephone.

In the preparation of this hearing, the NMC had indicated to Mr Jankowski that it was the NMC’s intention for Colleague 1 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Colleague 1, Mr Jankowski made the decision

not to attend this hearing. On this basis Mr Lee advanced the argument that there was no lack of fairness to Mr Jankowski in allowing Colleague 1 to give evidence over the telephone.

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

The panel gave the application in regard to Colleague 1 serious consideration.
The panel considered whether either the panel itself or Mr Jankowski would be disadvantaged by the change in the NMC's position of hearing Colleague 1's testimony by telephone.

The panel considered that as Mr Jankowski had been provided with a copy of Colleague 1's statement and, as the panel had already determined that Mr Jankowski 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.

As regards to the panel's own position, it was satisfied that it would not be disadvantaged by relying on only telephone evidence from Colleague 1 because Mr Jankowski had not questioned the reliability of her evidence and the panel was satisfied that it could assess her evidence adequately by hearing it given by telephone.

In these circumstances, the panel came to the view that it would be fair and relevant to allow Colleague 1 to give evidence over the telephone.

Further request in relation to the evidence of Colleague 1

In relation to Colleague 1's evidence, Mr Lee also asked permission from the panel to ask Colleague 1 questions about a matter which she does not address in her witness statement regarding the events of 14 November 2018, namely, whether or not she signed the room chart herself. He submitted that there would be no injustice to Mr Jankowski if

this additional evidence is given orally by Colleague 1 and that evidence on this point exists elsewhere within the hearing documents.

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

The panel considered that Mr Jankowski was aware that Colleague 1 had been invited to give oral evidence at this hearing and it would be able to explore this matter with her. The panel had already determined that Mr Jankowski had chosen voluntarily to absent himself from these proceedings and 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.

In these circumstances, the panel came to the view that it would be fair and relevant to permit Colleague 1 to be questioned on this matter. The panel decided that it would attach the appropriate amount of weight to this once all of the evidence has been reviewed and evaluated.

Decision and reasons on application to admit hearsay evidence of Mr 5

The panel heard an application made by Mr Lee under Rule 31 to allow the hearsay evidence of Mr 5 which included photographic and video evidence. Mr 5 was not present at this hearing and has provided the NMC with reasons for his non-attendance. However, he has not given permission for those reasons be shared with the panel.

Mr Lee submitted that it is fair to receive the evidence. The video footage shows Mr Jankowski in the dining room lying down on a recliner underneath a blanket with the lights off. Mr Lee referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*, and submitted that the evidence is not the sole and decisive evidence on this issue and is demonstrably reliable.

In the preparation of this hearing, the NMC had indicated to Mr Jankowski that it was the NMC's intention for Mr 5 to provide evidence to the panel. Despite knowledge of the nature of the evidence to be given by Mr 5, Mr Jankowski made the decision not to attend this hearing. On this basis Mr Lee advanced the argument that there was no lack of fairness to Mr Jankowski in allowing the hearsay evidence of Mr 5.

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 considered that the video footage was relevant and speaks to the charges of Mr Jankowski sleeping on duty. The panel considered that Mr 5's hearsay evidence was demonstrably reliable and was not the sole and decisive evidence on the issue of Mr Jankowski sleeping on duty. 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 hearsay evidence of Mr 5, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to allow Colleague 2 to give evidence by telephone

The panel heard an application made by Mr Lee under Rule 31 to allow Colleague 2 to give evidence via telephone. Mr Lee submitted that Colleague 2 has indicated in a telephone call to the NMC that he was unable to join the meeting virtually using the link provided using his smart phone. Colleague 2 also said he did not have a working computer and did not have access another one for the purpose of this hearing. Mr Lee submitted that efforts have been made to assist Colleague 2 to join the hearing virtually

but these have been unsuccessful. Mr Lee therefore asked the panel to allow Colleague 2 to give their evidence over the telephone.

In the preparation of this hearing, the NMC had indicated to Mr Jankowski that it was the NMC's intention for Colleague 2 to provide evidence to the panel. Despite knowledge of the nature of the evidence to be given by Colleague 2, Mr Jankowski made the decision not to attend this hearing. On this basis Mr Lee advanced the argument that there was no lack of fairness to Mr Jankowski in allowing Colleague 2 to give evidence over the telephone.

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

The panel gave the application in regard to Colleague 2 serious consideration.
The panel considered whether Mr Jankowski would be disadvantaged by the change in the NMC's position of hearing Colleague 2's testimony by telephone.

The panel considered that as Mr Jankowski had been provided with a copy of Colleague 2's statement and, as the panel had already determined that Mr Jankowski had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. The panel accepted that Colleague 2 was unable to join the meeting virtually. The panel determined that Colleague 2 evidence could be properly tested and would not be diminished by telephone. 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 allow Colleague 2 to give evidence over the telephone.

Decision and reasons on 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 Mr Lee on behalf of the NMC.

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

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 who, at the time of the events, were employed in the following roles:

- Colleague 1: Health Care Assistant at Ashford Lodge Care Home;
- Colleague 2: Health Care Assistant at Ashford Lodge Care Home;
- Ms 3: Registered Nurse at Ashford Lodge Care Home;
- Ms 4: Registered Nurse/Manager at Ashford Lodge Care Home.

