Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
10 - 21 January 2022
23 January 2023 – 3 February 2023
14 July 2023
8 August 2023 – 11 August 2023

Virtual Hearing

Name of registrant:	**Emerly Gumbura**
NMC PIN:	07H3441E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – 16 February 2008
Relevant Location:	Wakefield, West Yorkshire
Type of case:	Misconduct
Panel members:	Mary Hattie (Chair, Registrant member) Jocelyn Griffith (Lay member) Melanie Lumbers (Registrant member)
Legal Assessor:	Michael Epstein (10 – 22 January 2022, 23 January 2023 – 3 February 2023) Peter Jennings (14 July 2023, 8 August 2023 – 11 August 2023)
Hearings Coordinator:	Max Buadi (10 – 22 January 2022) Opeyemi Lawal (23 January 2023 – 3 February 2023, 14 July 2023, 8 August 2023 – 10 August 2023) Nandita Khan Nitol (11 August 2023)
Nursing and Midwifery Council:	Represented by Scott Smith, Case Presenter (10 – 22 January 2022) Represented by Michael Smalley, Case Presenter (23 January 2023 – 3 February 2023)

	Represented by George Hugh-Jones, Case Presenter (14 July 2023, 8 August 2023 – 11 August 2023)
Mrs Gumbura:	Present and represented by Shivani Jegarajah, Not present and not represented orally at hearing (8 August 2023 – 11 August 2023)
Facts proved:	1a, 1b, 1d,1e, 1g, 1h, 2a, 2b, 2c, 3b, 3d, 4, 5a, 5b, 6b, 6c, 6d, 6e, 6f, 6g, 6i, 6j, 6k, 6l, 6m, 6n, 6o, 7a, 7b, 7c, 7d, 8a, 8d, 8e, 8f, 8g, 9, 10
Facts not proved:	1c, 1f, 1i, 3a, 3c, 6a, 6h, 8b, 8c
Fitness to practise:	Impaired
Sanction:	**Conditions of Practice Order (18 months)**
Interim order:	**Interim Conditions of Practice Order (18 months)**

Details of charge (as amended)

That you, a registered nurse while working as a Registered Manager of Carr Gate Care Home:

1) Between March 2017 and September 2017, neglected Resident A by failing to ensure or put in place effective systems to ensure:

   a) that staff appropriately managed a sore on Resident A's groin area that had been discovered in June 2017 and was not treated adequately until September 2017;
   b) that Resident A's personal care was attended to promptly and wet pads changed regularly despite requests being made for Resident A to be changed;
   c) that medical assistance was sought when Resident A was unwell despite repeated requests made by Resident A's family for a doctor to be called;
   d) that Resident A wore his own clothing and was not made to wear clothing that belonged to other Residents;
   e) that Resident A's clothing was changed frequently;
   f) that Resident A's hearing aid was put in allowing him to communicate with staff;
   g) that despite smelling strongly of urine, on one or more occasion, Resident A was attended to/and or changed;
   h) that Resident A's feet were washed;
   i) that Resident A's care plan was followed to ensure that Resident A received the 1:1 care he required;

2) On 12 October 2017 following a safeguarding referral in relation to Resident A, you:
   a) did not accept that Resident A's needs had not been met;
   b) did not accept that Resident A had a sore on his groin at the time of his admission to Hospital on 6 September 2017;
   c) did not accept that the standard of care provided to Resident A was particularly poor and/or neglect;

3) On or before 15 February 2018 you did not:
   a) complete Deprivation of Liberty Safeguard Applications (DoLs) in relation to Resident B, C and/or D, all of whom suffered from dementia and were at risk;
   b) ensure that MAR charts were completed fully and/or accurately;
   c) ensure that MAR charts belonging to Residents were kept secure and not left in an unsecure reception drawer;
   d) ensure that confidential information including documents with Residents' names on them were kept secure;

4) On 14 May 2018 during an appeal hearing you failed to adequately explain the process followed when completing Deprivation of Liberty Safeguarding Applications;

5) Between 27 September 2017 and 2 October 2017 following a CQC inspection, breached the following regulations of the Health and Social Care Act (Regulated Activities) Regulation 2014:

   a) Regulation 9: person-centred care;
   b) Regulation 17: good governance;

6) Between 8 November 2017 and 31 January 2018 following inspections by Wakefield Care Commissioning Group, you did not make sufficient improvements by failing to:

   a) carry out monthly audits of the Home;
   b) ensure that the Home was kept clean and tidy;
   c) ensure that Residents' documentation were kept secure;
   d) ensure that offensive odours previously identified had been managed appropriately;
   e) ensure that Residents' rooms were kept clean and/or dirty bedding changed;
   f) ensure that shower rooms were kept clean;
   g) ensure that the laundry room and sluice room was kept secure;
   h) ensure safety of Residents by having inappropriate wall fixings including loose wires on walls;

i) ensure that fluid charts, nutrition charts and/or repositioning charts for Residents were completed accurately;
j) ensure that risk assessments for falls and/or nutrition and/or pressure care and/or infection control had been completed adequately and correctly;
k) ensure that bedrail and hourly checks on Residents had been completed adequately;
l) ensure that Residents' care plans were kept up to date;
m) ensure that audits had been completed accurately and/or correctly reflected the position at the Home;
n) ensure that staff communicated with Residents and/or sought consent prior to intervention;
o) ensure that Residents always had access to call bells;

7) On or before 6 December 2017 following a Dependency Review carried out at the Home by the Clinical Director, you failed to:

a) ensure that the quality of the food provided to Residents was to a good standard;
b) ensure that fluid charts were kept up to date;
c) ensure that Residents' mattresses were set to the correct weight;
d) ensure that each Residents' room had a call bell;

8) On 24 January 2018 following a routine visit to the Home by senior management, you failed to ensure that:

a) the Home was kept clean as it continued to smell strongly of urine;
b) Residents were clean and had their clothing changed regularly;
c) Residents were given their meals on time;
d) staff engaged with Residents at an appropriate level;
e) Residents' care plans were completed fully and within a timely manner;
f) staff had completed all the required training;

g) Residents who had been identified as losing weight and/or having a low Body Mass Index were weighed on a weekly basis;

9) On or before 24 January 2018, you produced completed audit documentation that did not accurately reflect the standards of care provided at the Home;

10) Your actions at charge 9 above were dishonest as you knew that you had not completed the audits accurately and had sought to mislead your employer and/or external inspectors;

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

Background

On 30 July 2019, the NMC received a referral about your fitness to practise from the HR Manager Carr Gate Group Home (the Home) which is owned by HC-One. At the time of the concerns, you had been working as manager of the Home starting on 29 June 2015.

The referral related to the neglect of Resident A, the failure to keep medical records secure, the failure to make relevant Deprivation of Liberty Safeguard Applications (DoLs), the failure to ensure adequate care for residents at the Home and the production of audit documentation that did not accurately reflect the standards of care provided at the Home. It is alleged that these incidents took place between March 2017 and February 2018.

In June 2017, Resident A was found to have a sore on his penis which required medical attention. Resident A suffered a fall in September 2017 and was admitted to hospital where the sore was discovered again by hospital staff. The hospital doctor considered that the sore had been there for some time and, as a result, a referral was made to safeguarding due to the suspected neglect of Resident A.

On 27 September 2017, the Home was inspected by the Care Quality Commission (CQC) who raised concerns as to the standard of care provided at the Home. The Home was also inspected by the Wakefield Care Commissioning Group (CCG) on 8 November 2017 and again on 3 June 2018. On both occasions, similar concerns were identified (Charge 6).

It is alleged that you were made aware of these concerns through meetings and it is further alleged that you did not adequately address the concerns raised.

Several witnesses noted that the dementia ward, in particular, was “uninhabitable” and “inhumane”. Some witnesses stated that the walls were made of Astro turf with an overpowering smell of urine.

There are allegations relating to incomplete or “box ticking exercises” having been taken with various pieces of paperwork. It is alleged that DoLs assessment were noted as being completed but not on file, or not being completed at all for some of the Residents (Resident C and Resident D).

It is also alleged that paperwork relating to a number of residents, including MAR charts, risk assessments and hourly checks, were incomplete, inaccurate or generically completed. Witnesses alleged that MAR charts were in drawers in reception desks with your knowledge. It is also alleged that Boots were permitted to leave medication in the reception area.

Charges 9 and 10 relate to audits undertaken by you. It is alleged that these audits were treated like “box ticking exercises” and did not reflect the true state of the Home. It is the NMC’s case that these audits were misleading, dishonestly completed and did not reflect the true state of the Home.

Application for disclosure

During the cross-examination of Ms 2, but not in her presence, Ms Jegarajah made an application for disclosure. She informed the panel that you have told her about a tool called “cornerstone” which is used by HC-one. She submitted that all your performance reviews during your tenure at the Home, audits you had undertaken and medical notes completed by you are on this system. She submitted that you cannot access this as you are no longer working at the Home but she cannot see why the Home cannot produce this for you.

Ms Jegarajah submitted that there is a massive disparity in what the Home has disclosed to the panel and nothing that supports your case.

Ms Jegarajah reminded the panel that Ms 2 has said that if you made a complaint to senior management then you have to escalate it. However, if you do not do this, then it raises an additional concern. Ms Jegarajah submitted that you have stated that you repeatedly raised concerns.

Ms Jegarajah submitted that she hopes the NMC can get this disclosed. She informed the panel that this was not done by your previous representative and Ms Jegarajah was only instructed on 31 December 2021. She submitted that you are going into this case with “one hand tied behind your back” without this disclosure.

Mr Smith informed the panel that he was told by the NMC that your previous representative had made a request for disclosure. He submitted that he can only repeat the previous responses provided by HC-One.

With regards to emails from you to your line manager, Mr Smith informed the panel that the IT team at HC-One stated that without specific details they cannot narrow down the search.

With regards to the information on cornerstone, the Head of Department meeting notes, and the record of supervision meeting notes, Mr Smith stated that these were not provided and no reason was provided.

With regards to an email you said you sent Boots to stop leaving medication in the Home lobby, again, Mr Smith reiterated the response previously provided by the IT team at HC-One.

With regards to the minutes of the Wakefield council and HC-One meeting, Mr Smith informed the panel that minutes were not taken.

Mr Smith submitted that the NMC has asked for the information but HC-One have not been forthcoming. He submitted that the NMC do not have the power to summon documentation.

Ms Jegarajah submitted that it is too much of a coincidence that the information requested, that could be potentially helpful to your case, cannot be provided. She submitted that she may have to make an application to the High Court.

Ms Jegarajah informed the panel that she took the case on 31 December 2021 and you both have been working all day and all night on it with four hours sleep. She submitted that they have not reached out to HC-One themselves as a result. Ms Jegarajah informed the panel that your previous representative had done nothing and “damaged” your case. She also informed the panel that she only became aware of your previous representative’s correspondence with HC-One a few days after she took over your case.

Ms Jegarajah submitted that she is making the application because your case has always been that you have been scapegoated and senior management had been involved in discussions regarding improvement. In light of Ms 2’s aforementioned comments, Ms Jegarajah submitted that this application is important.

She told the panel that you started work in the Home in 2015. Ms Jegarajah said that if the IT team of HC-One cannot provide the emails specified, then can they provide all your emails during your tenure at the Home and you and Ms Jegarajah will go through them.

The legal assessor advised that Ms Jegarajah list what she wanted disclosed this afternoon and send it to HC-One. He asked if Mr Smith could support this application on behalf of the NMC and if the Chair could support this request as a matter of urgency.

The panel supported this motion.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Smith, on behalf of the NMC, to amend the wording of charge 1(a).

The proposed amendment was to change the date within the charge. It was submitted by Mr Smith that the current date, March 2017, was incorrect and should in fact be June 2017. He drew the panel's attention to the 'Personal Care and Support Plan' and the "Skin Integrity Care and Support Plan" of Resident A. These are both dated 1 June 2017. Mr Smith submitted that the proposed amendment would provide clarity and more accurately reflect the evidence.

Mr Smith also submitted that no injustice would be caused. He submitted that if the charge is found proved then the shorter time period, which would be from June 2017 to September 2017 would assist you in the next stage of the hearing. He submitted that if the charge is not proved, then it "falls away" anyway. He submitted that it would be fair to amend the charge in this way.

