# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Tuesday, 2 May 2023 – Friday, 5 May 2023, Tuesday, 9 May 2023 – Friday, 12 May 2023, Monday, 15 May 2023 - Thursday, 18 May 2023**

Virtual Hearing

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|---|---|
| **Name of Registrant:** | **Deborah Wright** |
| **NMC PIN** | 93J0147O |
| **Part(s) of the register:** | Adult Nursing (Level 1) – 27 October 1993 |
| **Relevant Location:** | North Yorkshire |
| **Type of case:** | Misconduct/Lack of knowledge of English |
| **Panel members:** | Philip Sayce (Chair, Registrant member)<br>Linda Tapson (Registrant member)<br>Paul Leighton (Lay member) |
| **Legal Assessor:** | John Donnelly |
| **Hearings Coordinator:** | Max Buadi |
| **Nursing and Midwifery Council:** | Represented by Shekyena Marcelle-Brown, Case Presenter |
| **Ms Wright:** | Present and not represented |
| **Facts admitted:** | Charge 4 |
| **Facts proved:** | Charges 2a, 2b, 3b, 3c, 3e and 5 |
| **Facts not proved:** | Charges 1a, 1b, 3a, 3d and 3f |
| **Fitness to practise:** | Impaired |
| **Sanction:** | Striking off order |
| **Interim order:** | Interim suspension order (18 months) |

**Details of charge**

That you, a registered nurse:

1. On or around 16 and 17 January 2019 failed to provide safe and effective care to Patient A in that:

    a) Failed to recognise or ignored the fact that Patient A was in pain;

    b) Failed to administer or refused to administer appropriate pain relief to Patient A.

2. On or around 4 March 2021 failed to provide safe care to Patient B in that:

    a) You left him unattended in the bathroom;

    b) You disobeyed a clear instruction to provide 1:1 care to Patient B.

3. Poor medication management and administration in that:

    a) Frequently omitted to administer prescribed nutritional supplements;

    b) Recurrent failures to sign MAR charts;

    c) Frequent omission of medications and specifically to Patient C, Patient D and Patient E;

    d) Unable to administer insulin via insulin pen;

    e) Administered a double dose of lansoprazole to Patient F;

f) Failing to appropriately store medication.

4. Worked as a registered nurse at a time when you knew your registration had lapsed.

5. Inability to practise safely arising from an insufficient knowledge of the English Language.

And in the light of 1, 2, 3 and 4 above your fitness to practise is impaired by reason of your misconduct.

And in the light of 5 above your fitness to practise is impaired by reason of your not having the necessary knowledge of English Language.

After the charges were read, the panel heard you make full admissions to charges 1b and 4.

The panel therefore finds charge 4 proved in its entirety, by way of your admission. The panel having heard all the evidence determined that charge 1b was not proved, despite your admission.

**Background**

You joined the NMC Register in October 1993. You were referred to the NMC on 15 August 2019 by Scarborough and Rydell Clinical Commissioning Group in relation to a number of concerns that arose when you were working at Tankered Hall Nursing Home (the Home) (which is now known as Peacock Manor). At the relevant time, you were employed at the Home as a nurse and began working there in May 2018.

The concerns in this case relate to failing to provide safe patient care to Patient A and failing to treat them with dignity in relation to end of life care. Further alleged concerns relate to unsafe medication management, poor record keeping and a lack of knowledge of the English language.

Another alleged concern pertains to unsafe patient care in relation to Patient B and leaving them unattended when it is alleged that you disobeyed a clear instruction to provide one to one care.

In January 2019, a Care Quality Commission (CQC) audit took place which revealed that you had not administered end of life medication, which was PRN (as required), to Patient A. This is allegedly despite the medication being requested by Patient A's son and your Line Manager at the time, Ms 1, and also being brought to your attention by Ms 4, the healthcare assistant (HCA), who was on duty with you. You stated that Patient A was not showing any signs of pain when you assessed him. However, Ms 1, Ms 2 and Ms 4 stated that Patient A was thrashing about, was agitated and verbally communicated that he was in pain.

Ms 2 gave Patient A the medication and allegedly discussed it with you. It is alleged that you explained that you did not want to provide Patient A with the medication because you felt that it could accelerate his death. However, it is alleged that the decision to not administer the medication was not documented.

It is alleged that you made a number of medication management and record keeping errors with regards to Patient C, D, E and F between December 2018 and January 2019. A medication audit was undertaken which allegedly revealed numerous errors across three days.

It is alleged that you did not administer paracetamol to Patient C on 1 December 2018 nor to Patient D on 1 January 2019. Additionally, it is also alleged that you failed to administer

nutritional supplements that were prescribed for patients who were losing weight, and that you repeatedly failed to sign MAR charts.

It is also alleged that you failed to book in a delivery of nutritional supplements that had been delivered. This was after you had been requested to do so by Ms 1 which meant that the nutritional supplements were not stored properly and resulted in those patients not receiving their supplements. It is also alleged that you did not have sufficient knowledge on how to use an insulin pen.

You accept that you practiced as a nurse, despite having a lapsed NMC pin. You started your readmission application on 8 January 2019, three months after it had lapsed. Your re-registration was granted on 25 April 2019. You are currently working as a HCA at the Home.

Patient B was on close one to one monitoring due to being high risk of falls. It is alleged that on 4 March 2021, you left Patient B unattended, and he had a fall. It is the NMC's case that you should have called for assistance and ensured that another member of staff was present with Patient B. As a result of the fall, Patient B was admitted to hospital and had to have a CT scan which showed that he had sustained a complex fracture to his pelvis and had to undergo reconstructive surgery.

Ms 2 and Mr 3, a Registered Manager of the Home, allege that you did not have the necessary knowledge and understanding of the English language to practise safely and effectively. Additionally, they also allege that there was a lack of comprehension by you, that you never really listened and had difficulty understanding what was said. They say staff struggled to relay information.

Following your referral, the NMC directed you to undertake an ILETS assessment which you did on 11 December 2021. However, you failed to achieve the overall score of seven or more, which is the minimum level required by the NMC. You scored a 5.