Background

Mr Jankowski has been a registered nurse for over 29 years and had been employed as a registered nurse at Ashford Lodge Care Home (the Home) for over 15 years, where the

charges arose. The Home accommodated 16 – 18 residents, the majority of whom have dementia.

Mr Jankowski worked night shifts at the Home with a carer between 8.30pm – 7.30am. His tasks included handover, giving residents drinks/snacks, administering medication and assisting residents to bed. There were four scheduled monitoring rounds every two hours starting at 11pm. Mr Jankowski was required to undertake the rounds jointly with a carer.

Some concerns relate to incidents on three specific night shifts between June and November 2018:

- 15/16 June 2018 – Mr Jankowski allegedly moved Resident C (and other residents) alone and slept on duty, therefore not providing adequate supervision and care.

- 13/14 November 2018 – Mr Jankowski allegedly moved Residents A and B alone, did not document Resident A's injury in the daily notes, or accident book, or on the handover sheet, and did not verbally handover to Colleague 3. Mr Jankowski assisted a resident up alone but documented as a colleague being present.

- 25/26 November 2018 – Mr Jankowski allegedly slept on duty.

There was also evidence of further instances of Mr Jankowski sleeping on duty and not conducting monitoring rounds with the carer between June – November 2018 but without specific dates.

Mr Jankowski made responses at the local investigation conducted by the employer. He engaged with the NMC until April 2020 and stated that he does not wish to respond to the case as he wished to voluntarily retire from nursing.

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

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

Charge 1a

On one or more occasions between June and November 2018,

a. Directed colleague 1 and colleague 2 to carry out the 1am round on their own and then record their initials as well as yours on the resident room charts.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 1 and Colleague 2.

Mr Jankowski's response in the investigation meeting dated 14 December 2018 is *"The 01.00 if it's not busy, umm it was my sort of suggestion that one person does that*…"

Colleague 1 said in her written statement *"[Mr Jankowski] would make me do the 1am round on my own even though I was told that the nurse and carer would work together as a pair…when I did the 1am round, I would document this in the room chart for each resident. In the initials column, I would put mine and [Mr Jankowski] as he asked me to…I later found out I shouldn't do this*". Colleague 1 corroborated in her oral evidence that this happened on every shift.

The panel also took into account the evidence of Colleague 2. He stated "*Every resident has a room chart in their room. When a round is done and a resident is checked as part of a round, the chart was supposed to be signed by one person for both members of staff doing the round. When doing a round alone, I would sign the chart with… my initials and*

then [Mr Jankowski] told me to put his initials too even though he was not with me when I was doing the rounds"

The panel found Colleague 1 and Colleague 2's evidence to be credible and reliable. It considered their oral and written accounts to be consistent and the panel accepted their evidence.

The panel also took into account that Mr Jankowski appeared to accept in his response to the local investigation that it was his suggestion that one person do the round. The panel was satisfied that there was evidence that Mr Jankowski directed Colleague 1 and Colleague 2 to carry out the 1am round on their own and then record their initials as well as his on the resident room charts. The panel therefore found charge 1a proved.

Charge 1b

On one or more occasions between June and November 2018,

b. Unnecessarily woke residents up and got them dressed before 6am.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 1 and Colleague 2.

The panel noted that Mr Jankowski does not comment on this issue in his responses to the NMC and he was not asked about it in the local investigation.

In her local statement, Colleague 1 stated *"Before 6am [Mr Jankowski] wants to start getting the few people we get up. He doesn't wait for me to help him as he keeps telling me he wants to get done […] By 7am [Mr Jankowski] is in the small lounge eating breakfast."* In her NMC statement she stated *"At the Home, we are not supposed to wake*

up the residents before 6am as otherwise it makes it a very long day for them. [Mr Jankowski] would finish a round at say 5.20am and would want to start waking up people then which would make their day longer…The correct thing to do is to start getting residents up at 6am".

Colleague 2's statement said *"In the morning he used to say that we would do that 5am rounds which was a breathing check and he also said "I want to start at 5.30 and get some people dressed" I think this was because [Mr Jankowski] said he didn't like to rush in the morning in getting the residents up. On a particular shift I saw one of the residents fully dressed at 5:40am. I cannot recall the date of this shift. Residents were not supposed to be woken up or dressed before 6am. This is because that is the policy of the Home and it is against the CQC policy as far as I am aware".* This was corroborated by Colleague 1 in her oral evidence and, in her local statement said Mr Jankowski would get residents up before 6am regularly.

Although Colleague 2 said in his statement that he could not recall the date of the shift that he was referring to, he only worked alongside Mr Jankowski on night shifts between June – July 2018, so he must have been referring to a shift during this period.

The panel also took into account Ms 4's statement. She stated *"At the Home we start getting residents up at 6am in the morning, some are already awake by this point but we don't tend to wake them up before 6am".*

The panel found the evidence of Ms 4 credible and reliable. Her evidence supported that it was not necessary to wake the residents up and get them dressed before 6am.

