Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Thursday 14 September 2023 – Friday 22 September 2023
Monday 9 October 2023
Tuesday 5 December 2023 – Thursday 7 December 2023

Virtual Hearing

Name of Registrant:	**Aji Asok**
NMC PIN	21K1363O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (November 2021)
Relevant Location:	Somerset
Type of case:	Lack of competence
Panel members:	Nicola Jackson (Chair, Lay member) Alison Hayle (Lay member) Rosalyn Mloyi (Registrant member)
Legal Assessor:	Caroline Hartley (14 - 15 September 2023) David Swinstead (18 - 22 September 2023, 9 October 2023 and 5 - 7 December 2023)
Hearings Coordinator:	Margia Patwary (14 - 22 September 2023 and 9 October 2023) Monsur Ali (5 - 7 December 2023)
Nursing and Midwifery Council:	Represented by Shoba Aziz, Case Presenter (14 - 22 September 2023) Mary Kyriacou, Case Presenter (5 - 7 December 2023)
Mr Asok:	Not present and unrepresented at the hearing
Facts proved:	Charge 1
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Asok was not in attendance and that the Notice of Hearing letter had been sent to Mr Asok's registered email address on 10 August 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing/that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Asok's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Asok

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

Ms Aziz referred the panel to the documentation concerning proceeding in absence and summarised the contact with Mr Asok chronologically since his case was referred to the Fitness to Practice committee. She took the panel through the bundle, referring to the relevant documents, and the emails sent to Mr Asok.

Ms Aziz submitted that there had been no engagement at all by Mr Asok with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised 'with the utmost care and caution' as referred to in the cases of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5 and *R (Raheem) v NMC* [2010] EWHC 2549 (Admin).

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

- No application for an adjournment has been made by Mr Asok;
- Mr Asok has not engaged with the NMC and has not responded to any of the emails sent to him about this hearing;
- Mr Asok has not provided the NMC with details of how he may be contacted other than his registered address;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Two witnesses had been warned to attend the hearing to give live evidence, and not proceeding would potentially inconvenience the witnesses, their employer and, for those involved in clinical practice, their clients who need their professional services;
- The charges relate to events that occurred in 2021;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Asok in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email address, he has made no response to the allegations beyond disputing the facts of the alleged incidents. The panel further acknowledged that Mr Asok would not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel could make allowance for the fact that the NMC's evidence would not be tested by cross-examination and, of its own volition, it could explore any inconsistencies in the evidence which it identified. Furthermore, the limited disadvantage is the consequence of Mr Asok's decision to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge and Schedule (as amended)

That you, a registered nurse, between July 2021 and January 2022:

1. Failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision, as set out in, but not limited to, the incidents in Schedule 1:

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

Schedule 1

1. On 8 September 2021, in respect of an unknown patient:

    a. Filled the patient's water jug with hot water

b. Failed to answer the patient when questioned on your conduct at 1.a

2. On 8 September 2021, during the lunchtime drug round:

    a. Took 1 hour 20 minutes to complete the round when it should have taken 45 minutes
    b. Failed to listen to patients
    c. Failed to identify an unknown patient's abdominal pains and/or need for laxatives
    d. Failed to turn on the nebuliser for an unknown patient
    e. Required prompting to sign for PRN paracetamol administered to an unknown patient

3. On 4 October 2021, failed every section of your simulated OSCE exam,

4. On 7 October 2021, in respect of Patient D:
    a. Failed to complete their IV fluid chart between 06:00 and 12:00
    b. Failed to question their O2 levels

5. On 26 October 2021, during the morning drug round, failed to:
    a. Communicate with patients
    b. Obtain consent from patients prior to prompting
    c. Wash your hands prior to administering medication
    d. Wear gloves when administering medication
    e. Refer to an unknown patient's diabetes drug chart
    f. Administer an unknown patient's insulin prior to prompting
    g. Complete observations when they were due

6. On 5 November 2021, during the morning drug round:

    a. Failed to introduce yourself to patients prior to prompting
    b. Failed to sign an unknown patient's drug chart prior to prompting
    c. Attempted to halve medication with scissors and/or your bare hands

d. Handled medication with your bare hands

7. On 8 November 2021, failed to wear your surgical mask correctly

8. On 9 November 2021, in respect of 1 or more unknown patients, helped said patient(s) off the toilet without first communicating with them

9. On 15 November 2021:

    a. Failed to seek a doctor's advice in respect of an unknown diabetic patient's high temperature and/or low blood pressure
    b. In respect of an unknown patient with high blood pressure, failed to implement their doctor's plan for blood culture and ECG
    c. Failed to complete an unknown patient's admission paperwork after their arrival from the emergency department

10. On 18 November 2021, failed to identify an unknown patient's deteriorating condition

11. On 18/19 November 2021:

    a. When asked to provide a list of morning tasks, only listed the required paperwork
    b. Began to give a "nil by mouth" patient oral medication
    c. Failed to identify the deterioration of an unknown patient with high blood monitoring
    d. When asked, failed to complete a list of required tasks
    e. Did not know why an unknown patient under your care was on IV antibiotics for a fracture
    f. Handed over that all pressure area care was intact when an unknown patient had a Grade 2 pressure sore
    g. Failed to notice an unknown patient's nasal cannula was not in their nose

h. Failed to recognise the importance for regular checks in respect of pressure area care and mobility
i. Failed to ask an unknown patient about their pain
j. Informed a colleague that an unknown patient was under supervision and frame for mobility when they were independent

12. On 29 November 2021:

a. Had to be reminded about hand hygiene when administering medication,
b. Failed to delegate tasks to health care assistants
c. Failed to include all patients under your care in your handover

13. On 30 November 2021, failed to ask patients about medication allergies,

14. On 13 December 2021:

a. Failed to complete any paperwork in the morning
b. Failed to recognise the issue with not completing the morning paperwork
c. Failed to communicate with patients
d. Recorded observations against the incorrect patient

15. On 13 December 2021, in respect of an unknown patient's fall, failed to:

a. Document the fall in their handwritten bedside notes
b. Take blood sugar and/or blood pressure recordings
c. Record the doctor's plan
d. Inform next of kin

16. On the night shift of 20 to 21 December 2021:

a. Failed to answer call bells prior to prompting
b. Recorded all documentation entries at 20:00
c. Were unable to explain the plan for the day at handover

d. In respect of Patient A, failed to:
    i. Offer subcutaneous morphine
    ii. Ask a doctor to prescribe IV paracetamol
    iii. Remove the spigot from their nasogastric tube
e. In respect of Patient B, failed to advise them to increase fluid intake following a low blood pressure reading
f. In respect of Patient B and/or Patient C, failed to wean them off the catheter as per the handover notes from the previous day.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Aziz, to amend Schedule 1, element 16. a, to add the words *"Failed to".* Ms Aziz stated the wording in the proposed amended charge aligned with the evidence on which the NMC relied, and the proposed amendment avoided any risk of prejudice to Mr Asok. Accordingly, she submitted that the amendment could be made without injustice to Mr Asok.

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

The panel considered that the addition of the words in Schedule 1, element 16. a, would avoid confusion and make Schedule 1 clear that there was an alleged failing in Mr Asok's practice. The panel noted that the proposed amendment to Schedule 1 was a typographical error within a large number of alleged failed incidents. The panel was satisfied that the amendment did not change the nature of the lack of competence allegation and would not prejudice Mr Asok in any way. The panel therefore accepted the proposed amendment and altered the wording of element 16 a in Schedule 1 to provide more clarity.

On 20 September 2023, day five of the hearing, Ms Aziz made an application to make a further amendment to Schedule 1, in relation to element 11. She proposed to add an additional date relating to the allegations.

The panel accepted the advice of the legal assessor.

The panel was satisfied that the amendment did not change the nature of element 11 as the dates are one day into the next, this would not prejudice Mr Asok. The panel therefore accepted the proposed amendment and accepted the additional date in 11 which would read as *"18/19 November 2021"* to provide further accuracy and clarity.

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

At the outset of the hearing, Ms Aziz made an application that the hearsay application relating to Witness 3 should be held in private. She submitted that in making the application, she would refer to [PRIVATE] with regard to Witness 3. The application was made pursuant to Rule 19.

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

Having heard that there will be reference to Witness 3's [PRIVATE], the panel determined to hold the entirety of the hearsay application in private in order to preserve the confidential nature of those matters.

