Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 15 May 2023 – Friday 19 May 2023
Monday 22 May 2023 – Wednesday 24 May 2023
Monday 27 November 2023 – Thursday 30 November 2023

Virtual Hearing

Name of Registrant:	**Rajgopal Ramanah**
NMC PIN	75U3012E
Part(s) of the register:	Registered Nurse – Sub Part 1 RN3 Mental Health Nurse L1 – July 1977 RN1 Adult Nurse L1 – April 1980
Relevant Location:	Buckinghamshire
Type of case:	Misconduct
Panel members:	Nicholas Rosenfeld (Chair, lay member) Marian Robertson (Registrant member) Jayanti Durai (Lay member)
Legal Assessor:	Graeme Sampson
Hearings Coordinator:	Shela Begum
Nursing and Midwifery Council:	Represented by Michael Way, Case Presenter
Mr Ramanah:	Not present and unrepresented at the hearing
Facts proved:	Charges 1a(i), 1a(ii), 1a(iii), 1a(iv), 1a(vi), 1a(vii), 1a(viii), 1a(ix), b(i), b(ii), c, d(i), d(iv), d(v), e(i), e(ii), e(iii), e(iv), f(i), f(ii), f(iii), f(v), g(ii), g(iii), i(iv), i(vi), j(i), k(i), k(iii) and k(iv)
Facts not proved:	Charges 1a(v), d(ii), d(iii), d(vi), e(v), f(iv), g(i), h, i(i), i(ii), i(iii), i(v), j(ii), j(iii), j(iv) and k(ii)
Fitness to practise:	Impaired

Sanction:	**Striking off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Ramanah was not in attendance and that the Notice of Hearing letter had been sent to Mr Ramanah's registered email address by secure email on 27 March 2023.

Mr Way, 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, and, amongst other things, information about Mr Ramanah's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Ramanah

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

Mr Way informed the panel that as Mr Ramanah and his representative were expected to attend this hearing, attempts to contact both Mr Ramanah and his representative have been made. Mr Way informed the panel that Mr Ramanah's representative contacted the NMC on the evening of day one of the hearing and stated that he had attended a case management conference in relation to this case on 6 April 2023 and indicated that he might or might not be attending the substantive hearing on Mr Ramanah's behalf. Mr Ramanah was contacted on day one of the hearing by his case officer by telephone and during that conversation, he had informed the case officer that his representative was dealing with his case and suggested he would be absent. Further enquiries had been made to Mr Ramanah to confirm whether he is aware that his representative is not appearing at this hearing in his absence, but the NMC received no communications from Mr Ramanah to confirm this.

Mr Way informed the panel that Mr Ramanah had made an application for voluntary removal (VR) on 13 September 2022 but that this was considered by the Assistant Registrar and refused on 21 October 2022. He informed the panel that the VR applications were discussed at the case management conference and that it was explained to Mr Ramanah's representative that a substantive hearing would likely take place before any application for VR could be considered. Mr Way informed the panel that there have been no subsequent applications for VR made by Mr Ramanah and attempts have been made by the NMC to contact Mr Ramanah to confirm his position on this, but he has not responded.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mr Ramanah;
- Mr Ramanah's representative has informed the NMC that he has been instructed by Mr Ramanah not to contact NMC further;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Three witnesses have been warned to attend to give live evidence,
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred between 2018 – 2020;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Ramanah in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he has made ambiguous responses to the allegations. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel 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 Mr Ramanah's decision to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Way, on behalf of the NMC, to amend the wording of charges d(iv) and k(iv).

The proposed amendment was as follows:

"That you, a registered nurse:

[…]

d) Failed to ensure adequate recording and record storage systems were in place and being followed by staff including:

i) […]
ii) […]
iii) […]
iv) Resident**s**~~'s~~ records;
v) […]

[…]

k) In relation to Resident E:

i) […]
ii) […]
iii) […];
iv) Failed to ensure the ~~patient~~ **resident** was positioned appropriately in order to avoid tissue injury.

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

It was submitted by Mr Way that the proposed amendment would provide clarity and more accurately reflect the evidence.

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 was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Ramanah and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered nurse:

1) Between 2018 and 2 June 2020, whilst working as the Nominated Individual and Registered Manager of a care home:

    a) Failed to ensure safe care was being provided to residents in that you:

        i) Failed to ensure staff were inducted adequately or at all;
        ii) Failed to ensure safe staffing levels at all times;
        iii) Failed to implement systems to ensure staff had adequate rest;
        iv) Failed to ensure staff were appropriately supervised;
        v) Failed to ensure staff were adequately trained;
        vi) Failed to assess staff understanding of training and guidance adequately or at all;
        vii) Failed to ensure a safe and clean living environment for residents;
        viii) Failed to ensure adequate safeguarding measures were in place;
        ix) Failed to ensure adequate care planning

b) Failed to ensure incidents of abuse between residents:

   i) Were reported to safeguarding;
   ii) Were adequately assessed in order to mitigate future risk

c) Failed to ensure accidents were reported to safeguarding

d) Failed to ensure adequate recording and record storage systems were in place and being followed by staff including:

   i) Home maintenance records;
   ii) Fire safety and maintenance records;
   iii) Staff supervision records;
   iv) Residents' records;
   v) Staff rotas;
   vi) Staff signing in/out records.

e) Failed to adequately manage health and safety issues in that you:

   i) Failed to carry out infection control risk assessments;
   ii) Failed to ensure adequate infection control measures were in place;
   iii) Failed to adequately assess and/or mitigate fire risks;
   iv) Failed to maintain sufficient staffing levels to carry out safe fire evacuations;
   v) Failed to ensure fridge and freezer temperatures were monitored regularly.

f) Failed to ensure adequate medication management including:

   i) Failing to provide adequate guidance to staff on medication administration;
   ii) Failing to ensure medication was administered correctly;
   iii) Failing to ensure medication records were completed and signed;
   iv) Failing to ensure there were records for topical medication administration;

v) Failing to provide and/or maintain suitable storage facilities for medication.