Having found their evidence credible and reliable, the panel accepted the evidence of Colleague 1, Colleague 2 and Ms 4. The panel was satisfied that there was evidence that Mr Jankowski unnecessarily woke residents up and got them dressed before 6am between June and November 2018. The panel considered that there was no clinical

justification for getting the residents up before 6am and it appeared that Mr Jankowski did this for his own convenience. The panel therefore found charge 1b proved.

Charge 2

> When acting as set out at charge 1(a), you acted without integrity, in that you directed junior colleagues to behave dishonestly and create inaccurate records.

This charge is found proved.

Having found the facts of paragraph 1(a) of the Charge proved, namely that Mr Jankowski directed Colleagues 1 and 2 to carry out the 1am round to check on the residents on their own but then record Mr Jankowski's initials on the resident room charts as well as their own, the panel had to decide whether this amounted to acting without integrity on the part of Mr Jankowski by directing junior colleagues to behave dishonestly and create inaccurate records.

In order to reach a decision on this paragraph, the panel had first to decide whether the records created by Colleagues 1 and 2 were inaccurate and if so, whether creating such records was dishonest on the part of Colleagues 1 and 2 and if the answer to both those questions was 'Yes' whether Mr Jankowski was acting without integrity by directing his junior colleagues to record the 1am round in this way.

Both Colleague 1 and Colleague 2 gave written and oral evidence that they were told by Mr Jankowski to carry out the 1am round on their own but to record Mr Jankowski's initials alongside theirs on the relevant entry on the resident's room charts, as seen on the room sheet for Resident A. At the investigatory meeting on 14 January 2019, Mr Jankowski claimed that he insisted on his initials being included on the room charts simply to indicate that he was on duty at the time in the same team as the healthcare assistants who actually carried out the round, but the panel rejected this explanation. The only reasonable explanation for including his initials was as an indication that he had been physically

present during the round and would therefore be in a position to verify the factual information contained in the relevant entry. The panel is satisfied that Mr Jankowski knew that he was supposed to carry out the 1am round alongside the Healthcare Assistant who was on duty on the relevant night shift and his insistence on having his initials recorded on the residents' room charts was intended to conceal the fact that he did not in fact take part in the 1am round.

In these circumstances, the panel is satisfied that the record created by colleagues 1 and 2 of the 1am round was inaccurate in that it gave the false impression that Mr Jankowski had been present on the round and was in a position to confirm the accuracy of any comments documented in the room charts. Although the panel noted that both healthcare assistants did raise concerns about this with the Home's management, the panel is also satisfied that Colleagues 1 and 2 were acting dishonestly in creating these inaccurate records on the basis that their conduct in this regard satisfies the test of dishonesty provided by the legal assessor. That test is that they knew that the records were inaccurate in that they falsely represented that Mr Jankowski had been present on the round and their conduct in creating these inaccurate records would be regarded as dishonest by the ordinary standards of reasonable and honest people. The actions of Colleagues 1 and 2 may meet the legal definition for dishonesty but, in the panel's view, they were acting under Mr Jankowski's instructions and reported the practice to management at the Home which was an honest action to take, and shows they were concerned about what they had been instructed to do.

The panel being satisfied that Mr Jankowski directed Colleagues 1 and 2 to behave dishonestly, it remained to decide whether by so doing Mr Jankowski himself acted without integrity. In deciding this issue, the panel has accepted the guidance provided by the legal assessor that integrity involves adhering to the high ethical standards that society expects of professional persons like nurses or, putting it in lay terms, doing the right thing. The panel was satisfied that, by directing carers to create inaccurate records which gave the false impression that Mr Jankowski took part in a night shift round of inspection of residents in a care home when in fact he was not present, Mr Jankowski was acting

without integrity and with the deliberate intention of concealing from his employer that the 1am round was not being carried out in the manner prescribed by the management of the care home. The panel therefore found charge 2 proved.

Charge 3a

> Moved resident(s) by yourself when it was unsafe and/or clinically inappropriate to do so on:
>
> a. 15/16 June 2018, in respect of resident C and/or one or more other resident(s).

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Colleague 2.

The panel noted that Mr Jankowski does not comment on this incident in his responses to the NMC and he was not asked about it in the local investigation.

Colleague 2 said in his NMC statement *"I noticed that some residents had already gone to bed and some of those required two people to move them. This means that [Mr Jankowski] must have lifted these residents on his own and put them in a wheelchair to take them up to bed. At the Home, we had a lift. At all times, Resident D and Resident C were to be moved by two people and this was not followed by [Mr Jankowski]…As far as I can remember Resident C and Resident D were two residents who were already in bed meaning [Mr Jankowski] would have moved them himself. Resident D used a stand aid to get up and two people were required to move residents with a stand aid too, otherwise it becomes a health and safety risk. Resident C and Residents D were old and I was concerned about them being moved by [Mr Jankowski] on his own. I saw [Mr Jankowski] move Resident C and Resident D into a wheelchair when the night shift started on 15 June 2018".*

The panel had sight of the ‘Mobility, moving and handling care plan’ for Resident C which indicated that two carers were required to handle the resident at all times. The panel noted that the care plan had not been updated since 2015. However, it saw no evidence that the care plan was no longer an appropriate care plan.