Decision and reasons on application to admit hearsay evidence

The panel heard an application by Ms Aziz, under Rule 31 to admit Witness 3's NMC written witness statement as hearsay evidence. Witness 3 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she is unable to attend the hearing due to [PRIVATE]. Ms Aziz referred the panel to the documentation and correspondence between Witness 3 and Mr Asok's case officer which outlined the reasons for Witness 3's absence.

The panel accepted the legal assessor's advice in respect of this application. This included that Rule 31 provides that, so far as it is '*fair and relevant*', a panel may accept

evidence in a range of forms and circumstances, whether or not it would be admissible in civil proceedings.

The panel considered the provisions of Rule 31(1), having considered the written witness statement of Witness 3, it was satisfied that the evidence contained was relevant. The panel noted that Witness 3's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by her. The panel noted Witness 3's written evidence relates to the alleged incidents in element 16 within Schedule 1.

The panel considered whether Mr Asok would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 3 to that of a written statement.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 3, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The charges arose whilst Mr Asok was employed at Yeovil District Hospital NHS Foundation Trust ('the Trust'). The Trust employed Mr Asok as a Preceptorship Nurse and then Staff Nurse between July 2021 and January 2022. The Trust raised concerns with the NMC regarding Mr Asok's ability to practise safely as a nurse without supervision.

The Trust witnesses raised concerns with hospital management that led to the implementation of a formal performance improvement plan with regard to Mr Asok's lack of competence. Allegedly Mr Asok failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision in the following areas:

- Documentation

- Communication
- Care provision
- Medication administration
- Listening
- Infection control

Witness 1 sets out the efforts the Trust made to support Mr Asok including:

- Transition course
- Objective Structured Clinical Examination (‘OSCE’) practice placement
- Supernumerary periods
- Formal preceptorship period
- Improvement action plan
- The mentor that was allocated to Mr Asok

Witness 2 informed the NMC that she offered Mr Asok help with medicines management and that he was not able to practise safely and effectively without direct supervision.

Witness 3 informed the NMC about what happened during the nightshift of 20 December 2021 and with regard to Mr Asok’s management of Patients A, B and C.

In December 2021, a decision was made to end Mr Asok’s employment at the Trust.

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 Ms Aziz on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mr Asok, however the panel did consider the issue of his failure to give evidence and whether if it should draw an adverse inference, and the panels decision is set out below.

The panel noted that the NMC in the notice of hearing sent to Mr Asok stated:

> '***If you don't give evidence***
> *If you choose not to give evidence at the hearing the panel may in certain circumstances draw an adverse inference. You can read more about this at our guidance on 'Engaging with your case…*
>
> *If you think it wouldn't be reasonable for you to give evidence, you'll have an opportunity to explain why at the hearing. If the panel doesn't think you have a reasonable explanation, you'll have a further opportunity to give evidence.*'

The panel noted that the NMC invited it to draw an adverse inference from Mr Asok's failure to give evidence at this hearing.

The panel took careful note of the legal advice it was given and in particular took account the case of *R (Kuzmin) v GMC* [2019] EWHC 2129 (Admin). The panel noted under criterion 2 that Mr Asok had been given the appropriate warning that if he did not give evidence before the panel, an adverse inference might be drawn.

However, the panel noted the charge in Mr Asok's case concerned purely clinical matters of which it had extensive evidence. The panel therefore determined that it was not necessary to draw an adverse inference although Mr Asok had not given evidence.

In the circumstances of Mr Asok's case, the panel determined that it would not be appropriate for it to draw any adverse inference.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged. Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

- Witness 1: Senior Sister at the Trust on Ward 6A.
- Witness 2: Manual Handling and Medical Device Trainer.

Consideration of registration status

Prior to considering the elements of Schedule 1, the panel noted that elements 1 to 5, inclusively fall on dates from 8 September 2021 to 26 October 2021. During this period Mr Asok had neither passed his OSCE which he achieved on 1 November 2021 nor obtained his NMC PIN.

The panel drew Ms Aziz's attention to its concerns with regard to matters that were alleged to have occurred before Mr Asok obtained his NMC registration. Ms Aziz invited the panel to consider Article 23(3) of the Nursing and Midwifery Order 2001 (the Order) and submitted that the panel were entitled to consider matters which took place prior to a registrant's registration.

The panel carefully looked at elements 1 to 5 in Schedule 1. Following legal advice, the panel considered that although these matters may provide context for later findings, it would not be fair or reasonable to find failings against a registrant who was still in training for the UK practice and registration. The panel carefully considered Article 22 (3) of the Order and concluded that although the article could technically apply in this case, it determined that it would not apply the principal to this case as the case does not concern serious misconduct before registration, but concerns clinical errors that took place during training.

Accordingly, the panel considered that during this training period none of these alleged incidents could be found to be failings of a duty, however the panel did carefully

consider in each element whether the alleged incidents in terms of the facts had occurred according to Schedule 1. Further, the panel undertook this exercise since it considered that it would be relevant to any later findings of matters considered after Mr Asok received his NMC PIN and undertook his employment as a registered nurse.

The panel was informed by the NMC that Mr Asok had passed his OSCE in Ireland on 1 November 2021, and that he had obtained his NMC PIN on 18 November 2021. Elements 6 to 9 therefore fall within this period. The panel again carefully considered Article 22 (3) of the Order and concluded that although the article could technically apply in this case, it determined that it would not apply the principal to this case as the case does not concern serious misconduct before registration, but concerns clinical errors that took place during training. The panel considered that the fact that Mr Asok had passed his OSCE did not necessarily mean that he was completely competent in all aspects of his practise. However the panel considered that during this period, Mr Asok, although not yet registered, would take the opportunity to hone his skills to the point where he would be competent in all areas of his practice. On this basis, the panel determined that, again, it would not make finding of failings with regard to elements 6 to 9. However, the panel decided that it would have regard to the context of the evidence for these elements when considering elements 10 to 16 which are alleged to have occurred after he was registered.

Charge 1

That you, a registered nurse, between July 2021 and January 2022:

1. Failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision, as set out in, but not limited to, the incidents in Schedule 1:

This charge is found proved.

Before considering charge 1, the panel first considered the facts in the alleged incidents in Schedule 1 and made the following findings.

1. On 8 September 2021, in respect of an unknown patient:
    a. Filled the patient's water jug with hot water
    b. Failed to answer the patient when questioned on your conduct at 1.a

In reaching this decision, the panel took into account all the oral and documentary evidence before it. In particular the panel considered the signed witness statement and oral evidence of Witness 1.

Witness 1 in her oral evidence explained to the panel that when she asked Mr Asok about filling the patient's water jug with hot water, he explained that in his culture it was usual to provide warm drinking water. The panel therefore determined this was an acceptable explanation. The panel also noted that on further questioning, Witness 1 said that the water in the jug was warm and not hot.

Therefore, the panel found the incident in element 1a did NOT occur as alleged.

In respect to 1b, the panel noted Witness 1's written statement stated:

> *'A patient raised concerns about Aji's listening. I cannot recall the patient's name. She first asked Aji to fill her water jug which he did but with hot water. When the patient told Aji that it was hot water, he walked away.'*
>
> *'The patient also reported Aji walking into the room and saying, "I am going to put a cannula in". The patient reported that she asked him not to as she had had a lot of problems. She said that Aji then tried to say it again and she again told him no. She reported that Aji then walked out without saying anything and with no explanation.'*

However, the panel had no direct evidence as to what the patient had initially said.

Therefore, the panel found the incident in element 1b did NOT occur as alleged.

2. On 8 September 2021, during the lunchtime drug round:
    a. Took 1 hour 20 minutes to complete the round when it should have taken 45 minutes

The panel found that as identified the drug round did take 1 hour and 20 minutes to complete, where Witness 1 identified she would have expected it to take 45 minutes. However, in Witness 1's written statement she stated that:

> *'I would expect it to take 45 minutes to complete, but as Aji was new to it, I would not want him to rush as errors can occur…There was lots of noise in the bay as patients were talking which I guess could haze what Aji was thinking about, but there was nothing major at the time that would have prevented Aji from completing the round sooner than he did.'*

Based on the evidence before it, the panel puts no weight on the fact that the drug round should have taken 45 minutes as Mr Asok was in training.

Therefore, the panel found the incident in element 2a was NOT a failure as alleged.

    b. Failed to listen to patients
    c. Failed to identify an unknown patient's abdominal pains and/or need for laxatives

The panel looked at elements 2b and 2c together as the alleged matters were closely related to each other.