g) Failed to ensure adequate resident records were kept including:

i) Health appointments and outcomes;
ii) Care plans;
iii) Deprivation of Liberty Safeguards (DoLS)

h) Failed to ensure staff had adequate understanding of legislation including the Mental Capacity Act 2005

i) Failed to provide a safe and clean environment for residents including:

i) Suitable home layout;
ii) Sufficient corridor lighting;
iii) Hygienic laundry room;
iv) Safe and serviceable fittings, furniture and equipment;
v) Safe pathways;
vi) Clear fire escape routes.

j) Failed to ensure the privacy and dignity of residents including:

i) Resident C's door being left open;
ii) Failing to ensure staff provided adequate reassurance and support to residents;
iii) Failing to ensure the wishes and preferences of residents were sought and acted upon.
iv) Failing to ensure information was provided to residents in formats suitable for their needs.

k) In relation to Resident E:

i) Failed to ensure adequate hydration;

ii) Failed to escalate deterioration of the resident's condition in a timely manner;

iii) Failed to put in place adequate procedures in place to maintain the resident's skin integrity and condition;

iv) Failed to ensure the resident was positioned appropriately in order to avoid tissue injury.

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

Decision and reasons on application to admit written statements as hearsay evidence

The panel heard an application made by Mr Way under Rule 31 to allow the written statements of Paramedic 1, Emergency Care Assistant 1, Safeguarding Practitioner 1, Social Worker 1, Nurse 2, Nurse 1 and Head of Service 1 into evidence. The panel was informed that these witnesses were not present at this hearing and Mr Way made an application to allow the written statement of these witnesses into evidence.

Mr Way informed the panel that Paramedic 1 was the paramedic who attended in relation to Resident E on 15 April 2020 and that the statement of Paramedic 1 comments on observations made on arrival and assessment of the Resident.

Mr Way submitted that the statement of Emergency Care Assistant 1 has been signed on 5 May 2020 and contains a statement of truth. Emergency Care Assistant 1 was working on the ambulance crew who had attended in relation to Resident E.

Mr Way informed the panel that Safeguarding Practitioner 1 signed her statement on 12 May 2020 and that she is an employee of Buckinghamshire Council and speaks to visiting the care home with Witness 2. Mr Way submitted that Witness 2 will be able to provide corroborative evidence to support the hearsay evidence of Safeguarding Practitioner 1.

In relation to the statement of Nurse 1 and Social Worker 1, Mr Way informed the panel that the panel have before them a signed police statements, both dated 11 May 2020, and both accompanied by a statement of truth.

Mr Way informed the panel that Nurse 2's statement has been signed by her on 6 May 2020 and is also accompanied by the statement of truth. She attended the Residential Home in relation to Resident E.

Mr Way submitted that on the basis that there are three witnesses who spoke in some detail to the matters being considered in this case, it would not be proportionate to require these remaining witnesses to attend in circumstances where they have provided a police statement with a statement of truth. He informed the panel that it was decided by the NMC that they were not essential witnesses to prove the case and that the weight applied to their witness statements would be a matter for the panel in due course.

Mr Way submitted that these statements are relevant to provide further observations. He stated that it is not crucial evidence and is not the sole or decisive evidence in relation to any of the charges and this may provide some mitigation in terms of fairness in the statements being admitted into evidence where it is not able to be tested in cross examination.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel had regard to the seven principles set out in the case of Thorneycroft v NMC [2014] EWHC 1565. The panel gave the application in regard to the seven statements serious consideration. It took particular account of the fact that the witnesses were professionals acting in the course of their employment and had no reason to fabricate their evidence. The panel noted that the statements were prepared as police statements and have been signed and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by each of the authors of the statements.

A crucial feature for the panel was the fact that the statements were not the only evidence in relation to the issues to which they related. Further, the panel noted that where they were relied upon, they were corroborated by other evidence, either by the live evidence of witnesses or documentary evidence.

The panel considered whether Mr Ramanah would be disadvantaged by allowing hearsay testimony into evidence. The panel noted that Mr Ramanah made the decision not to attend this hearing and on this basis the panel determined that there was no lack of fairness to Mr Ramanah in allowing the written statements as hearsay evidence as he would not be able to question or probe that evidence in any case given his non-attendance.

The panel considered that as Mr Ramanah has been sent a copy of the statements and, as the panel had already determined that Mr Ramanah had chosen voluntarily to absent himself from these proceedings, he would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. the panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of the authors of the statements and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statements of Paramedic 1, Emergency Care Assistant 1, Safeguarding Practitioner 1, Social Worker 1, Nurse 2, Nurse 1 and Head of Service 1 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

Mr Ramanah was referred to the NMC by the Care Quality Commission (CQC) on 24 April 2020. At the time of the referral Mr Ramanah was a registered nurse but employed as a registered manager at Keep Hill Care Home (the Home).

The Home was subject to CQC inspections on an annual basis, but the reports produced by the CQC in relation to the Home between 2015 – 2019 identified various failings and overall rated the Home in the 'Requires Improvement' category. A CQC inspection in 2020 concluded that the Home was 'Inadequate' and raised concerns about safe care and treatments of residents, governance issues, staffing issues and care planning.

It is alleged that the management and resolution of these issues was the responsibility of the registrant as he was acting as the registered manager of the Home at the time.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mr Ramanah.

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: Inspector, Care Quality Commission
- Witness 2: Head of Service for Integrated Commissioning, Buckinghamshire Council
- Witness 3: Nurse Consultant, Buckinghamshire Healthcare NHS Trust

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 the NMC.

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

Charge 1a(i)

1) Between 2018 and 2 June 2020, whilst working as the Nominated Individual and Registered Manager of a care home:
    a) Failed to ensure safe care was being provided to residents in that you:
    i)Failed to ensure staff were inducted adequately or at all;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, including the Home's Statement of Purpose document, Home's Care Quality Commission (CQC) inspection report dated 2020, and the written statements of Witnesses 1 and 2.