The panel also had sight of the care plan for ‘Mobility, moving and handling care plan’ dated 20 March 2018 for Resident D which also indicated that two staff were required to attend on transfers.

The panel accepted the evidence of Colleague 2.

The panel was satisfied that there was sufficient evidence to find that on 15/16 June 2018 Mr Jankowski had moved Resident C and Resident D by himself when the care plans for each of the residents indicated that this was clinically inappropriate. The panel therefore found charge 3a proved.

Charge 3b

> Moved resident(s) by yourself when it was unsafe and/or clinically inappropriate to do so on:
>
> b. 13/14 November 2018, in respect of B and/or A.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 1, Colleague 2 and Mr Jankowski’s evidence of his actions given to the local investigation by the Home.

Mr Jankowski appeared to accept his wrongdoing in the local investigation notes dated 14 December 2018. He stated *"I have to admit to something that is naughty and I don't normally do this as there is two of us… What I did was I moved the wheelchair next to the bed, I didn't actually lift her, I slid her you know which I shouldn't have done, I don't normally do that there is normally two of us, because I'm afraid of something happening. Why I did that I don't know, maybe it was just because I was hurrying at that moment. That it really maybe because I wasn't thinking".* In his response to the NMC dated 4 January 2020 he stated *"Yes I did move the resident, Resident A incorrectly".*

Colleague 1 said in her witness statement

> "*I found [Mr Jankowski] in Residents B's room and saw that he had already put Resident B into her wheelchair. He really shouldn't have done this on his own as Resident B was a big lady and it wasn't safe. I did not see [Mr Jankowski] move Resident B but Resident B was in her wheelchair when I went into the room. Resident B required two people to move her, she could stand on her own but you needed to support her, similar to Resident A. Sometimes Resident B didn't want to move, so we would have to get the hoist out. Resident B has since passed away. When I found [Mr Jankowski] I told him to meet me in Resident A's room and I went to do something else and then returned to Resident As room.*
>
> *When I went back to Residents A's room, I called [Mr Jankowski] to see where he was and he responded from Residents A's room so I went inside it. When I opened the door to Residents A's room, I realised that [Mr Jankowski] had lifted Resident A on his own and put her into the chair. [Mr Jankowski] was making Resident A's bed. He should have moved both Resident A and Resident B together with me.*
>
> *[Mr Jankowski] should have waited for me to come. Being a nurse, he should have known that we needed to lift Resident A out of bed together, and hoisted her. However, [Mr Jankowski] had already lifted Resident A out by himself. This made me very angry as it was the wrong thing to do."*

Colleague 1 confirmed the accuracy of this account in her oral evidence at the hearing. The panel also had sight of the care plan 'Mobility, moving and handling care plan' for Resident A, dated 2017, but signed as reviewed in 2018 by Ms 4 which indicated *"She needs the assistance of two staff at all times*" for transfers.

The panel accepted the evidence of Colleague 1 and Colleague 2. The panel was satisfied that there was sufficient evidence to find that on 13/14 November 2018 Mr Jankowski had moved Resident A and Resident B by himself and the care plans for Resident A indicated that this was clinically inappropriate to do so.

The panel therefore found charge 3b proved.

Charge 3c

> Moved resident(s) by yourself when it was unsafe and/or clinically inappropriate to do so on:
>
> c. On one or more further occasions between June and November 2018

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 1, as cited above in support of its findings in charge 1b.

Colleague 2 said in his witness statement *"[Mr Jankowski] dressed Resident C every time he was on shift. This was a concern as moving Resident C on his own was risky and could cause accidents and injuries*". Colleague 2 also stated in his oral evidence that Mr Jankowski would move residents by himself when he ought not to have.

Having found the evidence of Colleague 1 and Colleague 2 to be credible and consistent, the panel accepted their evidence. It was satisfied that there was sufficient evidence to find that between June and November 2018 Mr Jankowski had moved one or more residents by himself when it was unsafe and/or clinically inappropriate to do so. The panel therefore found charge 3c proved.

Charge 4a

On the nightshift of 13/14 November 2018,

a. Did not document resident A's injury in her daily notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 3 and Mr Jankowski's responses.

Mr Jankowski said in his responses to the NMC dated 4 January 2020 *"When something did occur I didn't hesitate to document it onto the daily notes. On the shift of 13/14 November 2018 I wrote nothing, I honestly don't know why".* The panel also noted in the local investigation, it was put to Mr Jankowski that *"there was nothing in the notes, no accident report and you didn't hand it over".* He replied *"No, no''*.

Ms 3 stated in her witness statement *"On the daily notes, there is an entry from me on 14 November 2018 and no entry from [Mr Jankowski] relating to Resident A's injury that I can see".*

The panel had sight of Resident A's daily notes and noted that the first and only entry on 14 November 2018 was made at 10:40am by Ms 3.

The panel considered Ms 3 evidence to be credible and reliable. The panel accepted her evidence and also took into account that Mr Jankowski appeared to accept that he did not document Resident A's injury in her daily notes . The panel was satisfied from the evidence that Resident A's injury was not documented on the nightshift of 13/14 November 2018 in the daily notes. The panel therefore found charge 4a proved.

