Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday, 11 May 2023 – Wednesday, 17 May 2023

Virtual Hearing

Name of Registrant:	**Maria Lourdes Kasmai**
NMC PIN	74F0499E
Part(s) of the register:	RN2: Adult nurse, level 2 (1 December 1976) RN1: Adult nurse, level 1 (25 April 1998)
Relevant Location:	Norwich, Norfolk.
Type of case:	Misconduct
Panel members:	Debbie Hill (Chair, lay member) Manjit Darby (Registrant member) Michael Glickman (Lay member)
Legal Assessor:	Trevor Jones
Hearings Coordinator:	Nandita Khan Nitol
Nursing and Midwifery Council:	Represented by Sam Smart, Case Presenter
Ms Kasmai:	Not Present and unrepresented at the hearing
Facts proved:	Charges 1a, 1b, 1c, 2a, 2b, 2c, and 3
Facts not proved:	N/A
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 Ms Kasmai was not in attendance and that the Notice of Hearing letter had been sent to Ms Kasmai's registered email address by secure email on 27 March 2023.

Mr Smart, 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 that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Kasmai's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Kasmai 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 Ms Kasmai

The panel next considered whether it should proceed in the absence of Ms Kasmai. It had regard to Rule 21 and heard the submissions of Mr Smart who invited the panel to continue in the absence of Ms Kasmai.

Mr Smart referred the panel to the email from Ms Kasmai's representative, Bahman Kasmai, dated 14 April 2023, which stated:

'I am writing to inform you that due to health reasons, Maria will not be able to attend the hearing scheduled from May 11th to May 17th. As her representative, I am also unable to be away from work for such a long period to represent her.'

Mr Smart also referred the panel to the email from Ms Kasmai's representative, Bahman Kasmai, dated 4 May 2023, which stated:

'i [sic] *am afraid we will away* [sic] *on 11th May. Happy for the panel to proceed without our presence.'*

Mr Smart submitted that Ms Kasmai had voluntarily absented herself. He submitted that Ms Kasmai has not made an application to adjourn, and that adjourning today's hearing will not secure her attendance at a future hearing. Mr Smart informed the panel that three witnesses have been warned to give oral evidence to this panel, and delaying this matter further may have an adverse effect on their recollection in relation to the charges. He submitted that the public interest elements of this case suggest that this matter should be dealt with expeditiously.

The panel accepted the advice of the legal assessor, who referred it to the guidance in *Adeogba v GMC* [2016] EWCA Civ 162.

The panel has decided to proceed in the absence of Ms Kasmai. In reaching this decision, the panel has considered the submissions of Mr Smart, the email from Bahaman Kasmai on Ms Kasmai's behalf, and the advice of the legal assessor. It has had particular regard to any relevant case law and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Kasmai;
- Ms Kasmai's representative has informed the NMC that she has received the Notice of Hearing and confirmed that she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure Ms Kasmai's attendance at some future date;

- Three witnesses have been warned to give oral evidence;
- Not proceeding may inconvenience the witnesses, their employers and, should they be involved in clinical practice, the patients or those who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of the witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Kasmai.

There is some disadvantage to Ms Kasmai in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address and she has made responses to the allegations by her representative via email, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Kasmai's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

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

At the outset of the hearing, Mr Smart made a request that parts of this case be held in private on the basis that proper exploration of Ms Kasmai's case involves reference [PRIVATE]. Therefore, he applied for those parts of the hearing to be conducted in

private in accordance with the powers available to the panel under Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

Having received advice from the legal assessor, the panel concluded that it would be appropriate to proceed in private for those parts of the hearing in which [PRIVATE] would be discussed. The panel considered that there was no public interest in those [PRIVATE] being discussed in a public forum, and that witnesses' and Patient A's right to privacy in that regard outweighed the public interest in the hearing being conducted fully in public. The panel was satisfied that it would be possible, appropriate and fair to limit the private sections of the hearing to those [PRIVATE] would be discussed.

