Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 26 September – Friday 30 September 2022

Virtual Hearing

Name of registrant:	**Primrose Matovu Namusisi**
NMC PIN:	17B1097E
Part(s) of the register:	Registered Nurse – Learning Disabilities Effective – 6 July 2018
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Melissa D'Mello (Chair, Lay member) Dorothy Keates (Registrant member) Colin Sturgeon (Lay member)
Legal Assessor:	Graeme Sampson
Hearings Coordinator:	Amanda Ansah
Nursing and Midwifery Council:	Represented by Rebecca Upton, Case Presenter
Miss Namusisi:	Present and represented by Adewuyi Oyegoke
Facts admitted:	Charges 4a, 4b, 4c (partial admission), 6, 7
Facts proved:	Charges 1, 2, 3, 4c, 4d, 5
Fitness to practise:	Impaired
Sanction:	**Suspension order with a review (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you as a registered nurse working as a bank learning disability nurse on the night shift of the 4th June 2019

1. Failed to keep and maintain Patient A's safety, a patient known to be suffering from Parkinsons and hospital acquired pneumonia.

2. You failed to maintain constant observation within eyesight of Patient A.

3. You fell asleep during your shift.

4. You caused or permitted and/or failed to redress Patient A's predicament on his bed, namely

(a) His head lowered down unsupported rather than sitting upright. .
(b) The bed elevated at approximately 45 degrees with the legs elevated above head height.
(c) His pyjama top unbuttoned, his legs exposed, his body uncovered by a blanket.
(d) The development of secretions in his airways for which you should have sought help in suctioning.

5. Your conduct particularised above at 1-4 inclusive exposed Patient A to the risk of aspiration.

6. You and Colleague 1 agreed and/or permitted one or the other to lock Patient A's door without any clinical reason.

7. When Patient A's grandson attended at 03.00 am on the 5th June 2019 together with Colleague 2, you delayed in opening the door to them.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Upton, on behalf of the NMC, to amend the wording of the first line of the schedule of charges, namely the date, and Charge 7.

The proposed amendment was to change the date in the first sentence from 4th June 2019 to 8th June 2019, and the date in Charge 7 from 5thJune 2019, to 9th June 2019. It was submitted by Ms Upton that the proposed amendment would provide clarity and more accurately reflect the date of the incident. She submitted that there is evidence of these correct dates within the exhibit bundle, and the dates currently within the charges relate to the interviews that were held on 4th and 5th July 2019, which are not the dates of the incidents in question.

> "That you as a registered nurse working as a bank learning disability nurse on the night shift of the ~~4th June 2019~~ **8th June 2019**:
>
> 7. When Patient A's grandson attended at 03.00 am on the ~~5th June 20~~19 together with Colleague 2, you delayed in opening the door to them.
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

The panel heard from submissions from Mr Oyegoke, on your behalf, that he has no objection to the application and that he is aware of and has taken instructions from you regarding the correct dates. He submitted that it is perfectly right that the incidents happened on 8th and 9th June 2019 as opposed to 4th and 5th June 2019.

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 you 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.

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

[PRIVATE]. Ms Upton then made a request that those parts of the case referenced by the panel and any further such matters arising, be marked in private. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Oyegoke indicated that he did not oppose the application.

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

The panel determined to adjudicate on whether to go into private session as and when such issues are raised to maintain the privacy of the parties.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Oyegoke who informed the panel that you made admissions to Charges 4a, 4b, 4c (partially, in as much as Patient A's pyjama top was unbuttoned, his left leg exposed and right leg was covered, but not admitting to his body being uncovered by a blanket), 5 (partially, in so far as charges 4a, 4b and 4c are concerned), 6 and 7. He submitted that your fitness to practise is an issue for the panel, but you deny your fitness to practise is currently impaired. He submitted that you deny charges 1, 2, 3 and 4d.

The panel therefore finds charges 4a, 4b, 6, and 7 proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel considered all the oral and documentary evidence in this case together with the submissions made by Ms Upton and Mr Oyegoke.

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:

- Witness 1: A relative of Patient A; Registered Paramedic.

- Witness 2: Junior Sister and Nurse in Charge at Chelsea and Westminster Hospital NHS Foundation Trust.

The panel also heard evidence from you under affirmation.