Charge 4b

On the nightshift of 13/14 November 2018,

b. Did not complete an entry in the accident book.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 4 and Mr Jankwoski's responses.

The panel did not have sight of the accident book but it heard from witnesses who gave oral evidence that they had looked at the accident book and there was no reference to Resident A's injury.

Mr Jankowski said in his response to the NMC dated 4 January 2020 *"When something did occur I didn't hesitate to document it onto the daily notes. On the shift of 13/14 November 2018 I wrote nothing, I honestly don't know why".* The panel noted in the local investigation, it was put to Mr Jankowski that *"there was nothing in the notes, no accident report and you didn't hand it over".* He replied *"No, no".*

Ms 4 said in her written evidence *"I can confirm that I could not find an entry in the accident book by [Mr Jankowski] in relation to Resident A's wound."*

The panel considered Ms 4's evidence to be credible and reliable. The panel accepted her evidence and also took into account that Mr Jankowski appeared to accept that he did not document Resident A's injury in the accident book. The panel was satisfied from the evidence that Mr Jankowski did not complete an entry in the accident book in relation to Resident A's injury on the nightshift of 13/14 November 2018. The panel therefore found charge 4b proved.

Charge 4c

On the nightshift of 13/14 November 2018,

c. Did not handover that resident A had suffered an injury.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 3, Ms 4 and Mr Jankowski's responses.

The panel had sight of the handover sheet from the 13 November 2018 and saw no reference to Residents A's injury.

Mr Jankowski said in his responses to the NMC dated 4 January 2020 regarding this incident *"On the shift of 13/14 November 2018 I wrote nothing, I honestly don't know why".*

The panel noted in the local investigation, it was put to Mr Jankowski by Ms 4 that *"there was nothing in the notes, no accident report and you didn't hand it over".* He replied *"No, no".* He also stated about the incident *"I was probably knackered. I wasn't as if someone had gashed their head, I was talking about other things, I should have said something but I didn't…It was much, much later that day that I realised I hadn't said anything. Just not thinking… So to me everything going on, I was probably knackered, I know I was*

knackered, so probably to me the incident I minimized it in my mind, if it was something bigger it would be there and I don't know whether I just blocked it I would normally say that straight away".

Ms 3 stated in her written evidence about the incident that Mr Jankowski had done the handover and *"No information on Resident A's wound on handover"*.

The panel considered Ms 4's evidence to be credible and reliable. The panel accepted her evidence and also took into account that Mr Jankowski appeared to accept that he did not hand over Resident A's injury. The panel was satisfied from the evidence that Mr Jankowski did not handover Resident A's injury on the nightshift of 13/14 November 2018.

The panel therefore found charge 4c proved.

Charge 5a

Slept on duty and did not provide supervision or prioritise patient care on:

a. 15/16 June 2018,

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 2 and Mr Jankowski's responses.

In Mr Jankowski' responses to the NMC and in the local investigation he denied ever sleeping at work and always maintained that he used a recliner to meditate during his breaks.

Colleague 2 said in his witness statement *"On the night shift on 15 June 2018 I worked with [Mr Jankowski], he would go into the conservatory, move the table down from the dining room, put a recliner there, get some blankets and a pillow and then recline himself. On 15 June 2018, I popped my head in and [Mr Jankowski] was asleep with all the lights off. This was at approximately 1.40am."* Colleague 2 also expanded on this in his oral evidence. He said that he had been cleaning in the hallway when he heard Mr Jankowski snoring and saw him asleep.

Having found Colleague 2's testimony to be credible, the panel accepted his evidence that Mr Jankowski had slept on duty on 15/16 June 2018. The panel considered that as it found Mr Jankowski did sleep on duty, he could not have been providing supervision or prioritising patient care. The panel therefore found charge 5a proved.

Charge 5b

Slept on duty and did not provide supervision or prioritise patient care on:

b. 25/26 November 2018,

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 5 and Mr Jankowski.

The panel had sight of video footage taken by Mr 5. It noted that the video doesn't show Mr Jankowski asleep but shows him lying down on a recliner in a darkened room covered by a blanket.

In Mr Jankowski's responses to the NMC and in the local investigation he denied ever sleeping at work. In the video footage he can be heard saying that he was not sleeping when he was confronted by Mr 5.

Colleague 1 said in her evidence *"I did not see [Mr Jankowski] asleep as I never went into the dining room. However, the light was off and this is what [Mr Jankowski] always did. I went to the door of the dining room and opened it and told [Mr Jankowski] I was going to do the 1am round…I called a couple of times and there was no response…It was dark in the room so I couldn't see if he was asleep but as the light was off and he didn't respond, I thought he was".*

The panel accepted the evidence of Colleague 1. The panel considered that Colleague 1's account that Mr Jankowski did not respond when she had called out to him and also the video footage of him in a reclined position with a blanket over him in a darkened room was sufficient to conclude that Mr Jankowski had been asleep on the shift on 25/26 November 2018. The panel considered that as it had found Mr Jankowski was sleeping on duty, he could not have been providing supervision or prioritising patient care.

The panel therefore found charge 5b proved.

