Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday 20 June 2023- Thursday 22 June 2023

Virtual Hearing

Name of Registrant:	**Garby Tengu Ndumu**
NMC PIN	01U0998E
Part(s) of the register:	Registered Nurse – Adult – 19 July 2005
Relevant Location:	Woking
Type of case:	Misconduct
Panel members:	Des McMorrow (Chair, Registrant member) Lorraine Shaw (Registrant member) Caroline Taylor (Lay member)
Legal Assessor:	Nigel Pascoe KC
Hearings Coordinator:	Renee Melton-Klein
Facts proved:	Charges 1a, 1b, 1c(i), 1c(ii), 2b
Facts not proved:	Charges 2a
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Conditions of practice order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Miss Ndumu's registered email address by secure email on 16 May 2023.

Further, the panel noted that the Notice of Meeting was also sent to Miss Ndumu's representative on 16 May 2023.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, the time, date and the fact that this meeting was heard virtually.

In the light of all of the information available, the panel was satisfied that Miss Ndumu has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

1) On 23 July 2019, in relation to Patient A:

    a. Moved Resident A; **[Proved by Admission]**

    b. Failed to make sufficient efforts to contact the emergency services/escalate Resident A's care; **[Proved by Admission]**

    c. Failed to commence basic life support:
        i. in a timely manner; **[Found Proved]**

        ii. using an appropriate/effective method of CPR in that the rate of compressions were slow and/or not of adequate depth; **[Found Proved]**

2) On 25 October 2019, in relation to Resident B:

    a. Failed to escalate Resident B's care by contacting the out of hours doctor and/or emergency services; **[Not Proved]**

    b. Failed to record Resident B's fluid input and/or urine output; **[Proved by Admission]**

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

Background

Miss Ndumu was referred to the Nursing and Midwifery Council (NMC) on 17 October 2019 by the Maria Mallaband Care Group Ltd in relation to clinical concerns. Miss Ndumu was employed as a bank nurse at Kingsbury Court ("Home 1") between 21 March 2019 and 23 July 2019 and completed 24 shifts there.

Home 1 alleged that on the 23 July 2019 Miss Ndumu failed to preserve patient safety after Resident A fell. The day nurse contacted the emergency services who advised that the resident remain on the floor until their arrival and in the event of the patient showing signs of deterioration, to call them back. It is alleged that Miss Ndumu did not follow these instructions. It is alleged Miss Ndumu moved the patient and when they began to deteriorate Miss Ndumu used an ineffective method of CPR whilst waiting for emergency services to arrive.

Another concern was raised relating to an incident on 25 October 2019 at Gracewell of Woking ("Home 2"), where Miss Ndumu was then working as a bank nurse. This allegation is that Miss Ndumu failed to escalate the health concerns relating to Resident B appropriately by contacting the out of hours doctor and/or emergency services and failing to record Resident B's fluid input or urine output.

Subsequently, Miss Ndumu was allocated day shifts to receive more support and be supervised on these shifts for a three-month period. Within these three months Miss Ndumu completed three shifts. On 31 July 2020, Miss Ndumu's name was included in the Adult's Barred List and the Children's Barred List. On 14 August 2020, Miss Ndumu informed the General Manager at Home 2 that she had been barred by the DBS and could not work with vulnerable patients. Following this, Miss Ndumu's upcoming shifts with Gracewell were cancelled. Miss Ndumu's last shift was on 13 August 2020.

On 21 October 2020, Miss Ndumu's name was removed from the Adult's Barred List and the Children's Barred List. Since August 2020, Miss Ndumu has not worked in a clinical capacity as a nurse.

Decision and reasons on facts

At the outset of the meeting, the panel noted the Case Management Form (CMF) from Miss Ndumu, which stated that Miss Ndumu has made admissions to charges 1a, 1b, and 2b.

The panel therefore finds charges 1a, 1b, and 2b proved, by way of Miss Ndumu's admissions.

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Home manager of Kingsbury Court.
- Witness 2: Collaborative Ltd Agency as an Agency Nurse. Worked the day shift at Kingsbury Court Care Home on 23 July 2019 before handing over to Miss Ndumu for the night shift of 23 July 2019.

- Witness 3: Worked as Bank Carer at Kingsbury Court Care Home at the time of the allegations.
- Witness 4 General Manager of the Home 2, Gracewell of Woking.
- Witness 5 Registered Paramedic employed by the South East Coast Ambulance service NHS Trust as a Specialist Paramedic in Critical Care. Attended Kingsbury Court Care Home on the 23 July 2019.