**Decision and reasons on application to admit documents provided by Mr 3**

During the examination of Mr 3, he made reference to the Investigatory Meeting Notes, which took place on 9 March 2021, regarding the incident on 4 March 2021 in relation to Patient B. Neither you nor the NMC were privy to this document.

The panel heard an application made by Ms Marcelle-Brown under Rule 31 to allow the documentation provided by Mr 3 into evidence. She submitted that it would be fair to admit this document and it is relevant because it goes directly to charge 2.

Ms Marcelle-Brown submitted that she appreciates that you have not been provided with the document but in the same light, neither had the NMC. As a result, she submitted that there would not be any unfairness in introducing the documents at this stage subject to it being seen by you.

After the document was sent to you, you told the panel that while there were parts of the Investigatory Meeting Notes that you disagreed with, you would raise them with Mr 3 when you cross examine him. You accepted that it was relevant to charge 2 and had no objection to the panel seeing it.

You also made reference to a second interview which occurred on 18 March 2021. Mr 3 provided Disciplinary Hearing Minutes in relation to this. You wanted the panel to see this document.

The panel heard an application made by Ms Marcelle-Brown in relation to the Disciplinary Hearing Minutes for the same reasons as the same grounds as the Investigatory Meeting Notes.

The panel took as its starting point Rule 31. This explains that evidence is only admissible in NMC proceedings if it is both (a) relevant and (b) fair. The panel also reminded itself of the advice of the legal assessor.

The panel determined to admit both the Investigatory Meeting Notes and the Disciplinary Hearing Minutes. It bore in mind that you did not object to either document being admitted. It was of the view that both were fair and relevant.

**Decision and reasons on application to amend the charge**

The panel heard an application made by Ms Marcelle-Brown, on behalf of the NMC, to amend the wording of the stem of charge 3 and charge 3f.

Ms Marcelle-Brown reminded the panel that charge 3a makes reference to nutritional supplements which are not medications. She submitted that this proposed change does not affect the merits of the case and all the NMC's evidence has been heard. She submitted that it has always been the NMC's case that the box left on the floor contained nutritional supplements. She submitted that this has been properly explored with all the NMC witnesses. She submitted that the proposed amendments would provide clarity to the charge and more accurately reflect the evidence and what the allegation is.

Ms Marcelle-Brown submitted that there would be no injustice caused to you because you have been well aware of the NMC's case from the outset.

**Proposed Amendment**

3. Poor medication **and/or nutritional supplement** management and administration in that:

    f) Failing to appropriately store medication **and/or nutritional supplements**.

You opposed the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel noted that you had consistently said that medications and supplements were viewed differently at the Home. As a result, it was the panel's view that to amend the charge, just before the panel considered the facts of the case, to include nutritional supplements acknowledges the fact that medications and supplements were viewed differently but also denies you the opportunity to question the NMC witnesses further.

The panel also noted that it had no policy documentation from the Home that addresses the management and administration of medication and nutritional medication.

Additionally, the panel took into account your opposition to the application, where you stated that your approach to the charge would have been different had it been amended as proposed.

In light of the above, the panel was of the view that such an amendment, as applied for, could not be made without prejudice to you. The panel therefore rejected the application.

**Decision and reasons on facts**

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Marcelle-Brown on behalf of the NMC and by you.

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:

- Ms 1: At the relevant time, Registered Manager at the Home;

- Ms 2: At the relevant time, a Registered Nurse, Deputy Manager of the Home;

- Mr 3: Current Registered Manager at the Home.

- Ms 4: At the relevant time, a Healthcare Assistant;

The panel also heard evidence from you under affirmation.

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

**Charge 1a**

1. On or around 16 and 17 January 2019 failed to provide safe and effective care to Patient A in that:

    a) Failed to recognise or ignored the fact that Patient A was in pain;

**This charge is found not proved.**

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 2, Ms 4 and your evidence.

In its consideration of the evidence of the NMC witnesses in relation to this charge, the panel accepted the position as set out in *R (Dutta) v GMC [2020] EHWC 1974 (Admin)* that there is no reliable connection between a witness's confidence and the likelihood that

the account is accurate. The panel further accepted that an individual's memories are fluid and malleable, 'being constantly rewritten whenever they are retrieved.

The panel bore in mind that the incident took place in 2019, the witness statements were signed 2021 and these witnesses are providing oral evidence in 2023 – four years after the incident.

The panel also bore in mind that this charge describes two separate incidents, one occurring on the night of 16 January 2019 and the other happening in the early hours of the morning of 17 January 2019.

With regards to the 16 January 2019, Ms 4 in her witness statement stated:

> *"I was on duty with Deborah on the night of the 16th January 2019. Patient A was on end of life, palliative care. So therefore we used to pop in his room every 15 minutes. His son was there this particular night.*
>
> *A couple of times I'd gone in and he was fine and settled, and then one time he wasn't settled. His son said why is he fighting? I said they sometimes do this and the son was quite upset. So I said I'll go get the nurse as she can give him medication to stop this and calm him down…. So she did so, and she looked at him, she went in the room had a look at him, come out of the room and said to me, do you really think he needs something? I said yeah I do, it's not fair that he should be fighting like this, he must be in pain."*

Ms 4 in her oral evidence described Patient A as restless. When she was asked why, she stated that she did not know and presumed he was in pain as he was groaning. Ms 2 was asked if she spoke to Patient A to ascertain if he was pain. She stated that Patient A was not really conscious and not responding to staff. At this point, she stated that she went to get you.

Ms 4 stated that you went to get, what she assumed to be, some sort of pain relief medication. She stated that you had told her you had given Patient A something. Ms 4 stated that Patient A was settled after.

You stated that Patient A was not in pain. You said that after being told that he was by Ms 2, you went to Patient A, whispered in his ear to ask if he was in pain and he told you he was not. Ms 4 in her oral evidence stated that this was not the case, and that you were by the door of Patient A's room.

In your oral evidence, you stated that Patient A was not in pain. You also stated several times that you would have administered paracetamol first as opposed to a stronger pain relief medication.

However, the panel noted that it had no direct contemporaneous evidence to demonstrate the care provided by you or any other clinician on 16 January 2019.