Details of charge

That you, a registered nurse:

1. On 29 June 2019 inadequately responded to an emergency situation in respect of Patient A in that you:
    a. left Patient A with a healthcare assistant to call 999;
    b. lacked the knowledge on how to deflate an airflow mattress to enable cardiopulmonary resuscitation (CPR) to be administered;
    c. Failed to move Patient A into the recovery position.

2. Failed to administer CPR without clinical justification, in that you:

a. did not ask for assistance to move Patient A on to the floor to administer CPR;
b. did not check Patient A's vital signs;
c. did not act in the best interests of the patient.

3. Whilst in the presence of Person A, indicated a lack of skill and/or willingness to commence CPR in that you said "I am 62 years of age, I cannot do CPR anymore" or words to that effect.

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

Background

The charges arose whilst Ms Kasmai was employed as a registered nurse by Select Health Care Group at Oak Court (the Care Home). The NMC received a copy of the Regulation 28: Report to Prevent Future Deaths on 2 March 2020 from Norfolk Coroner Service.

On 5 July 2019 an investigation began into the death of Patient A and concluded at the end of the inquest on 21 February 2020. The conclusion of the inquest stated that the patient had not had prophylactic heparin since his arrival at rehabilitation unit and that staff did not commence CPR when he collapsed. The patient died from Pulmonary Embolism and Infarction of Spinal Cord.

The Coroner stated that '*in this instance any intervention by* [Ms Kasmai] *is unlikely to have been successful but I believe that if any other emergencies occur whilst she is on duty the same situation will occur and another patient may have a collapse which is reversible'*.

When the Patient A collapsed, it is alleged that Ms Kasmai asked a Health Care Assistant (HCA) to call for an ambulance which he did and then she went on to call 999 herself leaving Patient A in the care of an untrained HCA. It is also

alleged that she did not flatten the bed to put the patient into the recovery position and that she did not know his bed had a special device on it to enable CPR.

It is alleged that she did not accept at the inquest that she should have stayed in the room to carry out CPR, displayed no indication in her evidence that she knew what to do in the event of an emergency and that she panicked. It was further reported that she said at the time of the incident in the presence of members of the public, "*I'm too old to do CPR*".

Whilst the Care Home's internal investigation found no care failings, the inquest revealed the following matters of concern:

- *Inability, lack of training/experience of nurse in charge to deal with an arrest/collapse of a patient. Clear panic in the face of an emergency;*
- *Nurse leaving collapsed patient in care of an untrained HCA whilst she made unnecessary second phone call;*
- *Her lack of knowledge about the special bed which Patient A had which allowed CPR on the bed and her stating that she put Patient A into the recovery position when he was semi recumbent, she did not flatten the bed and she did not do a mouth sweep to see if his airway was occluded by his tongue.*

Ms Kasmai's employment was suspended on 10 March 2020 by Select Health Care Group pending investigation and her employment was subsequently terminated.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Smart on behalf of the NMC and the email response to the charges from Ms Kasmai and her representative.

The panel has drawn no adverse inference from the non-attendance of Ms Kasmai.

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

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

- Witness 1: Manager of the Care Home at the time
- Witness 2: Paramedic who was the first responder to the incident
- Person A: Person A

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

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

Charge 1a)

That you, a registered nurse:

1) On 29 June 2019 inadequately responded to an emergency situation in respect of Patient A in that you:
   a. left Patient A with a healthcare assistant to call 999;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, the Inquest Report and Response (Coroner's report), Root Cause Analysis Investigation/Incident Report (RCA report) carried out by the Care Home and the response to the charges from Ms Kasmai and her representative.

The panel considered whether Ms Kasmai had a duty to not leave Patient A with a healthcare assistant to call 999.

The panel noted that Patient A was gravely unwell which was clear from Ms Kasmai's statement to the internal investigation where she said that '*when she reached the patient he was breathing but unarousable*' and she was '*very concerned*'. The panel then noted that Ms Kasmai first asked an HCA to call 999 and then left the patient to make a second 999 call by herself. The panel considered the oral and written evidence of Witness 1, where she told the panel that Ms Kasmai was the only registered nurse on duty and that it was contrary to what a registered nurse should have done in those circumstances. As the only registered nurse on duty, she was required to carry a cordless phone in the event of emergencies and should not have left Patient A in a state of significant collapse in the care of untrained personnel. Witness 1 also told the panel it might have been appropriate for Ms Kasmai to leave Patient A to get any required equipment if the patient was in the recovery position.