Charge 5c

Slept on duty and did not provide supervision or prioritise patient care on:

c. On further occasions between June and November 2018.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 1 and Colleague 2.

In Mr Jankowski's responses to the NMC and in the local investigation he denied ever sleeping at work. The panel noted that in his response to the NMC dated 4 January 2020, Mr Jankowski insisted that he used his breaks during night shifts only to rest [PRIVATE] and that staff were aware of this. However, the panel rejected this evidence, and accepted the clear evidence of Colleague 1 and Colleague 2 that Mr Jankowski regularly slept for periods during the shift when he was not on his break.

Colleague 1 stated in her statement that *"He said he would be in the dining room resting but not asleep. This was not the first time he told me this, this happened on every shift I worked with him."*

Colleague 2 stated in his NMC witness statement that *"[Mr Jankowski] slept during the night shift on 15 June but also generally on all of the shifts I worked with him."*

The panel also noted Ms 4 said to Mr Jankowski in the Home's local investigation: *"See, what is worrying from my point of view as a nurse more than anything else, you've segregated yourself off, you've got the door shut, lights out, your laid out, the carer is somewhere in this building, which is quite a big building, with 17 residents all vulnerable adults, but you're in charge of the shift, you're in charge of the building."*[sic].

The panel accepted the evidence of Colleague 1 and Colleague 2, that Mr Jankowski had slept on further occasions between June and November 2018. The panel considered that as it had found Mr Jankowski was sleeping on duty, he could not have been providing supervision or prioritising patient care.

The panel therefore found charge 5c proved.

Charge 6

On 14 November 2018, inaccurately recorded that both you and colleague 1 had 'assisted [resident A] up as awake' and recorded colleague 1's initials against this inaccurate entry.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague 1, Ms 4 and Mr Jankowski's responses.

Mr Jankowski said in his evidence during the Home's local investigation: "*I have to admit to something that is naughty and I don't normally do this as there is two of us… What I did was I moved the wheelchair next to the bed, I didn't actually lift her, I slid her you know which I shouldn't have done, I don't normally do that there is normally two of us, because I'm afraid of something happening. Why I did that I don't know, maybe it was just because I was hurrying at that moment. That it really maybe because I wasn't thinking".*

In his response to the NMC dated 4 January 2020, he stated *"Yes I did move the resident, Resident A incorrectly".*

Ms 4 stated in her NMC witness statement: *"the room chart of Resident A from 13/14 November 2018 has an entry from 14 November 2018 at 06:45 by [Mr Jankowski] stating "assisted up as awake" This handwriting is [Mr Jankowski's] and my understanding is that [Colleague 1] hasn't signed the entry, but [Mr Jankowski] has signed his and [Colleague 1's] initials which is incorrect practice. During the day shifts, two carers would work together or it would be a carer and a nurse but as per policy, care must be done by two people (for those as stated in their care plans). In terms of the room chart, one person can write in what was observed or done but those present must sign the chart themselves.*

Colleague 1 said in her written statement: "*I realised that [Mr Jankowski] had lifted Resident A on his own and put her into the chair. [Mr Jankowski] was making Resident A's bed. He should have moved both Resident A and Resident B together with me".* When

questioned in her oral evidence by the panel about the initials on the room sheet, Colleague 1 confirmed that the initials entered on the sheet at 06:45 was not in her handwriting. She also confirmed that she had not assisted Mr Jankowski with Resident A.

The panel had sight of the room sheet and saw the entry of 14 November 2018.

The panel accepted Colleague 1's evidence that she had not been with Mr Jankowski when Resident A was moved and she had not signed the room sheet.

The panel was satisfied that there was sufficient evidence to find that Mr Jankowski inaccurately recorded that both he and Colleague 1 had 'assisted [Resident A] up as awake' and he recorded Colleague 1's initials against this inaccurate entry on 14 November 2018.

The panel therefore found charge 6 proved.

Charge 7

Your conduct at charge 6 was dishonest in that:

a. You knew you had moved resident A out of bed by yourself,

b. You intended to mislead any subsequent reader of that entry into believing you and colleague 1 had moved resident A when this was not the case

This charge is found proved in its entirety.

Having found the facts of charge 6 proved, namely that Mr Jankowski had inaccurately recorded and that both he and Colleague 1 had assisted Resident A up as awake and

recorded Colleague 1's initials against this inaccurate entry, the panel had to decide whether this amounted to dishonesty on the part of Mr Jankowski.

In order to reach a decision in relation to charge 7, the panel had first to decide on Mr Jankowski's state of knowledge as to the two issues set out in charge 7, namely whether he knew that he had moved Resident A out of bed by himself and whether, by making the entry that he did in Resident A's room chart, he intended to mislead any subsequent reader of the entry into believing that he and Colleague 1 had moved Resident A together when this was not the case, as he had moved her on his own.

As to the first issue at charge 7a, the panel is satisfied that Mr Jankowski knew that he had moved Resident A out of bed by himself because he admitted this when questioned about it at his first investigatory meeting on 14 December 2018 and never subsequently sought to withdraw this admission. The panel also relied on the oral evidence of Colleague 1 at the hearing, when she confirmed that she had not written her initials in the relevant column of Resident A's room chart for the 6.45am entry for 14 November 2018 which indicated that it must have been Mr Jankowski who did so.