With regards to the 17 January 2019, Ms 1 in her witness statement stated:

> *"I remember going to check on [Patient A] after I was alerted that he had been left in pain on the 17th of January 2019. I can't remember if he said something to me about being in pain but he looked in pain. I remember walking to the nurses station downstairs in the main hall and saying [Ms 2] I'm concerned about Patient A he seems to be in pain. [Ms 2] said I'll go and check on him again.*
>
> *[Patient A's son] I think on the night of the 16th had reported his father was in pain, and [Ms 4] had reported to [Ms 1] that Deborah had not given his medication. When I heard about this on the morning of the 17th I said I would speak with her. When she came in we discussed end of life medication being necessary and she again raised the issue of it being an accelerant. After this I checked on Patient A who showed signs of pain…*

*Later that day there was a care assistant who came to me very concerned that Patient A's son had asked to see the nurse regarding pain relief, and the nurse had not given it because he was thrashing around because he was 'half asleep half awake.' I checked on Patient A whose son said that he reported his father's thrashing to Deborah who said this was because he was half awake and half asleep…. [Mrs Wright] went to check and said that he wasn't showing pain, said it was because he was half asleep and half awake. [Ms 1] was on her way up and went to check, and even though she was not qualified as a nurse she could recognise that he was in pain, thrashing and verbally told her he was in pain…."*

Ms 2 in her witness statement stated:

*"When I first spoke to her about it on 16 January, I can't remember if she said she would give the medication, but I do know she didn't give it and I had to give it again. I had to give it to him as she said he was comfortable and he clearly wasn't comfortable. There wasn't room for doubt at all, it was clearly obvious he was in pain, thrashing around and agitated, telling us he was in pain, and his son said he was in pain."*

Ms 2 in her oral evidence stated that you would not administer anticipatory medication on 16 January 2019 and that Ms 4 had told the manger and Ms 2. She also stated that she accepted that it was your clinical judgement to not administer pain relief medication.

Ms 2 was asked if Patient A's state could have changed from being in pain to being settled. She said she would not have thought so in that short space of time but accepted that she was not in Patient A's room when you were.

The panel noted that Ms 2, on 17 January 2019, went to see Patient A minutes after you had seen him, assessed him and provided him with anticipatory medication. This has not been contested and in fact was corroborated by you.

The panel took account of an email sent to the NMC, dated 23 June 2020, which stated that there had been a lapse in your registration between 01 November 2018 and 25 April 2019. Further, you had started the readmission application on 8 January 2019. As a result, on 16 and 17 January 2019, you were not on the NMC register as a nurse.

The panel noted that the concerns raised by management at the Home, pertaining to this charge, does not include the fact that your registration has lapsed, yet you are the Nurse in Charge of this shift. It was of the view that the Home was aware of the lapse in your registration and continued to let you work as a nurse.

Despite this, the panel noted that you yourself did not deny working as a nurse on the shift in question. Therefore, you bear the responsibility of a registered nurse and are bound by the NMC Code of Conduct.

The panel also reminded itself that it is for the NMC to prove the charge. It bore in mind Mr Justice Warby in the case of *Dutta* when he stated:

> *"The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. "This does not mean that oral testimony serves no useful purpose… .But its value lies largely….in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth."*

The panel heard evidence that Patient A went from being in pain to being settled within a 15-minute timeframe. It had no evidence before it to suggest that medication had been administered.

The panel also noted that it had no direct contemporaneous evidence of the care provided to Patient A from the Home in the form of MAR charts or patient records. Additionally it had no direct contemporaneous evidence or the actions you took on either 16 or 17 January 2019.

The panel noted that it had no evidence from other clinicians involved in the care of Patient A. It bore in mind that Ms 2 stated that she assessed Patient A, after being told he was in pain, and administered medication to him on 17 January 2019. It noted that it had no direct contemporaneous evidence to demonstrate that this had occurred which may have indicated that Patient A was in pain.

The panel took account of the Clinical Concerns record of Ms 2 pertaining to the 17 January 2019. It stated that Ms 1 called her to say that she had:

> *"…received a call from a care assistant who was working with Deborah Wright nurse on the 16/01/19. It was to say that Deborah would not administer end of life drugs to Patient A when she told her that Patient A was agitated and in pain. [Ms 4] the care assistant also said that Patient A son…pointed out to Deborah that his Dad was agitated and in pain…"*

The panel did not give this much weight. It noted that they are not complete, and they do not reference records for Patient A. It also noted that this was signed by Ms 1 on 19 January 2019. Additionally, in oral evidence Ms 2 stated that she did not check Patient A's notes regarding the care he had received.

The panel concluded, on the balance of probabilities, that the evidence adduced by the NMC was insufficient to establish that you failed to recognise or ignored the fact that Patient A was in pain.

The panel therefore finds this charge not proved.

**Charge 1b**

1. On or around 16 and 17 January 2019 failed to provide safe and effective care to Patient A in that:

    b) Failed to administer or refused to administer appropriate pain relief to Patient A.

**This charge is found not proved.**

The panel bore in mind that you had admitted this charge at the outset of this hearing. It noted that prior to this hearing commencing, you did have legal representation who provided a response to an allegation that was worded differently to this charge. However, it bore in mind that you are not currently represented.

In light of the above and taking into account its findings in relation to charge 1a, the panel determined that it would be appropriate to consider this charge.

The panel reminded itself that the NMC had not provided it with enough evidence to establish that you had failed to recognise that Patient A was in pain. In the absence of a failure to recognise pain (Charge 1a), there could be no subsequent failure to administer pain relief (Charge 1b).

The panel therefore finds this charge not proved.

**Charge 2a**

2. On or around 4 March 2021 failed to provide safe care to Patient B in that:

    a) You left him unattended in the bathroom;
    b) You disobeyed a clear instruction to provide 1:1 care to Patient B.

**These sub-charges are found proved.**

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Mr 3 and your evidence.

The panel bore in mind that on 4 March 2021, you were employed as an HCA because your registration had lapsed. However, the panel took account of that fact that at the time you were still on the NMC register as a nurse. Therefore, you were still subject to the NMC Code of Conduct.