The Home's Statement of Purpose document sets out that:

> *"The Home will ensure that all staff will undergo induction training and on-going training and personal development"*

The panel noted that in the 2019 CQC report it stated that "*staff received appropriate support through inductions, supervisions and appraisal"* and that most staff had been employed for a long period of time and would have been inducted a while ago.

The panel noted the CQC inspection report on the Home dated 2020 which states:

> *"The newest staff members had an induction checklist in place"*

However, the panel had regard to Witness 1's written statement which states:

> *"During the inspection, […] Staff were not suitably inducted, trained and supervised."*

Further, the written statement of Witness 2's states:

> *"We found no evidence of staff inductions. We asked [Person 1] what the staff induction process was but she was not adequately able to articulate this, nor was she able to provide any written induction material. This was a concern because if the Home had brought in agency staff to increase their staff to resident ratio, they were not given an induction so it was not clear how they could ensure quality care was provided to the residents…*

[…]

… I spoke to a member of staff […] This staff member told me it was her first day and she had come from an agency. They were a carer who had been brought in to provide one-to-one care to one of the female residents. This staff member told me it was her first day and she had come from an agency […] This reinforced the importance of an induction and it was clear that she had not had one as I asked her if she had received one and she said she had not."

In a document outlining Witness 1's discussions with staff members in interviews, it sets out that Staff member E states "*Staff gave me training but don't recall what training or induction*".

The panel took into account all of the above was therefore not satisfied, that on the balance of probabilities, that Mr Ramanah ensured staff were inducted adequately or at all. It therefore concluded that, it is more likely than not, that Mr Ramanah did fail to ensure safe care was being provided to residents in that he did not ensure staff were inducted adequately or at all.

Charge 1a(ii)

1) Between 2018 and 2 June 2020, whilst working as the Nominated Individual and Registered Manager of a care home:
   a) Failed to ensure safe care was being provided to residents in that you:
      ii) Failed to ensure safe staffing levels at all times;

This charge is found proved.

In reaching this decision, the panel took into account written statement of Witness 2, the CQC inspection report, and documentation detailing concerns raised following Buckinghamshire County Council's visit to the Home.

Witness 2's written statement states:

> "*There were not sufficient staffing levels on the day of the unannounced visit with the Nurse off site.*
>
> *[…]*
>
> *There seemed to only be two carers working at one time plus the cook, cleaner and activities planner. This would made it difficult to evacuate all the residents in an emergency as there would not be enough carers. […] I would consider that there should have been the minimum of at least one more carer at the Home […] The lack of appropriate staffing would have been the responsibility of the Nurse."*

In a document outlining Witness 1's discussions with staff members in interviews, Staff Member D was asked about staffing levels, and they stated: *"A senior & care staff on each shift. At night one waking & one sleep in staff member – I have mentioned to Roger staffing is not enough but not taken on board"*

The panel had regard to the CQC inspection report on the Home dated 2020 which states:

> *"The staffing levels not sufficient to ensure staff were not working excessive hours and changes in people's need had not resulted in a review of the staffing levels…*
>
> *[…]*
>
> *safe staffing levels were not maintained…*
>
> *[…]*

The service had no system in use to enable them to determine the number of staff required to meet people's needs."

The panel found that there is considerable evidence before it in support of the charge. The panel is therefore satisfied that it is more likely than not that Mr Ramanah failed to ensure safe care was being provided to residents in that he did not ensure safe staffing levels at all times.

Charge 1a (iii)

1) Between 2018 and 2 June 2020, whilst working as the Nominated Individual and Registered Manager of a care home:
   a) Failed to ensure safe care was being provided to residents in that you:
      iii) Failed to implement systems to ensure staff had adequate rest;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 1 which states:

"Safe *staffing was not provided, and staff worked excessive hours."*

During her evidence she informed the panel that there was not a rota which allowed any oversight and that the shifts were all planned in a handwritten diary. She stated that some staff were working excessive hours and that staff were not safe in the roles.

The panel had regard to the CQC inspection report on the Home dated 2020 which states:

"One staff member regularly worked the sleep-in shift but also worked day time shifts. Over a period of three consecutive weeks they worked long days (14 hours) followed by a sleep in and a 12 hour shift the following day, on week one of the rota

viewed they worked 62 hours day shifts and seven sleep in shifts. Week two they worked 70 hours day shifts and seven sleep in shifts and week three they worked 62 hours day shifts and seven sleep in shifts […] On two consecutive dates another staff member worked the late shift from 3pm and then went on to work the waking night shift. This was a total of 17 hours followed by another 17 hours the afternoon and night after…

The registered manager told us staff signed a document to opt out of the 48 hour per week working time directive, but they had not considered the risks to people of staff working excessive hours"

The panel found the evidence before it to be consistent and credible. It found that the evidence before it clearly sets out that some staff were working excessive hours. Based on the evidence before it, it was satisfied that Mr Ramanah did fail to ensure safe care was being provided to residents in that he failed to implement systems to ensure staff had adequate rest.

Charge 1a(iv)

1) Between 2018 and 2 June 2020, whilst working as the Nominated Individual and Registered Manager of a care home:
   a) Failed to ensure safe care was being provided to residents in that you:
      iv) Failed to ensure staff were appropriately supervised;

This charge is found proved.

In reaching this decision, the panel took into account the CQC inspection report on the Home dated 2020 which states:

"The providers supervision policy outlined that one to one supervision would take place every other month and all staff would have an annual appraisal. Staff told us

they had supervision occasionally. Some staff felt they were supported well by the deputy manager. Other staff described the support as "variable".

The supervision records viewed showed some staff had two recorded supervisions each year, whilst other staff had only one recorded supervision each year. Two of the seven staff files viewed had a record of annual appraisal. The other five staff had no evidence of appraisals even though staff have worked at the home for many years. This was not line with the provider's policy on supervision."

The panel considered the CQC report both credible and consistent and found the information as set out above supports the charge.