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

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

Charge 1c(i)

On 23 July 2019, in relation to Patient A:

c. Failed to commence basic life support:
   i. in a timely manner;

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Witness 5, the case notes of Patient A, and the transcript of the audio recording of Witness 5's evidence from the coroner's inquest on 5 October 2021.

The statement of Witness 5 dated 15 June 2020 stated:

‘The staff had left the patient in the chair while undertaking other tasks, however, were around him frequently. The nurse then stated that approximately 30 minutes prior to the cardiac arrest 999 call that the patient had been found unresponsive in the chair, with “noisy” breathing. She stated she took a blood pressure which was very low around 70 systolic (exact reading recorded on the continuation sheet). I asked what she had done in response to this and she stated that she had tried to make a worsening call to 999 but it didn’t work. On having asked EOC to see if we had any duplicate calls, we had received no further 999 calls from what the EOC team could see on the CAD. I was concerned about this and that having recognised how hypotensive the patient was and the fact he was unconscious, that they had not moved him to the floor and placed him in the recovery position.’

The panel also had before it the care notes of Patient A that were written by Miss Ndumu on 24 July 2019. In these notes she stated the following:

‘l first attempted to call 1111, then tried 9999 at about 20;50 but the line didn't go through. In between checking on Resident A, l was trying to sort out my login details for the computer and gave few medications to the residents under my care. While Resident A was in the chair, he appeared alet but very sleepy. I left and came back to the nursing floor to carry on with my medication rounds. At about 21:45 Resident A stared breathing heavily, I advised the carers to be with him while I tried to call 999 again, this time it rang but the line was very busy so I decided to drop because I had to give medications especially to those who have Parkinson Disease. While doing drug rounds at about 22:55pm, one of the carers called me and informed me that Resident A was unresponsive. I went back to the ground floor and saw Resident A unresponsive. I immediately tried to check observations but this time I could not get a reading. So I managed to get 9999 and I was advised lo stay on the line. I was asked if Resident A is breathing, I said no, he appeared unconscious. I was asked by the Ambulance crew if Resident A was warm to touch, I said yes, So they asked me to put Resident A back on the floor and commence CPR. It took 4 of us to get Resident A back on the floor and I immediately started CPR with Ambulance's Instructions on the loud speaker.(sic)’

The panel also noted that in addition to Miss Ndumu's failure to escalate Resident A's worsening condition and the delay in commencing ineffectual basic life support, such as putting Resident A on the floor in a recovery position and administering chest compressions, there were also additional delays in providing continuing life support from the paramedics. The transcript of Witness 5's audio interview at the coroner's inquest dated 5 October 2021 details the following:

> *' Q. …What would expect if you go to a care home as a paramedic?*
>
> *A. So we attend care homes frequently. They often know a lot about the residents, and I sought some clarity as to whether it was a care home or a nursing home because the level that you would perhaps expect from the staff may differ slightly. They'd normally have an organised care folder. They would very much know if someone had a do not resuscitate form, and even if the staff member wasn't able to tell you all of the person's past medical history, they would have it easily accessible to them, which wasn't what we found during this incident, ma'am.*
>
> *Q. And, as with the fact that you had to wait to be let in, would I be right to think that every second counts with one of these type of events?*
>
> *A. You would be correct and, from my experience, people that have made a 999 call for that reason ask to wait to meet the ambulance crew. It's unusual for us to not be able to access a call of that high acuity.*
>
> *Q. Okay, so I think you carried on and you went on to provide advanced life support.'*

The panel found Witness 5 to be a consistent and reliable witness and found that this corresponded with Miss Ndumu's own account of the events of 23 July 2019. The panel concluded, on the basis of everything before it, that Miss Ndumu did fail to commence basic life support in a timely manner to Resident A both in the sense that she did not escalate and provide it quickly enough and that she did not communicate and provide clarity and access to the paramedics to continue life support in a timely manner. The panel

was of the view that as a registered nurse, Miss Ndumu should have known what to do in this situation and that she should have commenced life support whilst she delegated someone else to call 999. Accordingly, the panel find this charge proved.

Charge 1c(ii)

On 23 July 2019, in relation to Patient A:

c. Failed to commence basic life support:
    ii. using an appropriate/effective method of CPR in that the rate of compressions were slow and/or not of adequate depth;

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Witness 5, the transcript of the audio recording of Witness 5's evidence at the coroner's inquest on 5 October 2021.