Background

The charges arose whilst you were employed as a bank Registered Learning Disabilities Nurse by Chelsea and Westminster Hospitals Trust on 8 to 9 June 2019 whilst working on a night shift. You were one of the two mental health nurses allocated to provide two to one care to Patient A for the entirety of your shift. Patient A suffered from Parkinsons and had additional needs due to hospital acquired pneumonia. Patient A was producing thick secretions and due to his current condition was at risk of aspiration. When Patient A was not in bed, he risked falling due to his comorbidities, and was considered a vulnerable patient for these reasons.

Due to the complexities in managing his condition, Patient A was allocated a side room. Witness 2 was the sister in charge at the time of the incident.

When the Trust investigated these concerns, you initially denied the allegations, but did accept that you had locked the door.

Oral Evidence

Witness 1 is the Grandson of Patient A and a Registered Paramedic. He attended the hospital at 3am to visit Patient A but upon reaching his room, he could not gain access as it was locked. Witness 1 tried knocking for several minutes but there was no response. Due to his concern, Witness 1 was joined by Witness 2 who also had to knock for one to two minutes and call out *"hello"* to gain access. Eventually, you opened the door a little, and then closed it again. When you reopened the door a few minutes later, it appeared to both witnesses that you had just woken up because of your appearance and as the room was in virtual darkness. Witness 1 also saw blankets rolled into pillows and other blankets on the chairs which gave him the impression that you had been sleeping on a makeshift bed.

When Witness 2 turned the light on, Witness 1 and Witness 2 found Patient A unresponsive on the bed with his head lowered down below his legs, and his legs bent but elevated at a 45-degree angle. Patient A's head was against the headboard and touching the bedrails which were raised. Patient A had mucus all over the right side of his face and was at a high risk of aspiration. In addition, Witness 2 was very clear that Patient A's pyjama top was up under his armpits and that the rest of his body was not covered.

Witness 1 described him as *"hypoxic and blue*", with secretions covering his face. When Witness 1 listened for Patient A's breathing, he heard gurgling, and there were no clinical monitoring machines in the room that would have detected his conditions. Witness 2 told the panel that they were very concerned on entering the room for Patient A's wellbeing and then sought to suction Patient A immediately. However, the suction machine was not ready for use and there was a delay in getting it ready. Witness 2's evidence was that it took around two hours to stabilise Patient A, clean him and make him comfortable.

You told the panel that you had maintained constant observation within eyesight of Patient A, that you did not fall asleep during any time of the shift, that Patient A was not at risk of aspiration, and that the secretions on his face were because of Patient A coughing episode a few minutes before Witness 1 and Witness 2 entered the room. You said that the room was not in total darkness and that you were able to see Patient A throughout your shift. You said that Patient A was wearing pyjamas and was covered by a blanket when Witness 1 and Witness 2 came in. During your oral evidence you insisted that Patient A's head was supported by a pillow and that Patient A's head was higher than his legs.

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 both the NMC and Mr Ogekoye, in addition to the evidence you provided orally.

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

Charge 1

"That you as a registered nurse working as a bank learning disability nurse on the night shift of the 8th June 2019

1. Failed to keep and maintain Patient A's safety, a patient known to be suffering from Parkinsons and hospital acquired pneumonia."

This charge is found proved.

In reaching this decision, the panel considered the fact that you knew you had a duty to ensure Patient A was cared for at all times. Patient A's Interim Care and Support Plan for use by RMNs (Care Plan), updated on 29 May 2019, states:

*"**Problem/need: Risk of harm to self/Safety***

RMN/Nurse's actions
Ensure constant observation, which in this case means within eyesight at all times and in close proximity. This requires being within arm's length when he is walking around and within 2 metres at the most when he is on his bed but awake…

…. Observe for signs of escalation and attempt to avoid this through distraction or diversion where possible….
When a break is covered by a colleague, ensure the oncoming person is briefed and understands risks/main points of this plan."