Based on the evidence before it, the panel finds that, on the balance of probabilities, it is more likely than not that Mr Ramanah failed to ensure safe care was being provided to residents in that he failed to ensure staff were appropriately supervised.

Charge 1a(v)

1) Between 2018 and 2 June 2020, whilst working as the Nominated Individual and Registered Manager of a care home:
    a) Failed to ensure safe care was being provided to residents in that you:
        v) Failed to ensure staff were adequately trained;

This charge is found NOT proved.

In reaching this decision, the panel took into account the CQC inspection report on the Home dated 2020 which states:

"*Staff told us they had access regular training. The training matrix viewed showed staff were trained in topics such as moving and handling, safeguarding, infection control, fire safety and dementia care."*

The panel also had regard to the training matrix which was provided by the NMC but was illegible and therefore of limited evidential value.

The panel found, based on the evidence before it, that Mr Ramanah did not fail to ensure staff were adequately trained. The panel therefore finds this charge not proved.

Charge 1a(vi)

1) Between 2018 and 2 June 2020, whilst working as the Nominated Individual and Registered Manager of a care home:
    a) Failed to ensure safe care was being provided to residents in that you:
        vi) Failed to assess staff understanding of training and guidance adequately or at all;

This charge is found proved.

In reaching this decision, the panel took into account the CQC inspection report on the Home dated 2020 which states:

> *"Staff were trained but the training was not effective to enable them to deliver safe and effective care. Staff were not supported in line with the provider's policy and daily practices were not monitored and poor practice was not addressed […*
> *…] The training matrix viewed showed staff were trained in topics such as moving and handling, safeguarding, infection control, fire safety and dementia care. However, their practices and understanding of topics they had been trained in demonstrated that the training was not always effective in giving staff the skills to do their job."*

The panel therefore was satisfied that Mr Ramanah did fail to ensure safe care was being provided to residents in that he failed to assess staff understanding of training and guidance adequately or at all.

Charge 1a(vii)

1) Between 2018 and 2 June 2020, whilst working as the Nominated Individual and Registered Manager of a care home:
    a) Failed to ensure safe care was being provided to residents in that you:
        vii) Failed to ensure a safe and clean living environment for residents;

This charge is found proved.

In reaching this decision, the panel had regard to the written statement of Witness 1 and the CQC inspection reports on the Home from 2019 and from 2020.

The written statement of Witness 1 states:

> *"Their bedroom was dirty, with no bed linen on the bed , other than a dirty quilt which did not have a cover on. There were empty alcohol bottles strewn all over the room and the bedroom smelt of smoke*
>
> *[…]*
>
> *Some furniture was damaged, and service user bedrooms and furnishings were unhygienic and lacked care and attention."*

The CQC investigation report dated 2019 states:

> *"People were protected from the risk of infection. Toilets and bathrooms were kept in a clean condition and were stocked with handwashing products. Staff wore*

disposable gloves and aprons when they supported people with personal care…
[The registered manager] told us they hired equipment as and when they needed it. We mentioned this would involve delay in cleaning up spillages, such as bodily fluids and asked why the home did not have its own shampooing equipment. The registered manager told us they had equipment in the past, but it had broken. No action had been taken to replace it.
We recommend the home obtains its own equipment for maintaining floors in a clean and hygienic condition."

The CQC investigation report dated 2020 states:

"The service had a part time cleaner and a cleaning schedule was in place, however we found areas of the home and soft furnishings were not suitably cleaned and hygiene. The toilets in people's bedrooms were dirty, the cooker and oven were dirty, carpets were stained and some people's beds, including the divan, duvets and pillows were unhygienic."

The panel noted the CQC report dated 2019 states that the residents were protected from risk of infection and that measures were being taken to ensure a safe and clean living environment for residents. However, it had regard to the CQC report dated 2020 which demonstrated a further deterioration in the safety of the environment from 2019. The panel is satisfied based on the evidence from the CQC investigation report in 2020 that this charge is found proved. It concluded that, it is more likely than not, that Mr Ramanah did fail to ensure safe care was being provided to residents in that he failed to ensure a safe and clean living environment for residents.

Charge 1a(viii)

1) Between 2018 and 2 June 2020, whilst working as the Nominated Individual and Registered Manager of a care home:
    a) Failed to ensure safe care was being provided to residents in that you:

viii)Failed to ensure adequate safeguarding measures were in place;

This charge is found proved.

In reaching this decision, the panel took into account the CQC inspection reports on the Home from 2020 which states:

> *"People were not safeguarded from abuse…*
>
> *… However, the risks associated with behaviours that challenged were not identified or mitigated to safeguard people…*
>
> *Systems were not in place to safeguard people. Staff were trained in safeguarding but some aspects of practice, such as sleeping on shift and ignoring guidance had the potential to put people at risk.*
> *Staff understood that incidents between people would be perceived as a safeguarding incident. However, we saw in records viewed a number of incidents of physical abuse between people which was not reported to the Local Authority safeguarding team to be investigated. As a result, no safety measures were put in place to safeguard individuals…*
> *[…]*
> *… they failed to respond to our request for information to be sent to us after the inspection and did not make the required referrals to safeguard people."*

The investigation report provides a clear finding that there were inadequacies in relation to safeguarding people at the Home in 2020. The panel was therefore satisfied that Mr Ramanah did fail to ensure safe care was being provided to residents in that he failed to ensure adequate safeguarding measures were in place.

Charge 1a (ix)

1) Between 2018 and 2 June 2020, whilst working as the Nominated Individual and Registered Manager of a care home:
    a) Failed to ensure safe care was being provided to residents in that you:
        ix) Failed to ensure adequate care planning

This charge is found proved.