1) Between March 2017 and September 2017, neglected Resident A by failing to ensure or put in place effective systems to ensure:

a) that staff appropriately managed a sore on Resident A's groin area that had been discovered in ~~March~~ June 2017 and was not treated adequately until September 2017;

Ms Jegarajah did not oppose the application.

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):

> *'**28.—** (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—*
>
> > *(a) the charge set out in the notice of hearing; or*
> >
> > *(b) the facts set out in the charge, on which the allegation is based,*
>
> *unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.*
>
> > *(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.'*

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 also bore in

mind that this application was supported by Ms Jegarajah. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision on further amendment

After the panel had retired to consider its decision it invited the advocates to make observations on the wording of charges 1g and 6g.

Mr Hugh-Jones applied, on behalf of the NMC, to amend the wording of both charges. In relation to charge 1g the application was to delete the word ‘not’ where it appeared twice in sub-charge g, as the effect of the word was to give the charge the opposite meaning to that which was obviously intended. In relation to charge 6g the application was to change the word ‘and’ to ‘and/or’ to allow for the possibility that the panel may consider that the charge was proved in relation to one room but not the other.

It was submitted by Mr Hugh-Jones that the proposed amendments would better reflect the intended meaning, would provide clarity and would reflect the evidence.

1) Between March 2017 and September 2017, neglected Resident A by failing to ensure or put in place effective systems to ensure:

    g) that despite smelling strongly of urine, on one or more occasion, Resident A was ~~not~~ attended to/and ~~not~~ changed;

6) Between 8 November 2017 and 31 January 2018 following inspections by Wakefield Care Commissioning Group, you did not make sufficient improvements by failing to:

    g) ensure that the laundry room and**/or** sluice room was kept secure;

Ms Jegarajah, after communicating with you, told the panel that you understood the proposed amendments and that she had no objection to them.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that these amendments, as applied for, were 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 amendments. The panel also bore in mind its duty to ensure that the charges properly reflect the mischief alleged. The panel was satisfied that the amendments should be made to ensure clarity and to reflect the mischief the charges were intended to cover.

The panel accordingly made both amendments.

Decision and reasons on application to adjourn

Mr Smith informed the panel that he sought an adjournment of the proceedings after the conclusion of Ms 8's evidence but before the NMC closes its case. This will mean going part heard on Ms 6's evidence. He submitted that the NMC's case will not close before the time allocated for this hearing and asked for the hearing to resume at a later date.

Mr Smith reminded the panel of the various disclosure comments made throughout the hearing. He submitted that this prompted various disclosure requests by you which have been actioned by the NMC.

Mr Smith reminded the panel that the latest disclosure request was in relation to Ms 6's evidence which has not been particularised and justified by Ms Jegarajah. This was passed to the NMC who will have to submit it to Wakefield Council.

Mr Smith informed the panel that there has been insufficient time for Wakefield Council to respond as the time they have been given to address the disclosure request has been short. Wakefield Council would have to discuss this with their legal team and this is unlikely to be resolved in the next couple of days.

Mr Smith reminded the panel of what was heard during the hearing. It was suggested that Ms 6 should see any documents obtained as a result of the disclosure request before she is cross-examined and that he should see these documents before Ms 6 is asked any questions pertaining to them.

Mr Smith therefore submitted that Ms 6's evidence should not continue as these documents may undermine her credibility or contradict something in her witness statement. He further submitted that you should be able to instruct Ms Jegarajah on the documents before Ms 6 is cross-examined on them.

Mr Smith informed the panel that Ms 8 can continue her evidence today.

With regards to fairness, Mr Smith submitted that if the documents are available then you should be able to see them and use them for your case. He submitted that the NMC has not had the opportunity to try and obtain the documents and have not had enough time to get these documents. He submitted that this opportunity should be granted to the NMC in the interest of fairness.

Mr Smith submitted that it is in the public interests that this case is fully presented and the NMC's "hands are not tied" due to closing its case before further evidence is received. He further submitted that you should have all documentation relevant to your case.

In light of the above, Mr Smith invited the panel to adjourn the hearing after Ms 8 has concluded her evidence.

Ms Jegarajah supported the application as it "goes to the heart of the conflict of facts".

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

The panel noted that Ms 6 had given her evidence in chief and was partly cross examined. As a result of her evidence, matters have arisen and documentation from Wakefield Council has been requested by you from the NMC.

The panel took account of the fact that this documentation is currently being considered along with other documentation requested earlier in the hearing from HC-One. It noted that these matters have not been resolved and it appears that it will not be forthcoming within the time allocated which is the rest of day 8, day 9 and day 10.

The panel noted that there has been no indication from Wakefield Council or HC-One as to whether they can or cannot obtain this information. In light of this, and the fact that the hearing was likely to go part heard anyway, the panel was of the view that it would be fair to the NMC to provide the time for them to make their enquiries with regards to the information requested for Ms 6's cross examination to be completed. It was also of the view that it would be fair to you to have documentation that could potentially support your case. The panel also considered it to be in the public interest that it had all documentation before it.

The panel determined to adjourn the hearing after the conclusion of Ms 8's evidence.

Decision and reasons on application to re-call Ms 4

The legal assessor raised an issue that arose during the cross examination of Ms 8. Ms Jegarajah had made suggestions that Ms 4 may have removed documentation from the DoLS folder when you were on leave in February 2017. He noted that this was not put to Ms 4 when she was giving evidence.

Ms Jegarajah accepted that when she cross examined Ms 4, she did not put this suggestion to her because that is not where the evidence was going. She submitted that it was only when she cross examined other witnesses that the evidence led to her making that suggestion.

Ms Jegarajah conceded that she did not put this to Ms 4 but would like the opportunity to recall Ms 4 and put it to her. She submitted that if she is not granted the opportunity to recall Ms 4 it would be unfair and any submission in relations to this would be unfounded and disregarded as a result. She submitted that she would like to recall Ms 4 given the gravity of the allegation.

Mr Smith opposed the application. He submitted that it had been raised in cross examination that the documentation for the DoLS had been there and completed. Therefore, the inference is that someone had removed them. He submitted that the question was available that either Ms 4 or someone else had removed the documentation. He submitted that your instructions should have been actioned from the beginning and saw no reason why Ms Jegarajah could not have put to Ms 4 the suggestion that she removed documentation from the DoLS folder at the time she was giving evidence.

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

The panel noted that the allegation is that you failed to complete the DoLS application. It was of the view that your case in relation to this matter was clear from the beginning and you would have instructed Ms Jegarajah accordingly.

The panel also considered that Ms Jegarajah would have known that Ms 4 had undertaken an investigation in relation to this allegation. As a result, it was of the view that Ms Jegarajah had the opportunity to ask Ms 4 questions in relation to this and chose not to.

In the panel's view, nothing has changed since Ms 4 gave evidence such that there is now a need for this line of questioning when the opportunity to do so should have been taken when Ms 4 was giving evidence.

The panel also determined that it is not in the public interest for a witness, who has already attended this hearing on two occasions and told her evidence was competed, to be recalled in these circumstances.

The panel did not accept the application.

Hearing resumed on 23 January 2023.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Jegarajah of no case to answer in respect of all the charges. This application was made under Rule 24(7).

In relation to the no case to answer application, Ms Jegarajah submitted both written and oral submissions to the panel, the written submission reads as follows;

> *'The Registrant ("R") relies on the detailed care notes concerning resident A, compiled from the date of his admission to the date after his admission to A&E on 6 September 2017.*
>
> *The notes show that all staff at the care home had insight in relation to resident A's condition. He had multiple acute needs. He was cared for very sympathetically and compassionately, despite the fact that he presented with a number of behavioural difficulties. He would punch, bite and at one point, force a fork into the hands of carers.*

As soon as there was discomfort or sores to the penis, he was either taken on an emergency basis to the hospital or he was referred to the GP. He was visited on a very regular basis by his wife and daughter who were and are, extremely articulate and robust when it comes to defending resident A's needs. They had certainly seen him shortly before the emergency admission on 6 September 2017. They had no complaint to make in respect of any hygiene issues in the genital area previously as evidenced contemporaneously by the care notes or the interview concerning the family's application for one-to-one care. What is clear from the notes, is that resident A's behaviour was extremely difficult in the few days before his admission. That is when he plunged a fork into the hand of a carer.

The care notes also show that the resident liked being around staff. It shows that he presented with behavioural difficulties around the issue of personal hygiene. But these difficulties were met consistently and patiently. In view of the actual contemporaneous records which carry the most weight, it is quite outrageous for the staff in the home to be accused of neglect in this way.

On the day of the fall, 6 September 2017, before Resident A was taken to the hospital in an ambulance, the records shows that at 0800hrs on the same day, Resident A's incontinent pad was changed by a Nursing assistant in charge of shift that day. A wound of that nature cannot be missed by a trained Nursing assistant. A left for A&E without a sore to his groin area. He left the care home at 0845.

Crucially, he reached the hospital in a few minutes because it is very close to the care home, there is a complete absence of evidence as to whether, and if so when, he was triaged, did that triage involve physical examination? When was he admitted onto the casualty ward? When was he physically examined by the A&E team?

At its highest, Dr Owen stated that notes from admissions confirmed a serious sore. It is highly significant that there is a complete absence of these critical notes.

There has been no evidence from the person who made the safeguarding alert.

Dr 1 noted the potential difficulty of addressing personal hygiene in the hospital given residents A's behavioural problems. Certainly, there were significant behavioural problems only a few days before admission. Those behavioural problems related to staff who were well known to resident A. Therefore if the casualty staff were not able to attend to resident a is personal hygiene needs, because he was being aggressive, then there is a strong likelihood that: a man who is doubly incontinent, who has fragile skin around the penis anyway, and where there is evidence that he pulls at the penis, then it is highly likely that he developed serious sores by the time of recorded examination, that being 11:45 am.

In many ways, and with respect to Dr 1, who has not been produced, if the care home is not identified as responsible for neglect, then logically it would be staff at the hospital who would be responsible for neglect and the hospital itself would face investigation. However, Dr 1 was not called and her evidence has not been tested. Therefore, limited weight can be attached to her letter.

Resident A's family were entirely happy with the Registrant's care as far as the care notes are concerned. There were no complaints about his care in respect of the application the family made for one-to-one care and following the interview of wife and daughter.

The complaints only begin to arise following the application for one-to-one care.

The social worker relies heavily on the diary in respect of her referral. But the diary entry stops on the 19th of May 2017, whilst her summary of the diary refers to the number of critical entries well after that.

It is very difficult to know what is going on.

Resident A's wife's evidence was very different to the witness statement which was very detailed and clearly been embellished by someone else. She was not aware of what was in the statement neither was she aware of the nature of the diary entries that she was said to have written and which subsequently became unclear as a result of a fortuitous flooding.

However, Ms 6's referral triggered an investigation of the registrants management.

There was a pretence whereby senior management were working with the registrant intensively in order to secure improvement following negative assessments by CQC and Wakefield. The fact of the safeguarding referral without waiting for the police investigation provided HC1 with the perfect opportunity to scapegoat the registrant.

HC1 underplayed the role of the safeguarding referral in its decision to dismiss the register for gross misconduct. There were other issues relating to DOLS and the structural nature of the home.

However since 2015 the registrant was valiantly holding the care home together despite the fact that: management was absent, she was expected to work as a nurse as well as a manager, despite repeated emails to management HC1, they refused to invest in the home in terms of new flooring and carpeting which was responsible for the smell. Most of the staff were agency workers which was responsible for inadequate completion of records. And most significantly, there is an absence of the actual DOLs applications to the local authority which would prove conclusively whether the applications were made, as the registrant insists. she has repeatedly asked HC1 for her work emails to show how very regularly she asked management for support, staff and investment in the infrastructure.

The only conclusion that can be drawn is that the whole point of placing HC1 senior management in post, what is to develop a case against the Registrant.

In fact the very day after she had been dismissed, there had been a meeting in Wakefield between the local authority, and HC1 informing them that the registrant had been dismissed.

Again it is very telling that the minutes of this meeting have not been provided.

The strong inference is that the registrant's dismissal was a route to assuage the local authorities concerns. However, as Ms 5 explains in her witness statement and in evidence, the same problems remain. Therefore, the core problems the attributed to the registrant cannot logically be attributed to the registrant.