Mr 3 in his witness statement confirms that you were working as a HCA during this period when he stated:

> *"[Mrs Wright] is still actively working as a Care Assistant."*

Mr 3 continues:

> *"She was recently suspended on the day of an incident because she failed to ensure the safety of the resident and we suspended her pending investigation. During the investigation she admitted the mistake, the resident was on 1:1 care and she was not to leave the patient without another staff member. She did so and the patient fell. She also admitted that she should have rung the call bell, and made sure the patient was attended to, which she did not. We consulted the employment policy and she was given a final written warning. She was reinstated as Care Assistant from last week."*

Mr 3 reiterated this in his oral evidence.

In your oral evidence, you accepted that you had left Patient B in the bathroom unattended when you went to get him a change of clothes because he was wet.

The panel noted that in the written representations from your former legal representatives, you stated that do not believe you provided unsafe patient care to Patient B by leaving him unattended. However, it was of the view that you knew that he was at risk of falls and suffered from dementia, but still chose to leave him unattended.

Under cross examination, you accepted both at the time and during this hearing that you were given clear instructions to provide one to one care to Patient B from the moment you took over his care. You also explained to the panel what you understood one to one care namely, always staying with the patient. You accepted that you disobeyed the instruction to provide Patient B with one-to-one care.

The panel turned to the stem of the charge. It bore in mind that while you were a HCA at the time, you were still registered as a nurse. As a result, it was of the view that you had a duty to provide safe care to Patient B which you did not do when you left him unattended in the bathroom and disobeyed a clear instruction to provide one to one care to him.

The panel therefore finds these sub-charges proved.

**Charge 3a**

3. Poor medication management and administration in that:
    a) Frequently omitted to administer prescribed nutritional supplements;

**This charge is found not proved.**

In the panel's judgement, nutritional supplements are not medicines. Additionally, it was of the view that they do not become medicines if they are prescribed.

Therefore, the panel find this charge not proved.

**Charge 3b,3c and 3e**

3. Poor medication management and administration in that:

   b) Recurrent failures to sign MAR charts;

   c) Frequent omission of medications and specifically to Patient C, Patient D and Patient E;

   e) Administered a double dose of lansoprazole to Patient F;

**These sub-charges are found proved.**

The panel considered each of these sub-charges separately but as the evidence in relation to each is similar it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Ms 1, Ms 2 and your evidence.

With regards to charge 3b and 3c, Ms 1 in her witness statement stated:

> *What I can recall is every month when [Ms 2] did a medication audit, every month it was Deborah's errors. There were errors in there like the blister pack, the wrong tablet being popped out or she'd missed a signature on a mar sheet, that was common.*

With regards to charge 3b, Ms 2 in her witness statement stated:

> *"I have been asked to comment clinically on some of the issues raised by CQC. I saw the report and there were pictures of various of the errors. It was given to me. Regarding points raised about Deborah's medications, my comments are as follows:-*
>
> *- Medications must be signed for after they are given. This prevents errors if*

*medications have been refused, as there is a risk that otherwise medication is signed out and not taken by the patient."*

With regards to charge 3c, Ms 2 in her witness statement stated:

> *"Nutritional supplements had been delivered from the pharmacy for four residents and they weren't unpackaged when she came in, and the medications hadn't been unpackaged either. The supplements were still not given the following day, so supplements which were vitally important to the people who needed them still weren't given. Deborah had said she did not give the supplements out because 'we have plenty'. This means that she had not checked signed medication in and had not administered medication s prescribed."*

With regards to charge 3e, Ms 2 in her witness statement stated:

> *"One of our ladies Patient F was taking lansoprazole twice a day and they didn't have room in the blister pack so they were sending a box, but in the evening it was blistered. On 2 January 2019, Deborah gave it both from the box and from the blister. She obviously hadn't recognised the medication. I think she hadn't checked what was in the blister and ended up giving two lots of the same medication at one time."*

The panel bore in mind that the NMC had not provided the panel with any MAR charts to support the charge. It also noted that in your oral evidence, you stated you were never shown any MAR charts in relation to the charge by the Home.

The panel took account of the notes of a meeting was between yourself and Ms 1 held on 28 January 2019 which stated:

*"Deborah apologised for missing medication and [Ms 2] feels that medication is unsafe, currently being prescribed. Evidence is clear that medication is present I gone and totals don't tally as medication is still present.*

*Discussed at length apparent mistakes and Deborah apologised if she had missed or administered in error." [sic]*

The panel noted that you had signed your name at the bottom of these notes and dated it 28 January 2019.

The panel therefore finds these sub-charges proved.

**Charge 3d**

3. Poor medication management and administration in that:

    d) Unable to administer insulin via insulin pen;

**This charge is found not proved.**

In reaching this decision, the panel took account of Ms 1, Ms 2 and your evidence.

Ms 1 in her witness statement stated:

*"I remember an incident with the insulin pen. She didn't know how to use it and said she wanted additional training. I remember saying to [Ms 2] what do you mean she can't use a pen, she doesn't feel she has the knowledge, what's that about."*

Ms 2 in her witness statement stated:

> *"Deborah in January 2019 had been unsure how to administer insulin and had called in district nurses to assist. She seemed very unsure about how to deliver medication to the gentleman we were caring for at the time. It was the actual device she didn't understand. Following on from this, I'd asked her to do some self-directed learning regarding diabetes. No harm was caused and she did learn how to use the device."*

The panel noted that the charge refers to an insulin pen. This is reflected in the examination of the NMC witnesses, the witness statements and the documentary evidence that supports this charge.

In your oral evidence you stated that you know how to administer insulin using the "traditional method", namely via a syringe and needle. However, you had also stated that you had previously administered insulin using the particular insulin pen referred to by the NMC witnesses before. You stated that as it had been so long since you had used it, you had become unfamiliar with it. You also stated that the pen came without a needle and without instructions. As a result, you requested additional equipment and information on how to use it. In the panel's view you took the correct course of action in light of this.

The panel bore in mind that the charge does not particularise with any detail the type of insulin pen that you allegedly cannot use.

The panel concluded, on the balance of probabilities, that the evidence adduced by the NMC was insufficient to establish that you were unable to administer insulin via insulin pen.

The panel therefore finds this charge not proved.