As to the second issue at charge 7b, the panel is equally satisfied that, by making this entry, Mr Jankowski intended to mislead any later reader of the entry into believing that he had not moved Resident A alone, when this was not the case. At no time did Mr Jankowski offer an adequate explanation for his conduct in this regard and he admitted in the first investigatory meeting on 14 December 2018 that he should not have done this, no doubt because he was aware that Resident A's care plan, which was a document that the panel had sight of, stipulated that Resident A needed the assistance of two staff at all times and that two carers were needed when carrying out any interventions at any time.

Having decided that Mr Jankowski knew that he had moved Resident A out of bed by himself and his entry in resident A's room chart about this move was intended to be misleading, the panel went on to consider whether his actions were dishonest, based on the advice received from the legal assessor as to the test of dishonesty. Applying that test,

Mr Jankowski knew that the entry was inaccurate in seeking to mislead any later reader that he had been assisted in moving Resident A when in fact he had not been. The panel then had to decide whether Mr Jankowski's conduct in making a misleading entry in a resident's records would be regarded as dishonest by the ordinary standards of reasonable and honest people. Mr Jankowski having offered no adequate explanation for his conduct in making this misleading entry, the panel was satisfied that his actions would be regarded as being dishonest by the ordinary standards of reasonable and honest people.

The panel therefore found charge 7 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Jankowski'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 has borne 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 Jankowski'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.'*

Mr Lee invited the panel to take the view that the facts found proved amount to misconduct. He identified the specific, relevant standards where Mr Jankowski's actions amounted to misconduct.

Mr Lee submitted that Mr Jankowski's actions were serious, repeated and risked patient safety and care of vulnerable residents at the Home.

Mr Lee submitted that Mr Jankowski knew he was acting in a way contrary to resident's care plans despite obvious discomfort expressed by junior colleagues. He submitted that Mr Jankowski directed junior colleagues to follow his lead which compromised the care provided by the Home and his actions lowered the standards of care provided on his night shifts.

Mr Lee submitted that Mr Jankowski demonstrated a lack of integrity in directing junior colleagues to fill in records incorrectly and other colleagues and independent inspectors would have been misled about the standards of care being provided. Mr Jankowski's actions by moving residents by himself contrary to resident care plans, risked causing injury and he encouraged junior colleagues to do the same.

Mr Lee submitted that Mr Jankowski dishonestly recorded incorrect records which concealed that he had moved a resident without assistance contrary to the care plans which had the potential to cause serious harm. Mr Lee submitted that Mr Jankowski also failed to report in the records that an injury had occurred or make an accident report and he did not raise it in handover.

Mr Lee submitted that Mr Jankowski also woke residents early, contrary to the residents best interest and against the policy of the Home and contravened their basic right to comfort. Mr Jankowski's sleeping on shift on a number of occasions affected the level of care provided and amounted to serious and repeated misconduct.

Mr Lee submitted that individually and collectively Mr Jankowski's actions were a serious departure from the standards expected of a nurse and amounted to misconduct.

Submissions on impairment

Mr Lee 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 maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Lee submitted that Mr Jankowski has indicated that he does not intend to return to nursing practice. However, he submitted that a finding of impairment was still necessary as Mr Jankowski has not engaged with the NMC in relation to these proceedings and there is no evidence that he has strengthened his nursing practice in any clinical or care role.

Mr Lee submitted that Mr Jankowski has provided no reflection into these matters and several charges are more difficult to put right as they involve concerns about his honesty and integrity.

Mr Lee submitted that Mr Jankowski's conduct put residents at risk of harm and there is a risk of repetition because he has not provided evidence of remediation. Mr Lee submitted that an informed member of the public would be alarmed if a finding of impairment was not

made. He therefore submitted that a finding of impairment is required on the grounds of public protection and the wider public interest.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor that misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the nurse and thereby prejudices the reputation of the profession.

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

'1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively
1.5 respect and uphold people's human rights

8 Work co-operatively
To achieve this, you must:
8.5 work with colleagues to preserve the safety of those receiving care

10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

11 Be accountable for your decisions to delegate tasks and duties to other people
To achieve this, you must:
11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions
11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place
To achieve this, you must:
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

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
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
To achieve this, you must:
25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'

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 Mr Jankowski's actions were serious, involved wide ranging clinical and attitudinal concerns and showed a consistent pattern of unacceptable behaviour over a period of time.

Before reaching its decision on misconduct, the panel considered carefully the reasons given by the registrant for his actions in the written documents he submitted to the NMC, but it did not find that any of these reasons in any way lessened the seriousness of his misconduct.

The panel found that Mr Jankowski's actions, both individually and collectively, fell significantly 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 Jankowski'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, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel found limbs a, b, c and d engaged in the *Grant* test. The panel determined that residents were put at risk of psychological and physical harm as a result of Mr Jankowski's misconduct. The panel found that his misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel considered that Mr Jankowski had behaved dishonestly by making inaccurate records and acted without integrity by directing junior staff to behave inappropriately and create inaccurate records. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that Mr Jankowski had demonstrated very limited insight into his misconduct. It took into account his most recent statement dated 4 January 2020 and considered that he has not demonstrated an understanding of how his actions put residents at risk of harm or how they impacted negatively on his colleagues and the reputation of the nursing profession. The panel had no evidence that Mr Jankowski would behave differently in the same situation in the future.