The panel took note of the following description of the CPR administered by Miss Ndumu in the written statement of Witness 5:

'The Nurse performing CPR on Patient A on 23 July 2019.

I remember seeing the Nurse who was the only member of staff wearing what it looked like a nurse's uniform. She was the only one wearing that uniform and she was performing a CPR on Patient A. I believe that person was the Nurse and she was wearing a nursing uniform.

I was concerned that the CPR the Nurse was performing on Patient A was not appropriate. I was concerned that the CPR the Nurse was performing was lower down below the Patient A's chest area where it should have been done. The compressions were shallow, but should have been deeper. The compression rate was slower than it should have been. So the compressions were slow, shallow and incorrectly performed by the Nurse.

The CPR, performed by the Nurse as described above could lead to decreased chance of patient's survival. It was reported that Patient A had had a fall earlier in the day. However Patient A's fall or any potential injuries did not have any impact on how the CPR should have been performed.'

The panel also noted the following excerpt from the transcript of Witness 5's audio interview at the coroner's inquest dated 5 October 2021:

Q. Okay, and was anybody undertaking CPR when you arrived?

A. So there was CPR being undertaken, yes.

Q. Yeah. Do you recall who by?

A. I don't – I believe the nurse that I had the interaction with was doing the CPR until the point I asked the ambulance crew to take over – so the nurse I just mentioned. I don't know if you need to ask me about that, but I had observed that the CPR was perhaps not of the highest quality when we arrived.

Q. Can you tell me what was wrong with it?

A. So for CPR to be effective, we'd look for the rate to be correct, so between 100 and 120 compressions per minute and at an adequate depth, and neither of those things were happening, so they were slow, and they were not compressing the chest adequately.

The panel found the paramedics witness statement and the original documents relating the coroner's inquest to be consistent and reliable. The panel also took note of Miss Ndumu's own reflection dated 5 November 2019 in which she said that:

'I have not really been in a stable working environment for a long time and I feel, because of that, it has affected my clinical practice. Sad that it has taken a few

incidence to happen for me to realise I need to update my clinical practice in many areas. For the past years, I have worked in various health settings and I now realise, that is has been a risk I have been taking to my clincal practise (sic).'

Accordingly, on the basis of everything before it, the panel concluded that Miss Ndumu did fail to use an appropriate/effective method of CPR in that the rate of compressions were slow and/or not of adequate depth and therefore failed to commence basic life support and found this charge proved.

Charge 2a

On 25 October 2019, in relation to Resident B:

a. Failed to escalate Resident B's care by contacting the out of hours doctor and/or emergency services;

This charge is found NOT proved

In reaching this decision, the panel took into account Patient B's progress notes from 25 October 2019 and the written statement of Witness 4.

The panel noted in the contemporary progress notes of 25 October 2029 that before handover that day Resident B was reported as of 15:30 to have been:

'..cheerful and chatty and friendly. Visited by his friend and children.'

The panel noted that at just after midnight on 26 October 2019 Resident B was catheterised by the previous nurse on duty but complained of the catheter being uncomfortable at that time. Miss Ndumu notes in Resident B's progress notes that he was already settled in bed when she took over the shift and that their medications were administered and that a bladder washout was performed at 06:21, at which time she noted that Resident B had blood-stained urine. At 08:15 that morning Miss Ndumu made the following note in the progress report:

‘Resident B was sent to the hospital via Ambulance, because of blood in urinary bag and blood coming out from his penis after catheter was removed . Left with Ambulance at about 7:45am . Complained of no pain, observations taken- BP 173/77, pulse 63 and temperature 35.6 . Due medication taken before he was taken to the hospital. Daughter informed about Patient B' s transfer to the hospital.’

The panel did not have before it what would have been an appropriate escalation time, but considered that from the evidence before it Miss Ndumu recognised there was an issue at 06:20 in the morning, took the necessary clinical steps and escalated the issue to an emergency services such that he was taken in ambulance by 07:45. The panel concluded that this timeline did not suggest a failure to escalate and concerns that she had about Resident B’s condition. Furthermore, the panel also noted that the investigation report conducted by Home 2, which concluded on 5 November 2019, stated:

‘According to GN there was a small blood noticed in the catheter bag, GN monitored the resident closely throughout the night and the Vital signs are stable.GN decided to communicate with EH, RGN via text message, who was on the day shift on 25th October 2019. Following that GN decided to flush the catheter by using the sodium chloride in stock cupboard. According to GN resident was not in pain or distressed and he managed to sleep well. In the morning of 26th October, around 6 am GN noticed there is fresh blood around the penis area and in the catheter bag. As the named resident is on Anticoagulant (Rivaroxaban). Considering the risk of bleeding and distress to the resident GN decided to call Paramedics. Before the ambulance arrived GN decided to remove the catheter. After the assessment paramedics decided to take Resident B to the hospital. Resident B’s daughter was informed by GN about the incident.