**Charge 3f**

3. Poor medication management and administration in that:

f) Failing to appropriately store medication.

**This charge is found not proved.**

In reaching this decision, the panel took account of the evidence of Ms 2 and your evidence.

Ms 2 in her witness statement stated:

> *"Nutritional supplements had been delivered from the pharmacy for four residents and they weren't unpackaged when she came in, and the medications hadn't been unpackaged either. The supplements were still not given the following day, so supplements which were vitally important to the people who needed them still weren't given. Deborah had said she did not give the supplements out because 'we have plenty'. This means that she had not checked signed medication in and had not administered medication s prescribed." [sic]*

Although Ms 2 made the distinction, in her witness statement, between nutritional supplements and medication, the panel determined that in her oral evidence concerning "medications" Ms 2 was so generalised to include nutritional supplements within it. The panel accepted your evidence that nutritional supplements and medication are classified and stored differently. The panel noted that it did not have the benefit of the policies and procedures active at the time and therefore could not confirm that the task had been delegated to you.

Whilst accepting there were concerns around the storage of medication more generally at the Home, these were not directly attributed to you. The panel accepted your evidence that you were the only nurse on shift and as such if your caring duties elsewhere in the Home meant you did not have time book in the medication, the medications remained in the delivery box which was kept in the medicines room.

The panel reminded itself that it is for the NMC to prove the charge. It noted that the panel had no evidence before it to show that you were on shift at the time referred to by Ms 2.

In any event, the panel was of the view that the NMC have not provided the panel with sufficient evidence to demonstrate that you were responsible for failings relating to the storage of medication.

The panel therefore finds this charge not proved.

**Charge 5**

5. Inability to practise safely arising from an insufficient knowledge of the English Language.

**This charge is found proved.**

In reaching this decision, the panel took account of the NMC Guidance titled “Not having the necessary knowledge of English” (reference: FTP-2e) dated 6 November 2017 and “Guidance on registration language requirements” dated February 2023, the IELTS Test Report dated 11 December 2021, the evidence of Mr 3 and your evidence.

The panel took account of the NMC “Guidance on registration language requirements” dated February 2023. It bore in mind that you were readmitted to the NMC register in April 2019 and particularly noted the section titled “Readmission” which stated:

> *25. If you are seeking to return to the register through our readmission process we need to be satisfied that you have maintained the necessary knowledge of English since you were last on our register. We will accept one of the following types of evidence:*
>
> ***Evidence type 1: English language test***

*26. You must have recently achieved the required score in the academic IELTS or OET. You must achieve the required scores in reading, writing, listening and speaking, and you must have achieved the required score within the last two years at the point we are considering your complete application (see evidence type 1 for further details).*

The panel took account of the IELTS test you had undertaken 11 December 2021. It bore in mind that the minimum level required by the NMC is an overall score of seven or more. You achieved a score of 5.

The panel bore in mind that in your oral evidence, you stated that you "had missed a page" in the assessment. However, it accepted that a score of 5 is below the level required by the NMC to demonstrate sufficient proficiency of the English language.

Within the aforementioned NMC guidance the panel also noted it stated:

***Evidence type 3: Recent practice in a majority English-speaking country***
*28. You must have: 28.1. been registered with us within the last two years, or*

*28.2. practised for either 450 hours in the previous three years, or 750 hours in the previous five years, in a majority English-speaking country.*

The panel bore in mind that the evidence had to be recent, objective and independent. The panel took account of the evidence provided by your colleagues. Ms 2 in her witness statement stated:

*"I don't feel that Deborah's comprehension of the English language is very good."*

Ms 4 in her witness statement stated:

*"Deborah's communication was quite bad. You can ask any one of the carers, we used to dread our shifts with Deborah. She won't listen to you. She wouldn't listen*

*to carers, and carers are front line. They're with the patients more than any nurses, we'd say so-and-so isn't looking good and she wouldn't believe us. We would have to sort of like make her do it. She was reported to safeguarding by paramedics. She was a nightmare."*

Mr 3 in his witness statement stated:

*"She speaks English well. Sometimes of the day she's brilliant, and we would see her as part of the care team, but other times of the day staff have reported they struggle to relay information. It's not a spoken language issue, it's about waiting for a response from her."*

Mr 3 in his oral evidence stated that it was not so much your grasp of English, it was waiting for a response time. He also stated that he had to rephrase and speak slowly for you to understand.

The panel bore in mind that you were present at this hearing and you have represented yourself. It took account of the fact that these NMC proceedings are technical and can be stressful. However, in the panel's judgment, Mr 3's assessment has been corroborated in this hearing. It noted that at times, the panel found it difficult to communicate some of its questions to you. While you are able to understand basic communication, when it is complicated or nuanced, you appear to be unable to understand or comprehend what is being communicated.

The panel bore in mind that you have had a long career in nursing with apparently no issues raised pertaining to your competence with the English language. However, in light of the contemporaneous IELTS assessment, the assessment of your colleagues and the panel's assessment within this hearing, it was of the view that there was sufficient evidence to suggest there is an inability to practise safely arising from an insufficient knowledge of the English Language.

The panel therefore finds this charge proved.

**Fitness to practise**

Having reached its determination on the facts of this case, the panel then moved on to consider, whether charges 2a, 2b, 3b, 3c, 3e and 4 amount to misconduct, whether charge 5 amount to a lack of knowledge of English and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

**Ms Marcelle-Brown's submissions on misconduct, lack of knowledge of English and impairment**

Ms Marcelle-Brown invited the panel to take the view that the facts found proved amount to misconduct. She referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Marcelle-Brown directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and identified where, in the NMC's view, your actions amounted to misconduct.

Ms Marcelle-Brown submitted that you have not adhered to the Code. She submitted that by leaving Patient B, who was at risk of falls, unattended amounted to misconduct. She

further submitted that practicing without an NMC PIN is clearly a risk to the public and amounted to misconduct.

Ms Marcelle-Brown submitted that your actions reflect a pattern of behaviour as you had been subject to a caution order for similar concerns. She informed the panel that this was related to a referral in 2015 and the Conduct and Competence Committee imposed a two year caution order in February 2017. Ms Marcelle-Brown submitted that there is a risk of repetition and there is clear misconduct in your case.