When asked about the duty of RMNs, Witness 2 stated:

"RMNs are expected to keep patients safe, comfortable, report to us any problems, do nursing assessment…"

You were aware of this duty as you had a handover prior to starting your shift and you were aware that Patient A had Parkinsons and hospital acquired pneumonia as you mentioned this in your oral evidence before the panel and in your statement at paragraph 2:

> *"I have worked on this ward before with another patient and also dealt with this gentleman before when he was in the bay. I started my shift at 19.45. The patient was handed over to me and my colleague at 19.45. At this point the patient's family were visiting and they left around 20.00. The patient has a diagnosis of dementia and Parkinsons disease."*

The panel further considered Witness 1's evidence. Witness 1 stated that Patient A was in a cyanosed state, a blue look, and along with Witness 2 tried to wake Patient A up by speaking and using visible pain stimuli to rouse Patient A but he was unresponsive and *"hypoxic".* Witness 2 told the panel that she was very concerned for Patient A's safety and took immediate action. Witness 2 stated that you did not request any assistance from her prior to the incident in question.

The panel found both Witness 1 and 2's accounts compelling and cogent, and it accepted their evidence. The panel determined that you failed to keep and maintain Patient A's safety and that Patient A was at risk of harm. Patient A was only attended to once Witness 1 and 2 gained access to the room. The panel therefore finds this charge proven on the balance of probabilities.

Charge 2

> "2. You failed to maintain constant observation within eyesight of Patient A."

This charge is found proved.

In reaching this decision, the panel considered Patient A's Care Plan and whether you were following the Trust's guidance on Engagement and Observation Policy of Patients (Adults and Young Persons and Children) with Mental Health Needs Policy (expiry 1 November 2019). The panel had particular regard to section 4.2 (Constant Engagement and Observation) of this policy.

The panel rejects the evidence you gave stating that you were always watching Patient A, as his head was found lowered below his legs and he was lying at an angle that put him at risk of harm. The panel was of the view that you failed to maintain constant observation within eyesight partly because it found that you fell asleep during your shift and additionally because of the state in which Patient A was found, his position on the bed, and his state of undress with secretions around his face. The panel accepted the evidence of Witnesses 1 and 2 and determined that this could not have happened if you were constantly observing him. The panel also accepted Witnesses 1 and 2's evidence that it would have been physically impossible to visually monitor Patient A with the room having been found to be in virtual darkness. The panel found this evidence compelling as it was supported by the same account given in Witness 2's DATIX report which stated that upon entering:

> *"...the room was completely dark, the main lights were off, the small lamp was covered with blanket, and the arm chairs were covered with blankets as well."*

The panel accepted Witness 2's evidence that she completed the DATIX report at the end of her night shift; this was supported by a screenshot of the DATIX submission time and date at 08:58am on 9 June 2019.

The panel found the evidence of Witness 1 and Witness 2 to be cogent and compelling. The panel therefore finds this charge proven on the balance of probabilities.

Charge 3

"3. You fell asleep during your shift."

This charge is found proved.

In reaching this decision, the panel considered both Witness 1 and Witness 2's evidence and accepted their accounts. It considered your account improbable, and it was of the view that had you and your colleague been actively observing Patient A, there would have been no need to lock the door. Aside from you being asleep, there cannot be any other plausible explanation as to why you took so long to open the door.

The room was in darkness, and it considered that you had fallen asleep, despite the evidence you gave stating that the small table light covered by a blanket was dimmed, and the room was not in total darkness. The panel could not understand how two nurses could not have seen Patient A's precarious position and difficulties if they were not asleep. It was persuaded by Witness 1 and 2's statements in which they concluded that given the room being locked, the delay in you opening the door despite the knocking and calling out, the fact the door was then closed for a short time before being reopened, your appearance (especially your eyes and voice), the fact you looked "stunned" and the fact that the room was dark with the presence of blankets and other blankets rolled into pillows on the chairs in the room and their positions, that you were sleeping during your shift.

Witness 2's DATIX report was produced on 9 June 2019 at 8:58am, and stated the following:

> *"…Patient's grandson who was a paramedic, dropped by the ward around 3am to see his grandfather. He couldn't get in his room even after several times of knocking so he called me, we both knocked the door which shouldn't be locked at all times in the first place. After several knocks, the RMN, who was obviously just woke up finally opened the door but was very adamant to let us in the room."*

The panel considered this evidence along with the statement provided by Witness 2 on 5 July 2019 in which it was stated:

> *"They were very adamant to let us in and they were obviously just woke up judging by the look of their eyes and the sound of their voice and instead of widely opening the door for us, they closed it again and took a few more seconds before opening the door again and finally letting us in."*

The panel further considered Witness 2's witness statement to the NMC dated 29 April 2021 in which it was stated:

> *"The blankets that ought to be used for the patient were selfishly being used for Primrose's own benefit. The patient was very cold, we ensured that we covered the patient."*

The panel was of the view that the consistency and detail in Witness 2's evidence over time is compelling and cogent to support the allegation that you were sleeping during your shift. The panel therefore finds this charge proven on the balance of probabilities.