The panel had regard to the response from Ms Kasmai's representative in an email dated 14 April 2023, which stated that:

> *'Maria was working with a carer who had insufficient knowledge of the English language to make an effective emergency call. After balancing the risks, she decided that it would be less risky to leave the patient with the carer for a couple of minutes to make a call to the emergency services. This took less than 2 minutes during which the patient was still breathing but in some degree of discomfort.'*

The panel noted the admission of Ms Kasmai via her representation that she left Patient A but did not accept the justification behind her action that she left Patient A in an unresponsive state because she was working with a carer who had insufficient knowledge of English. The panel considered the evidence of Witness 1, who said in evidence that the HCA who was sent to make the call was a native English speaker and there were no issues with verbal communication with any of the other HCAs working at the Home.

The panel also had regard to the Coroner's report where it is stated that:

> *'She then left an unresponsive patient in the care of an unqualified person to make another call to 999. She did not accept that she should have stayed, she displayed no indication in her evidence that she knew what to do in the event of an emergency and she panicked.'*

Taking account of all the evidence above the panel found that Ms Kasmai left Patient A in an unresponsive state in the care of an unqualified person and at the very least Ms Kasmai should have had moved Patient A into the recovery position if he was breathing but unresponsive before leaving him to call 999. Therefore, based on the evidence above the panel found that for a qualified Registered Nurse on duty, this was an inadequate response to an emergency situation.

Accordingly, the panel found this charge proved.

Charge 1b)

1) On 29 June 2019 inadequately responded to an emergency situation in respect of Patient A in that you:

    b. lacked the knowledge on how to deflate an airflow mattress to enable cardiopulmonary resuscitation (CPR) to be administered;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and 2, the Inquest Report and Response (Coroner's report), Root Cause Analysis Investigation/Incident Report (RCA report) carried out by the Care Home and the response to the charges from Ms Kasmai.

The panel heard evidence from Witness 1 that in order to perform CPR either the air mattress needed to be deflated or patients needed to move on to the floor to undertake CPR as a patient would bounce back on a fully inflated mattress. Witness 1 also told the panel in her evidence that when a patient was in an unresponsive state but breathing, that patient should be moved into the recovery position.

The panel also heard evidence from Witness 2 where he stated that when he arrived, Patient A was in a semi- recumbent position in bed and that there was a pillow behind him to prop him up. The patient was cyanosed and in a state of collapse and the staff were trying to rouse him by talking to him. He also told the panel that he got assistance from staff members who were present and moved Patient A to the floor to carry out CPR.

Based on the evidence above the panel found it clear that Ms Kasmai failed to deflate the air mattress. The panel noted the evidence of Witness 1 and 2, where they confirmed that either the bed should have been flattened or Patient A should have been moved on to the floor to undertake CPR because of Patient A's agonal breathing.

The panel then considered whether Ms Kasmai's failure to deflate the mattress was due to her lack of knowledge. Given that the panel had not had the benefit of directly asking Ms Kasmai in live evidence and factually deduce her state of mind, the panel put significant weight on the finding of the Coroner in relation to the lack of knowledge.

Witness 1 confirmed that Ms Kasmai had the necessary training and knowledge on CPR which specially covered patients on an air flow mattress bed.

The panel had regard to the Coroner's report where it is stated that:

'The nurse did not flatten the bed to put Patient A into the recovery position, she did not know that his bed had a special device on it to enable CPR, despite having worked at the unit for 4 years.'

Based on all the evidence above the panel found that Ms Kasmai had received training on it but attending training does not necessarily result in the acquisition of knowledge. The panel noted the evidence of the Coroner who heard live evidence from Ms Kasmai and concluded that she did not know about the special device on the bed to enable CPR. The panel noted that the Coroner's finding implied lack of knowledge. It also noted that Ms Kasmai attended training but when it came to practice, she was unable to perform it. Therefore, the panel determined that Ms Kasmai appeared to have lacked the knowledge despite having the specific training.