In Witness 1's written statement, the panel noted there was a clear example where Mr Asok had not listened to an unknown patient's concerns in regard to their abdominal pain.

In Witness 1's oral evidence, she gave a further example regarding not listening to a patient who was not able to reach their nebuliser. The panel noted there was also a

third example as Mr Asok failed to listen to a patient who did not want to take their prescribed medication however, Mr Asok dispensed the medication regardless.

However, the panel was clear that this incident had occurred during Mr Asok's supervised training and in Witness 1's oral evidence, she told the panel that she noted he had made improvements whilst he was under supervision.

The panel noted that it was clear that Mr Asok had not listened to patients and had failed to identify the patients' abdominal pains and/or need for laxatives.

The panel found the incidents in element 2b and 2c had occurred as alleged, however were not considered as failings.

d. Failed to turn on the nebuliser for an unknown patient

The panel noted Witness 1's written statement stated:

> *'Aji set up a nebuliser but did not put it on. … Aji should have put the mask on the patient's face and turned it on himself. Some patients if independent manage to do this themselves, however in this situation, the way the bed space was laid out and the position of the nebuliser, meant the patient would not have been able to get to the nebuliser. The patient was in the chair which was beside the bed, and the nebuliser was on top of the locker which was the other side of the bed…..'*

The panel noted that this was also consistent with Witness 1's oral evidence and therefore the panel found that this incident had occurred as alleged.

The panel found the incident in element 2d had occurred as alleged, however was not considered as a failing.

e. Required prompting to sign for PRN paracetamol administered to an unknown patient

The panel noted that Witness 1 identified that during the medication round Mr Asok administered PRN paracetamol and did not sign the drug the drug chart.

Witness 1 in her written statement stated:

> *'Aji gave one patient PRN paracetamol but was not going to sign the drug chart. I asked him to sign it and he did not know what I meant. I tried to explain but he closed the drug chart without signing it. I then had to enter the date, time, dose, and route, then made him sign it. I cannot recall the name of the patient.'*

The panel found the incident in element 2e had occurred as alleged, however was not considered as a failing.

The panel remained concerned about what may have underpinned these issues, particularly in terms of cultural practises and understanding and communication issues. Although Witness 1 and Witness 2 declared on other occasions that Mr Asok had understood them, the panel did not see clear evidence evaluating this.

The panel noted Mr Asok did show signs of improvement which could be seen as him understanding instructions. The panel also noted that Witness 1 in her written statement stated that *'For a lot of the morning, Aji was just walking around and did not look like he was completing any tasks'.* The panel was careful not to attribute any causes for this but considered that cultural norms and practices could have been a factor.

The panel also noted Witness 2 stated that there were times Mr Asok would show signs of improvement and on occasions would demonstrate his understanding. Witness 2 based this assessment on tasks he completed when he was asked to.

3. On 4 October 2021, failed every section of your simulated OSCE exam

The panel had regard to the simulated OSCE exam feedback form which read:

'…Please do not be too disheartened with these results as there is nothing here that you can't fix with a little practice before your formal exam.'…

The panel also noted during Witness 1's oral evidence she stated:

"…That it is not uncommon for preceptorship nurses to fail the exam as they are still learning."…

Therefore, the panel found the incident in element 3 was not a failing as alleged.

4. On 7 October 2021, in respect of Patient D:
    a. Failed to complete their IV fluid chart between 06:00 and 12:00

The panel had regard to Witness 1's written statement and the supervisory feedback provided by the Practice Educator at the Trust.

The panel noted there was conflict in the evidence provided and it was mindful to give the greatest weight to the accounts given closest to the incident. The panel therefore could not determine whether Mr Asok was assigned to Patient D's care and if he was responsible for completing their IV fluid chart.

Therefore, the panel found the incident in element 4a had NOT occurred as alleged.

    b. Failed to question their O2 levels

For the same reasons stated in element 4a, it was not clear to the panel that Patient D was indeed one of Mr Asok's patients and therefore whether Mr Asok was responsible for delivering the care identified.

Therefore, the panel found the incident in element 4b had NOT occurred as alleged.

5. On 26 October 2021, during the morning drug round, failed to:
    a. Communicate with patients

The panel noted in Witness 2's written statement she stated:

> *'I advised Aji that it is always good practice to introduce yourself and your role. He was not communicating with any of his patients. In his position, I would have said to patients, "Hi, my name is [Witness 2]. How are you? How was your sleep?". He did not have normal conversations with his patients, it was very robotic and socially awkward, like he did not know what to say to them. He would check the patient's name, date of birth, and allergies, but I recall him not speaking to any patients throughout the drug round. I cannot recall the names of any patients who Aji did not introduce himself to.'*

This account was consistent as Witness 2 explained this incident to the panel in her oral evidence. However, the panel remained concerned about Mr Asok's communication and/or cultural issues underlying this matter.

Overall, the panel found the incident in element 5a had occurred as alleged but was not considered as a failing.

    b. Obtain consent from patients prior to prompting

The panel noted in Witness 2's written statement she stated:

> *'…that I reminded Aji he should gain consent from the patient before performing any tasks. I cannot recall what I was referring to here. We must always gain consent otherwise we are doing tasks without the patient's permission. Without doing so, it is not okay to perform the task for ethical and legal reasons. The patient must have the options explained so that they have informed choice.'*

Although the panel had very limited evidence, Witness 2 had explained this incident to the panel during her oral evidence and had recorded the incident in her feedback to Mr Asok following the supervision on 26 October 2021.

The panel noted it was clear that Mr Asok had to be reminded by Witness 2 to gain consent from patients prior to prompting.

Therefore, the panel found the incident in element 5b had occurred as alleged but was not considered as a failing.

c. Wash your hands prior to administering medication

The panel noted in Witness 2's written statement she stated:

> *'During the drug round, Aji failed to wash his hands in between each patient when administering drugs. I had to keep reminding him that it is best practice to do this in between each patient.…He barely spoke throughout the whole time I was with him, not just in this supervision but in every supervision. He would just say 'Yes'. He knew what I was saying but it was as if he thought he did not need me to tell him and he did not want to take on my advice…*
>
> *…Aji touched lots of medication during the drug round. By washing your hands after each patient, you are doing your best not to spread anything. I recall that Aji was working in a bay of men, but I cannot recall the names of any patients who Aji provided care to without first washing his hands…'*

This account was also consistent in Witness 2's oral evidence. Witness 2 informed the panel that although she was unable to confirm that Mr Asok has read the Trust's Hand Hygiene Policy, this incident occurred during the COVID-19 pandemic, when there was extensive information given about hand washing including posters reminding staff to wash their hands frequently.

Therefore, the panel found the incident in element 5c had occurred as alleged but was not considered as a failing.

d. Wear gloves when administering medication

Although there was clear discussion of not touching medication with bare hands and the need to wash hands between patients, the panel could find not find clear evidence relating to the wearing of gloves either in the hand hygiene policy or witness accounts.

Therefore, the panel found the incident in element 5d had NOT occurred as alleged.

e. Refer to an unknown patient's diabetes drug chart
f. Administer an unknown patient's insulin prior to prompting

The panel looked at element 5e and 5f together as the alleged matters concerned one incident.

The panel noted Witness 2 in her written statement stated:

> *'…At the Trust we have different medication charts for diabetic medication. I think what happened on this occasion was that Aji did not bring a patient's diabetes drug chart to the bed and almost missed administering the patient their insulin. During handover diabetic patients are highlighted. Me and Aji would have known which of our patients were diabetic. I cannot recall the name of the patient...'*

The panel considered this was a clear training or information issue regarding an additional chart separate to the main drug chart and that it had no evidence as to whether or not the training had been given to Mr Asok. The panel could not find any reference in the contemporaneous feedback which refers to the need to check an additional chart for diabetic patients.

Therefore, the panel found the incident in element 5e and 5f had NOT occurred as alleged.

g. Complete observations when they were due

The panel noted Witness 2 in her written statement stated:

> *'I told Aji that it was good practice to ensure he knows all policies regarding the timings of physical observations, especially if a patient is post-operative. We have little iPods that we record patient observations on using a package called VitalPAC. We set observations at special times depending on whether the patient is pre-operative or post-operative. The iPods have clocks on them that change colour as and when observations are due. The clock turns white when the observations are due, and then orange followed by red the longer observations are left not done. During the supervision, I noticed several of the clocks on Aj's patients were red. I cannot recall the names of any patients who had red clocks.'*

This evidence was also supported by Witness 2 in her oral evidence and her evidence remained consistent when asked questions by the panel.