There have been no complaints against the registrant by patients, those in the dementia ward to present with very demanding needs. The registrant worked incredibly hard and effectively. It is appalling that she has been treated in this way. It is submitted that there is no case to answer.'

In these circumstances, it was submitted that all the charges should not be allowed to remain before the panel as all the charges are connected.

Mr Smalley submitted that the evidence before the panel is sufficient for a case to answer. He relied on the contents of the 11-page evidence matrix he had prepared which he had served on the panel, you and your representative.

Mr Smalley invited the panel to find that there is a case to answer on all charges.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Smalley on behalf of the NMC and by Ms Jegarajah, on your behalf.

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 the 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:

- Ms 1: Resident A's wife
- Ms 2: Nurse for safeguarding adults
- Ms 3: Regional Quality Director at HC-One
- Ms 4: Area Direct at HC-One

- Ms 5: Quality Support Manager for Care Homes with the Wakefield Clinical Commissioning Group.
- Ms 6: Social Worker for Wakefield Council.
- Ms 7: Care Coordinator at Wakefield Council
- Ms 8: Regional Direct at HC-One
- Ms 9: Head of Clinical Quality at HC-One
- Ms 10: Release Manager at HC-One

The panel also heard evidence from you under oath. You acknowledged that you were the Registered Home Manager at the Home for two years eight months, covering the period applicable to all charges. The panel considered the witness and documentary evidence provided by both the NMC and Ms Jegarajah.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1a

"1) Between June 2017 and September 2017, neglected Resident A by failing to ensure or put in place effective systems to ensure:

a) that staff appropriately managed a sore on Resident A's groin area that had been discovered in June 2017 and was not treated adequately until September 2017"

This charge is found proved.

In reaching this decision, the panel took into account the diary entry submitted by Ms 1, safeguarding referral reports and evidence from Ms 1 and Ms 6 and your evidence.

The panel accepts Ms 1's evidence that she maintained a diary from 29 May 2017 until 7 September 2017 in which she logged concerns she had regarding the care provided to her husband, Resident A. The panel accepted the original diary was no longer available due to it being destroyed in a flood. However, all the diary entries were seen by Ms 6 and were recorded and exhibited by her. The panel determined that it would be appropriate and fair to consider the weight to be applied to each of the individual entries as it accepted Ms 1's view was subjective.

The panel accepted the opinion of Dr 1 who examined Resident A's medical notes and gave their opinion that the injury would have occurred over a period of days to weeks. The panel bore in mind that this evidence is hearsay and that it had not had the opportunity to hear Dr 1's opinion explored in oral questioning, neither was it provided with Resident A's medical notes. The panel had however no reason to think that Dr 1's opinion was other than genuine and objective and it concluded that their commentary was credible.

The panel noted that in your oral evidence you stated that such an injury could happen within 1-2 hours and you referred to the clinical literature which you said supported this timescale. However, the panel referred to and considered the article you relied on but found no evidence to support your statement.

The panel took the view that the injury likely happened whilst Resident A was still at the Home, as opposed to occurring whilst he was at the hospital and that there is nothing to suggest that Resident A's skin was checked at 8am when he was in the Home. The damage was recorded at 11:44 at the accident and emergency department at the hospital.

The panel saw written entries from care home notes stating on 1 June 2017 Resident A had a sore area, associated with moisture, to the end of his penis. A record confirms that Resident A was seen by a GP on this date for this condition. A note and signature on 1 July 2017 on the care plan states “area now healed”. This is the only documentation confirming that the damage has healed. No further care details, or descriptions are provided. The panel did not hear any evidence that the sore had been adequately treated prior to the hospital admission in 2017.

The panel concluded that between June and September Resident A was not appropriately managed or treated adequately and that you neglected Resident A by failing to put in place effective systems to ensure that he was. It finds this charge proved.

Charge 1b)

b) “that Resident A’s personal care was attended to promptly and wet pads changed regularly despite requests being made for Resident A to be changed;”

This charge is found proved.

In reaching this decision, the panel took into account the elimination records, personal care and support plan, evidence from Ms 1 and Ms 6 and your evidence.

In your oral evidence, you stated that you did not consider that not changing Resident A’s pads regularly was poor practice: instead you stated that his pads were changed when the blue line indicated the pad was full. The elimination record noted the condition of the pad when checked, noting whether the pad was wet, dry or bowels opened. Oral evidence explained this information was gained from a visual view of the blue line visible on the outer aspects of the pad. There was no evidence to demonstrate this was checked on a regular basis. The elimination records showed irregular, and sometimes infrequent checks of the pad being undertaken. The panel noted that the elimination record and your

oral evidence indicated that Resident A was not given a regular opportunity to use the toilet as set out in his care plan.

The panel gave weight to Ms 1's evidence regarding having to ask for Resident A to be changed but considered her evidence that Resident A was left for 4 and a half hours on one occasion could have been an exaggeration. However, it accepted there were occasions when Resident A was not changed regularly despite her requests.

In the panel's judgement your explanation of how and when Resident A's pads were changed is not supported by the documentation and the panel does not accept that only changing the pads when they were full to the blue line would be acceptable, and in any event the panel concluded that changing the pads was not done promptly.

Therefore, the panel finds this charge proved.

Charge 1c)

c) "that medical assistance was sought when Resident A was unwell despite repeated requests made by Resident A's family for a doctor to be called"

This charge is found not proved.

In reaching this decision, the panel took into account the evidence from Ms 1 and Ms 6 and your evidence.

In Ms 1's oral evidence she was unable to provide dates when requests had been made for Resident A to be seen by a GP and at times contradicted herself.

The panel had sight of Resident A's care records which listed GP visits, but it is not clear as to whether the requests were made by the family and this was not actioned.

The panel was not persuaded that Resident A had been left unseen by a GP when he was unwell, and requests made by his family for medical attention had been ignored.

Therefore, the panel find this charge not proved.

Charge 1d)

d) “that Resident A wore his own clothing and was not made to wear clothing that belonged to other Residents”

This charge is found proved.

In reaching this decision, the panel took into account the diary entries, meeting notes and evidence from Ms 6 and Ms 1 and your evidence.

In Ms1’s evidence she was asked how she knew that Resident A was wearing clothing that belonged to other Residents and she responded saying that she saw names of other Residents on the clothes, Resident A was wearing.

In your oral evidence you stated that Ms 1’s daughter had brought other clothes for Resident A, so Ms 1 may not have been aware of the additional clothes, but he never wore clothing that belonged to other Residents. This would not explain names other than his being on the clothing he wore.

The panel noted that, in the meeting notes, Ms 6 agreed to return the clothing that Resident A was wearing upon admission to hospital as they were not his clothes. The panel was also aware that the laundry was washed per unit, not individually for each patient, and clothing was separated by laundry staff, so it is likely that errors would occur.

The panel found your statement that clothing was never worn by a resident to which it did not belong to be unrealistic and unlikely. The panel preferred the evidence from Ms 1. The

panel was satisfied that you failed to put in place appropriate systems to ensure that this did not occur. It therefore finds this charge proved.

Charge 1e)

e) “that Resident A’s clothing was changed frequently”

This charge is found proved.

In reaching this decision, the panel took into account the diary entry and the evidence of Ms 1 and your evidence.

The panel was aware through documentation that Resident A was reliant on staff to dress and undress him. Ms 1 stated that she brought in extra clothing for Resident A, so there were no issues in the quantity of his clothes.

Ms 1 raised particular concern that Resident A’s socks were not regularly changed and made a number of entries regarding this in her diary. She further stated she had tested the frequency of his sock changing by placing a piece of paper in them and checking on following days whether that paper was still present, which it was.

In your evidence, you contested what Ms 1 had said and maintained that the entries were fabricated. You said you had investigated whether Resident A’s socks were changed frequently and found nothing to support Ms 1’s concerns.

The panel preferred the evidence from Ms 1; it found her to be credible and consistent in respect of her concerns over Resident A’s clothing being changed frequently. The panel was satisfied that you failed to put in place appropriate systems to ensure that Resident A’s clothing was changed frequently.

This charge is found proved.

Charge 1f)

f) “that Resident A’s hearing aid was put in allowing him to communicate with staff”

This charge is found not proved.

In reaching this decision, the panel took into account Ms 1’s evidence and your evidence.

Ms 1 stated that her husband wore his hearing aids and would allow her to put them in. However, there was evidence before the panel that on at least one occasion Ms 1 tried to put in Resident A’s hearing aid but he refused to allow this.

In your oral evidence, you stated that staff supported Resident A to wear his hearing aid but due to his condition he did not understand why he needed it and often refused or took it out. You also stated that it was in Resident A’s interest to not always have his hearing aid as he would at times be distressed by staff putting it in.

The panel was of the view there is evidence in the daily care notes to show that Resident A was supported to wear his hearing aid but did not always want to wear it. However, it noted that these instances were infrequently documented.

Therefore, the panel finds this charge not proved.

Charge 1g)

g) “that despite smelling strongly of urine, on one or more occasion, Resident A was attended to/and or changed”

This charge is found proved.

In reaching this decision, the panel took into account Ms 1's evidence and your evidence.

In Ms 1's statement she said she noted her husband smelt of urine and asked staff to change him, but they failed to do so for some time and that she asked to have him changed on a number of occasions.

During your evidence you stated that you could not smell anything unless the pad is saturated, and the incontinence products used by the home would deal with odour. You stated you smelt no odour and Ms 1 would claim her husband was wet when he was not to see how staff reacted.

The elimination record demonstrated irregular and infrequent pad checks with no indication of a cleansing regime being delivered when pads have been used. Very infrequent records for using the toilet were made, at times only once a week. There was limited documentation on personal hygiene being delivered such as bath, showers or assisted washing and no evidence to support when clothes were changed.

The panel noted the provision of inadequate documentation and Ms 1's oral evidence of him being wet and unchanged.

The panel accepts Ms 1's evidence that she had asked staff to change Resident A on a number of occasions because he was wet and that staff failed to do so for some time. It was satisfied that you failed to put in place systems to ensure that he was attended to and changed.

Therefore, the panel finds this charge proved.

Charge 1h)

h) "that Resident A's feet were washed"

This charge is found proved.

In reaching this decision, the panel took into account the photograph of Resident A's foot, Ms 1's evidence, the personal hygiene record for Resident A, the hospital safeguarding referral and your evidence.

The panel heard from you that the marking seen in the photograph could have been blood as he had suffered a head injury which was bleeding. You further stated that there is no evidence to suggest that the photograph had been taken at the time of admission.

The panel noted from the personal hygiene records that Resident A's baths were infrequent, there were periods he had apparently gone for several weeks without a bath. The photograph corroborated the written information provided within the safeguarding referral, which stated "feet are black underneath and you can tell his feet have not been washed in a long time".

The panel preferred the evidence of the hospital safeguarding report to your evidence. It was satisfied that you failed to put in place systems to ensure that Resident A's feet were washed and finds this charge proved.

Charge 1i)

i) "that Resident A's care plan was followed to ensure that Resident A received the 1:1 care he required"

This charge is found not proved.

In reaching this decision, the panel took into account Ms 1's evidence and your evidence.

The panel noted that it had not heard any evidence regarding a care plan which indicated that Resident A required 1:1 care. Whilst there is information about a meeting to discuss the funding of 1:1 care it is not clear if this funding was in place.

The panel determined that the NMC has not persuaded it that this charge is proved on the balance of probabilities.

This charge is found not proved.

Charge 2a)

"On 12 October 2017 following a safeguarding referral in relation to Resident A, you:

a. did not accept that Resident A's needs had not been met"

This charge is found proved.

In reaching this decision, the panel took into account Ms 6's evidence and your evidence and had sight of the safeguarding referral from the hospital where various concerns were raised. Those concerns included the condition of Resident A's penis and the failure to change his socks or to wash his feet.

In your evidence you did not accept the issues and claimed Resident A's needs had been met. However, in light of the panel's earlier findings that the concerns raised in the safeguarding referral were proved, the panel found that this charge is proved.

Charge 2b)

b) "did not accept that Resident A had a sore on his groin at the time of his admission to Hospital on 6 September 2017"

This charge is found proved.