Ms Marcelle-Brown referred the panel to the NMC Guidance on determining seriousness of concerns.

Ms Marcelle-Brown also referred the panel to the NMC Guidance titled “Not having the necessary knowledge of English” (reference: FTP-2e). She reminded the panel that this is a two-stage test where it will first have to consider whether patients are placed at potential or actual risk of harm. She submitted, secondly, the panel must consider the IELTS result as the primary measure to determine if you have necessary knowledge of English to practice safely.

Ms Marcelle-Brown reminded the panel that it heard evidence that your command of the English language was such that it was difficult for you to understand what was being asked of you and for others to understand what you were saying. She submitted that this was aggravated by the fact that you were the nurse in charge of the shift which would put patients at risk of harm.

Ms Marcelle-Brown submitted that your IELTS test result of 5 is evidence that you lack the required knowledge of English. She submitted that there is no other evidence to suggest that your English has improved since you have taken the test.

Ms Marcelle-Brown moved on to the issue of impairment and invited the panel to consider the NMC Guidance on Insight and strengthened practice (reference: FTP-13).

With regards to insight, Ms Marcelle-Brown submitted that the panel can consider your level of engagement at this NMC hearing and the local investigation. She also submitted that you have demonstrated remorse in relation to Patient C, E, D, and F and submitted reflective statements done at the time of the incident and recently.

Ms Marcelle-Brown reminded the panel that you have continued to work in a healthcare setting as a HCA and an activities coordinator. She submitted that some of the concerns found proved occurred while you were working as a HCA and not working as a nurse.

Ms Marcelle-Brown submitted that although you have engaged with these proceedings and provided reflective statements as evidence of insight, she invited the panel to consider whether this is sufficient insight.

Ms Marcelle-Brown submitted that the insight you have provided is insufficient. She submitted that you have not taken a step back to look at the situation objectively, reflected on what went wrong and what could have been done differently in the future. She submitted that your reflective statements are incomplete. She submitted that there is no evidence that you truly understand what went wrong or why your actions were an issue.

With regards to remediation, Ms Marcelle-Brown submitted that you have not demonstrated strengthened practice. She submitted that you have provided training certificates which touch on the areas of concern, the most recent certificate dated 2022.

Ms Marcelle-Brown submitted that the testimonials provided are old and the authors do not state that they were aware of the allegations you face or the issues the panel have to consider. In the absence of any evidence that you have strengthened your practice, Ms Marcelle-Brown submitted that there remains a risk of you repeating this behaviour.

Ms Marcelle-Brown submitted that you have not worked as a nurse since these incidents and informed the panel that you were previously subject to a two year caution order for

similar concerns. She submitted that this clearly shows a risk of repetition and a pattern of behaviour. She submitted that there is little to no evidence that you would be safe to return to practice as a nurse without some sort of restriction and a finding of impairment.

**Your submissions on misconduct, lack of knowledge of English and impairment**

With regards to charge 2a and 2b, you said that there were mistakes in the circumstances of this charge. You said that this was not so serious. You told the panel that you accompanied Patient B to casualty and waited for the results of his fall. You said that the results showed that there was no fracture.

You said that you are not impaired as you communicated with Patient B and reassured him and made him comfortable. You said that you also communicated with the junior doctor and adhered to your duty of candour by contacting the NMC.

You said that you are very sorry for this and if you had known Patient B had Parkinson's Disease, you would not have left him on his own. You said that you would have waited for someone to come into the bathroom to assist you. You further said that had you known of the Parkinson's diagnosis and needed help, you would have pressed the emergency button. You also said that you could have delegated.

With regards to charges 3a, 3b and 3e, you told the panel that the Home is a psychiatric Home. You said that the mental state of the residents differs from unit to unit. You said you were the only nurse on duty and that it is not easy to travel to different units. Therefore, your priority is to focus on the floor you are on.

You said that if you could, you would have communicated to the management that the Home needed more nurses as this shortage was not addressed.

You said that you are very sorry for not signing MAR charts. You said that you cannot do everything at once and you cannot cope with all your responsibilities. You said that you are truly sorry for not following what was asked of you.

You said that it was not serious as three missing signatures would not adversely affect the residents. You said that this is also not an issue especially if you are very busy. However, you said that next time you would apologise to management and explain.

You said that you are not impaired because when there is an issue, you would inform management.

With regards to charge 5, you said that you are very sorry for this. You told the panel that you have been a registered nurse since 1993. You said that up until 2020 you have never had complaints about your English from previous employers or carers.

You said that you have always been able to demonstrate that you have the necessary knowledge of English and can practice safely.

You said that you have attended university in both the Philippines, your country, and the United Kingdom. You said that you can speak and understand the English language. You said that just because someone fails the English exam, does not mean that the person does not fully understand English.

You said that you have undertaken a postgraduate course in Law part time in Leeds and passed two of the three modules. You informed the panel that you had failed an English language assessment, which was part of one of your courses. You said that you would be willing to undertake another English language course if money was made available as you love studying.

You said that this was not serious because you are able to communicate in English – the British and the American way.

With regards to charge 4, you said that you are very sorry for this. You said that you were in a compromising position as you were told that you were the only nurse at the Home and that you were needed.

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

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

**Decision and reasons on misconduct**

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

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

> ***1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> *'**7 Communicate clearly***

*To achieve this, you must:*

*7.5 be able to communicate clearly and effectively in English.'*

***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*

***16 Act without delay if you believe that there is a risk to patient safety or public protection***

*To achieve this, you must:*

*16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can*

***18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations***

*To achieve this, you must:*

***20 Uphold the reputation of your profession at all times***

*To achieve this, you must:*

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

***22 Fulfil all registration requirements***

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

With regards to charges 2a and 2b, the panel noted that that you stated in your oral evidence that you knew Patient B had a history of falls and dementia. You told the panel, that at the onset of caring for Patient B, you knew you had been instructed to provide one to one care. You also confirmed that you knew one to one care to mean that you must not leave him unattended. Despite this, you left Patient B unattended and he fell. In the panel's view you failed to maintain a safe environment for Patient B who was vulnerable. It considered your actions did fall short of the conduct and standards expected of a nurse and were serious departures from the standards, amounting to misconduct.