In reaching this decision, the panel had regard to the CQC inspection report dated 2020 states:

> *"People's care plans outlined their nutritional needs and risks. However, these did not always clearly state how nutritional risks were to be managed. For example, the water given with a Percutaneous Endoscopic Gastronomy (PEG) feed and sips of other drinks taken was not recorded, so there was no record to show this was provided and nutrition maintained.*
>
> *A person's care plan indicated they needed to be reminded to eat. Their care plan did not outline how staff encouraged the person to eat to promote their well-being."*

It further states:

> *"Person centred care was not provided. Care plans were in place and whilst some care plans outlined people's needs and the support required, care plans lacked the specific detail on how person-centred care was to be delivered. Care plans indicated that a person was to be supported with personal care regularly, however the frequency was not determined. A personal care record was in place, but this was not routinely completed to indicate the care given.*
>
> *Care plans made reference to medical conditions such as diabetes but did not outline hypoglycaemic and hyperglycaemic symptoms of the condition for staff to be able to respond in a timely manner.*

A person was requiring daily exercises to promote their mobility. Guidance was provided by a physiotherapist who had been involved in the person's care. However, the records were not updated to reflect the required exercises were encouraged. The last entry was dated the 23 October 2019.

Care plans were reviewed but the review failed to address changes in people or a person's lack of engagement in their plan of care.

[…] care plans did not evidence that people's end of life wishes were routinely explored and identified. They did not outline the end-of-life care required to ensure people had a comfortable and dignified death."

The panel saw the care plans of Resident C and G. It noted that the care plans of Resident's C and G seemed complete. However, it noted that the CQC report found deficiencies in the care plans for other residents.

The panel was therefore satisfied that, based on the evidence before it, on the balance of probabilities, it is more likely than not that Mr Ramanah failed to ensure safe care was being provided to residents in that he failed to ensure adequate care planning.

Charge b(i)

b) Failed to ensure incidents of abuse between residents:
   i) Were reported to safeguarding;

This charge is found proved.

In reaching this decision, the panel took into account the written statement of [ECW] dated 12 May 2020 and safeguarding referral documentation.

The written statement of [ECW] states:

> *"Additionally, the staff did not seem to be reporting accidents, injuries or safeguarding incidents effectively, which was a real concern"*

Further, the safeguarding referral documentation states:

> *"We inspected the service on 3 and 4th February 2020. We saw in peoples files incidents of SU on SU abuse which had not been perceived as SOVA and reported to yourselves the LA SOVA or CQC. We asked the provide/ manager at the inspection to make those referrals. We have followed up with 2 emails to him but to date these have not been actioned. As a result I am reporting incidents I have records of."*

The panel found that the evidence before it satisfies that Mr Ramanah did fail to ensure incidents of abuse between residents were reported to safeguarding.

Charge b(ii)

b) Failed to ensure incidents of abuse between residents:
   ii) Were adequately assessed in order to mitigate future risk

This charge is found proved.

In reaching this decision, the panel took into account correspondence between the CQC and Buckinghamshire and the written statement of Witness 1.

In her written statement, Witness 1 states:

> *"Records showed that incidents between service users were not managed and reoccurred which resulted in service users being exposed to injury."*

It had regard to an email dated 25 February 2020 from the inspection manager which states:

> *"Since the inspection we have raised with Bucks CC and we are aware that a visit to the service is arranged for this week. We have also raised safeguarding alerts in relation to incidents we discovered during the inspection that the provider failed to report even when we requested that he did so.*
>
> *Our most pressing concern is the unsuitable placement of Resident A who poses a huge risk to himself, other people using the service and staff… The provider has been unable to assure us that he has taken the appropriate steps to mitigate this risk since the inspection and if this risk is not mitigated soon we may have to consider taking urgent action to close the service "*

Based on the evidence before it, the panel found that, on the balance of probabilities, Mr Ramanah failed to ensure incidents of abuse between residents were adequately assessed in order to mitigate future risk.

Charge c)

c) Failed to ensure accidents were reported to safeguarding

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Witness 2.

In her written statement, Witness 2 states:

"We were made aware, by looking at the accident book in the Home and cross checking this with safeguarding, that accidents had happened at the Home and put in the accident book but these had not been reported to safeguarding"

The panel considered the evidence of Witness 2 in relation to this charge and it found that she was both a credible and reliable witness. It found that her evidence in relation to this were clear and it therefore concluded, based on this evidence, that it is more likely than not, that Mr Ramanah failed to ensure accidents were reported to safeguarding.

Charges d(i), d(iv) and d(v)

d) Failed to ensure adequate recording and record storage systems were in place and being followed by staff including:

i) Home maintenance records;
ii) […]
iii) […]
iv) Residents' records;
v) Staff rotas;
vi) […]

These charges are found proved.

In reaching this decision, the panel took into account the CQC investigation report dated 2020 and the written statement of Witness 1.

The CQC report in relation to Home maintenance records states:

"Records were not suitably maintained. We found records were insecure, disorganised, inaccessible, contradictory, inaccurate and some records were

incomplete. Records were inaccessible such as the maintenance book and fire folder"

In relation to the Home maintenance records, Witness 1's written statement states:

"records such as the […] maintenance records were not available…
…Some records were inaccessible, such as the maintenance book […]. By day two of the inspection […] the maintenance folder was not made available to us.

In relation to the Residents' records, the CQC report dated 2020 states:

"People's records were contradictory and incomplete.

… Personal care records, exercise recording sheets, staffing signing in and out sheets, medicine records, food, fridge and freezer temperature records all showed gaps in recording"

Witness 2's written statement states in relation to the Residents' records:

"When we looked at the old office it did look like it had been ransacked. We were told by [Person 1] that it contained old paperwork and none of this related to the current residents so, as far as we were concerned, it did not matter that it was a mess. However, I saw a file in this room with the name of a current resident on it, although I cannot remember his name (I remember though that he had capacity)."

In relation to staff rota's, the CQC report states:

"a diary was used to record the staff rota, which was unclear and in parts illegible due to crossing out and poor handwriting."

The panel also had documentary evidence showing the staff rota's which showed unclear and poor handwriting, had been crossed out in areas and deemed it to be illegible.

Based on the evidence before it, the panel was satisfied that, it is more likely than not that Mr Ramanah failed to ensure adequate recording and record storage systems were in place and being followed by staff including home maintenance records, residents' records and staff rotas.