In reaching this decision, the panel took into account Ms 6's evidence, including her report of the opinion of Dr 1, documentation from the Home and your evidence.

During your oral evidence you did not accept the issues and claimed the injuries to Resident A must have been sustained outside of the Home. However, in light of the panel's acceptance of Dr 1's view that the wound was longstanding and its earlier findings regarding the sore having been found proved, the panel found that this charge is proved.

Charge 2c)

c. "did not accept that the standard of care provided to Resident A was particularly poor and/or neglect"

This charge is found proved.

In reaching this decision, the panel took into account Ms 6's evidence, documentation from the Home and your evidence.

During your oral evidence you did not accept the issues but did not provide evidence to refute the allegation. However, while there was a small number of matters relating to Resident A which the panel did not find proved, in light of the panel's earlier findings regarding the concerns which were proved, the panel is satisfied that the standard of care provided to Resident A was indeed particularly poor. The panel regards this as neglect.

Accordingly, the panel found that this charge is proved.

Charge 3a)

"On or before 15 February 2018 you did not:

a. complete Deprivation of Liberty Safeguard Applications (DoLS) in relation to Resident B, C and/or D, all of whom suffered from dementia and were at risk”

This charge is found not proved.

In reaching this decision, the panel took into account Ms 4’s evidence, documentation from the Home and your evidence.

The panel was aware, from your evidence and Ms 4’s evidence, that Resident C’s DoLS application was submitted but rejected. You stated Resident D already had DoLS but Resident B did not need DoLS because he had capacity.

The panel noted that while within the evidence before it there was reference to an individual not having DoLS in place it was not possible to identify this as Resident D or B.

The panel also took into account the findings of the CQC report of 2017 which stated that the DoLS applications were being reviewed and outstanding ones chased up.

The panel finds this charge not proved.

Charge 3b)

b. “ensure that MAR charts were completed fully and/or accurately”

This charge is found proved.

In reaching this decision, the panel took into account Ms 4’s evidence, documentation from the Home and your evidence.

In Ms 4's witness statement, she stated that she found MAR Charts that contained errors. Resident A's MAR chart was submitted as evidence as part of his daily record of care and errors were identified within this. There were cases when medication was not signed for as given, but neither was there any record that it had been withheld and why. They were sufficient of these that in the panel's judgement you must have been aware of these errors.

In your evidence you refuted the allegation stating MAR charts were fully completed. However, you then went on to concede that there were issues relating to MAR charts and they were being addressed regularly. The panel did not accept this. In the panel's judgement the number of these errors and the lack of indication of any improvement show that you were failing to take adequate steps to ensure that the charts were completed fully and/or accurately.

Given the evidence before it, the panel finds this charge proved.

Charge 3c)

c. "ensure that MAR charts belonging to Residents were kept secure and not left in an unsecure reception drawer"

This charge is found not proved.

In reaching this decision, the panel took into account Ms 4's and Ms 10's evidence and your evidence.

You stated that when you had commenced as the Home Manager in 2015, you had recognised that the practice of leaving MAR charts in the drawer in the reception area to be collected by Boots was not good practice and you had implemented changes so this no longer happened. You said you were made aware of one incident of a MAR chart being found in the drawer but you did not know by whom or when.

The panel found the evidence before it was unclear as to when this incident with the MAR Chart being found in the drawer in the reception area had occurred or who had discovered it. Accordingly, the panel is not persuaded that the NMC has discharged its onus of proof in respect of this charge and the panel finds it not proved.

Charge 3d)

d. "ensure that confidential information including documents with Residents' names on them were kept secure"

This charge is found proved.

In reaching this decision, the panel took into account the 'perfect ward reports', Ms 2's and Ms 5's evidence and your evidence.

The panel accepted your evidence that Residents' documentation was kept in the nurses' offices which were lockable. However, the panel noted the perfect ward report carried out on 8 November 2017 which stated in relation to Residents' documentation "kept in nurses room which were unlocked, in two units the doors were open, on the nursing unit the code was written on the door and door was unlocked". The 31 January 2018 report states in relation to Residents' documentation "door not locked or kept in a secure cabinet" and this was confirmed in witness statements from Ms 2 and Ms 5.

You stated that someone would have been in the office when the offices were found unlocked, but the panel noted you were not present when the doors were found open and it accepted the evidence of Ms 2 and Ms 5 but there was nobody in the office.

The panel preferred the evidence of Ms 2 and Ms 5 and the inspection report to your evidence.

Therefore, the panel finds this charge proved.

Charge 4)

> "On 14 May 2018 during an appeal hearing you failed to adequately explain the process followed when completing Deprivation of Liberty Safeguarding Applications"

This charge is found proved.

In reaching this decision, the panel took into account Ms 8's evidence and your evidence.

Ms 8 stated during the disciplinary hearing you were unable to explain the two stages of the capacity assessment and how to correctly document the information from the capacity assessment.

Within your evidence, you described the need for undertaking a capacity assessment in order to complete the DoLS assessment. However, upon questioning from the panel, you were unable to adequately explain the process followed when undertaking a capacity assessment or completing Deprivation of Liberty Safeguarding Applications.

In light of this, the panel find this charge proved.

Charge 5)

> "Between 27 September 2017 and 2 October 2017 following a CQC inspection, breached the following regulations of the Health and Social Care Act (Regulated Activities) Regulation 2014:
>
> a. Regulation 9: person-centred care;
> b. Regulation 17: good governance;"

This charge is found proved.

In reaching this decision, the panel took into account the CQC inspection report 2017, Ms 4's evidence and your evidence.

From Ms 4's statement, the panel was aware that Ms 4's visit to the Home in January was because of the breaches listed in the CQC report.

In your oral evidence you accepted that the breaches had occurred. You explained that this related to one Resident and one issue where there had been a delay in making arrangements for a specialist chair for the Resident. You stated that there had been a delay by you in recognising that this was needed, which you said was in part due to pressures and priorities, and further delays in the authorisation of the purchase of the equipment by HC-One management.

Despite your explanation and the circumstances of your working environment, the panel determined on the evidence provided that it finds this charge proved.

Charge 6a)

> "Between 8 November 2017 and 31 January 2018 following inspections by Wakefield Care Commissioning Group, you did not make sufficient improvements by failing to:
>
> a. carry out monthly audits of the Home"

This charge is found not proved.

In reaching this decision, the panel took into account documentary evidence, Ms 4's and Ms 5's evidence and your evidence.

The panel noted that the Pressure audit for September was carried out but had inaccuracies.

Both Ms 4 and Ms 5 in their evidence accepted that audits were carried out but were not accurate.

The panel determined that the evidence provided demonstrated that the audits were completed and the concerns were centred around the inaccuracies within them.

Therefore, the panel finds this charge not proved.

Charge 6b)

b. “ensure that the Home was kept clean and tidy”

This charge is found proved.

In reaching this decision, the panel took into account the perfect ward reports from November 2017 to September 2018, photographs contained within these, evidence from Ms 2, Ms 5 and Ms 4 and your evidence.

Ms 2 stated “we took pictures of dirty bed linen and faeces in shower areas” “the main concern of the environment was the cleanliness of the Home…” “the Home was particularly dirty in the communal lounge areas”.

Ms 5 stated “I recall the dementia unit being dirty” and “overall the Home was in a bad state there was a strong odour in the Home”.

In your oral evidence, you accepted that you were the registered Home Manager, but said you were not able to act in this role due to the presence of other senior staff who attended the Home following the CQC report. You said you were not involved in any of the decision

making and you accepted there had not been an improvement in making the Home clean and tidy. However, you appeared to contradict your lack of involvement by saying there were insufficient cleaning staff, which you raised as a concern to area managers.

The panel did not accept your evidence that you had not been responsible for the Home between 8 November 2017 and 31 January 2018. The role of the senior managers had been to provide you with support and your responsibilities as the registered Home Manager remained with you.

The panel noted that Ms 5 visited the Home twice, approximately 10 weeks apart, and she drew your attention to these issues, so there was sufficient time to make improvements.

The panel accepted the evidence of Ms 4, that the Home had been allocated adequate housekeeping staff.

Therefore, the panel finds this charge proved.

Charge 6c)

c. “ensure that Residents’ documentation were kept secure”

This charge is found proved.

The panel noted that this charge related to a failure to maintain security of documentation during a defined period, which falls within the period covered by charge 3d which also addresses security of documentation.

The panel finds this charge proved for the same reasons.

Charge 6d)

d. “ensure that the offensive odours previously identified had been managed appropriately”

This charge is found proved.

In reaching this decision, the panel took into account the CQC report of 2017, evidence from Ms 2, Ms 4 and Ms 5 and the perfect ward reports and your evidence.

The report from the CQC stated that the odours on the dementia unit reduced during the day following cleaning.

Both perfect ward reports stated that there was a strong smell of urine within the dementia unit.

Both the witness statements of Ms 2 and Ms 5 make reference to there being a strong odour in the Home when they visited on 31 January 2018. Ms 4 stated that when she visited the Home on 24 January 2018 there was an “eyewatering and overpowering” smell of urine on the dementia unit.

During your oral evidence you said that you had been advised by an external cleaning company that the odour was in the floorboards and the carpet was old. You said you had raised this with management and requested a replacement carpet, the company did not supply this but cleaned it instead. However, the panel noted the carpets had all been changed in 2016 and Ms 4 said that it had been agreed immediately to change the carpet due to the offensive odour when it was raised.

The panel preferred the evidence of Ms 2, Ms 4, Ms 5 and the CQC report, and was of the view that you failed to ensure that the odour had been managed appropriately.

The panel finds this charge proved.

Charge 6e)

e. “ensure that Residents’ rooms were kept clean and/or dirty bedding changed”

This charge is found proved.

In reaching this decision, the panel took into account the perfect ward reports, Ms 2’s and Ms 5’s evidence and your evidence.

Ms 5’s statement described finding beds made up of dirty linen, urine on mattresses and shower chairs with faeces on them. All of this was confirmed in pictorial evidence in the perfect ward reports.

Ms 2’s evidence confirmed that they found beds made up of dirty linen. When asked what time of day this was, she stated this was around lunch time.

You stated that staff would go back and change beds and clean shower rooms after Residents had been given their breakfast, but some Residents would make their own beds up and this could explain the dirty linen. You said staff would go round and recheck the beds later in the day.

The panel determined that your oral evidence in relation to this charge was not credible and preferred the account of Ms 2 and 5. It noted that the dirty linen had been found in the late morning; it was reasonable to expect that any soiled bedding should have been stripped as soon as the Resident got up to ensure they did not, for any reason, get back into an unclean bed.

The panel finds this charge proved.

Charge 6f)

f. “ensure that shower rooms were kept clean”

This charge is found proved.

In reaching this decision, the panel took into account photographs contained in the perfect ward reports, Ms 5’s evidence and your evidence.

Ms 5 described finding chairs and bathroom equipment with faeces and urine on them; the pictures confirmed this.

During your oral evidence you disputed the allegation and stated that the photograph illustrates stains as opposed to faeces. You said shower rooms would be cleaned after use by each Resident.

The panel accepted the photographic evidence and found it unlikely that the stains were not faecal matter. It further noted that the photographs did not appear to show showers that had recently been used. The panel did not consider your explanation as to how the showers were kept clean as credible. It therefore finds this charge proved.

Charge 6g)

g. “ensure that the laundry room and/or sluice room was kept secure”

This charge is found proved.

In reaching its decision the panel took into account the perfect ward reports and the evidence of Ms 5 who stated that they found the laundry room and sluice unlocked. The panel noted that the sluice room is not large and if there had been somebody in there this would have been apparent. However, on reviewing the pictures in the perfect ward reports these clearly show pictures of the sluice door open and of the linen cupboard door open.

In your evidence you told us that there is one laundry for the whole of the home, and this is not within any of the units. Each unit does have a linen cupboard for storage of linen and hoist slings. You disputed that the sluice would have been left open with no one there and stated there would have been a nurse in the room but out of sight.

In reaching its decision the panel took the view that there was clear evidence that the sluice and linen cupboard had been left insecure, but there was no evidence before it that the laundry had been left unsecured.

The panel therefore finds this charge proved, but in relation to the sluice room alone.