Outcome

It is clear from the investigation that hospitalization of Resident B was unavoidable. GN took the correct decision to call paramedics. Concern arises why GN didn't call out of hour's doctor instead of contacting the RGN off duty. GN explained RGN on day shift inserted the catheter so thought it would be better to contact RGN rather than calling OHH doctor.’

Accordingly, the panel concluded that Miss Ndumu had escalated Resident B's care appropriately and found this charge not proved.

Fitness to practise

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

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

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

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Miss Ndumu's actions amounted to misconduct and submitted that the breaches of the Code that amount to

misconduct are serious because Ms Ndumu's failings involved a serious departure from the standards expected of a registered professional. The failings are likely to cause risk to patients in the future if they are not addressed and also undermine trust and confidence in the profession.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Miss Ndumu's fitness to practise impaired on the grounds that the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are met on the first three limbs of the test. Namely:

> *a) The failures to provide appropriate care to a seriously deteriorating patient by not escalating the deteriorating condition to emergency services in an appropriate and timely manner raise an obvious risk of harm as does the failure to commence CPR in a timely manner or by using an appropriate/effective method of CPR. Failing to ensure adequate standards of patient care and poor communication with colleagues and record keeping had the potential to put vulnerable residents at risk of harm.*
>
> *b) Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. Nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. Ms Ndumu's failings relates to basic and fundamental nursing duties. As such her misconduct is liable to bring the profession into disrepute.*
>
> *c) The nursing profession is a caring profession. Ms Ndumu has breached the*

fundamental tenet of providing safe and effective care for patients. Further, the individual provisions of the professional Code, constitute fundamental tenets of the nursing profession. The conduct involved engaged, and breached, the above provisions.

The NMC outlined that impairment is a forward-thinking exercise which looks at the risk Miss Ndumu's practice may pose in the future. In considering this the panel may look to whether the failures identified can be addressed and are capable of being remediable. In respect of this the NMC noted that Miss Ndumu admitted charges 1(a), 1(b) and 2(b) and she also admitted that her fitness to practise is impaired. She has engaged with the NMC about her case and provided a formal response in her statement. She has also provided a local reflective piece and expressed some remorse. The NMC submitted that a testimonial from General Manager of Gracewell of Woking is relevant to the risk of repetition in that it suggests that Miss Ndumu practised with management support and supervision without concerns in a care home setting between 2018 and 2019 and completed further training.

However, the NMC submitted that there has not been a full reflection to all the failures concerned and that Miss Ndumu's insight is limited and requires greater development. It submitted that though she has undertaken some training, there is no evidence to demonstrate that she has completed training in the relevant areas of CPR, life support/emergency care and clinical record keeping. Accordingly, the NMC submit that the concerns have not been remediated and there is a continuing risk to the public.

In regard to repetition, the NMC submitted that Miss Ndumu has not practiced in a clinical setting since August 2020 and that this, taken together with her lack of full insight and up to date training in all the areas of concern lead to a risk of repetition.

The NMC submitted that there is a public protection requirement in a finding of impairment being made in this case to protect the public. Furthermore, it submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour as Miss Ndumu's conduct fell far below the proper professional standards.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

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

1. Treat people as individuals and uphold their dignity
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

8. Work co-operatively
To achieve this, you must:
8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individual with other health and care professionals and staff
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

10. Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

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

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
13.2 make a timely referral to another practitioner when any action, care or treatment is required
13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

15. Always offer help if an emergency arises in your practice setting or anywhere else
To achieve this, you must:
15.1 only act in an emergency within the limits of your knowledge and competence
15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Miss Ndumu's actions did fall seriously short of the conduct and standards expected of a nurse. The panel was of the view that it was absolutely imperative for a registered nurse to say up-to-date in basic life support techniques and to be able to assess, lead, and delegate in life threating situations.