Accordingly, this charge is found proved.

Charge 1c)

1) On 29 June 2019 inadequately responded to an emergency situation in respect of Patient A in that you:

    c. Failed to move Patient A into the recovery position.

This charge is found proved.

Witness 1 stated that one of the concerns raised by the Coroner was that Ms Kasmai told the Coroner that she had placed Patient A in the recovery position when she had not. The panel heard evidence from Witness 2 who was very clear both in his oral evidence and his contemporaneous notes that the patient was in a semi – recumbent position. The panel noted the evidence of Witness 1 and 2 that Patient A should have been at the very least moved into the recovery position should the patient had been breathing but unresponsive.

Therefore, the panel found that this was a failure to adequately manage Patient A in that Ms Kasmai did not move Patient A into the recovery position.

Accordingly, this charge is found proved.

Charge 2a)

2) Failed to administer CPR without clinical justification, in that you:

    a. did not ask for assistance to move Patient A on to the floor to administer CPR;

This charge is found proved.

The panel determined that having found 1b) proved, the next course of action should have been to put patient A on the floor.

Witness 2 told the panel that although the initial call stated that Patient A had shallow breathing, when he arrived at the scene, he found no signs of life. Witness 2 further stated that, he would have fully expected to have seen staff trying to resuscitate Patient A, but nothing was being done, leading him to question whether a Do Not Resuscitate order was in place. Witness 2 said that he got assistance from staff members who were present at the time and moved Patient A to the floor to carry out CPR.

The panel noted the patient record card where at the pre ambulance arrival action, the recovery position was not ticked. The panel found that there was no active management of Patient A to move him onto the floor. From the evidence of Witness 2 , it was clear that there was more than one person in the room when he got there. Witness 2 also said in evidence that they were all standing around and was trying to talk to him, but nobody moved him onto the floor or administered CPR. Therefore, the panel determined that Patient A could have moved to floor before the arrival of the paramedic to carry out CPR.

Accordingly, this charge is found proved.

Charge 2b)

2. Failed to administer CPR without clinical justification, in that you:

    b. did not check Patient A's vital signs;

This charge is found proved.

Witness 2's evidence was that when he arrived at the scene, he was not given any handover and his initial observation was that Patient A was in a semi recumbent position in a bed, unresponsive to verbal stimulus and appearing blue in colour with no signs of life. Witness 2 said that '*he would fully have expected to have seen staff trying to resuscitate him, but nothing was being done'*. Witness 2 further stated that the staff were surrounding Patient A's bed attempting to gain verbal response from him rather than doing any emergency intervention.

The panel noted some reference that Ms Kasmai fetched a thermometer and went to Patient A's room to check Patient A's temperature with the HCA. However, there was no suggestion or evidence that vital signs were taken or recorded. The panel also noted that the RCA report which suggested that Ms Kasmai was undertaking further checks while the HCA went to call 999 but the panel had no evidence that showed that those checks were carried out. Further, the panel considered that Ms Kasmai obviously recognised that Patient A was very ill as she had asked the HCA to call an ambulance upon recognising the fact that there was an acute episode happening but apart from that there was nothing to indicate that vital signs were taken. The panel also had regard to the Coroner's report where it is stated that '*she did not do a mouth sweep to see if his airway was occluded by his tongue'*. The panel also noted the evidence of Witness 2 who gave clear evidence that upon arrival at the scene he did not receive any handover. Along with that the panel noted the evidence of Witness 2 where he said that there was nobody waiting at the door to guide him to Patient A or to give him a handover by telling

him what was happening at the time. Witness 2 also noted that he had no idea who was the nurse in charge throughout his time attending the incident.

Based on the evidence above, the panel is satisfied that it is more than likely that Ms Kasmai did not attempt to take any vital signs.

Accordingly, this charge is found proved.

Charge 2c)

2. Failed to administer CPR without clinical justification, in that you:

    c. did not act in the best interests of the patient.

This charge is found proved.

The panel determined that having found Charge 2a and 2b proved, Ms Kasmai did not act in the best interests of Patient A.