Charge 6h)

h. “ensure safety of Residents by having inappropriate wall fixings including loose wires on walls”

This charge is found not proved.

In reaching this decision, the panel took into account the CQC report of 2017 and your evidence.

The panel noted that the CQC report praises the Home for having dementia-friendly sensory elements within the unit.

During your oral evidence, you stated that the CQC had made positive comments. You had visited another unit which had won an award for its dementia friendly environment and tried to replicate some of the things you had seen there. You explained that the fittings in the Home were brought from a dementia-friendly catalogue. You conducted a risk assessment for the sensory installation which you state your area manager approved.

Looking at the photographs supplied the panel saw no evidence relating to loose wires on walls.

Therefore, it finds this charge not proved.

Charge 6i)

i. “ensure that fluid charts, nutrition charts and repositioning charts for Residents were completed accurately”

This charge is found proved.

In reaching this decision, the panel took into account Ms 2’s and Ms 5’s evidence, the perfect ward document inspection reports from the 8 November 2017 and 31 January 2018 and your evidence.

The document inspection report from 8 November noted that nutrition charts and repositioning charges are only partially completed. In the inspection report for 31 January it is noted that these charts do not contain the required information.

Ms 5 stated these documents were not completed correctly and there was no action plan in place to address this. Ms 2 noted that fluid balance charts had not been completed, and that other charts had not been completed to an acceptable standard.

The panel noted there was a discrepancy between a fluid chart and close observation chart which recorded a resident as having been given fluids at a time when he was recorded as asleep.

The panel also noted that the repositioning chart details how the Resident was positioned for example right, left or back. It did not contain any information regarding the Resident’s skin condition, risks or vulnerabilities.

You stated that there was no clinical requirement for any of your residents to have a fluid chart, you were not required to ensure these charts were completed accurately but had put them in place due to the high number of agency staff working in the home. Your explanation for the discrepancy noted above was that the patient would have been woken and given a drink, but this had not been recorded on the close observation chart. You acknowledged there were issues with supplementary documentation and said you had provided examples of correctly completed sheets for staff to use as a guide, had provided training to staff, undertook audits and discussed these at heads of department meetings.

The panel was of the view that adequately completed fluid and nutrition charts were good practice when caring for vulnerable residents. The panel acknowledged some action was taken by you in relation to this issue but it did not sufficiently address it.

Therefore, the panel finds this charge proved.

Charge 6j)

j. “ensure that risk assessments for falls and/or nutrition and/or pressure care and/or infection control had been completed adequately and correctly”

This charge is found proved.

In reaching this decision, the panel took into account the perfect ward reports and Ms 2’s and Ms 5’s evidence and your evidence.

The inspection report contained the inadequate risk assessments specified in the charge.

You stated that Ms 2 only provided parts of the assessments. However, the panel noted that the falls risk assessment evaluation was inadequately completed. You stated that a falls risk assessment was not required for every resident.

In the panel's view the assessment of risk, whether in relation to pressure area management, falls or nutrition needs, is required to be undertaken on all residents to identify whether a risk exists to dictate further management.

Therefore, the panel finds this charge proved.

Charge 6k)

k. "ensure that bedrail and hourly checks on Residents had been completed adequately"

This charge is found proved.

In reaching this decision, the panel took into account the perfect ward reports, Ms 2's evidence and your evidence.

The perfect ward report records that the bedrail checks do not state anything to do with bedrails or access to call bells as stated in guidance and all close observation forms had very little detail except sleeping or awake. This is confirmed in the associated pictures.

You said that the checks and paperwork had been completed correctly.

The panel preferred the pictorial evidence as supported by the evidence of Ms 2 and finds this charge proved.

Charge 6l)

l. "ensure that Residents' care plans were kept up to date"

This charge is found proved.

In reaching this decision, the panel took into account Ms 2's and Ms 3's evidence, the perfect ward reports of June 2018 and your evidence.

Ms 3's evidence was that during the visit she had checked the care plan of a resident who had been admitted 13 days previously. The resident's care plan had only been partially completed and the initial seven-day care plan remained in place. She also checked the file of a resident who had been admitted the previous day; the initial seven-day care plan was not in place.

The panel noted that within the documentary evidence there was an incomplete assessment for nutrition, inadequate reviews of a falls care plan, and a skin integrity care plan which had not been updated since May 2017.

You acknowledged there were issues with paperwork but stated you had worked hard to have these addressed and that you regularly audited care plans. You disputed that the care plans were not up-to-date.

The panel found Ms 3's evidence and the photographic evidence from the perfect ward report to be credible.

Therefore, the panel finds this charge proved.

Charge 6m)

m. "ensure that audits had been completed accurately and/or correctly reflected the position at the Home"

This charge is found proved.

In reaching this decision, the panel took into account the perfect ward report, the evidence of Ms 2, Ms 3, Ms 4, Ms 5, Ms 7 and Ms 9 and your evidence.

Ms 4 stated "*during the perfect ward review the registrant scored 100% for her leadership. This meant her paperwork, audits (Cornerstone information governance) were in place, you only had to step out of the office to see what was documented in the audits was not triangulated throughout the Home*." She also said "*The registrant appeared to be ticking boxes rather than to be completing paperwork accurately*".

Ms 3 stated "I *found that several mealtime audits were fantastic which was not a true reflection of what I had witnessed in the dining room*". She also said "*The cornerstone file was completed to a very good standard. If you had not gone to the Home, you would think that the registrant was on top of her duties and that everything in the Home was fantastic*".

Ms 9 had also corroborated that what was seen in the audits did not match what was seen in the Home.

The panel noted that the perfect ward report for 31 January stated that, looking at the audits, these were completed but the Home environment did not reflect what the audits said. The Home was not clean: there were dirty skirtings and finger marks on walls and an unpleasant odour. However, the audit score was 100%. The report continued "*Issues from the perfect ward report (November 2017) had not been actioned… and there were 17 new issues that had arisen.*"

You disputed that the audits were inaccurate.

The panel determined on the evidence before it that your audits did not accurately reflect the position at the Home.

Therefore, the panel finds this charge proved.

Charge 6n)

n. “ensure that staff communicated with Residents and/or sought consent prior to intervention”

This charge is found proved.

In reaching this decision, the panel took into account Ms 5’s evidence and your oral evidence.

In Ms 5’s statement, she detailed occasions where staff were not communicating with Residents. One of these was a meal time where staff were task focused and failing to communicate with residents while feeding them. She also noticed that staff did not communicate with residents or ask for their consent prior to intervention. The panel was of the view that Ms 5 was describing a cultural issue rather than isolated errors by individual carers.

Upon questioning during your cross-examination, you stated staff would be so discreet with their communication with the residents that it would not be noticed by the inspectors. The panel did not find this credible and preferred the evidence of Ms 5. It did not consider that Ms 5 had missed or misinterpreted contact between the staff and residents.

The panel finds this charge proved.

Charge 6o)

o. “ensure that Residents always had access to call bells”

This charge is found proved.

In reaching this decision, the panel took into account Ms 5's and Ms 9's evidence and your oral evidence.

Both Ms 5 and Ms 9 stated in their evidence they found residents without call bells in their rooms. Ms 5 stated where there was not a call bell she did not always find a care plan in place to ensure the resident was on close observation. Ms 9 stated she notified maintenance of the lack of call bells and it was addressed before she left the unit.

You accepted that not everyone had call bells but said that where residents that did not have access to the call bells it was because they were unable to use them and they would be under close observation.

The panel preferred the evidence of Ms 5 in this regard.

Therefore, the panel finds this charge proved.

Charge 7a)

> "On or before 6 December 2017 following a Dependency Review carried out at the Home by the Clinical Director, you failed to:
>
> a. ensure that the quality of the food provided to Residents was to a good standard."

This charge is found proved.

In reaching this decision, the panel took into account Ms 9's evidence and your oral evidence.

The panel noted Ms 9's description of the 'textured diet' (liquidised food for residents with swallowing difficulties) being produced in jugs which was inadequate and poorly

presented. She reported that residents had also informed her that the food was of poor quality.

You accepted in your evidence that the textured diet had been poorly presented and stated that it was new to the chef. You disputed this meant it was of poor quality.

The panel found that presentation was part of the quality of a meal and that the textured diets were not appetising in appearance and therefore were not of a good standard.

The panel finds this charge proved.

Charge 7b)

b. “ensure that fluid charts were kept up to date”

This charge is found proved.

The panel noted that the issue of completing fluid charts during this period is already addressed in charge 6i and finds it proved based on the same evidence.

Charge 7c)

c. “ensure that Residents mattresses were set to the correct weight”

This charge is found proved.

In reaching this decision, the panel took into account Ms 9’s evidence and your oral evidence.

The panel noted that Ms 9 stated that the mattresses needed to be set to the correct weight for each Resident, and that during her visit she reset mattresses to the correct weight and advised you this needed to be reviewed

However, you stated that you did not believe she did this as she would need to check the weight of the residents to do so, and that this allegation was made with a malicious intent. You stated there was ‘one incident that this happened, we changed the way this was monitored, we devised a system that when I go round on twice daily I will take the weight charts with me and compare the mattress and weight.’

The panel preferred the evidence of Ms 9. It noted that your evidence was contradictory in that you were disputing that there was any real problem but also saying that you had to change the system in order to monitor the mattress settings. The panel was satisfied that you did not ensure that the mattresses were set to the correct weight.

The panel finds this charge proved.

Charge 7d)

d. “ensure that each Resident’s room had a call bell”

This charge is found proved.

The panel determined that this issue has already been addressed in charge 6o and finds it proved on the basis of the same evidence.

Charge 8a)

‘On 24 January 2018 following a routine visit to the Home by senior management, you failed to ensure that:

a. the Home was kept clean as it continued to smell strongly of urine’

This charge is found proved.

In reaching this decision, the panel took into account Ms 3's and Ms 4's evidence and your oral evidence.

Ms 3's evidence was that on entering the dementia unit had a horrendous smell of urine. She further stated this was emanating from the Astro turf attached to the wall. Ms 4's evidence was that the smell of the urine was overpowering, she stated that "the registrant would have been aware of the smell as it was eye wateringly bad."

You acknowledged it was your responsibility to keep the Home clean. However, you stated that the unit did not have a strong urine smell, but carpet and floorboards were old and these caused a smell. You stated the carpet had been due to be changed since your arrival at the Home and this had not been actioned by management and you could not be held responsible for the smell, the responsibility for this was with HC-One.

The panel found your evidence contradictory and preferred the evidence of Ms 3 and Ms 4. The panel found that it was your responsibility and you failed to keep the Home clean and free from the smell of urine.

The panel finds this charge proved.

Charge 8b)

b. "Residents were clean and had their clothing changed regularly"

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Ms 3 and your oral evidence.

Ms 3 stated she saw soap dry in residents' rooms which was indicative of it not being used and she also noted that residents in the dining area looked unkempt.

You disputed the allegation and stated that the residents were kept clean and had their clothing changed regularly. You referred to the CQC report and independent reviews on Care UK which supported this. You stated that the purpose of Ms 3's visit that day was to build a case against you.

While the panel does not accept your contention as to the motivation of Ms 3 it finds the evidence in support of this charge sparse and the NMC has not persuaded it that the charge is well founded.

The panel therefore finds this charge not proved.

Charge 8c)

c. "Residents were given their meals on time"

This charge is found not proved.

In reaching this decision, the panel took into account your oral evidence and the evidence of Ms 3.

You stated that due to the need to assist some residents with their meals, mealtimes can take a long time, 'it was our residents that mattered.'

The panel determined that there is no evidence before it that shows what time the residents were supposed to be served food or what could be considered an unacceptable delay in mealtimes. The panel accepts that due to the differing levels of support needed by residents meals can take a long time. Due to the lack of clarity as to an acceptable

timeframe for serving meals the NMC has not persuaded the panel that the charge is well founded.

The panel finds the charge not proved.

Charge 8d)

d. “Staff engaged with Residents at an appropriate level”

This charge is found proved.

In reaching this decision, the panel took into account Ms 4’s evidence and your oral evidence.

The panel noted during Ms 4’s oral evidence, she stated

“You do not expect someone to walk in a room and tut and huff and roll their eyes because someone could be having a major event that requires emergency assistance. There was nothing verbal, apart from tuts, eye-rolling and huffs and puffs.”