Charges d(ii), d(iii) and d(vi)

d) Failed to ensure adequate recording and record storage systems were in place and being followed by staff including:

i) […]
ii) Fire safety and maintenance records;
iii) Staff supervision records;
iv) […]
v) […]
vi) Staff signing in/out records

These charges are found NOT proved.

In reaching this decision, the panel considered the written statement of Witness 1 which states:

"By day two of the inspection the fire folder was located […]"

The panel noted that the evidence shows that fire safety and maintenance records were in place as the evidence of Witness 1 demonstrates that although it was not available on day one of the inspection, it was located by day two of the inspection.

The panel also had regard to the CQC inspection report dated 2020 which states:

"The fire records showed the fire system and equipment was services and weekly fire checks were carried out…
… People had a personal Emergency Evacuation Plan (PEEP) in place…"

In relation to the staff supervision records, the panel noted that Witness 1's written statement states:

"There was a delay in accessing other documents (such as staff supervision records) as they were not available."

The panel found that there is insufficient evidence before it in support of a lack of staff supervision records. The panel found that it was not clear from the evidence of Witness 1 whether the staff supervision records were not accessible at the point of request during the inspection or whether they were not available at all.

Further, the panel had regard to the CQC report dated 2020 which states:

"The supervision records viewed showed some staff had two recorded supervisions each year, whilst other staff had only one recorded supervisions each year…"

It therefore found that there is evidence before the panel which confirms that the supervision records were accessed.

In relation to staff singing in and out records, the panel had regard to documentation which showed a record of staff members recording the time they signed in, the time they signed out with a signature of the staff member.

The panel therefore concluded, based on the documentary evidence before it, it could not be satisfied that on the balance of probabilities Mr Ramanah failed to ensure adequate recording and record storage systems were in place and being followed by staff including

fire safety and maintenance records, staff supervision records and staff signing in/out records.

Charges e(i) and e(ii)

e) Failed to adequately manage health and safety issues in that you:

i) Failed to carry out infection control risk assessments;
ii) Failed to ensure adequate infection control measures were in place;
iii) […];
iv) […];
v) […].

These charges are found proved.

In reaching this decision, the panel took into account the CQC inspection report dated 2020 which, in relation to infection control risk assessments, stated:

> *"Infection control risks were not identified and managed. The service had no infection control risk assessment in place and infection control audits were not taking place….*
> *… infection control risks were not mitigated."*

In relation to the presence of adequate infection control measures, the panel had regard to the written statement of Witness 2 which states:

> *"We were not asked to sign in, when I would have expected us to have to sign in, and we were not asked to sanitise our hands. For context, this was at a time when settings were expected to have extra infection control measures in place. During our visit it also became apparent that visitors were not asked to sign in….*

… they were unable to articulate what infection control measures were in place to prevent the spread of Covid-19. There was also no contingency plan in place if staff were to catchCovid-19… they had not put other measures in place in terms of infection control for other visitors nor in terms of contingency plans for staff sickness"

[ECW]'s evidence states:

"We were greeted at the door by one of the carers (name not known) who granted us entry into the property. We were not asked to sign in as visitors, nor were we asked to sanitise our hands as per Covid-19 guidance"

The panel found the evidence before it to be clear and consistent. In view of the documentary evidence before it, the panel concluded that on the balance of probabilities, Mr Ramanah failed to adequately manage health and safety issues in that he failed to carry out infection control risk assessment, failed to ensure adequate infection control measures were in place

Charges e(iii) and e(iv)

e) Failed to adequately manage health and safety issues in that you:

i) […];
ii) […];
iii) Failed to adequately assess and/or mitigate fire risks;
iv) Failed to maintain sufficient staffing levels to carry out safe fire evacuations;
v) […]

These charges are found proved.

In reaching its decision, the panel took into account, the Buckinghamshire Fire & Rescue service letter dated 4 March 2020. The letter states:

In relation to clear escape routes:

> *"Some doors were not capable of preventing the spread of fire for long enough to enable people to escape….*
>
> *…Ensure that the cleaning equipment and clothing are removed from under the stairs and hallway.*
> *It is recommended that these items are relocated to an area away from the escape route(s) in an area protected by the fire-resisting structure…*
> *… a fire breaking out in the hallway would affect the escape routes both from the ground floor and the 1st floor, which may prevent persons from making their escapes in the event of fire.*
>
> *[...]*
>
> *The fire detection and alarm system is not suitable if it can be switched off. This means that people would not be warned of fire in the building and could be trapped by it."*

In relation to the sufficient staffing levels, the panel had regard to the CQC inspection report dated 2020 which states:

> *"However, the fire evacuation procedure indicated sufficient staff were not provided to enable them to evacuate people in line with the provider's procedure"*

The Buckinghamshire fire and rescue service letter states in relation to competent people to supervise:

“At night there are not enough people available to supervise an evacuation in case of fire and to keep everyone safe.”

The panel found that there is sufficient evidence before it to be satisfied, on the balance of probabilities, that Mr Ramanah did fail to adequately assess and/or mitigate the fire risks. In addition, the panel concluded that the evidence before it in relation to this matter is sufficient to satisfy that it is more likely than not that Mr Ramanah failed to maintain sufficient staffing levels to carry out safe fire evacuations.

Charge e(v)

e) Failed to adequately manage health and safety issues in that you:
   i) […]
   ii) […]
   iii) […]
   iv) […]
   v) Failed to ensure fridge and freezer temperatures were monitored regularly.

This charge is found NOT proved.

In reaching this decision, the panel took into account the written statement of Witness 1 which states:

“food, fridge and freezer temperature records […] all showed gaps in recording.”

The CQC inspection report dated 2020 states:

“Personal care records, exercise recording sheets, staffing signing in and out sheets, medicine records, food, fridge and freezer temperature records all showed gaps in recording.”