The panel determined that as the only Registered Nurse on duty Ms Kasmai had a professional responsibility as a Registered Nurse and in line with the Care Home's First Aid policy to ensure emergency care was effectively coordinated and managed. In these circumstances she failed in her duty to respond effectively to the situation and provide emergency resuscitation pending the arrival of the paramedics. Whilst any intervention by her is unlikely to have been successful she had an obligation to use her professional skills and knowledge to provide basic life support until the first responder attended.

Accordingly, this charge is found proved.

Charge 3)

3. Whilst in the presence of Person A, indicated a lack of skill and/or willingness to commence CPR in that you said “I am 62 years of age, I cannot do CPR anymore” or words to that effect.

This charge is found proved.

The panel heard live evidence from Person A. Person A said in evidence that when she heard the comment that she was less than half a metre away from Ms Kasmai; if she had stretched out her arm, she could have touched her. In answer to the panel’s question about possible misinterpretation of the remark, Person A said that she was clear that this was not something she would have misinterpreted and that at the time of the incident she immediately responded, ‘*That’s not right’*, at which point Ms Kasmai walked away.

The panel had regard to the response from Ms Kasmai and her representative in an email dated 14 April 2023, which stated that:

> *‘The allegation …is baseless and based on gossip with cleaners and cooks working in the care home. The unfounded gossip that Maria admitted to not knowing how to administer CPR is a vicious lie based on rumours.’*

Given that the panel did not have the benefit of asking Ms Kasmai directly about the charge and determining factually her state of mind at the time, the panel considered that the comment on balance of probabilities had the meaning attributed to it by Person A. There was no evidence before the panel to make out Ms Kamai’s statement above. On the contrary, the panel found Person A’s evidence to be clear and consistent and it accepted the evidence of Person A.

The panel determined that Ms Kasmai had said the words as per the charge or words to that effect. The panel then went on to consider in respect of Charge 3 that whether that comment was a direct response to a query or a general comment. Either way, the panel

determined that under the circumstances it was an insensitive and inappropriate remark.

The panel then went on to consider whether the comment indicated lack of skill or unwillingness to do the CPR.

The panel determined that based only on the comment and without asking Ms Kasmai in live evidence, it could not be satisfied Ms Kasmai lacked the skill to commence CPR. The panel noted the evidence of Ms Kasmai that she left the room during the incident to check the other patients. However, as the only Registered Nurse on duty who was qualified and properly trained to deal with emergencies, she had a duty to remain in the room to carry out CPR and manage the incident. It determined that Ms Kasmai could have delegated the other HCAs present at the time to check on the rest of patients while she attended to Patient A. The panel concluded that the fact that she chose to be outside the room at the time of emergency indicated Ms Kasmai's unwillingness to carry out CPR.

Accordingly, this charge is proved on basis that she indicated unwillingness to commence CPR.

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 Ms Kasmai'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, Ms Kasmai's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Smart 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.

Mr Smart referred the panel to the case of *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 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.'* He also referred to the cases of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin). Further he referred to the case of *Spencer v General Osteopathic Council* [2012] 1 WLR 1307, where it was held that unacceptable professional conduct requires '*a degree of moral blameworthiness on the part of the registrant likely to convey a degree of opprobrium to the ordinary intelligent citizen*'.

Mr Smart drew panel's attention to its determination on facts and invited the panel to take a common-sense approach to these allegations. He submitted that this was a single incident made up of multiple failures. Further, he submitted that the misconduct is rooted in the first part of the allegation that Ms Kasmai inadequately responded to Patient A's emergency situation. He added that the fact that Ms Kasmai left Patient A to go dial 999, did not deflate the air mattress of the bed, did not move Patient A into the recovery position and failed to administer CPR without clinical justification were examples of that failure.

Mr Smart referred to the specific sections of the code and submitted that Ms Kasmai's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to breaches of the Code.