The panel conclude that the seriousness of these of failures and the consequences of them amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel finds that patients were put at risk and were caused physical and emotional harm as a result of Miss Ndumu's misconduct. Miss Ndumu's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Miss Ndumu has made some admissions though has not demonstrated an understanding of how her actions put the patient(s) at a risk of harm and the impact of her failures on Resident A's family. Miss Ndumu has demonstrated some understanding of why what she did was wrong and how this impacted negatively on the reputation of the nursing profession. The panel noted there is nothing before it to demonstrate that she has apologised to the patient's family for her misconduct nor sufficiently demonstrated how she would handle the situation differently in the future.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Miss Ndumu has taken steps to strengthen her practice. The panel took into account that there has been some reference to training, however not in all the relevant areas of concern. Furthermore, Miss Ndumu has undertaken a reflective piece at the local level but has not submitted a reflection to the NMC, particularly with regard to further insight about the impact of her misconduct and what she would do differently in the future.

Accordingly, the panel is of the view that there is a risk of repetition as she has not strengthened her practice through relevant training courses and was only able to work under supervision for three shifts and has since then not worked in a clinical role since August 2020. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required as the test set out by Dame Smith in the Shipman Report is met on the first three limbs not just for the past, but Miss Ndumu remains liable in the future to put the public at risk of harm, bring the reputation of the profession into disrepute and breech fundamental tenets of the profession.

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

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Miss Ndumu's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

Representations on sanction

The panel noted that in the NMC's submissions it had stated that either a conditions of practice or suspension would be appropriate orders in this case, if it found Miss Ndumu's fitness to practise currently impaired.

The NMC submitted that taking no action or imposing a caution order would not be appropriate in this case.

The NMC put before the panel the sanction guidance and in regard to a conditions of practice order submitted that the facts behind such conduct, do not indicate harmful deep-seated personality or attitudinal problems. The misconduct covers clinical concerns which whilst serious, can be more readily addressed by way of training, supervision and assessment. There are practical conditions that could be put in place that would protect the public and maintain public confidence. Therefore, it is submitted that a conditions of practise order could be appropriate in this case.

The NMC again referenced the sanction guidance in regard to a suspension order. It submitted that whilst the misconduct does not indicate harmful deep-seated personality or attitudinal problems, the misconduct does cover more than one incident with serious failures in fundamental nursing care with the potential for serious harm to patients and damage to the reputation of the profession. In the absence of full admissions and given the limited insight of Miss Ndumu, a suspension order would also be appropriate in this case.

The NMC submitted that that to strike Miss Ndumu off the register would be disproportionate in the circumstances. Whilst the misconduct is serious, it all relates to clinical concerns and is remediable. The misconduct therefore is not fundamentally incompatible with remaining on the register.

Decision and reasons on sanction

Having found Miss Ndumu'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 full insight into failings
- Serious failures in relation to basic nursing care, with the potential for unwarranted, serious, patient harm

- Potential to damage the reputation of the profession

The panel also took into account the following mitigating features:

- Some admissions
- A reflective piece provided
- Reference to some training
- Evidence of some remorse
- A number of contextual factors including:
    - pressure in the work environment and
    - difficulty in accessing the computer system.

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 Miss Ndumu'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 Miss Ndumu's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*

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

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

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

The panel was of the view that to impose a suspension order or a striking-off order would be disproportionate and would not be a reasonable response in the circumstances of Miss Ndumu's case because the panel concluded that failings identified are remediable and that Miss Ndumu has shown some insight. The panel was of the view that a suspension order would not give Miss Ndumu the opportunity to return to nursing and strengthen her practice.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

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

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

1. You must not be the sole nurse on duty of any shift.

2. You must ensure that you are working at all times on the same shift as, but not always directly observed by a registered nurse more senior than you.

3. You must work with your line manager or supervisor to create a personal development plan (PDP). Your PDP must address the concerns about relevant areas of CPR, life support/emergency care and clinical record keeping. You must send your case officer a copy of your PDP and progress ahead of any review.

4. You must complete training in the relevant areas of CPR, life support/emergency care and clinical record keeping and send evidence of this to your case officer ahead of any review

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

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

7. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).

d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

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

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

The period of this order is for 12 months.

Before the end of the period of the order, a panel will hold a review hearing to see how well Miss Ndumu has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at any review
- A further reflective piece
- Any evidence of training
- Any updates on your current work or future plans in nursing

This will be confirmed to Miss Ndumu in writing.

Interim order

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

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

Representations on interim order

The panel took account of the representations made by the NMC that Miss Ndumu's fitness to practise is impaired on a public protection basis and a restrictive sanction imposed, we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.