Ms 4 went on to describe the staff as ‘disengaged and hostile’.

You did not believe that staff failed to engage with residents at an appropriate level. You further stated that Ms 4 should have dealt with the issue at the time and then told you about it as staff attitudes were a matter for you.

The panel prefers the evidence of Ms 4.

The panel finds this charge proved.

Charge 8e)

e. “Residents’ care plans were completed fully and within a timely manner”

This charge is found proved.

In reaching this decision, the panel took into account Ms 3’s evidence, documents within the exhibits bundle and your oral evidence.

Ms 3’s evidence was that during the visit she had checked the care plan of a resident that had been admitted 13 days previously. His care plan had only been partially completed and the initial 7-day care plan remained in place. She also checked the file of a resident who had been admitted the previous day. The initial 7-day care plan was not in place.

The panel noted that within the exhibit bundle there were incomplete assessment for nutrition, inadequate reviews of a falls care plan and a skin integrity care plan which had not been updated since May 2017.

You acknowledged that there were issues with paperwork and stated that you had worked hard to have these addressed and that you regularly audited care plans.

The panel found Ms 3’s evidence to be credible. In the light of the documentary evidence it found that care plans were not completed fully or in a timely manner. It did not accept that you regularly audited care plans.

Therefore, the panel finds this charge proved.

Charge 8f)

f. “staff had completed all the required training”

This charge is found proved.

In reaching this decision, the panel took into account Ms 3's evidence and your oral evidence.

In Ms 3's statement she said on checking the online training records during the visit she found that only 28% of the staff had completed fire drill training which was part of the mandatory training. She said the target was 85%.

During your cross examination, you attempted to argue that the printout submitted as evidence was from a later date, after you had left your post, and was not a reflection of the Home at the time you were in charge.

The panel determined that your explanation did not match up with Ms 3 as she stated that she looked at all the data online during the visit on 24 January 2018.

The panel accepted Ms 3's evidence and therefore, finds this charge proved.

Charge 8g)

g. "Residents who had been identified as losing weight and/or having a low Body Mass Index were weighed on a weekly basis"

This charge is found proved.

In reaching this decision, the panel took into account Ms 3's evidence and weight charts and your oral evidence.

Ms 3 stated that one resident had lost significant weight and that when she checked his weight chart on 24 January the last recorded weight was on 6 January. She stated that the recordings for the 13 and 20 January marked as 'amended from original copy' had not been there when she visited the Home.

The panel had sight of the BMI chart and noted there were gaps of longer than a week within this chart.

You acknowledged that the resident's weigh-in was missed for one week, but stated he was weighed every other week and Ms 3 had visited the Home with the intention of building a case against you and was being 'nit picky'. The panel regarded that as an acceptance by you, that weekly weighing was appropriate.

The panel accepted Ms 3's evidence that on 24 January the last recorded weight was 6 January and rejected your evidence that the resident was weighed every other week.

The panel finds this charge proved.

Charge 9)

> "On or before 24 January 2018 you produced completed audit documentation that did not accurately reflect the standards of care provided at the Home"

This charge is found proved.

The panel determined that the charge has already been addressed in charge 6m and will not make further comment on it as the 24 January 2018, falls within the date period listed in charge 6m.

Based on the same evidence, the panel finds this charge proved.

Charge 10)

> “Your actions at charge 9 above were dishonest as you knew that you had not completed the audits accurately and had sought to mislead your employer and/or external inspectors”

This charge is found proved.

In reaching this decision, the panel took into account Ms 4’s evidence and your oral evidence.

You acknowledged your role as the Registered Care Home manager and you were experienced as you have been in managerial posts before securing your role at Carr Gate.

During your oral evidence, you stated that you reached out to senior management and made them aware of the issues you have seen but were not receiving any help.

In reaching its decision the panel bore in mind that the question it must decide is whether you were dishonest in the particular respects alleged in the charge. The panel must first ascertain subjectively the actual state of your knowledge and belief as to the facts. When once your actual state of mind is established, the question whether your conduct was honest or dishonest is to be determined by applying the objective standards of ordinary decent people.

The panel determined that you had the knowledge and expertise to understand that your audits were not an accurate reflection of what was happening at the Home. The panel accepted the evidence that your audit scores did not correspond to the actual state of affairs at the Home and determined that you knew this. The panel found that you created these fictitious audits to mislead your employers and/or external inspectors. In the panel’s judgement this was clearly dishonest by the standards of ordinary decent people.

The panel finds this charge proved.

Hearing resumed on 8 August 2023

Decision and reasons on continuing with Hearing

When the hearing reconvened on 8 August 2023 the panel was informed that neither Mrs Gumbura nor her representative Ms Jegarajah were in attendance. The notice of the resuming hearing relating to the dates of 14 July and 8 – 11 August had been sent to Mrs Gumbura's registered address by recorded delivery and by first class post on 18 April 2023. Further, the panel noted that the notice of the resuming hearing was also sent to Mrs Gumbura's representative on 18 April 2023 via email.

Mr Hugh-Jones, on behalf of the Nursing and Midwifery Council (NMC), submitted that Ms Jegarajah had indicated in email correspondence that she and Mrs Gumbura would not be attending on 8 – 11 August and would rely on written submissions and that they were happy for the hearing to resume on 8 August. He submitted that the hearing should continue.

The panel accepted the advice of the legal assessor.

The panel took into account that, in accordance with Rule 32(3), the notice of the resuming hearing provided details of the time, dates and that the hearing was to be held virtually, including instructions on how to join.

The panel had regard to the email dated 8 August 2023 from Ms Jegarajah, which stated;

> *'I am happy for the panel to go ahead with the hearing and consider the submissions today along with the testimonials that have been sent by my client.'*

The panel noted that:

- No application for an adjournment has been made by Mrs Gumbura;

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

In these circumstances, the panel has decided to accede to the invitation of Mr Hugh-Jones and Ms Jegarajah and to proceed with the resumed hearing. It is satisfied that this is the fair course.

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 amounted to misconduct and, if so, whether Mrs Gumbura'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 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, Mrs Gumbura's fitness to practise is currently impaired as a result of that misconduct.

The panel, in reaching its decision, has recognised its statutory duty to protect the public, to maintain public confidence in the profession and in the NMC as its regulatory body and to declare and uphold proper standards of conduct. 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 took into account all of the evidence which it had received in the case, together with the submissions of Mr Hugh-Jones and Ms Jegarajah. It accepted the advice of the legal assessor which included reference to the principles in a number of relevant judgements.

Submissions on misconduct and impairment

Mr Hugh-Jones provided the panel with written submissions and said that, in the light of Mrs Gumbura's and Ms Jegarajah's absence from the hearing, he would not be adding to those submissions orally so as to avoid any disadvantage to Mrs Gumbura. The submissions are as follows;

> '
>
> …
>
> *In either assessment, a full review of the facts is helpful. It is not proposed to segregate this review as between misconduct and impairment but deal with the facts together.*
>
> *As a very basic starting point, the Panel may want to analyse if the facts demonstrate an isolated incident of serious misconduct or whether such an assessment would be clearly wrong.*
>
> *(1) The charges span the period March 2017 to January 2018.*
> *(2) The nature of the charges allege a continuing form of neglect towards residents throughout the period given the Registrant's role as manager.*
> *(3) There are clearly multiple failings, largely of the most fundamental kind, where ordinary care and attention could easily have been deployed to the basic needs of residents.*
> *(4) There is a failure to accept the very deficiencies which inspections and external witness evidence attested as being glaring, terrible and distressing. [Charge 2]*
> *(5) There is dishonesty in the Registrant's auditing to conceal the seriously substandard care in the Home from her employers and external inspectors.*

1. *Managerial care provided by the Registrant to residents in her charge was egregiously poor. It is noteworthy that*

    (i) *Director of HC One found the home on 24.1.18 to be in a "terrible state" with the residents in a "poor state of care", an experience she actually found "distressing". The smell of urine was overwhelming and eye-watering.*

"There was a huge amount of work to do in Carr Gate Care Home. It was very unsafe."

    (ii) *Ms 3 also attended on 24.1.18, and agreed that the astroturf walls smelt of urine implying male residents were urinating on it.*

    (iii) *Ms 3's description of lunch reflected chaotic organisation and disorder. There is something almost Dickensian in the type of neglect being described.*

2. *The above is a snap-shot looking back at a point in time when improvements should have been made. A wider overview can be seen below.*

    (i) *In October 2017, the standard of care given to Resident A was particularly poor and/or neglect. 2 c)*

    (ii) *Between 27.9.17 and 2.10.17, there were breaches of patient centred care contrary to Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as well as a breach of good governance under Regulation 17*

    (iii) *Insufficient improvement was made between 8.11.17 and 31.1.28*

3. *An overview does not however do justice to the detailed disregard the Registrant demonstrated towards the residents in her charge, a disregard which when compartmentalised to the various health risks in play makes the totality of her neglect even more egregious.*

(i) *Hygiene (risk of sores and inflammatory conditions, which in fact occurred)*

(ii) *Nutrition (6 (j) risk of weight loss, which occurred with loss of BMI)*

(iii) *Fluid (denied by Registrant as a clinical requirement - Panel rejected)*

(iv) *Changing pads before full (denied by Registrant as required until full) -sores.*

(v) *Overpowering smell of urine (denied by Registrant or due to floor/carpet)*

(vi) *Bathing (weeks apart), dry soap, no records – blackening of soles. The Registrant claimed the frequency of baths was dictated by the resident. See 26.1.23 p. 43 Ms. Gumbura xx G-H. Resident A lacked capacity.*

(vii) *Poor quality of food -→ nutrition -→ weight loss.*

(viii) *Weight loss. BMI scores required weekly. Registrant thought BMI not apply to small people.*

"Some people have low BMI not because they have lost weight but because they are very small people and they weigh very little yes"

(ix) *Staff not engaging → residents sleeping in lounge → not eating → weight.*

(x) *Repositioning charts → Bedsores → intractable.*

(xi) *Care plans not up to date → general lack of attention to needs.*

4. .***<u>Auditing</u>***

Four witnesses gave clear evidence about the nature of the auditing :

(i) *Ms 3 at para 31 described how the audit was scored 100%. "You only needed to step out of the office to see that what was documented in the audits was not triangulated through the home."*

(ii) *Further, Ms 3, HC One Director, says "it was clear that she had completed the audits for the care plans however, she had not actioned her audits"*

(iii) *Ms 4, Regional Quality Director of HC One felt the same that the audit did not reflect what had not been done in the home.*

(iv) *Ms 4 also said looking at the cornerstone files alone, you would think the home was in a "fantastic" state.*

(v) *Ms 5 stated that what they found in the home did not match up with the leadership inspection.*

(vi) *Ms 9, Head of Clinical Quality HC One also felt that the cornerstone document did not reflect the true state of the home*

(vii) *Ms. Gumbura in cross examination [30.1.23] claimed that the reference to "100%" meant "yes", "100%", an audit did exist and it contained an action plan. The consequence of the Panel rejecting this is highly material.*

5. ***Lack of insight and rejecting the Registrant's defence***

Case law is emerging that guides Panels in this nuanced area of disciplinary law. It is perhaps best to try and formulate general principles

(1) To any given charge, it is wrong in law to add a charge in relation to the practitioner's denial of that charge Misra v GMC [2003 UKPC 7.

(2) Being found to have not have told the truth before the Panel is not per se a reason to conclude that lack of insight should be an aggravating feature.

(3) The Registrant has an inalienable right to contest the charges, and to expect some Damascene conversion at the close of the factual stages would be a Kafkaesque requirement – it would also damage his fundamental right to appeal.

(4) Maintenance of innocence is not to be equated with lack of insight.

(5) However, attitude to the underlying allegation will be a feature that may be taken into account. Sawati v GMC [2022] EWHC 283 citing Sayer v General Osteopathic Council [2021] EWHC 370.

(6) It is of course relevant that insight is concerned with the future risk of repetition.

6. *In Sawati, Rice J cited Mostyn J in Towuaghantse v GMC [2021] EWHC 681, where it was stated (set out in summary form)*

   (1) Where there was a "blatantly dishonest" defence advanced, it could say something about impairment as to future practise
   (2) Otherwise, the forensic stance of the Registrant should not be used against him in the later stages.
   (3) It is however helpful to distinguish between a defence to primary concrete facts and one based on secondary evaluation (or exercise of discretion) derived from primary facts. Dishonesty as to the former may inform impairment, to the latter or putting the Council to proof should not inform impairment. .