Charge 4a

> "4. You caused or permitted and/or failed to redress Patient A's predicament on his bed, namely
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> (a) His head lowered down unsupported rather than sitting upright."

This charge is found proved by your admission.

The panel were concerned by your evidence which suggested that your admission to this charge might be equivocal. Accordingly, it decided to reach its own conclusion as to

whether it was proved. It found that it was: that you caused and failed to redress Patient A's predicament on his bed, namely his head lowered down unsupported rather than sitting upright.

In reaching this decision, the panel took into account your admissions and the evidence provided by Witness 1 and Witness 2. It was of the view that given this evidence, it would have found this charge proven on the balance of probabilities even in the absence of your admissions.

Charge 4b

> "4. You caused or permitted and/or failed to redress Patient A's predicament on his bed, namely
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> (b) The bed elevated at approximately 45 degrees with the legs elevated above head height."

This charge is found proved by your admission.

Again, with this charge the panel were concerned by your evidence which suggested that your admission to this charge might be equivocal. Accordingly, it decided to reach its own conclusion as to whether it was proved. It found that it was.

In reaching this decision, the panel took account of Witness 2's DATIX report which stated:

> *"When I turned the light on, we saw the patient in bed with his head lowered down and his legs bent but elevated. The bed is fully slanted in an angle that the patient's legs were higher than his head."*

The panel noted that you gave evidence stating that you were aware Patient A needed to be kept upright due to risk of aspiration. Despite knowing this however, you failed to ensure that Patient A was kept upright as he was found by Witness 2 to have his head lowered down. The panel found Witness 1's and Witness 2's evidence compelling and cogent, and finds this charge proven on the balance of probabilities: that you caused and failed to redress Patient A's predicament on his bed, namely the bed elevated at approximately 45 degrees with the legs elevated above head height.

Charge 4c

> "4. You caused or permitted and/or failed to redress Patient A's predicament on his bed, namely
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> (c) His pyjama top unbuttoned, his legs exposed, his body uncovered by a blanket."

This charge is found proved.

In reaching this decision the panel accepted the evidence of Witness 2 as she gave a clear, compelling, and cogent account, corroborated by the contemporaneous DATIX report provided. When giving oral evidence, Witness 2 stated that Patient A's pyjama top was unbuttoned, with his head exposed. Witness 2 further stated that Patient A's pyjama top was rolled up under his armpits, he was otherwise naked, apart from an incontinence pad, his dignity was not preserved and that she was ashamed that Witness 1 had to see Patient A in that state. The panel considered that you did not follow the Trust's policy on Engagement and Observation of Patients (Adults and Young persons and Children) with Mental Health Needs, namely paragraph 4.2.6:

> *"Sensitive consideration needs to be given to issues of privacy dignity and the ethnicity and gender of the staff involved however safety issues are of*

greater importance than privacy. These considerations must be explained to the patient."

The panel determined that you caused and failed to redress Patient A's predicament on his bed, namely his pyjama top unbuttoned, his legs exposed, his body uncovered by a blanket.

The panel therefore finds this charge proven on the balance of probabilities.

Charge 4d

"4. You caused or permitted and/or failed to redress Patient A's predicament on his bed, namely

(d) The development of secretions in his airways for which you should have sought help in suctioning.

This charge is found proved.

In reaching this decision the panel accepted the evidence of Witness 1 who stated that he found Patient A to be blue in the face, unresponsive and hypoxic. Witness 1 then proceeded to listen to Patient A's airways and heard a gurgling fluid sound. In Witness 2's DATIX report, it stated that Patient A was found with a *"pool of phlegm all over his face"*; in which Witness 2 then suctioned him, cleaned him, and cleared his airways by suctioning up his secretions. The panel accepted Witness 1's and Witness 2's oral evidence that Patient A's secretions were deposited in the chamber of the suction machine.