Charges 3b, 3c and 3e related to poor administration and management of medications. It was of the view that this is a fundamental aspect of nursing and whether you miss medication once or multiple times, there can be substantial risks to patients. Further, administering a double dose of medication amounts to a serious failing.

The panel was also of the view that failure to complete MAR charts is vitally important as any nurse taking over the care of that patient would need to know what medication has been administered and what has not. There is clear risk to patients if that information is not available. It considered your actions did fall short of the conduct and standards expected of a nurse were serious to amounted to misconduct.

With regards to charge 4, the panel was of the view that practising while knowing your registration had lapsed is a serious failing and amounted to misconduct

Having considered the proven charges individually, the panel then stepped back and viewed them collectively. It therefore considered that charges 2a, 2b, 3a, 3b, 3c, 3e and 4 in this case amounted to a sufficiently serious departure from the standards expected of a registered nurse therefore made a finding of misconduct.

**Decision and reasons on lack of knowledge of English**

With regard to its decision on lack of knowledge of English, the panel had regard to Rule 31 (6A) of the Rules. The panel bore in mind that adequate knowledge of the English language is an essential part of safe and effective nursing practice and that the public expect registered nurses to be able to communicate safely and effectively.

The panel determined that you had breached standard 7 of the Code, in particular:

> ***'7 Communicate clearly***
>
> *To achieve this, you must:*
>
> *7.5 be able to communicate clearly and effectively in English.'*

The panel noted that you scored a 5 on the IELTS test. For IELTS you must achieve at least a 7 in reading, listening and speaking, and at least 6.5 in writing. The panel was of the view that communication is central to maintaining patient safety and to effective teamwork, which is critically important in maintaining patient safety. The panel heard evidence from your colleagues that communicating with you was an issue. Accordingly, the panel was satisfied that its findings in relation to charge 5 amounts to a lack of knowledge of English.

**Decision and reasons on impairment**

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

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

In paragraph 76, of the case of *Grant*, 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) ...'*

For reasons already set out above in relation to misconduct, the panel determined that limbs a, b, and c were engaged by your misconduct and lack of knowledge of English.

The panel finds that Patient B was put at risk, and you indirectly caused physical harm as a result of your misconduct. Additionally, your poor medication management and administration in relation to Patient C, D, E and F had the potential to put them at an unwarranted risk of harm. Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel also found that patients were put at risk as a result of your lack of knowledge of English. Your lack of knowledge of English had breached the fundamental tenets of the nursing profession by failing to be able to communicate safely and effectively and therefore brought its reputation into disrepute.

The panel recognised that it must make an assessment of your fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether you would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and considered whether the concerns identified in your nursing practice were capable of remediation, whether they have been remedied and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether you have provided evidence of insight and remorse.

With regards to charge 2a and 2b, while you showed some remorse the panel noted that you said your behaviour was not very serious. It noted that you were still referencing the fact that you did not know Patient B had Parkinson's Disease, although you did know that he suffered from dementia and was at a high risk of falls. It appeared to the panel that you seemed to try and minimise the decisions you made and the actual and potential consequences of your actions. You were told that Patient B needed one to one care which meant that you were not supposed to leave him, and, in the panel's view you did not seem

to understand that leaving Patient B to get new clothes for him meant that you left a vulnerable patient alone.

With regards to charge 3b, 3c and 3e, the panel were concerned about your lack of insight into your failings and the potential impact on patient safety. You also had a lack of insight into the safety and wellbeing of patients as a result of not signing the MAR charts indicating that you had not administered medication.

The panel noted that you showed some remorse, but you were unable to identify the issue arising from your actions in relation to charges 3b, 3c and 3e and the impact it had on patients, colleagues and the reputation of the nursing profession.

The panel also noted that there appeared to be another attempt to shift blame others and minimise the impact of your actions.

With regards to charge 4, the panel reminded itself that your registration lapsed in November 2018. You stated that management told you they needed you to work as a nurse due to the CQC inspection in January 2019. However, you had already been undertaking nursing duties for three months before the CQC inspection, knowingly, without an NMC pin.

The panel also took account of your reflective statements which also appeared to demonstrate a complete lack of understanding and insight into the concerns raised.

The panel was concerned that there appeared to be a theme in your evidence that sought to shift blame to others. It was of the view that you had no insight into your responsibility as a nurse to escalate to management, or beyond, if you do not believe your concerns are not being heard.

Whilst the panel noted your expressions of remorse to all your failings, this does not mitigate against future harm because of your lack of insight.

In light of the above, the panel determined that you had no insight into your misconduct.

With regards to Charge 5, the panel noted you are of the belief that you do not have a lack of knowledge of the English language citing your long nursing career with the issue never being raised against you. However, the panel noted that you achieved an overall score of 5 on your IELTS. You also said the reason for the score was because you "missed a page". However, despite this you have yet to retake the exam, which you could have done at any time since sitting the exam.

In light of the above, the panel determined that you had little to no insight into your lack of knowledge of English.

The panel was satisfied that the misconduct and a lack of knowledge of English in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you had taken steps to strengthen your practice.

The panel took into account the many certificates you have provided of training undertaken from 2019 to 2022, some of which are relevant to the concerns raised. However, the panel bore in mind that a lot of these certificates post-date the incident. It was of the view that none of these appear to have increased your insight into your failings, the effects of your actions or made a significant difference to your appreciation of the seriousness of the charges found proved. Additionally, you have not been able to retrospectively apply what you have learned from the training undertaken subsequent to these concerns.

The panel was of the view that the opportunity remains for you to re-take the IELTS examination and improve the score of 5. However, you have yet to do this and there is no information before the panel to suggest that your knowledge of English has improved.

The panel took account of the NMC's previous findings, in a letter dated 3 February 2017, which shows, similarly to this case, that there was a lack of escalation, a failure to assess a patient properly or recognise the health concerns of a patient. You also did not maintain patient safety when you tried to encourage the patient in that case to eat and drink when there was evidence that he had suffered a stroke.