Mr Smart stated that a breach of the Code does not automatically result in a finding of misconduct and that it was a matter for the panels professional judgment.
Mr Smart then referred back the panel's determination on facts and pointed out the observation made by Witness 2 that when he arrived at the scene, he found no signs of life and that he would have fully expected to have seen staff trying to resuscitate Patient A, but nothing was being done which led him to question whether a Do Not Resuscitate order was in place. Mr Smart submitted that little was done to help a dying man.

Mr Smart submitted that it was a matter for the panel to decide whether those acts or omissions would be considered as '*deplorable*' by fellow practitioners and whether an ordinary intelligent member of the public would react to this incident with a degree of criticism or reproach. Mr Smart submitted that it was a fundamental failure of care which led to a delay in the treatment of Patient A. He submitted that Ms Kasmai's failure included taking an inadequate course of action, not offering help in an emergency situation, not acting in the best interest of Patient A and making an insensitive remark. Further, in relation to the remark, Mr Smart submitted that the comment showed a lack of sympathy for Patient A.

Finally, Mr Smart submitted that Ms Kasmai's actions on 29 June 2019 did fall seriously short of the conduct and standards expected of a nurse. He added that the departure was so stark that it could be properly characterised as misconduct and invited the panel to do so.

Submissions on impairment

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

Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin) and the test formulated by Dame Janet Smith and adopted by Cox J as appropriate for panels considering impairment.

Mr Smart submitted that the first three of the four limbs of the Dame Janet Smith test are engaged.

With regards to the first limb, Mr Smart submitted that although the seriousness of Patient A's condition was not fully known at the time, Ms Kasmai's lack of adequate response put Patient A at unwarranted risk of harm. He added that any other patients in a similar situation would be put at unwarranted risk of harm by her inaction.

With regards to the second limb, Mr Smart submitted that Ms Kasmai's comments about '*being too old for CPR*' brought the profession into disrepute and any member of the public hearing those comments may think less of the profession as a result.

With regards to the third limb, Mr Smart submitted that Ms Kasmai failed to provide the most basic level of care in that emergency situation which was a breach of the fundamental tenets of the nursing profession.

Mr Smart submitted that in relation to insight Ms Kasmai's representations do nothing to support any finding of insight. Mr Smart submitted that Ms Kasmai's representations sought to deflect and dismiss the allegations against her. He further submitted that Ms Kasmai failed to look at this objectively to recognise what went wrong and what she could have been done to avoid things that went wrong and how to act differently in the future.

Mr Smart submitted that it is for the panel to determine whether Ms Kasmai's conduct is likely to be repeated in the future. He submitted that the panel was not provided with any evidence of Ms Kasmai undertaking work or training to remedy the failings in order to assure it that there was no risk of repetition. Therefore, Mr Smart submitted that there is a risk of repetition based on the lack of remediation which required a finding of impairment on public protection grounds.

Mr Smart submitted that in view of the seriousness of the case, public confidence in the profession would be undermined and a finding of impairment is required on the grounds of public interest.

Having regard to all of the above, Mr Smart invited the panel to make a finding that Ms Kasmai's fitness to practise is currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Ms Kasmai's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Kasmai's actions amounted to a breach of the Code, with particular regard to:

1.2 make sure you deliver the fundamentals of care effectively

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

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

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

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

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff

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

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

15 Always offer help if an emergency arises in your practice setting or anywhere else

20.1 keep to and uphold the standards and values set out in the Code

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It had regard to the case of *Roylance v General Medical Council* 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 panel determined that Ms Kasmai's actions in each of the individual charges did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct. The panel formed the view that Ms Kasmai's failures in not trying to preserve life was a gross clinical failure and the public would be appalled by this, and that other professionals would find this deplorable. In the panel's view, this was a serious departure from the standard expected of a registered nurse.

The panel considered that whilst it was only a single incident and despite the fact that Ms Kasmai did not know that any resuscitation attempt may have been futile, her failure

in duty to care in any other situation would have the potential to put any patient at serious risk of harm. The panel determined that as the only Registered Nurse on duty who was qualified and properly trained to deal with emergencies, she had an obligation to take the lead in carrying out resuscitation procedures. It determined that she had a duty to remain in the room to carry out CPR and manage the incident and to provide a handover to the responding paramedic, all of which she failed to do. It also determined that Ms Kasmai could have delegated the other HCAs present at the time to check on the rest of patients while she attended to Patient A. Her remark '*I am 62 years of age, I cannot do CPR anymore'* was deeply insensitive and [PRIVATE].