The panel accepted Witness 1's and 2's evidence that, after suctioning, Patient A's condition significantly improved, he was repositioned, became responsive and was able to communicate. The panel determined that, had you been correctly observing Patient A as required, you would have immediately noticed the gurgling sound and blue colour in his

face as Witness 1 stated, and you would have sought help in suctioning from the nurses on the ward. The panel was persuaded by both accounts of Witnesses 1 and 2 and determined that you permitted and failed to redress Patient A's predicament on his bed, namely the development of secretions in his airways for which you should have sought help in suctioning. The panel therefore finds this charge proven on the balance of probabilities.

Charge 5

> "5. Your conduct particularised above at 1-4 inclusive exposed Patient A to the risk of aspiration."

This charge is found proved.

In reaching this decision the panel considered the documentary evidence from Witness 1 and Witness 2. In the DATIX form provided by Witness 2, it was stated that:

> *"The patient should be sitting upright at all times even when he is sleeping as he has risk of aspiration which has been recurrent during this admission, he has poor swallowing and he was very chesty. He was not able to expectorate and swallow his secretions that is why he needs suctioning at times."*

The panel considered this evidence along with Witness 1's statement that you were seemingly unaware or unconcerned of the risk of aspiration that was evident and clearly documented in Patient A's notes. Witnesses 1 and 2 told the panel that your conduct placed Patient A at risk of aspiration and health deterioration; Witness 1 stated that his grandfather could have died were it not for Witness 2's and his intervention. Witness 2 concurred with the risk of morbidity to Patient A. The panel was persuaded by the oral evidence given by Witnesses 1 and 2 and was of the view that it was consistent with the witness statements they provided to the NMC, Witness 2's local level statement given to

the Trust, and Witness 1's telephone interview statement with the Trust. The panel therefore finds this charge proven on the balance of probabilities.

Charge 6

> "6. You and Colleague 1 agreed and/or permitted one or the other to lock Patient A's door without any clinical reason."

This charge is found proved by your admission.

In reaching this decision, the panel took into account your admissions and the evidence provided by Witness 1 and Witness 2. It was of the view that given this evidence, it would have found this charge proven on the balance of probabilities even in the absence of your admissions.

Charge 7

> "7. When Patient A's grandson attended at 03.00 am on the 9th June 2019 together with Colleague 2, you delayed in opening the door to them."

This charge is found proved by your admission.

In reaching this decision, the panel took into account your admissions and the evidence provided by Witness 1 and Witness 2. It was of the view that given this evidence, it would have found this charge proven on the balance of probabilities even in the absence of your admissions.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your

fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

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 Upton 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 Upton identified the specific, relevant standards where your actions amounted to misconduct. She submitted that considering the charges admitted and found proved after hearing all the evidence and considering Mr Oyegoke's submissions, your fitness to practise is impaired by reason of your misconduct.

Mr Oyegoke submitted that the charges found proven against you are regarding your clinical skills and your competence and that it is only after the panel determined that the charges constitute misconduct that it must consider whether the misconduct amounts to your fitness to practise being impaired. He further submitted that the emphasis at impairment stage is whether you are currently impaired today and whilst it is important to consider the charges, it is equally essential to consider all your efforts before and after the incident, to demonstrate insight, remorse, and remediation.

Submissions on impairment

Ms Upton 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2), Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council,* [2008] EWHC 581 (Admin) in which the High Court established the two separate questions to be considered at the "impairment stage":

a. Whether, on the basis of the facts admitted or found proved, the conduct in question amounts to one of the statutory grounds (set out in Article 22 of the Nursing and Midwifery Order 2001);
b. If so, whether the registrant's current fitness to practise is impaired?

Ms Upton submitted that the panel must consider all the evidence before it along with your engagement, or lack of it, with the proceedings. She submitted that in applying the test outlined in *CHRE v NMC and Grant,* the conduct found proved highlights that your actions make you liable in the future to act as to put a patient or patients at unwarranted risk of harm. She further submitted that your actions in the past make you liable in the future to bring the profession into disrepute, and liable in the future to act dishonestly.

In her written submissions, Ms Upton stated that the panel need to consider whether the conduct found proved indicated an attitudinal problem and whether such problems are capable of remediation. She submitted that you have showed no remorse, no acknowledgement of the near miss your actions constituted to Patient A's safety, and limited insight into the NMC's concerns. Although you engaged with the internal investigations carried out by the Trust, provided a written statement, and answered questions at a meeting in July 2019, you showed limited insight in both of those instances and maintained that you had done nothing wrong, other than you should have challenged your colleague's suggestion to lock the door.