The panel bore in mind the case of *PSA v NMC and M 2017 CSIH 29*. It took account that you stated that you faced difficulties at the Home. However, this does not explain the extent of the concerns raised nor the fact that there appears to be a pattern as the concerns have been repeated.

The panel noted that in 2017, you brought the nursing profession into disrepute and breached fundamental tenets of the profession and continued to do so with these current concerns. This is despite a previous finding of the NMC which resulted in a caution. It was apparent that there had been a continued and repeated risk to patients.

The panel concluded that that you had no insight and your apparent inability to apply what you had learned in your training means there remains a risk of repetition of the misconduct found proved. The panel is also of the view that there remains an insufficient knowledge of English to demonstrate safe and effective practice The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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.

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.'*

The panel was satisfied that, having regard to the nature of the misconduct in this case, "the need to uphold proper professional standards and public confidence in the profession would be undermined" if a finding of current impairment were not made. It was of the view that a reasonable, informed member of the public would be very concerned if your fitness to practise were not found to be impaired.

For all the above reasons the panel determined that a finding of impairment on public interest grounds is required.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

**Sanction**

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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

**Submissions on sanction**

Ms Marcelle-Brown submitted that a striking off order is the most appropriate sanction. She referred the panel to the NMC guidance titled "Available sanction orders".

Ms Marcelle-Brown submitted that taking no action would not be appropriate following the panel's findings. She submitted that the misconduct in this case is very serious therefore taking no further action would not be in line with the overarching objective of the NMC.

Ms Marcelle-Brown submitted that a caution order would not be appropriate for similar reasons. she also reminded the panel that you were subject to a caution order at the time of the current concerns and continued to put patients at harm which aggravates the matter.

With regards to the imposition of a conditions of practice order, Ms Marcelle-Brown submitted that the panel may consider there to be attitudinal concerns as you repeatedly failed to take accountability for your actions and sought to blame others. She further submitted that although there are identifiable areas of concerns she stated that can be addressed with conditions, she submitted that this would be subject to you passing the English language test. She submitted that while you are eager to study, she reminded the panel that it found that you had undertaken many training courses but failed to implement anything you had learned. She also submitted that conditions would not cover language concerns or the concerns surrounding you working without an NMC Pin.

Ms Marcelle-Brown submitted that there are numerous failings over a number of years. She submitted that as the panel have found that you have no insight, there is nothing to reduce the risk of repetition and the inherent risk to the public. She therefore submitted that conditions of practice order would not be suitable in this case.

With regards to a suspension order, Ms Marcelle-Brown submitted that there is evidence of attitudinal problems. She submitted that there is no evidence of repetition of the behaviour since the incident but reminded the panel that you have been working as a HCA

as opposed to working as a nurse. She submitted that the harm caused to patients, the medication errors, record keeping and working without a valid PIN fell far short of what is expected from a registered nurse. She submitted that a suspension order would not be appropriate in this case.

Ms Marcelle-Brown submitted that a striking off order is the only sanction that would sufficiently protect the public and maintain the professional standards.

You said that you have been practicing as a nurse continuously for 30 years. It was only in recent years that you have had issues.

You said that all the reading, training, and e-learning undertaken while practicing as a nurse would be lost if you could no longer practice as a nurse.

You told the panel that you receive a basic low wage due to working as an activity coordinator. You said that you are willing to study but due being in a financial crisis you currently have no money to undertake the English language exam without funding.

**Decision and reasons on sanction**

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

The panel took into account the following aggravating features:

- Previous regulatory findings for similar concerns;
- No insight into failings;

- A pattern of wide-ranging misconduct over a period of time which caused patients harm;
- Attitudinal concerns with a tendency to blame others and not take personal responsibility.

The panel also took into account the following mitigating features:

- You have undertaken some relevant training;
- You have demonstrated some remorse and apologised;
- Working in a challenging environment with little support and leadership from management.

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 your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel also bore in mind that neither of these sanctions are available to the panel due to its findings regarding your lack of knowledge of English.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. However, it was of the view that due to

your lack of insight, there were no practical or workable conditions that could be formulated, given the wide-ranging nature of the charges in this case.

The panel was mindful that support and training had been undertaken, but you have yet to demonstrate insight into the failings. It has also bore in mind the attitudinal concerns identified where you appear to blame others and not take personal and professional responsibility for your actions.

The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

Your conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that these were not a single failing and there has been repetition of this behaviour over several years.

The panel also noted that the failings relate to fundamental aspects of nursing which fell far below the standards expected. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by your actions are fundamentally incompatible with you remaining on the register.

The panel also bore in mind that the NMC had already imposed a two-year caution order for similar regulatory concerns. It was of the view that you have not learned from this. Additionally, the panel was of the view that due to your lack of insight, a period of suspension would serve no purpose. This is because it had no confidence that your insight would develop once the suspension period had been served.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel took account of the fact you have worked as nurse for 30 years with no complaints raised for the majority of these years. It also considered the challenging context within which you were working at the Home very carefully. It bore in mind the evidence of the NMC witnesses, Ms 1 in particular, who worked at the Home. It noted the toxic environment that existed there, and the fact that practices at the Home caused it to be an inefficient and dangerous place to work, which led to an unsatisfactory CQC inspection.

However, the panel was of the view that the contextual factors at the Home did not absolve you from your personal and professional responsibilities as a nurse. The panel reminded itself that the misconduct identified was wide ranging. You worked as a registered nurse knowing that your registration had lapsed for a significant amount of time. Further, there were medication errors, incomplete MAR charts and you left Patient B unattended despite clear instruction to the contrary. You left him alone and he fell, sustaining an injury as a result. The panel determined a striking off order to be the only order which would protect the public.

Additionally, in the panel’s view, your lack of knowledge of English exacerbated many of the issues you faced at the Home.

In the panel's view, your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct yourself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to you in writing.

**Interim order**

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

**Submissions on interim order**

The panel took account of the submissions made by Ms Marcelle-Brown. She submitted that given the panel's findings in relation to sanction, only an interim suspension order for a period of 18 months will be appropriate. She also submitted that an interim order should be made to allow for the possibility of an appeal to be lodged and determined.

You did not oppose the application.

**Decision and reasons on interim order**

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

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

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

That concludes this determination.