The panel acknowledged that the evidence before it demonstrates that there were gaps in the recordings of fridge and freezer temperature records. However, the panel is not satisfied that the NMC has adduced any evidence to determine what the standard of regular monitoring was. The panel were not provided with any documentation or policy which confirms how regularly the fridge or freezer temperature records should have been monitored or recorded. The panel therefore could not be satisfied that Mr Ramanah failed to ensure fridge and freezer temperatures were monitored regularly.

Charges f(i), f(ii), f(iii) and f(v)

f) Failed to ensure adequate medication management including:

i) Failing to provide adequate guidance to staff on medication administration;
ii) Failing to ensure medication was administered correctly;
iii) Failing to ensure medication records were completed and signed;
iv) […]
v) Failing to provide and/or maintain suitable storage facilities for medication.

These charges are found proved.

In relation to a failure to provide adequate guidance on medication administration, the panel took into account the CQC inspection report dated 2020 which states:

> *"Guidance was in place for some people's "as required" medicines such as paracetamol, however guidance was not provided for other "as required" medicines such as loperamide, cosmocol and codeine phosphate..*
> *… The service had six staff who were responsible for medicine administration. The registered manager confirmed staff were trained and had their competencies assessed to administer medicine. However, the registered manager and deputy manager were only able to locate a record of competency assessment for one of six staff which was completed in January 2019."*

It took into account the written statement of Witness 1 which stated:

> *"I had concerns about medicines management within the Home and the lack of oversight of this, which further meant the service users were not being safeguarded. For example, there was no guidance on Pro Re Nata ("PRN") , or "as required" medication, such as Trazadone, Loperamide, cosmocol and codeine phosphate"*

The panel concluded that based on the evidence before it, there was a failure to provide adequate guidance to staff on medication administration.

In relation to a failure to ensure medication was administered correctly and the failure to ensure medication records were completed and signed, the panel had regard to a statement provided by Witness 1 which stated:

> *"Service users 1, 2, 4, 7 8 and 9's medicine administrations records showed records were not maintained of the quantity of medicines received into the service.*
>
> *….There were gaps in medicine administration records…*
> *…Their medicine records showed [Tiotropium Bromide] was not offered as prescribed and when offered it was refused…*
> *… there was no indication any action was taken to address Service user 1's] lack of compliance with their prescribed medicines*
>
> *Service user 4's medicine administration records showed gaps in administrations of eye drops on 15 January 2020 and Co Trimoxazole was not recorded as administered on 29 January 2020"*

The panel also had regard to the medication administration record for Resident A which showed gaps in administration of the medicines. The panel could not determine whether

the gaps were to reflect whether the medications were not administered or whether the medications were not recorded after being administered.

In relation to the failure to provide and/or maintain suitable storage facilities for medication, it had regard to the CQC inspection report dated 2020 which states:

> *"On day one of the inspection we saw the medicine cupboard door had fallen off its hinges. Staff told us it had broken on Saturday which meant the medicines were insecure for three days. During the inspection it was repaired however we observed the medicine trolley had no lock and was only secured by a chain and small padlock, in a room which had a standard household lock on it. This is not in line with pharmaceutical guidance on the safe storage of medicines in care homes."*

Based on the evidence before it, the panel has concluded that there is evidence to satisfy the panel that Mr Ramanah failed to provide suitable storage facilities for medication.

Charge f(iv)

f) Failed to ensure adequate medication management including:

i) […]
ii) […]
iii) […]
iv) Failing to ensure there were records for topical medication administration;
v) […]

This charge is found NOT proved.

In relation to the records for topical medication administration, the panel had regard to Witness 1's written statement in which she states:

“there was not a topical medicine administration record in use to guide staff on where the topical creams were to be applied”

The panel found that there is insufficient evidence in support of this charge. The panel could not conclude that there was topical medication having been administered without it being recorded. The panel therefore could not be satisfied that Mr Ramanah failed to ensure there were records for topical medication administration.

Charge g(i)

g) Failed to ensure adequate resident records were kept including:

i) Health appointments and outcomes;
ii) […]
iii) […]

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence shown in the care plans.

It noted the care plan of Resident C which showed an adequate note of the resident’s appointment with the general practitioner.

Further, it had regard to the care plan of Resident G which had a clear and adequate note documenting that Resident G was seen by the General Practitioner who had reviewed medications that the resident was taking after having suffered a fall.

The panel concluded that there have been adequate recordings of heath appointments and outcomes which had been documented and therefore it could not be satisfied that Mr Ramanah failed to ensure adequate resident records were kept including health appointments and outcomes.

Charges g(ii) and g(iii)

g) Failed to ensure adequate resident records were kept including:

i) […]
ii) Care plans;
iii) Deprivation of Liberty Safeguards (DoLS)

These charges are found proved.

In reaching this decision, the panel took into account the written statement of Witnesses 1 and 2.

In her written statement, Witness 1 states:

> *"Alongside this I found service users' communication needs were not identified or met and care plans were not detailed and specific as to how staff should support service users with medical conditions such as diabetes*

The panel found that Witness 1's evidence provided a contemporaneous review of the records that were kept at the time and her evidence provides that there was a lack of adequate care plans.

The CQC inspection report dated 2020 states:

> *"Person centred care was not provided. Care plans were in place and whilst some care plans outlined people's needs and the support required, care plans lacked the specific detail on how person-centred care was to be delivered….*
> *… Care plans made reference to medical conditions such as diabetes but did not outline hypoglycaemic and hyperglycaemic symptoms of the conditions for staff to be able to respond in a timely manner.*
> *Care plans were reviewed but the review failed to address changes in people or a person's lack of engagement in their plan of care.*

Some people had 'do not attempt resuscitation' forms in place. Their care plans made reference to an appointed funeral director. However, care plans did not evidence that peoples end of life wishes were routinely explored and identified."

It also states:

"People's records were contradictory and incomplete…

…Personal care records, exercise recording sheets, staffing signing in and out sheets, medicine records, food, fridge and freezer temperature records all showed gaps in recording."

The panel found that the evidence before it is credible, reliable and sufficient to satisfy that Mr Ramanah did fail to ensure adequate resident records were kept including adequate care plans.