Therefore, the panel found the incident in element 5g had occurred as alleged but was not considered as a failing.

The panel noted that elements 6 to 9 occurred after Mr Asok had passed his OSCE on 1 November 2021 but before he obtained his NMC PIN on 18 November 2021. The implications of this are discussed above.

6. On 5 November 2021, during the morning drug round:
    a. Failed to introduce yourself to patients prior to prompting

The panel had regard to the feedback provided to Mr Asok following the drug round supervision on 5 November 2021.

The panel noted Witness 1 in her written statement stated:

> *'I had to prompt Aji to introduce himself to patients before he started the drug round. It is important to introduce yourself, so patients know who their nurse is. It offers the patient familiarisation and allows the nurse to recognise that they are looking after those patients for the day. There are not any risks to a patient in a nurse not introducing themselves before administering medication, it is more of a nice thing to do.'*

The panel noted previous evidence that Mr Asok had been told and reminded to do this, therefore although he had yet to receive his NMC PIN he had received appropriate information, training and support.

Therefore, the panel found the incident in element 6a had occurred as alleged but still was not considered as a failing.

b. Failed to sign an unknown patient's drug chart prior to prompting

The panel noted Witness 1 in her written statement stated:

> *'For the first patient, Aji forgot to sign the drug chart and I had to remind him to do so. I cannot recall the name of this patient or the medication. I think this patient had quite a few medications and Aji did not sign for any of them, he administered the medication and then closed the drug chart. I had to prompt him to sign the drug chart. He did not say anything but did then sign it. If Aji had not signed* the *drug chart and a doctor was later reviewing the patient, or another nurse was checking the drug chart and saw that the medication had not been signed, they may think that the patient had not received their medication and may administer them again which would be an overdose.'*

Therefore for the reasons noted above, the panel found the incident in element 6b had occurred as alleged but still was not considered as a failing.

c. Attempted to halve medication with scissors and/or your bare hands

The panel noted Witness 1 in her written statement stated:

> *'Aji inappropriately tried to halve a tablet with a pair of scissors. When I told him that this was incorrect, he attempted to halve it with his bare hands. I reiterated that this was again incorrect practice and taught. him how to use a pill cutter. Using scissors to halve a tablet is inappropriate because the tablet could split into different parts meaning the patient does not get the prescribed amount of medication. It is also an infection control issue as Aji took the scissors from the medicines trolley. They were not fresh, and he did not clean them before use. Any germs on the scissors could have been transferred to the medication that the patient would then have swallowed.'*

This account was consistent with Witness 1's oral evidence.

The panel was unable to find evidence that there had been information or training provided about using the pill cutter prior to this incident. There was also no reference to its use noted in the policy.

Therefore, the panel found that although the incident in element 6c had occurred as alleged but was still not considered as a failing.

d. Handled medication with your bare hands

The panel noted Witness 1 in her written statement stated:

> *'Using bare hands to halve medication is inappropriate as it also presents an infection risk as germs from the hands can be transferred to the medication which is then swallowed by the patient. Halving medication with bare hands also presented a risk to Aji as it could have contained ingredients that were harmful to him.'*

The panel determined that the above incident had occurred as alleged, as Mr Asok should have had the skills through his OSCE training, and the panel had evidence from element 5d that he had already been advised not to handle medication with his bare hands.

Therefore, the panel found the incident in element 6d had occurred as alleged but was still not considered as a failing.

7. On 8 November 2021, failed to wear your surgical mask correctly

The panel had regard to the email dated 7/8 November 2021 from Patient E expressing concern that Mr Asok was not wearing his mask properly. The panel noted despite the initial uncertainty by Patient E about the colour of Mr Asok's uniform, the description in the email made clear that it was indeed Mr Asok. The panel also noted that, although other staff were also being reminded to wear their mask correctly, this does not make it acceptable for Mr Asok to not wear his surgical mask correctly as this incident had occurred during the COVID-19 pandemic.

Therefore, the panel found the incident in element 7 had occurred as alleged but was still not considered as a failing.

8. On 9 November 2021, in respect of 1 or more unknown patients, helped said patient(s) off the toilet without first communicating with them

The panel took account of Witness 1's written statement, particularly paragraphs 33 to 44. The panel also had sight of an email dated 9 November 2021, from the Student Clinical Support Worker, who raised concerns about Mr Asok's lack of communication with patients as he was having no conversation with them whilst carrying out nursing procedures and/or activities of daily living. There was evidence that Mr Asok had been given information and training about this previously.

Therefore, the panel found the incident in element 8 had occurred as alleged but was still not considered as a failing.

9. On 15 November 2021:
    a. Failed to seek a doctor's advice in respect of an unknown diabetic patient's high temperature and/or low blood pressure
    b. In respect of an unknown patient with high blood pressure, failed to implement their doctor's plan for blood culture and ECG
    c. Failed to complete an unknown patient's admission paperwork after their arrival from the emergency department

The panel looked at element 9a, 9b and 9c together as the alleged matters were closely related to each other.

The panel took account Witness 1's written statement, particularly paragraphs 49 to 51. The panel also had sight of the written feedback provided by the Staff Nurse regarding a handover from Mr Asok on 20 December 2021.

Taking the above into account, the panel found the incident in element 9a, 9b and 9c had occurred as alleged but was still not considered as a failing.

The panel noted that the remaining elements alleged in Schedule 1 occurred on or after 18 November 2021 which was the date when Mr Asok received his NMC PIN, enabling for him to practise without restriction.

10. On 18 November 2021, failed to identify an unknown patient's deteriorating condition

The panel noted that this was a serious issue as it related to fundamental nursing care and patient safety.

The panel noted Witness 1 in her written statement stated:

> *'On 18 and 19 November 2021, Matron … completed supervised lunchtime drug rounds with Aji. Matron … raised concerns about Aii's [sic] clinical care and*

knowledge. Aji showed no recognition of a deteriorating patient and how to manage them…'

The panel also had regard to the supervised drug round feedback from 18 and 19 November 2021 provided by the Matron. However, the panel noted that the drug round supervision note did not mention the deteriorating condition and therefore cannot find the allegation proved.

The panel did NOT find element 10 proved.

11. On 18/19 November 2021:
    a. When asked to provide a list of morning tasks, only listed the required paperwork

The panel noted Witness 1 in her written statement stated:

'I met with Aji for his week one review meeting on 19 November 2021…At the top of the document, I discuss some concerns I had about Aji on 18 November 2021, prior to his supervised drug round with [Mr 1]. I had explained to Aji that [Mr 1] would be doing the morning drug round with him and that I wanted Aji to write a list of all the tasks he had to complete for the patient he was looking after from the handover. Before the drug round. I asked Aji to see his list. I was very concerned as all he had written was the paperwork he needed to complete and no other information. A copy of Aji's list is not available and I do not know the name of the patient to allow me to retrieve it. I am therefore unable to comment on what I would have expected Aji to have recorded on the list.'

The panel noted this account was consistent with Witness 1's oral evidence.

It was the panel's understanding that the list requested should have included information about patient care to be delivered rather than just a list of paperwork to be completed. This information would have been handed over to Mr Asok. The panel was

not provided with the list written by Mr Asok but was satisfied with Witness 1's written statement.

Therefore, the panel found element 11a proved.

b. Began to give a "nil by mouth" patient oral medication

The panel noted this incident had occurred on 18 November 2021.

The panel noted Witness 1 in her written statement stated:

> *'Before he started the drug round, I informed Aji that I was concerned about the blood monitoring of the patient in bed one. I told him the patient was nil by mouth and so no medication was to be given. As soon as Aji got to the bay, he started to do the medication. I was concerned because her blood monitoring was high, and she was due to go for a CT scan. Aji did not notice her deterioration and was going to continue to give her medication even though I had told him not to in front of …..'*

The panel noted this account was corroborated by the supervision notes dated, 19 November 2021 prepared by the HCA, who was supervising Mr Asok during this time. The panel also noted this was evidenced in the notes from the week one review meeting dated 19 November 2021.

The panel was satisfied with all three accounts.

Therefore, the panel found element 11b proved.

c. Failed to identify the deterioration of an unknown patient with high blood monitoring

The panel noted this incident had occurred on 18 November 2021.

The panel had regard to the drug round supervision notes dated 18 November 2021 and was satisfied with this evidence.

Therefore, the panel found element 11c proved.

d. When asked, failed to complete a list of required tasks

The panel noted this incident had occurred on 19 November 2021.