The panel was satisfied that the misconduct in relation to charges 3 and 4 which related to clinical issues were capable of being addressed. However, Mr Jankowski has not engaged with these proceedings and it saw no evidence that he has taken steps to strengthen his practice.

In relation to the charges found proved which related to Mr Jankowski's dishonesty and lack of integrity, the panel considered that misconduct of this nature was more difficult to

remediate. Mr Jankowski has provided only limited evidence of insight and no evidence of remorse or any attitudinal change.

Therefore, the panel is of the view that there is a risk of repetition based on the lack of evidence of Mr Jankowski's insight and strengthened practice. 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.

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 Jankowski's fitness to practise impaired on the grounds of public interest.

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

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 Jankowski off the register. The effect of this order is that the NMC register will show that Mr Jankowski 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 and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Lee asked the panel to consider a striking-off order. He outlined what the NMC consider are the aggravating and mitigating factors of this case. He submitted that Mr Jankowski's actions are fundamentally incompatible with being a registered professional. Mr Jankowski intentionally behaved in an unprofessional and unsafe manner and demonstrated a disregard for safety by sleeping on duty and moving residents in a way which was contrary to care plans.

Mr Lee referred the panel the SG specifically the guidance on 'Considering sanctions for serious cases'. Mr Lee submitted that misconduct concerning dishonesty is always serious. He submitted that Mr Jankowski misused his authority as the only nurse on duty and he behaved without integrity by directing junior colleagues to undertake rounds alone and directing them to falsely record that he was present.

Mr Lee submitted that Mr Jankowski's permanent removal from the register is the only sanction that would maintain public confidence in the profession and avoid repetition of the misconduct.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Mr Jankowski's conduct put vulnerable residents at real risk of suffering harm.

- Mr Jankowski abused his position of trust by instructing his colleagues to behave inappropriately and showed total disregard of residents' care plans.
- Mr Jankowski has demonstrated limited insight into his failings.
- Mr Jankowski demonstrated a pattern of repeated misconduct over a period of time.

The panel also took into account the following mitigating features:

- Mr Jankowski made some early partial admissions at the local investigation in relation to the clinical concerns.

The panel also considered the SG on 'Considering sanctions for serious cases'. The panel carefully considered the kind of dishonest conduct and took into account that not all dishonesty is equally serious. The panel determined that Mr Jankowski's conduct demonstrated a misuse of power by directing junior colleagues to behave dishonestly. His actions put vulnerable residents at risk of harm. It also considered that Mr Jankowski's misconduct was premeditated, and longstanding and he demonstrated a lack of integrity repeatedly. The panel determined that Mr Jankowski's conduct was not at the lower end of seriousness.

The facts of seven separate charges have been found proved against Mr Jankowski and, although only two of them, namely charges 6 and 7, involve dishonesty directly by Mr Jankowski and only in relation to a single night shift, two of the other charges, namely charges 1(a) and 2, involve repeated acts of dishonesty over an extended period committed by more junior staff (who were the staff who reported Mr Jankowski's conduct to management) on the registrant's direction, for which direction the panel has found him to have acted without integrity. Accordingly, the panel has concluded that it can properly treat this case as involving serious dishonesty, either committed by Mr Jankowski himself or committed by other more junior staff for whom he was responsible at his direction. The effect of this was to create a deliberately misleading impression that two members of staff had performed night time rounds to check on residents and to assist in dressing a

resident, when only one member of staff had in fact done so. This was contrary to the relevant care plans and put residents at risk of harm.

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 not protect the public nor be 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 Jankowski'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 Jankowski'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 conditions of practice on Mr Jankowski'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 considered that there is evidence of attitudinal problems and it saw no evidence that Mr Jankowski is willing to respond positively to retraining or comply with conditions.

The panel is therefore of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case in relation to lack of integrity and dishonesty was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Jankowski's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel determined that Mrs Jankowski's misconduct was not a single instance but occurred on a number of occasions over a period of time. The panel considered Mr Jankowski's insight into his misconduct was very limited. The panel was therefore not satisfied that Mr Jankowski would not repeat his behaviour. The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel determined that the serious breach of the fundamental tenets of the profession evidenced by Mr Jankowski's actions is fundamentally incompatible with Mr Jankowski remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *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?*

The panel determined that Mr Jankowski's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Jankowski's actions were serious and to allow him to continue practising would put the public at risk of harm in the future and undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Jankowski's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to 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.

This decision will be confirmed to Mr Jankowski in writing.

Interim order

As the striking-off 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 Jankowski's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Lee. He submitted that an interim suspension order for a period of 18 months is necessary to protect the public and is in the wider public interest. He submitted that the most recent information is the Mr Jankowski is retired although that information is two years old. He submitted that if an interim order is not imposed, Mr Jankowski could work in the intervening period.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the appeal period.

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

That concludes this determination.