In the panel's view, this conduct was a serious departure from the standard expected of a registered nurse. The panel determined that Ms Kasmai's conduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Therefore, the panel found that Ms Kasmai's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Kasmai'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 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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

d) *...'*

The panel determined that limbs a, b and c, of the *Grant* test are engaged.

The panel determined that Ms Kasmai's failures to act to preserve life was misconduct that breached the fundamental tenets of the nursing profession and that her actions brought the reputation of the profession into disrepute. The panel is aware that its decision on impairment is a forward-looking exercise and accordingly, it went on to consider whether Ms Kasmai's misconduct was remediable and whether it had been remediated.

The panel then considered the factors set out in the case of *Cohen v GMC* [2007] EWHC 581 (Admin). It determined that the misconduct in this case is capable of remediation should Ms Kasmai choose to recognise the gravity of the misconduct findings made against her and demonstrate insight.

The panel went on to consider whether Ms Kasmai remained liable to act in a way that would put patients at risk of harm, would bring the profession into disrepute and breach the fundamental tenets of the profession in the future. In doing so, the panel considered whether there was any evidence of insight and remediation.

The panel carefully considered the documentation and found that there was nothing that indicated any evidence of insight or remediation. The panel concluded that there was no evidence of any contextual, personal or working environment factors that may have adversely affected Ms Kasmai's ability to practise safely and professionally. The panel considered Ms Kasmai's response to the regulatory concerns through her representative and it determined that Ms Kasmai had not recognised her failings in respect of Patient A and continued to deny that she was at fault and to deflect blame onto others. The panel was therefore unable to find that Ms Kasmai had demonstrated any insight into her misconduct or that she had considered the impact of her behaviour on [PRIVATE], colleagues and the reputation on the profession.

Furthermore, the panel noted that it had no evidence of reflection and/or apology from Ms Kasmai.

In the absence of any evidence of steps to strengthen her practice or provide evidence of remediation, the panel concluded that Ms Kasmai had not remediated her actions.

In all the circumstances, the panel considered that there is a risk of repetition should Ms Kasmai return to practice as she remained liable to act in a way which could place patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future. The panel therefore determined 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 are to protect, promote and maintain the health, safety and wellbeing of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession.

Having regard to Ms Kasmai's actions in this case, the panel considered that members of the public and patients would expect a nurse to provide safe and effective care to patients in an emergency situation. The panel therefore determined that a finding of impairment is also necessary on public interest grounds.

Having regard to all of the above, the panel concluded that Ms Kasmai's fitness to practise is currently impaired.

Submissions on sanction

Mr Smart invited the panel to impose a 6-month suspension order with a review. He referred the panel to the NMC's Sanctions Guidance ('SG'), and the SG on considering sanctions for serious cases.

Mr Smart drew the panel's attention to its determination on misconduct and impairment and stated that the panel's consideration included fundamental failure in nursing skill and that there was no evidence of insight and/or remediation.

Mr Smart submitted that the following constitute aggravating features in this case:

- Conduct which put patients at the risk of suffering harm
- Failures in fundamental nursing skills
- Lack of insight into her failings

Mr Smart submitted that the following constitutes a mitigating feature in this case:

- This was an isolated incident in a career spanning 38 years.

Mr Smart invited the panel to assess the available sanctions in the ascending order from least restrictive first. He submitted that no further action or a caution order would not be sufficient to protect the public in this case given that Ms Kasmai is impaired on both public protection and public interest grounds. He submitted that there remains a risk of repetition and a risk of harm if the panel decides that no further action or a caution order is appropriate.

Mr Smart further submitted that conditions of practice order would not be appropriate given the fundamental nature of the failings and the lack of evidence of insight or remediation.

Mr Smart submitted that a suspension order would be appropriate in this case as this was a single instance of misconduct where a lesser sanction is not sufficient.