The panel noted Witness 1 in her written statement stated:

> *'I had again asked Aji for a list of all the jobs he needed to complete for his patients. After 15 minutes, I went back to him, and he had not done anything and was stood by the entrance of the bay.'*

The panel noted this account was corroborated by the drug round supervision notes dated 19 November 2021 and showed that Mr Asok had not completed the list of all the jobs he needed to carry out for his patients.

Therefore, the panel found element 11d proved.

e. Did not know why an unknown patient under your care was on IV antibiotics for a fracture

The panel noted Witness 1 in her written statement stated:

> *'We started the meeting by going through the handover of patients Ail was to be looking after that day. The patient in bed one was awaiting theatre for her fractured finger. She had an open wound on the finger and had been prescribed IV antibiotics to prevent any infection before theatre. I asked Aji why the patient was on IV antibiotics if she had a fracture, but he could not explain and said that he would have just given them the antibiotics. This concerned me because he did not know where the infection was or why the medication was being administered,*

he was just going to give it because the doctor had prescribed it. It is important to know why a patient is to have a certain medication, so it is known what the patient is being treated for to allow us to look out for adverse reactions. It also means we know the reason for administration if the patient was to query why they were having it. I do not know the name of the patient.'

The panel noted this account was consistent with the drug round supervision notes dated 19 November 2021 which stated:

'Bed 1 was awaiting theatre for her # finger, I asked why would the patient be on IVABx if it was a fracture, he could not explain this to me and would have just given the antibiotics, I explained I was concerned by this.'

The panel was satisfied with the evidence above and determined the incident had occurred.

Therefore, the panel found element 11e proved.

f. Handed over that all pressure area care was intact when an unknown patient had a Grade 2 pressure sore

The panel noted Witness 1 in her written statement stated:

'Aji was able to give a good handover and plan for the day for the patient in bed two. However, I was concerned that when I asked him about pressure area care, he stated that all was intact. I was aware the patient had a grade two pressure sore from admission. A grade two pressure sore is an area of broken skin, usually on the sacrum or any area of bony prominence. They are common in patients with decreased mobility as they sit on the area for some time, causing it to breakdown. Ajr had already documented the day before that the area was intact and reported to me that he had not seen the pressure areas. I explained to him that this was falsification of documentation. If other people came to see the patient and saw that their record indicated the area was intact, they would

assume the patient was mobile. Patients with mobility issues are put on two-hourly turns. By recording that the area was intact, it may have led to such turns not being performed which could have resulted in the wound breaking down further which could result in infection and a longer hospital stay. When providing care, it is important to check all areas that could have pressure sores, such as elbows, heels, and the sacrum. These checks are then recorded in the daily records. As such, Aji should have been aware of the pressure sore. I do not know the name of the patient so am unable to provide the documentation to evidence the concern.'

The panel noted this account was consistent with the drug round supervision notes dated 19 November 2021 which stated:

'Bed 2 – able to give a good hand over about the patient and the plan for the day. I was concerned that when I asked about pressure area care, he replied with all intact – I was aware that the patient had a grade 2 and this had be from admission – he had already documented the day before it was intact - he reported to me that he had not seen the pressure areas and I explained that this is falsification of documentation.'

The panel was satisfied with the evidence above and determined the incident had occurred as alleged.

Therefore, the panel found element 11f proved.

g. Failed to notice an unknown patient's nasal cannula was not in their nose

The panel noted Witness 1 in her written statement stated:

'When I was undertaking the drug round, I asked Aji to review the patient in bed three holistically because she was holding her nasal cannula in her hands, and I was aware from admission that her mobility was decreased so she was vulnerable to pressure area breakdown. Aji did not notice that the patient's nasal

cannula was not providing her with oxygen as it was not in her nose, and he did not correct this. It is important that we can take oxygen off, but we need to ween it off slowly. The patient did this herself so her oxygen levels could have dropped causing confusion or deterioration. Regarding pressure area care, I asked Aji about the importance of mobility, but he did not recognise that she could break down and therefore needed regular checks. It was important that Aji recognised this as without regular checks, the skin could have broken down further leading to infection and the need for additional treatment which can be painful. I cannot recall the name of this patient.'

The panel noted this account was consistent with the drug round supervision notes dated 19 November 2021 which stated:

'Bed 3 – When I was under taking the drug round I asked Aji to review the patient holistically because she was holding her nasal cannula in her hands and also I was aware that from her admission mobility was decreased and was very vulnerable of pressure area break down – he did not recognise about this. I explained the importance of the pressure area care and what he needed to do – he then explained he would do this.'

The panel was satisfied with the evidence above and determined the incident had occurred as alleged.

Therefore, the panel found element 11g proved.

h. Failed to recognise the importance for regular checks in respect of pressure area care and mobility

The panel noted Witness 1 in her written statement stated:

'Regarding pressure area care, I asked Aji about the importance of mobility, but he did not recognise that she could break down and therefore needed regular checks. It was important that Aji recognised this as without regular checks, the

skin could have broken down further leading to infection and the need for additional treatment which can be painful. I cannot recall the name of this patient'

The panel noted this account was consistent with the drug round supervision notes dated 19 November 2021 which stated:

'Bed 3 – I was aware that from her admission mobility was decreased and was very vulnerable of pressure area break down – he did not recognise about this. I explained the importance of the pressure area care and what he needed to do – he then explained he would do this.'

The panel was satisfied with the evidence above and determined the incident had occurred as alleged.

Therefore, the panel found element 11h proved.

i. Failed to ask an unknown patient about their pain

The panel noted Witness 1 in her written statement stated:

'I asked the patient in bed four about her pain and she reported that she had not had any for 24 hours. I asked Aji when he did the observations, did he ask about pain, and he said the patient was asleep but then we continued, and he said that he had asked about the patient's bowels. I asked him why he did not ask about pain at the same time, but he did not have an answer. I cannot recall the name of this patient.'

The panel noted this account was consistent with the drug round supervision notes dated 19 November 2021 which stated:

'Bed 4 – I had completed the drug round in the morning and asked the patient about her pain and she reported to me that she had not had pain for 24hours. I then asked him when he did the observations did he ask about the pain he said

the patient was asleep, but then we continued and he asked about the bowels – so I went back to ask why did he not ask at the same time about the pain, he didn't have an answer for this.'

The panel was satisfied with the evidence above and determined the incident had occurred as alleged.

Therefore, the panel found element 11i proved.

j. Informed a colleague that an unknown patient was under supervision and frame for mobility when they were independent

The panel noted Witness 1 in her written statement stated:

'For the patient in bed six, Aji was able to tell me that the patient had her NG tube out in the morning. He then said she was on sips of fluids although from the day before it was documented that she could have breakfast. I asked Aji how the patient mobilised, and he reported that she is supervision and frame. I explained that I was not sure that was correct. I explained that I had seen the patient walking up and down the corridor by herself the day before. He then corrected himself and reported that she was independent. I cannot recall the name of this patient.'

The panel noted this account was consistent with the drug round supervision notes dated 19 November 2021 which stated:

'Bed 6 – He was able to tell me that the patient had her NG tube out in the morning but then said she was on sips of fluids although from the day before it was documented that she could have breakfast. I asked him how does she mobilise – he reported back that she is supervision and a frame and I explained that I am not sure this is correct. I explained that I have seen her walking up and down the corridor by herself the day before – he then corrected himself and reported she is independent.'

The panel was satisfied with the evidence above and determined the incident had occurred as alleged.

Therefore, the panel found element 11j proved.

12. On 29 November 2021:

    a. Had to be reminded about hand hygiene when administering medication.

The panel noted Witness 2 in her written statement stated:

> *'I supervised Aji on 29 November 2021. I spent part of the early shift with him where he undertook a number of daily nursing tasks. I produce as exhibit NC/3, a summary of what was discussed. I saw a major improvement in Aji's drug round and daily nursing tasks.*
>
> *On a couple of occasions, I had to remind Aji of the hand hygiene policy. This was because he was not using the alcohol gel in between patients. I cannot recall the names of any patients Aji cared for without first washing his hands. The risks to the patients would have been the same as those set out regarding the 26 October 2021 supervision.'*

The panel also had regard to the feedback about Mr Asok following his supervision on 29 November 2021.