Ms Upton submitted your statement dated 27 September 2022 and your evidence to the panel has not been indicative of any real insight into your conduct. You denied almost all of the charges, even the facts of those admitted, and blamed others, including the patient himself, the ward sister and your RMN colleague. You minimised the seriousness of your conduct and do not appear to have remediated the concerns. In applying the case of *CHRE v NMC and Grant* again, she further submitted that public confidence in the profession would be undermined if a finding of impairment were not made in the circumstances.

Ms Upton submitted that your Remediation bundle reflective statement dated September 2022 comprised a repetition of your facts statement that had already been rejected by the panel, that you were still denying what had occurred and that there was no real evidence of remorse nor acceptance of responsibility for your actions. By way of example, Ms Upton cited from your statement your view that you '*recognise that the events that happened on the 8 June 2019 were unfortunate.'*

Mr Oyegoke submitted that since the conduct leading to the charges are clearly clinical, they are easily remediable and have been, as there has been no repeat of the conduct challenged by the NMC. He submitted that the NMC has not received any further referral since the incident and there was no interim order imposed whilst the NMC proceedings to

this substantive hearing were ongoing. He submitted that you continue to work full time without further concern, and you have prepared and submitted a written reflective account to the panel along with references and completed feedback forms.

Mr Oyegoke further submitted that you have attended numerous training courses which are relevant to the conduct found proved and that your fitness to practise is not impaired as of today.

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

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

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

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

4 Act in the best interests of people at all times

To achieve this, you must:

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process,

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.5 work with colleagues to preserve the safety of those receiving care

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written sometime 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

10.5 take all steps to make sure that all records are kept securely

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely and appropriate referral to another practitioner

when it is in the best interests of the individual needing any action, care or treatment

13.3 ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence

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:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers,

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress.'

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 your actions in sleeping on duty whilst caring for a vulnerable patient and, whilst doing so, deliberately placing his bed at a 45-degree angle so that his head was below his feet, leaving him uncovered and at risk of aspiration were deplorable, unprofessional, and put the profession into disrepute. It considered this behaviour to be wholly unacceptable. The panel noted that although you were one of the RMNs providing one to one mental health nursing to Patient A, you have a duty to provide basic nursing care to your patients and knew that Patient A should not have been put in the position he was found in when he had hospital-based pneumonia, a chest infection, and could not swallow properly. The panel determined that you selfishly placed your own interests over the needs of a highly vulnerable patient and your actions in rolling up blankets into pillows and setting up chairs into a makeshift bed, were deliberate and planned, leaving Patient A at a serious risk of severe harm as you placed him in a position that enabled you to sleep.

The panel further noted that Patient A's bed rails were put up and you were not watching him as you were required to. Patient A was found cold and due to the position of his bed, his movements were restricted with no clinical justification. The panel determined that you, in maintaining your account, even after you had admitted some of the charges, did not evidence any genuine admission to the charges, except for the fact that you accepted that you had locked the door. The panel accepted the account of Witness 1 in that you were rude when challenged about your actions and that you told him they should not have been in the hospital at those hours, and it was none of their business. It considered that Witness 2's account, corroborated that of Witness 1's, as she suggested that Witness 1 could make a formal complaint as the care that was supposed to have been provided to Patient A was not ongoing when they entered the room.

The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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 determined that limbs a, b, and c are engaged in this case.

The panel finds that Patient A was put at risk of unwarranted physical and emotional harm as a result of your misconduct. It determined that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that you have not appropriately demonstrated an understanding of how your actions put Patient A at a risk of harm. It determined that you had minimised the seriousness of your conduct, deflected blame onto others, demonstrated very limited insight, and taken little responsibility nor acknowledgement of the seriousness of risk.

Notwithstanding, the panel considers that, in principle, the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether you have taken steps to strengthen your practice. The panel considered the fact that you have completed several training sessions, and no further concerns have been raised.

However, the panel is of the view that there is a significant risk of repetition as you have not remediated your misconduct. The training you have completed only partially covers the issues and does not go to the heart of the charges found proved. There is also no evidence of you demonstrating the transfer of recent relevant training into your practice.