7. *To the list of findings at paragraph 8, the Panel may first want to examine if the failures to ensure standards and/or neglect and/or the failure to accept matters [under Charge 2] can demonstrate a lack of insight on the part of the Registrant in how to manage a home properly (and specifically <u>not</u> a lack of insight that any Panel might want to perceive in the manner of the Registrant's giving evidence). .*

   (i) To the risk of the sore, she said the genital sore in A only arose in a matter of hours. Dr. 1 said it would take a matter of days or weeks to arise.
   (ii) To nutrition and its allied point, weight loss, Ms 3 viewed that the Registrant simply had no idea what was going on with residents' weights.

(iii) *To the need for fluid charts, she stated It was not her clinical requirement, a common sense inference of which would be that she did not really foresee the risks of dehydration and so on.*

(iv) *Her stance on only changing pads when full was wholly illogical to a partially filled pad being left for any significant period. On her evidence, she did not address her mind to the obvious.*

(v) *Insufficient bathing or washing obviously may lead to sores or indeed infections or blackened feet. Not considering this was clearly not just an oversight. In capacitated patients, Ms. Gumbura illogically allowed residents to choose how frequently they should bathe. This in itself could hardly ensure good hygiene and an abdication of responsibility.*

(vi) *Lack of staff engagement creates the risk of inactive non-participating residents who may not eat enough.*

(vii) *The wording of Charge 2 (a) – c) in fact engages the issue of insight by the words "you did not accept"*

8. *The Registrant's defence to Charge 10 falls into a different category. Whether the Registrant's defence can be regarded as blatantly dishonest can be assessed by reference as to whether she advanced a "positive" defence.*

9. *Ms 5, Ms 3, Ms 4 and Ms 9 all gave evidence or provided statements which contended that the cornerstone file or audit did not reflect the true state of affairs at the home. Some stated that where the Registrant purported to mark herself at "100%", this clearly did not match the state of the home. The Registrant's defence was that the reference to "100%" was merely to confirm the existence of an audit and that it contained an action plan which identified those areas of concern which needed addressing.*

(1) This was a positive and direct case in that it called for direct challenge of the 4 witnesses supra who identified that the audit purported to indicate a clean sheet which was in direct conflict with the true state of affairs, namely the witness statement reference Ms 5, Ms 3, Ms 4, and Ms 9

(2) In fact a careful scrutiny of the cross examination does not reveal that this point was really put to these witnesses.

(3) Further, the positive defence demonstrated that the Registrant knew there were in fact areas of concern which had not been addressed.

(4) The audit was a "deceit" which would allow the risks at the home to run on unablated and unmonitored. Worse still, the very audits would conceal from others (namely employers or inspectors) the potential for detection of that ongoing risk.

10. ***Observations***

(1) Most if not all the matters at paragraph 8 involve primary facts. Charge 9 involved a primary factual allegation in relation to inaccurate audits.

(2) The NMC's contention concerning Charge 9/10 would be that this case falls into a category where the "nature and quality" of the rejected defence makes it permissible to take the rejected defence into account in relation to insight.

(3) Thus in Sawati at para 108, this point is raised and the question asked : "Was this a blatant, and manufactured lie, a genuine act of dishonesty, deceit or misconduct in its own right. Did it wrongly implicate and blame others or brand witnesses giving a different account as deluded or liars ? Or was it just a failed attempt to tell a story in a better light than eventually proved warranted ?

(4) Every Registrant is entitled to his/her defence and to cross examine on that case. Ms. Gumbura's representative knew full well the difference between proportionate and measured cross examination and the all-out attack against credit [see below].

(5) In this case, there were core attempts to target Ms 3 and Ms 4 as liars seeking to falsely implicate Ms Gumbura in a dishonest accusation.

(6) However, where a defence to a charge of dishonesty is blatant and excoriating, a Panel can, if it so assesses take into account the nature of the defence as evidence of insight or lack of it.

(7) Thus, the cross examination

(a) Of Ms. McDonald on 11.1.22 at p. 84 C-D

"You and other senior managers are scapegoating Ms. Gumbura and pinning all the failings of the home on her, is that not, in fact, the situation, the truth ?

(b) Of Ms. Ryan on 12.1.22 at p. 36 B-C in effect implying a conspiracy to monitor/supervise Ms. Gumbura

"Ms 4 was part of a team and all I am saying is , it is really not complicated was this team part of a project plan to get the home better or were there parts of the plan , maybe unknown to my client , that were about monitoring her suitability and whether or not she should be suspended"

c) Of Ms 4 on the 13.1.22 xx p. 27 D-F

"So I put it to you that you have scapegoated the Registrant to take the hit and then you all came in Ms 4 you came in to make the home better to satisfy the CQC and Wakefield so that funding could continue. Is that not the reality of it.

This cross examination is particularly blatant in that seeks to assert that Ms. Gumbura's future was part of a false scapegoating and that there were multiple parties to the scapegoating ; "you all came in". In all the circumstances, the dishonesty and the manner in which it was defended make this an egregious case.

d). That the case was that "the Registrant had been scapegoated and senior management [who] had been involved in discussions regarding improvement."

e) Notwithstanding the above, the Panel should take account of mitigating evidence ;eg. Ms 9 remarked on the Registrant's honesty.

11. *From all of the above, the Panel should only make a fair use of the rejected defence. Swwati is a potent case in reminding any Panel [109] that a Registrant is entitled to defend him or herself. Any Panel will be helped in assessing the relevance of a rejected defence by four things*
    - *(i) How far the state of mind or dishonesty was a primary fact rather than a secondary one (bearing in mind the danger of charging traps where dishonesty is alleged against the defence itself (Mirsa).*
    - *(ii) (ii) what if anything the Registrant was positively denying other than their own dishonesty or state of knowledge*
    - *(iii) How far "lack of insight" is evidenced by anything other than the rejected defence and*
    - *(iv) The nature and quality of the defence, identifying clearly any respect in which it was itself a deception, a lie or counter-allegation of others' dishonesty.*

12. *<u>Dishonesty</u>*

    (1) As stated, it was particularly serious.
    (2) It is well known that dishonesty is not easy to remediate.
    (3) Enclosed is NMC Guidance on the seriousness of dishonesty, redacted to exclude comment on sanction.

13. *By unpicking the case in this way, it begins to become apparent that Ms. Gumbura, a registered nurse, and the Manager in charge of Carr Gate Care Home*

    - *(i) Neglected the fundamental and basic needs of residents.*

(ii) By necessary implication, exposed them to the risk of harm following on from poor care.

(iii) Advanced a blatantly dishonest defence that can be proportionately taken into account in the later stages beyond fact finding.'

Ms Jegarajah also provided the panel with written submissions. The submission are as follows:

'

…

Length of time since events that gave rise to referral

1. *The Panel is asked to note that the conditions imposed on the registrant, on 23 August 2019 for 18 months. She was not to work as a manager and to tell the Fitness to Practice Panel of any changes of employment.*

2. *These conditions were removed after three months when the registrar attended the second hearing, before the case was referred to the NMC. And the registration has been working without conditions since 20 March 2020.*

3. *The allegations that arose from these incidents took place a significant amount of time ago. The Registrant was Manager at Carr Gate from June 2015 to February 2018. She has continued to practise safely in the interim. To that end, the registrant relies on the supervisions provided to the Panel, which demonstrate that her practice has been exemplary in all respects.*

4. *Please also see the testimonial from …, Consultant Psychiatrist, dated 5 January 2022. In particular he stated:*

“She is mindful of risk issues, particularly the safety of patients and staff. She is concerned for the welfare of patients and her colleagues.
As stated above, Emerly is conscientious. Her work is systematic and methodical. She makes thorough notes. She is mindful of the importance of defensible documentation.

5. *Please also see the letters of support from nursing colleagues and very strong and appreciative cards and letters from patients.*

6. *The Registrant has eased the time productively, not just in terms of her work, but bye* [sic] *further, educating herself, so that she can be a more specialised and skilled nurse. In 2021, she obtained a Masters from Leeds Beckett University, in public health and health promotion. The Masters is concerned with public health policies, creating supportive environments for the same and strengthening community action and personal skills.*

7. *The only charge of dishonesty was Charge 10. In the Panel’s findings on fact it stated that :*

The panel found that you created these fictitious audits to mislead your employers and/or external inspectors. In the panel’s judgement this was clearly dishonest by the standards of ordinary decent people.

8. *The relevant cross examination by Mr Smalley was that “ the audits that they considered were inconsistent with the state of the home and I think the suggestion is that you have tried to produce documentation which did not reflect what was going on in the the allegation. I think you would agree if the Panel found that to be true, I would agree that that would be dishonest”.*

9. *Charge 10 was "Your actions at charge 9 above were dishonest as you knew that you had not completed the audits accurately and had sought to mislead your employer and/or external inspectors;".*

10. *Neither charge 10 nor cross examination by the NMC was to the express effect that the registrant had created false documents. The alleged dishonesty was in respect of an allegation that the registration misled her employer and or external inspectors. The charge did not make any reference to fabricated audit but inaccurate audits.*

11. *There is therefore clear error/inconsistency in respect of the panel's findings of fact concerning dishonestly. There is therefore no factual basis or rational basis for a finding of serious misconduct.*

Relevance of disputing findings of fact by the registrant

12. *The registrant relies on the judgment in Towuaghantse v GMC [2021] EWHC 681 (Admin). She does so because she does not accept the findings of fact.*

13. *In Towuaghantse, [77] Mostyn J (as he then was) held:*

"Therefore, I have reached the conclusion that the decision-making processes that led to the finding of impairment, as well as the decision on sanction, were unjust because of a serious procedural irregularity. I reiterate my opinion in GMC v Awan at [40] that the absence of any significant gap between the findings of fact and the commencement of the impairment and sanctions phases means that it is unrealistic to expect a registrant who has unsuccessfully defended the fact-finding phase then almost immediately in the impairment phase to demonstrate full remediation by fully accepting in a genuinely sincere manner everything found against him. In my opinion the capacity of the registrant to remediate sincerely should be judged by reference to evidence unconnected to his forensic stance in

the fact-finding phase (unless the fact-finding decision included findings of blatant dishonesty by the registrant)".

14. *Whilst this may be an approach that the Panel can well understand and implement, it is in practice more elusive to a registrant who is not legally qualified. If she were to give oral evidence, there is a potential risk that that she might aggravate sanctions by challenging findings of fact in oral evidence. That is why the difficult decision has been taken, to respectfully ask the Panel to consider the issues of impairment and sanctions on the papers.*

15. *Given the passage of time, the absence of any behaviour relevant to the charges, which are not accepted by the registrant, the powerful testimonials from senior clinicians, nurses and patients, there is no requirement to protect the public from the registrant. The registrant submits that the panel ought to find that there is no impairment and/or significant impairment.'*

Decision and reasons 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.'*

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 Mrs Gumbura's actions did fall significantly short of the standards expected of a registered nurse, and that they amounted to a breach of the Code. Specifically:

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

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

2.1 work in partnership with people to make sure you deliver care effectively

4 ***Act in the best interests of people at all times***

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

6.2 maintain the knowledge and skills you need for safe and effective practice

7.2 take reasonable steps to meet people’s language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people’s needs

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

9 ***Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues***

9.1 provide honest, accurate and constructive feedback to colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

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.

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
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
10.5 take all steps to make sure that records are kept securely

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required

20.2 act with honesty and integrity at all times…

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 the concerns found proved against Mrs Gumbura encompassed a wide-ranging list of failings, that relate to basic nursing practice, patient care and managerial failings. Mrs Gumbura was the Registered Home Manager and as such had a responsibility to ensure the standards of care and cleanliness within the Home. The concerns also touch upon the privacy and dignity of residents and medication management and safety. These failings occurred over a significant period of time in spite of being identified by at least one patient's relative, senior management, and external agencies such as the CQC and the Clinical Commissioning Group.