The panel found element 12a proved.

    b. Failed to delegate tasks to health care assistants

The panel noted Witness 2 in her written statement stated:

> *'I reminded Aji that good communication is vital in a ward setting and to know who you are working with and their skill mix. He did not know which HCA he was*

working with and was not delegating observations to his nurses or bloods to the HCA. He was not using other's skill mix to make his life easier and to ensure care was delivered to the best standard in a timely manner. He knew what his HCA should and should not be doing but he was not asking them to complete tasks they were competent to do. At this stage, he probably would not have been signed off to take bloods, but his HCA would have been so he should have been delegating to them. He had no enthusiasm or motivation. There were no examples of him taking bloods when he should not have been.'

The panel also had regard to the feedback about Mr Asok following his supervision on 29 November 2021.

Following the reasons stated in 12a, the panel found element 12b proved.

c. Failed to include all patients under your care in your handover

The panel noted Witness 2 in her written statement stated:

'I have recorded that Aji missed a couple of his patients when handing over. I cannot recall the names of these patients or any specific information about the patients that Aji missed that he would have needed to handover. It is important to handover all patients as staff need to know information about their patients to ensure they provide the care the patients need.'

The panel also had regard to the feedback about Mr Asok following his supervision on 29 November 2021.

The panel noted that it was Mr Asok's duty to provide a handover for all patients under his care.

Therefore, the panel found element 12c proved.

13. On 30 November 2021, failed to ask patients about medication allergies

The panel noted Witness 2 in her written statement stated:

> *'At times, Aji nearly forgot to ask patients if they had any allergies and I had to ask him before he handed the medication over to the patients. I cannot recall the names of any patients where Aji did this or the medication that was involved. It is important to check a patient's allergies with them prior to administering medication as you do not want to give a patient medication that has traces of things that they are allergic to doing so can cause allergic reactions or even anaphylaxis.'*

The panel found that found that the Witness 2's written statement and supervision statement were inconsistent.

The panel noted that while the Trust may regard it as best practice to ask the patient about their medication allergies, the policy does not require the patient to be asked. In her oral evidence, Witness 2 mentioned that she noted that Mr Asok checking patient wrist bands and was not sure whether he was just checking the name or the allergies as well. The panel also noted that Witness 2 said that Mr Asok *'nearly'* forgot to ask patients about medication allergies.

Therefore, the panel found element 13 NOT proved.

14. On 13 December 2021:
    a. Failed to complete any paperwork in the morning
    b. Failed to recognise the issue with not completing the morning paperwork

The panel looked at element 14a and 14b together as the alleged matters were closely related to each other.

The panel also had regard to the feedback about Mr Asok following his supervision on 13 December 2021.

The panel noted that although Witness 2 mentioned there was one entry on the VitalPAC, there were no notes written about any patients regarding that morning.

Therefore, the panel found element 14a and 14b proved.

c. Failed to communicate with patients

The panel particularly noted the feedback comments in Mr Asok's supervision on 13 December 2021. Witness 2 stated clearly in the supervision notes that:

> *'During this time I seen [sic] a major improvement in Aji's communication skills and the ability to work in a team… Aji was very vocal today. I could see that his communication skills had improved. He was communicating with his TNA. When I asked Aji what the TNA's skill mix was he could tell me straight away. This is a major improvement from a few weeks ago…'*

The panel was satisfised that there was no evidence of a lack of communication with patients.

Therefore, the panel found element 14c NOT proved.

d. Recorded observations against the incorrect patient

The panel took account of Witness 2's written statement, particularly paragraphs 34 to 37.

During Witness 2's oral evidence, she confirmed that Mr Asok had told her that he had completed observations. She had checked and noted that the recorded observations were against the incorrect patient and had to correct Mr Asok's error.

Therefore, the panel found element 14d proved.

15. On 13 December 2021, in respect of an unknown patient's fall, failed to:

a. Document the fall in their handwritten bedside notes

The panel took account of Witness 2's written statement, particularly paragraphs 34 to 37. The panel had regard to the Trust's Prevention and Management of Inpatient Falls Policy which states there is a clear duty on Mr Asok to document a fall of a patient through the Trust's incident reporting procedure.

Therefore, the panel found element 15a proved.

b. Take blood sugar and/or blood pressure recordings

The panel took account Witness 2's written statement, particularly paragraphs 34 to 37. The panel also noted that Mr Asok had said that he had been too busy with the fall to make these measurements. However, given the length of time available to him and the fact that there were no serious injuries to the patient, the panel considered he had ample time to have carried out these measurements and recordings.

The panel had regard to the Trust's Health Records Management Policy which shows there is a clear duty on Mr Asok to undertake a clinical assessment and take blood sugar and/or blood pressure recordings.

Therefore, the panel found element 15b proved.

c. Record the doctor's plan

The panel had regard to the Trust's Health Records Management Policy which states that patients should be referred for appropriate medical assessment/treatment/review if deemed necessary. The panel noted that the policy does not require that a doctor be called unless a nurse deems it necessary. The panel had no evidence that a doctor had been called to attend to the patient.

Therefore, the panel found element 15c NOT proved.

d. Inform next of kin

The panel had regard to the Trust's Prevention and Management of Inpatient Falls Policy which states that the inpatient's next of kin/lasting Power of Attorney for Health should be informed of the fall.

The panel noted that Witness 2 in her written witness statement stated that she would have expected Mr Asok to have contacted the patients next of kin following a fall but in her oral evidence she was unclear to the panel that she did not know whether he had done so.

The panel had no satisfactory evidence as to whether or not Mr Asok informed the next of kin.

Therefore, the panel found element 15d NOT proved.

16. On the night shift of 20 to 21 December 2021:

    a. Failed to answer call bells prior to prompting

The panel had regard to Witness 1 and Witness 3's written statement.

The panel particularly noted Witness 3's written statement stated:

> *'During the nightshift, [Ms 2] raised her concerns to me that Aji was not answering the patient call bells. [Ms 2] did not state why Aji was not answering the patient call bells. The patients use the call bell to communicate with staff when they need the toilet, pain relief or any other assistance. The staff should respond to each patient's call bell, however when Ward 6A is busy, there may be delays with responding to the call bells.*
>
> *I had a conversation with Aji about not answering the patient call bells. Aji apologised to me and said that he was busy assisting a patient. I explained to Aji*

that once he had finished with the patient, he should answer the patient call bells. Once Aji had finished with the patient, he answered the remainder of the patient call bells and did not ignore any others.'

The panel noted that Witness 3 was the Staff Nurse working alongside Mr Asok on the nightshift on 20 to 21 December 2021. The panel had regard to the email provided by Witness 3 regarding concerns that HCA's raised in relation to Mr Asok not answering call bells.

This was also supported by the feedback on Mr Asok to Witness 1 following supervision on 21 December 2021.

The panel noted that Witness 3 in her written statement stated that she had a conversation with Mr Asok where he apologised for not answering call bells.

Therefore, the panel found element 16a proved.

b. Recorded all documentation entries at 20:00

The panel noted Witness 1 in her written statement stated:

'I reviewed Aji's documentation from the night shift and noted that all entries were timed as written at 20:00 which is when the shift started, and there were no further entries. I would expect staff to write in patient notes throughout the whole of the night shift. This should include whenever they have assisted the patient or any observations they have taken. I would then expect something to be written in the morning when the patients were woken to complete morning tasks. Minimal record keeping could lead to errors of treatment and the potential for inaccurate care given due to poor communication via documentation. Information will not be passed onto the next nurse taking over the patients' care if it is not recorded in the notes. I produce the daily nursing notes of Patient B from 20 December 2021…. I produce the daily nursing notes for Patient C from 20 December 2021 …. Both show Aji's minimal entries.'

The panel noted this account was consistent with Witness 1's oral evidence.

Therefore, the panel found element 16b proved.

c. Were unable to explain the plan for the day at handover

The panel noted Witness 2 in her written statement stated:

> *'During handover, Aji relayed word-for-word the patient information. When asked by [Witness 1] the plan of his patients, he couldn't explain the plan for the day. He went onto say that one patient was going to Musgrove Park Hospital ('Musgrove" that day as that is what the handover said. Musgrove is a hospital in Taunton, about 30 miles from the Hospital. It is larger and has better facilities so sometimes our patients go there. The patient had been to Musgrove the day before and had returned to the Hospital. When [Witness 1] questioned Aji and said that the patient had already been to Musgrove, he still insisted that they were to go that day. As the patient had been to Musgrove the day before, it was Aji's responsibility to check the patient's notes and on seeing that the patient had already been, removed this information from the handover. I cannot recall the name of the patient.'*

The panel noted in the feedback form on supervision 21 December 2021 provided by Witness 2 to Witness 1, Witness 2 stated under area of concern:

> *'When asked by [Ms 3] the plan for his patients he could explain the plan for the day.'*

The panel considered this very carefully but decided that the subsequent description where she describes Mr Asok, *'still insisted the patient was going today'* implied that the first sentence in Witness 2's notes contained a typographical error.