The panel did not place any weight on the references provided which were not on headed paper nor confirmed the authors' full and detailed knowledge of these proceedings. The panel placed limited weight on the references from your current employment agency as they did not confirm having read the detail of the charges against you, nor did they explain how you have remediated your 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 determined that a finding of impairment on public interest grounds is required because an informed member of the public, aware of the charges found proved in this case would be particularly horrified at the misconduct and breaches of the NMC code and standards. 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 your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Ms Upton submitted that that the minimum sanction in this case is a suspension order. It is for the panel to decide, considering all the evidence, whether the facts of this case in fact merit a higher form of sanction and the NMC leave that for the panel's assessment. She submitted that the training you undertook did not demonstrate remediation of your conduct that was found proved.

The panel also bore in mind Mr Oyegoke's submissions that the principle of proportionality requires it to consider the least restrictive order. He submitted that your participation in these proceedings alone has brought about sufficient warning and enlightenment that any deviation would be challenged. He submitted that should the panel wish to consider your conduct unacceptable, then a caution order for a few months should suffice.

Mr Oyegoke also submitted that a Conditions of Practice Order is available and can be professionally drafted to address the identified risk for only a few months. He further submitted that a lengthy period for either a conditions of practice order or a suspension order would be disproportionate and outrageous in all the circumstances of this case as the limited insight identified by the panel cannot be developed if you are suspended from practice.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Patient A was an elderly man with significant health issues and was very vulnerable
- Your actions placed him at risk of harm and a near miss of serious injury or death,
- Abuse of position of trust,
- Lack of insight into your failings.

The panel also took into account the following mitigating feature:

- The incident occurred over a single shift

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the misconduct found proved, and the public protection risk. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate

in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*

The panel also considered the NMC's guidance on seriousness. It determined that you were directly responsible for exposing Patient A to harm or neglect, especially where the evidence shows you were putting your own priorities before your professional duty to ensure patient safety and dignity. It also found that you failed to uphold Patient A's dignity, treat him with kindness, respect and compassion, deliver assistance and the fundamentals of care to him without undue delay.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and the lack of insight into your failings. The misconduct identified in this case was not something that can be addressed through conditions.

Furthermore, the panel concluded that the placing of conditions on your 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 repetition of behaviour*
- *No evidence of harmful deep-seated personality or attitudinal problems;*

The panel was satisfied that in the particular circumstances of this case, the misconduct was not fundamentally incompatible with remaining on the register.

The panel did seriously consider a striking off order but determined that given that you have been working for three years without any regulatory concerns being raised, it would be disproportionate to impose a striking off order. It considered that the seriousness of the charges found proved require a temporary removal and a period of suspension will be proportionate and sufficient to protect the public. Whilst the panel did determine some attitudinal issues were present, there is no evidence before it to suggest that these may be deep seated. The panel also considered that although there is a lack of insight, given the fact that you have been working unrestricted for three years with no concerns there is a public interest in a Registered Nurse being given the opportunity to remediate their misconduct to return to safe practise.

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

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 12 months with a review was appropriate in this case to mark the seriousness of the misconduct and the severity of

harm to which Patient A was exposed. It was of the view that anything less would not be proportionate as a sanction.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A detailed reflective piece including a full and unequivocal acceptance of the charges found proved, alongside evidence of genuine remorse and apology.
- Written evidence of the steps you have taken to remediate your practice, and any outcome of this.
- If working in a healthcare/voluntary setting, formal testimonials from your line manager as to how you have remediated the charges found proved.
- Evidence of training certificates relating to the charges found proved and how you may have applied that learning to your practice,

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interest until the suspension 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 Upton. She submitted that an interim order is necessary on the grounds of public protection and in otherwise in the public interest. Ms Upton also submitted that the interim order be of an appropriate level to cover the period until the sanction takes effect and/or during any period pending appeal.

The panel also took into account the submissions of Mr Oyegoke who indicated that he opposed the application as you have worked for three years since the incident without further concerns, so on this basis, you can work for a further month before the substantive suspension comes into force. You have indicated that you wish to lodge an appeal immediately today.

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

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 also recognised that it would be inconsistent to not make an interim order given the terms of the order imposed today and your express wish to appeal.

The panel therefore imposed an interim suspension order for a period of 18 months due to the delay in allowing time for appeals.

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

That concludes this determination.