The panel determined that residents were deprived of the care required and as a result suffered harm and were also put at risk of harm. The panel was of the view that the audit scores (of 100%) that Mrs Gumbura recorded on the audit forms were fictitious as they did

not reflect the reality of the circumstances of the Home of which she was aware and were as the panel has found, completed dishonestly with a view to misleading her employers and external inspectors.

The panel found that Mrs Gumbura's 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, Mrs Gumbura'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.

The panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) in reaching its decision. In paragraph 74, she said:

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

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… show that his/her fitness to practise is impaired in the sense that s/he:

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

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that residents were put at risk and were caused physical harm as a result of Mrs Gumbura's misconduct. Her misconduct brought the profession into disrepute. Further, the panel was of the view that Mrs Gumbura breached the principles of honesty and integrity and acting in the best interests of patients, which are fundamental tenets of the nursing profession.

Regarding insight, the panel considered that Mrs Gumbura demonstrated a lack of insight into the concerns raised against her. Mrs Gumbura is of course entitled to dispute the charges, and cannot be expected to have completely revised her view about them since the panel's decision on the facts. However, neither in her evidence to the hearing nor at the impairment stage has the panel seen any indication that she has reflected on what the panel finds to be the very unsatisfactory state of the Home and of the standard of care provided, or of her own responsibility for that state of affairs.

The panel noted that in her written statement Mrs Gumbura wrote:

‘I know that my practice is not impaired, this is evidenced because I have been working as a nurse for the last three years and I have practised competently…’

In these circumstances, the panel was of the view that Mrs Gumbura has not reflected on the bigger picture and on how her actions have impacted residents, their families and the nursing profession.

The panel was satisfied that the misconduct in this case is in principle capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Gumbura has strengthened her practice. The panel has been given no information as to what training or development she has undertaken relevant to the concerns found proved.

The panel had sight of the testimonials, supervision records and the master’s degree certificate that Mrs Gumbura provided. The panel acknowledged the positive comments but noted that the testimonials are from colleagues and patients who do not indicate they are aware of the nature of the charges against Mrs Gumbura, nor have the nursing colleagues provided their PIN numbers. The panel also acknowledges Mrs Gumbura’s achievement in obtaining a Master’s Degree in Public Health and Health Promotion in 2021. However, it has no information about the contents of the degree programme or of any other (non-mandatory) training undertaken since these events. It therefore has no information that Mrs Gumbura’s studies or practice have addressed the failings which have been proved in this case.

Ms Jegarajah informed the panel that Mrs Gumbura has been working without restriction on her practice since March 2020. However, the supervision records provided stop in 2021 and one of the testimonials dated May 2022 indicated that she was no longer working in the Unit. The panel has no information before it in relation to Mrs Gumbura’s employment or practice since this date.

In the panel's view therefore, it does not have evidence that Mrs Gumbura has strengthened her practice in the areas of concern.

The panel is accordingly of the view that there is a risk of repetition based on Mrs Gumbura's lack of insight and the absence of relevant evidence of strengthening her 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 is not only to protect, promote and maintain the health, safety, and well-being of the public and patients, but also to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding 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. It therefore also finds Mrs Gumbura's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. As a result of this order Mrs Gumbura's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case, including the reflective piece and further testimonials and evidence

of training provided by Mrs Gumbura at the sanction stage. It had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel took account of the submissions of Mr Hugh-Jones and of Ms Jegarajah. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Hugh-Jones informed the panel that the NMC had advised Mrs Gumbura that it would seek the imposition of a striking-off order if the panel found her fitness to practise currently impaired.

Mr Hugh-Jones provided the panel with written submissions and elaborated on those submissions orally. The submissions are as follows:

‘

…

14. <u>Dishonesty</u>

(4) As stated, it was particularly serious.

(5) It is well known that dishonesty is difficult to remediate.

15. The summary of the NMC case has already been stated save for adding (iv) below namely that the Registrant

(i) Neglected the fundamental and basic needs of the residents.

(ii) By necessary implication, exposed them to the risk of harm following on from poor care.

(iii) Advanced a blatantly dishonest defence that can be proportionately taken into account in the later stages beyond fact finding.

(iv) Her dishonesty in providing false audits was done knowingly and would surely have been done in the knowledge that the falsity could prevent or inhibit her employers and external inspectors from detecting the truth of her neglect in the home ; it thus posed a direct risk to residents.

16. *To the direct questions posed by the Guidance :*

    a. *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*

Continuing neglect over a protracted period and connected dishonesty that seeks to conceal an existing harmful and adverse state of affairs concerning the health and well being of residents clearly raises fundamental questions about professionalism.

    b. *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*

No.

    c. *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards*

This case involved egregious neglect that was not isolated. That and the connected dishonesty was incompatible with continued registration and a suspension order would not be sufficient.'

Ms Jegarajah also provided the panel with written submissions. The submissions are as follows:

'

…

1. *The Panel is asked to note that the conditions imposed on the registrant, on 23 August 2019 for 18 months. She was not to work as a manager and to tell*

the Fitness to Practice Panel of any changes of employment. Conditions were later removed.

2. *For nearly 4 years, the registrant has worked without raising any concerns whatsoever as to risk to the public. The testimonials, which include current testimonials, demonstrate that the registrant has overcome the concerns that the panel may have concerned record keeping and overall nursing competence. The testimonials also shows that the register is mindful of risk issues.*

3. *The registry notes the panel's findings, that the impairment is remedial. Whilst she conducted a robust defence and seeks to appeal, the findings, the fact that there has been a clear record for four years is a highly significant factor. She is clearly aware of the serious concerns that the panel has despite the fact that she seeks to appeal. The findings of fact do not mean that, she will ignore those concerns, but on the contrary will seek to allay those concerns. It is submitted that the proportionate sanction, notwithstanding the registrant's position. concerning appeal, are conditions which will ensure that the panel serious concerns are uppermost in the registrant's practice.*

4. *There was no personal financial gain from a breach of trust. Neither was there premeditated, systematic or longstanding deception. NMC guidance states:*
   "There is a distinction to be drawn between an allegation of conduct which is intrinsically dishonest, like fraud or forgery, as opposed to an allegation which relates to conduct (record-keeping, for example) which is capable of being performed either honestly or dishonestly. A rejected defence of honesty is less likely to be properly regarded as an aggravating factor if it is based on a disagreement between the panel and the professional about facts relating to the professional's subjective state of mind (for example a

situation where the professional's defence is that a record-keeping error was innocent, but the panel concludes that it was deliberate/dishonest)."

5. *It is submitted that this guidance is completely applicable to the registrant's case.*

6. *In those circumstances, the registrant submits that a caution order, is the most proportionate sanction, particularly given before the prior period of sound practice. It is also to be remembered that the registrant was without any, or any significant management assistance during her period of employment as an HC-One employee.'*

Decision and reasons on sanction

Having found Mrs Gumbura'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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Wide-ranging concerns that occurred over a period of time
- Incidents involved vulnerable patients
- Mrs Gumbura was in a managerial position.

The panel also took into account the following mitigating features:

- Mrs Gumbura was working in a challenging environment

The panel considered that following receipt of her reflective piece dated 10 August 2023 Mrs Gumbura has demonstrated that her insight, though still limited, is now developing. The panel considered that the facts found proved mainly relate to Mrs Gumbura's clinical and managerial failings. Her dishonesty arose in the context of those failings. The panel noted the contents of Mrs Gumbura's Master's Degree, the recent testimonials from nursing colleagues and the further explanation about her current employment. The panel noted that Mrs Gumbura has developed a skill set in a different field of nursing, in which she has both worked and studied since February 2018. The panel has seen that within this area, Mrs Gumbura is held in positive regard by both colleagues and patients. Further, following a period as an agency nurse Mrs Gumbura was offered a permanent position and subsequently given the role of interim clinical lead. She told the panel that she wishes to remain in a nursing rather than a managerial role and she does not want to return to working in a nursing home environment.

While Mrs Gumbura's misconduct was not an isolated incident, it occurred at a particular period and in a particular context. There is no previous history of misconduct and there has been no evidence of repetition since these events.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no 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 Mrs Gumbura'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 Mrs Gumbura'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 Mrs Gumbura's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel found proved that Mrs Gumbura acted dishonestly and it regards any dishonesty in a nurse as serious. However, the charge of dishonesty related to concerns around audit. There has been no indication that Mrs Gumbura has acted dishonestly in other respects and her testimonials speak of her integrity. In those circumstances, the panel is not of the view that the proven charge of dishonesty evidence harmful deep-seated personality or attitudinal problems. The panel, therefore, determined that this dishonesty has a potential for remediation with the use of conditions of practice.

The clinical failings found proved, though again arising in a managerial context, reveal identifiable areas of Mrs Gumbura's practice which are in need of further assessment or training. The panel accepted that Mrs Gumbura would be willing to respond positively to further training and to engage with conditions of practice.

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

judgment, suitable conditions will be adequate to protect patients and the public from being put in danger.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

In making this decision, the panel carefully considered the submissions of Mr Hugh-Jones in relation to the sanction that the NMC was seeking in this case. In the light of the matters which the panel has set out above, the panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate. The panel does not regard a suspension or striking-off order as necessary for the protection of the public and such an order would deprive the public of the services of a nurse who is otherwise competent and is now well-regarded by her current colleagues and patients. Such an order would not contribute to remedying or managing the failings which the panel has found proved.

The panel has considered whether suspension or striking-off is nonetheless necessary in order to satisfy the wider public interest and to maintain public confidence in the profession. It is satisfied that it is not necessary. In the panel's view a reasonable and properly informed member of the public would regard it as in the public interest to continue the registration of a nurse in these circumstances and would not find their confidence in the profession damaged by a conditions of practice order addressing the deficiencies identified.

Having regard to these matters, the panel has concluded that a conditions of practice order will adequately protect the public, will mark the importance of maintaining public confidence in the profession and will declare to the public and the profession the standards of conduct and practice required of a registered nurse.

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

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

1. You must not be the sole nurse on duty or work in a self-employed capacity.

2. You must not work as a Care or Nursing Home Manager

3. At any time that you are working you must ensure that you are supervised by a registered nurse. Your supervision must consist of working at all times on the same shift and on the same unit or floor as, but not always directly observed by, another registered nurse.

4. You must work with your manager or supervisor to create a personal development plan (PDP). Your PDP must address the concerns about:

    a) Wound care (including pressure area care and moisture associated skin damage)
    b) Continence
    c) DoLS
    d) Record keeping and security of records
    e) Communication skills
    f) Understanding the audit process and purpose
    g) Care planning
    h) Risk management
    i) Duty of Candour.

5. You must meet with your manager or supervisor every month to discuss your progress towards achieving the aims set out in your

PDP. You must send your case officer a copy of your PDP two weeks before the next hearing or meeting.

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

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

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

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

c) Any disciplinary proceedings taken against you.

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

The period of this order is for 18 months. The panel is satisfied that this order is proportionate.

Before the order expires, a panel will hold a review hearing to see how well Mrs Gumbura has complied with the order. At the review hearing the panel may extend the order, it may make a different order to commence when the order expires, it may revoke the order or reduce its length, it may revoke or vary any condition of it, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mrs Gumbura's attendance at the next hearing.
- Evidence of training and development that Mrs Gumbura has undertaken with a written summary of the contents of all training completed.
- Testimonials from current and recent employers
- A reflective piece addressing the impact of her actions on public confidence and the reputation of the nursing profession.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period or later if there is an appeal , 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 is in Mrs Gumbura's own interests. 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 Hugh-Jones. He submitted that an interim order is necessary to protect the public and it is also required on public interest grounds for the reasons identified by the panel earlier in their determination. He therefore invited the panel to impose an interim conditions of practice order for a period of 18 months to cover the 28-day appeal period and any period of appeal.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary to protect the public and is also 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 relied on the same factors as set out in its substantive decision, for imposing the interim order. The panel determined to impose an interim conditions of practice order. The conditions of the interim order will be the same as those detailed in the substantive order.

The order will be for a period of 18 months to allow for the time which may be taken for an appeal to be determined. The panel is satisfied that this order, and for this period, is appropriate and proportionate. In reaching that decision the panel has borne in mind the impact that the order will have on Mrs Gumbura.

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

That concludes this determination.

This will be confirmed to Mrs Gumbura in writing.