The panel noted this account was consistent with Witness 2's oral evidence.

The panel determined that there was evidence that Mr Asok had not been able to explain the plan for the day.

Therefore, the panel found element 16c proved.

d. In respect of Patient A, failed to:
    i. Offer subcutaneous morphine

The panel noted Witness 3 in her written statement stated:

> *'I had a conversation with Aji. Aji explained that Patient A's relatives had asked him to administer IV paracetamol to Patient A. Aji said that he informed Patient A's relatives that he could not give the medication as it had not been prescribed by a doctor. Aji said that he had then left Patient A's room.'*

The panel also noted this was consistent with Witness 3's email dated 30 December 2021 to Witness 1 in which she stated:

> *'Aji said patient was asking IV Paracetamol but there are no IV paracetamol in the prescription and he explained to relatives of [Patient A] he can't give IV paracetamol. There was S/C Morphine written in the prescription chart but he didn't inform the patient and family.'*

Further, the panel noted Witness 3 in her written statement stated:

> *'I do not know whether Aji had informed Patient A's relatives that Patient A had been prescribed subcutaneous morphine as I was not present during the conversation Aji had with Patient A's relatives.'*

The panel also had sight of the relevant prescription chart dated 16 December 2021.

The panel noted that Witness 3 had stated she was not in the room at the time of Mr Asok talking with Patient A's relatives. Therefore, she did not know if he had told them about the subcutaneous morphine. The panel considered the email dated 30 December 2021, quoted above, to be a contemporaneous document and was satisfied that it carries more weight and therefore the panel could rely upon its contents.

Therefore, the panel found element 16d(i) proved.

ii. Ask a doctor to prescribe IV paracetamol

The panel relied on the same evidence that it had considered under element 16d(i) as the two incidents were closely related to each other. In addition, Witness 3 stated that she had spoken to the doctor requesting for the IV paracetamol to be prescribed.

Therefore, the panel found element 16d(ii) proved.

iii. Remove the spigot from their nasogastric tube

The panel noted Witness 1 in her written statement described the incident and stated:

> *'Patient A was another of the patients for whom Ali was responsible for their care. She had a nasogastric ("NG") tube which is a medical catheter-like product that is inserted through the patient's nose and goes down into their stomach. It is often in place to empty the stomach contents to prevent patients feeling sick. A spigot is a bung that can be inserted into the NG tube to prevent backflow of products into the stomach which then increases absorption of oral products. When the spigot is removed, a bag is attached, and gravity causes fluid in the stomach to go into the bag to relieve any nausea and vomiting. This is known as free drainage. Patient A vomited as Aji had left the spigot in situ. He should have taken the spigot out and attached a bag so that the fluid would drain from the stomach. By leaving the spigot in place, Patient A could potentially have aspirated on the vomit as they had the NG tube in as well. They would have been in a lot of discomfort. I did not witness the incident; I was informed the following*

morning when I arrived on shift. I do not believe anyone was present at the point Patient A vomited apart from Patient A and Aji. After the event, Samantha was aware of it.'

The panel noted Witness 2 in her written statement stated:

'Aji was responsible for this patient. …Aji should have replaced the spigot with free drainage and then alerted the doctors so they could make a plan. Putting the patient on free drainage was the least he could have done to prevent the patient from retching which would have been painful due to her surgery. He could also have sought advice from another nurse. The patient ended up going to ICU and sadly died, but I am not sure if this was because of the issues with the NG tube. I cannot recall the name of the patient.'

The panel noted Witness 2 made it clear that Mr Asok was in charge of Patient A and he should have removed the spigot from Patient A's nasogastric tube.

Therefore, the panel found element 16d(iii) proved.

e. In respect of Patient B, failed to advise them to increase fluid intake following a low blood pressure reading

The panel noted Witness 3 in her written statement stated:

'The NMC has asked me to confirm whether Patient B had raised any further concerns about the care they received from Aji. They did not raise any other concerns. After the incident, I spoke to Aji about Patient B's concern. Aji confirmed that he understood that it was wrong to walk out of the room and not advise Patient B to increase her fluid intake and then repeat the blood pressure reading. Aji spoke to Patient B again during the nightshift, I do not know what about.'

The panel also noted Mr Asok admitted to this failing at the time of the incident.

Therefore, the panel found element 16e proved.

f. In respect of Patient B and/or Patient C, failed to wean them off the catheter as per the handover notes from the previous day.

The panel noted Witness 3 in her written statement stated:

> *'At approximately 07:30, I spoke to Aji and asked him whether he had any gynae patients and if so, whether he had TWOC the patients. Aji confirmed that he had two gynae patients but said that he did not TWOC the patients because the handover written by the previous nurse on shift was to TWOC the patients tomorrow. I then explained to Aji that the handover had been written on the previous day, regarding the present day. I told Aji that he needed to TWOC the patients today in order to get them discharge ready.'*
>
> *'…From reviewing the patients' medical notes referred to at exhibit SM/4 and exhibit SM/5, there is no evidence documented by Aji that suggests he did remove catheters from Patient B or Patient C.'*

The panel in this context considered that TWOC stood for 'trial without catheter' or 'to wean off catheter'.

The panel also considered document SM/1, which states:

> '*5.Aji didn't TWOC two gynae patients and I asked him just before 7.30 am and he said handover says" TWOC tomorrow ".Then I explained to him the protocol of the gynae patients needs to TWOC at 6 am.'*

Having considered all of the above, the panel was clear that Mr Asok had failed to wean the patients off the catheter as he had made an error concerning the day on which this was supposed to be done.

Therefore, the panel found element 16f proved.

Charge 1

That you, a registered nurse, between July 2021 and January 2022:

1. Failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision, as set out in, but not limited to, the incidents in Schedule 1:

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

This charge is found proved

The panel noted that there were three separate periods covered in the schedule of allegations. During the first period from 8 September 2021 until 26 October 2021, Mr Asok had yet to pass his OSCE and had not received an NMC PIN (Schedule elements 1-5). The panel therefore did not consider these elements as proved or not proved but considered whether there was evidence that an alleged incident had occurred or not. It determined that, where relevant, it would have regard to its findings on these elements when considering elements 10-16.

During the second period from 1 November 2021 until 15 November 2021, Mr Asok had passed his OSCE but had not yet received his NMC PIN (Schedule elements 6-9). Again, the panel did not consider these elements as proved or not proved but, given that he had passed his OSCE, gave greater weight to allegations it deemed had occurred when considering Mr Asok's competence.

During the third period from 18 November 2021 to 21 December 2021, Mr Asok had obtained his NMC PIN and, accordingly, the panel determined that failings of duty could be found proved or not proved. This covered Schedule elements 10-16.

The panel considered the standard of Mr Asok's knowledge, skill and judgement as a whole. It noted that during Mr Asok's employment at the Trust, there was a considerable number of tasks he was asked to carry out which he was unable to complete. The panel had regard to its findings which demonstrated that Mr Asok was unable to carry out basic nursing tasks and practice effectively as a registered nurse.

The panel noted that there were over 20 incidents found proved which demonstrated failings in wide areas of Mr Asok's basic nursing practice. These occurred despite the supervision, support and training provided to him. On this basis, the panel was satisfied that Charge 1 was found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether those facts it found proved amount to a lack of competence and, if so, whether Mr Asok's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on lack of competence

The NMC has defined a lack of competence as:

'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practice.'

Ms Kyriacou, on behalf of the NMC, invited the panel to take the view that the facts found proved amount to a lack of competence.

Ms Kyriacou stated that nurses occupy a position of 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 make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. She submitted that the facts found proved in charge 1 show that Mr Asok's competence at the time was below the standard expected of a registered nurse and therefore demonstrated a lack of competency by Mr Asok.

Ms Kyriacou submitted that Mr Asok made repeated errors and failures over a prolonged period of time, despite supervision, support and training from his employer. She further submitted that Mr Asok has failed to demonstrate the standards of knowledge, skills and judgment required to practise without supervision as a registered nurse. The failures relate to a variety of issues and across many areas of the nursing profession.

Ms Kyriacou invited the panel to find that these are basic nursing skills that Mr Asok should have been well aware of and put into practice.