Mr Smart, referring to the panel's determination on misconduct and impairment, submitted that although the conduct in this case is serious, it is remediable. Therefore, he added, a striking-off order would not be appropriate as the failures in this case are not fundamentally incompatible with Ms Kasmai continuing to be on the register.

In summary, Mr Smart then submitted that sanctions are there to protect the public, they must be proportionate, and a suspension order for 6 months is the proportionate response in this matter.

In answer to the panel's question as whether there are any attitudinal concerns that need to be addressed, Mr Smart submitted that there is some evidence of attitudinal problems but stated that it was entirely a matter for the panel to decide.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Ms Kasmai'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 SG published by the NMC.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Ms Kasmai'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:

- Ms Kasmai was the only qualified nurse on duty on that day
- Her conduct put Patient A at serious risk of harm
- Lack of acknowledgement and reflections on the impact of her actions on Patient A, [PRIVATE] and her colleagues.
- Deflecting blame onto others
- Failed to be open and honest with her manager regarding her concerns about CPR
- Ms Kasmai's comment about being too old to do CPR caused significant distress to [PRIVATE]
- Her limited engagement through her representative in the proceedings

The panel also took into account the following mitigating features:

- One single incident
- A career of 38 years without any prior regulatory concerns

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, nor would it protect the public.

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 Ms Kasmai'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 Ms Kasmai'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, nor would it protect the public.

The panel next considered whether placing conditions of practice on Ms Kasmai'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 determined that a conditions of practice order is not relevant to her misconduct.

The panel determined that in ordinary circumstances conditions of practice could have been formulated. However, in this case, it determined that several weeks before the incident Ms Kasmai had training on CPR and that she failed to seek support or escalate her concerns about her inability/unwillingness to do CPR which in the panel's view shows lack of insight into her lack of abilities expected of a Registered Nurse. This could not be addressed with conditions of practice.

The panel noted that Ms Kasmai's insensitive comment cause significant distress to [PRIVATE] and Ms Kasmai in response to the charge deflected the blame to others as opposed to offering any apology. The panel considered that the misconduct in this case reflected attitudinal problems. However, the panel determined that given the limited timeframe in which the incident happened, it was not satisfied that the attitudinal problems associated with the conduct was deep-seated.

The panel is of the view that in light of her lack of insight, remediation and reflection, there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on Ms Kasmai's registration would not adequately address the seriousness of this case, nor could workable conditions be formulated which would protect patients in the event of a similar incident occurring.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. Although there was evidence of a potential attitudinal problem, the panel did not feel that this was sufficiently deep-seated as to prevent Ms Kasmai strengthening her practice and meaningfully addressing the misconduct findings made by the panel should she choose to do so.

The panel did go on to seriously consider whether a striking-off order would be an appropriate sanction in light of the seriousness of the misconduct. However, the panel was of the view that a striking-off order would be disproportionate at this time. It heard no other issues relating to Ms Kasmai's practice as a nurse, and that she has been

practising for 38 years without any prior regulatory concerns. The panel considered that if Ms Kasmai is able to demonstrate insight and remediation, she should be able to return to nursing which would be in the public interest.

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

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

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

The panel determined that a suspension order for a period of 12 month was appropriate in this case to mark the seriousness of the misconduct.

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:

- Ms Kasmai's engagement with the NMC and her attendance at the next review hearing
- Reflections on the findings of the panel
- A written reflective piece addressing the impact Ms Kasmai's actions have had on [PRIVATE], on her colleagues and on public confidence in the profession
- Evidence of training on the role of the nurse in charge in leading and managing a crisis in clinical practice

- Evidence of any other relevant training undertaken in relation to strengthening her practice
- Evidence of any relevant work, paid or unpaid
- Testimonials from colleagues particularly those from a healthcare setting.

Submissions on interim order

Mr Smart submitted that an interim order is necessary to protect the public for the reasons identified by the panel earlier in their determination until the substantive suspension order comes into effect. He therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28-day appeal period and any period of appeal.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary 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 in line with the legal advice received.

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

This will be confirmed to Ms Kasmai in writing.

That concludes this determination.