Submissions on impairment

Ms Kyriacou moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of

Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin).

Ms Kyriacou submitted that Mr Asok's fitness to practise is impaired due to lack of competence. Ms Kyriacou referred the panel to the judgment in *Grant* in which Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

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

Ms Kyriacou submitted that Mr Asok put patients at risk of harm and breached fundamental tenets of the nursing profession in terms of the four principles and values set out in 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code). She submitted that this brought the profession into disrepute. She said that limbs a-c of Dame Janet Smith's "*test*" are engaged and there remains a significant risk of repetition.

Ms Kyriacou submitted that Mr Asok has failed to provide evidence of insight, reflection and remorse, and he has not engaged with the process. Ms Kyriacou stated that Mr Asok has not demonstrated any insight into his failures and this includes both the substantial risks to which patients were subjected and the broader implications of his behaviour on the reputation of the nursing profession as a whole. The totality of these circumstances highlights a significant challenge to his capacity to continue to practice as a nurse in a manner that upholds the requisite standards and competence expected of a registered nurse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *R (Remedy UK Ltd) v GMC* [2010] EWHC 1245 (Admin), *GMC v Meadow* [2006] EWCA Civ 1390, and *R (Vali) v GOC* [2011] EWHC 310 (Admin).

Decision and reasons on lack of competence

The panel bore in mind, when reaching its decision, that Mr Asok should be judged by the standards of the average registered nurse and not by any higher or more demanding standard.

The panel carefully considered whether the failings found proved are serious. These constitute over 20 errors across a wide range of areas of Mr Asok's nursing practice. Considering the implications of what has occurred, the panel determined that his failings are serious. For example, Schedule 1, Element 11:

- b. Began to give a *"nil by mouth"* patient oral medication;
- c. Failed to identify the deterioration of an unknown patient with high blood monitoring; and
- f. Handed over that all pressure area care was intact when an unknown patient had a Grade 2 pressure sore.

The panel considered that there was a pattern of failure over a fair sample of Mr Asok's work, and over a period of time. The panel was asked to consider matters from 8

September 2021 until 21 December 2021, however, the failings it found proved were on dates from 18 November 2021, (Elements 11 to 16) to 21 December 2021, when Mr Asok held an NMC PIN. The panel considered that there was a pattern of failings across a fair sample of Mr Asok's work and that these actions showed an unacceptably low standard of practice across areas of basic nursing such as hand hygiene, pressure sore assessment and handling handover information correctly. The panel noted that there were some improvements during the course of support, supervision and training given but the failings continued right to the end of the period in question despite this.

The panel has concluded that Mr Asok's practice was below the standard that one would expect of the average registered nurse acting in Mr Asok's role.

In all the circumstances, the panel determined that Mr Asok's performance demonstrated a lack of competence.

Decision and reasons on impairment

The panel next went on to decide if as a result of the lack of competence, Mr Asok's fitness to practise is currently impaired.

The panel found limbs a-c of *Grant* are engaged. Patients were put at risk of harm as a result of Mr Asok's lack of competence and that he had breached the fundamental tenets of the nursing profession. Therefore, he brought the reputation of the nursing profession into disrepute.

The panel had regard to the case of *Cohen* and considered whether the lack of competence identified is capable of remediation, whether it has been remedied and whether there is a risk of repetition. The panel considered that the lack of competence issues are capable of being remedied but there is no evidence before the panel which demonstrates Mr Asok had remedied the concerns identified or that he has taken steps to strengthen his practice. The panel noted that there is no evidence that Mr Asok has developed any insight into his failings.

Given the apparent lack of strengthening of his practice and absence of insight into his lack of competence, the panel was of the view that Mr Asok is liable, in future, to put patients at unwarranted risk of harm, to breach fundamental tenets of the profession and to bring the profession into disrepute.

The panel bore in mind that the overarching objectives of the NMC are: to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel therefore found that Mr Asok's fitness to practise is currently impaired on the grounds of public protection. In addition, it determined that public confidence in the nursing profession and in the NMC as the regulator would be undermined if a finding of impairment were not made.

Having regard to all the above, the panel was satisfied that Mr Asok's fitness to practise is currently impaired on the grounds of both public protection and also in the wider public interest.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Kyriacou submitted that, given the nature and seriousness of the lack of competence and the public protection and the public interest considerations identified by the panel, the appropriate sanction in this matter is a suspension order with a review for a period of 12 months.

Ms Kyriacou submitted that there are no mitigating features for Mr Asok's failures. However, she identified the following aggravating features:

- Wide range of concerns over a significant period of time
- Repeated pattern of behaviour despite support, training and supervision in place
- Local support given
- Lack of insight and remediation into the failures.

Ms Kyriacou submitted that given the nature of the lack of competence found proved by the panel, to impose no order or a caution order in this matter would not be appropriate. Similarly, she submitted that a conditions of practice order would not be appropriate as it would be difficult to envisage appropriate conditions which could be formulated given the wide ranging nature of the concerns about Mr Asok's practice as a nurse. Additionally, given that he has not engaged with the fitness to practise process, there is no evidence to confirm that he would engage with conditions of practice.

Ms Kyriacou submitted that Mr Asok's behaviour demonstrated a marked failure to uphold the reputation of the nursing profession. She said that a suspension order is appropriate given the panel's findings on lack of competence. She also submitted that a member of the public would be shocked were Mr Asok permitted to practise as a nurse unfettered or at all given the serious concerns which the panel have found proved.

Ms Kyriacou invited the panel to impose a suspension order with review for a period of 12 months to allow Mr Asok the time to reflect on his failures and to develop insight into his lack of competence. She said that a future panel could then take this into account when reviewing the order.

Decision and reasons on sanction

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

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

The panel took into account the following aggravating features:

- Lack of evidence of any insight into failings
- Pattern of failings over a period of time
- Significant number of wide ranging concerns
- Issues continued to occur despite the extent of support, training and supervision given
- Patients put at risk of harm

The panel determined that there are no mitigating features.

The panel carefully considered the impact of cultural issues given that Mr Asok was an overseas educated nurse. However, the failings identified were not seen as linked to cultural issues, particularly as there has been evidence of support and training. In addition to this, the environment he was in had a number of other overseas educated nurses who did not have similar challenges. Therefore, the panel did not consider cultural issues as a mitigating feature.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Asok's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Asok's lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Asok'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, but determined that conditions of practice would be inappropriate because of the following factors:

- *Evidence of general incompetence;*
- *No evidence of potential and willingness to respond positively to conditions;*
- *No evidence of insight into the failings*
- *Patients may be put in danger either directly or indirectly as a result of any conditions; and*
- *Conditions cannot be created that are workable, measurable, and that can be monitored and assessed.*

The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case and considering the lack of engagement by Mr Asok. Further, there is no evidence that suggests that Mr Asok would cooperate with any conditions. The panel noted that Mr Asok had a substantial amount of support, training and supervision in place to get him to a safe level of practice, however, failings continued and there is no evidence to demonstrate that any conditions would avoid such an outcome.

Moreover, as this is a case where the only concern is lack of competence, the panel considered that there would be a risk to the patient safety if Mr Asok was allowed to continue to practise even with conditions.

Furthermore, the panel concluded that the placing of conditions on Mr Asok's registration would not adequately address the seriousness of this case and would not protect the public and address the wider public interest.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was concerned at how far Mr Asok's practise fell below the standard expected of a registered nurse.

Whilst the panel acknowledges that a suspension may have a punitive effect, it concluded that this is the only sanction which is appropriate and proportionate in this case.

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

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standards required of a registered nurse.

The panel determined that a suspension order for a period of 12 months with a review was appropriate in this case to mark the seriousness of the lack of competence.

Further, it would give Mr Asok adequate time to reflect on his failings, to strengthen his practice, and to gather evidence of remediation for a future panel.

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

Any future panel reviewing this case would be assisted by:

- A reflective piece which addresses the impact of his failings on the patients, colleagues and the reputation of the wider profession
- Any evidence of work in a health related roles
- Testimonials from employers health related or otherwise
- Evidence of any relevant training
- Explain clearly his future intent in relation to nursing

This will be confirmed to Mr Asok in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Kyriacou. She submitted that an interim suspension order for 18 months is necessary to cover the period until the substantive suspension order comes into effect having regard to the panel's findings. Ms Kyriacou submitted that if Mr Asok appeals the decision of the panel, then he would

be able to practise without restriction until the appeal process is finished unless an interim order was in place.

Decision and reasons on interim order

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

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

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

That concludes this determination.