In relation to the DoLS, the panel had regard to the CQC inspection report dated 2020 which stated:

"record was maintained of the DoLS applications made. However, the records showed that some DolS had expired before an application to renew it had been made."

It also had regard to the deprivation of liberty safeguarding audits which clearly shows that there was a failure to ensure adequate records of the DoLS. It therefore concluded that the evidence before it is sufficient to prove this charge.

Charge h)

h) Failed to ensure staff had adequate understanding of legislation including the Mental Capacity Act 2005

This charge is found NOT proved.

In reaching this decision, the panel took into account the CQC report dated 2020. It states:

> *"The training matrix showed all staff were trained in the MCA. Staff spoken with had variable levels of understanding of the MCA and people's records showed staff were not applying their training to their practice."*

The panel was not aware which staff members were spoken to in relation to this matter, accordingly, it could not form an objective view of what the levels of understanding of the MCA and what the standard is for the level of understanding. The panel therefore finds that there is insufficient information before the panel to satisfy that Mr Ramanah failed to ensure staff had adequate understanding of legislation including the Mental Capacity Act 2005.

Charges i(i), i(ii), i(iii) and i(v)

i) Failed to provide a safe and clean environment for residents including:

   i) Suitable home layout;
   ii) Sufficient corridor lighting;
   iii) Hygienic laundry room;
   iv) […]
   v) Safe pathways;
   vi) […]

These charges are found NOT proved.

In relation to a suitable home layout, the panel took into account the evidence of Witnesses 1 and 2. The panel noted that it had not been provided with the layout of the home in order to make a determination and further, it found the evidence of Witnesses 1 and 2 on this matter to be contradictory, where they described the physical layout.

In relation to sufficient corridor lighting, the panel found that there was insufficient evidence in support of this. The panel noted that no evidence was adduced by the NMC which demonstrated what would constitute the standard of sufficient corridor lighting, and it did not have evidence of what the corridor lighting looked like. Further, there was no evidence adduced that the residents of the Home had complained or were put at risk as a result of the corridor lighting.

In relation to a hygienic laundry room, the panel found that there was insufficient evidence in support of this. The CQC inspection report dated 2020 states "*walls by the laundry room appeared to be damp with the paint flaking off, therefore unsafe and not fit for purpose".* However, the panel noted that this comment relates to the walls by the laundry room and not the laundry room itself.

Further it noted the statement of [JK] which states:

"I noticed the laundry area at Keephill was in a very small room and darkly lit"

The panel was not satisfied that this constitutes an 'unhygienic laundry room'.

In relation to the safe pathways, whilst Witness 1 referenced unsafe pathways near the fire escape, the panel noted that there is no reference to there being unsafe pathways in the letter from the fire service dated 4 March 2020. Further the NMC did not produce photographic evidence of the pathways for the panel to be able to conclude that the pathways were unsafe.

The panel has therefore concluded, that based on the evidence before it, it could not conclude that Mr Ramanah has failed to provide a safe and clean environment for residents including a suitable home layout, sufficient corridor lighting, hygienic laundry room and safe pathways.

Charges i(iv) and i(vi)

i) Failed to provide a safe and clean environment for residents including:

   i) […]
   ii) […]
   iii) […];
   iv) Safe and serviceable fittings, furniture and equipment;
   v) […]
   vi) Clear fire escape routes.

These charges are found proved.

In relation to safe and serviceable fittings, furniture and equipment, the panel had regard to the statement of Witness 1 which states:

> *"… cupboards were falling off their hinges and the worktop was damaged, no longer sealed and unhygienic. Furniture in service user's bedrooms had handles missing and drawers would not close…*
> *… Some furniture was damaged, and service user bedrooms and furnishings were unhygienic and lacked care and attention."*

This is supported by [ECW]'s written statement which was admitted as hearsay evidence which states:

"I would describe the service as a shambles. The property itself is in a poor condition with old and broken fixtures and fittings"

The written statement of Witness 2 states:

"the sitting room, there was a dining table with broken chairs around…. the boiler was last serviced in 2011…

…There were benches in the garden but what seemed like an old hand rail, which was there to assist residents going outside, did not look safe"

The panel also had regard to the letter from Buckinghamshire Council to the Home dated 3 April 2020 which stated:

"The property itself is still in a poor condition with old and broken fixtures and fittings."

The CQC inspection report dated 2020 stated:

"The service was not fit for purpose. […] the kitchen cupboards were falling off their hinges and the worktop was damaged and no longer sealed and hygienic. Furniture in people's bedrooms had handles missing and/or drawers wouldn't close."

The panel found that the evidence before it was consistent and credible and it concluded that Mr Ramanah failed to provide a safe and clean environment for residents including safe and serviceable fittings, furniture and equipment.

In relation to clear fire escape routes, the panel had regard to the fire and rescue service documentation. In relation to clear escape routes, it states:

"*this work is necessary to make sure that escape routes (corridors, stairs and doors) can be safely used whenever they are needed… A fire breaking out in the hallway would affect the escape routes both from the ground floor and 1st floor, which may prevent persons from making their escape in the event of fire."*

Based on this evidence, the panel was satisfied that on the balance of probabilities, it is more likely than not that Mr Ramanah failed to provide a safe living environment in that there was a lack of a clear fire escape routes.

Charge j(i)

j) Failed to ensure the privacy and dignity of residents including:

i) Resident C's door being left open;
ii) […]
iii) […]
iv) […]

This charge is found proved.

In relation to Resident C's door being left open, the panel had regard to the written statement of Witness 1. She stated:

"The bedroom was situated by the entrance to the Home and all visitors had view of Resident C. There was no evidence that the service user's privacy and dignity was promoted."

The panel had regard to the care plan of Resident C which was included in the service user records and it noted the vulnerabilities of Resident C.

Further, it had regard to the CQC inspection report dated 2020 which stated:

“However, where bedroom doors were open some staff walked in without informing the person. Throughout the inspection a person's bedroom door was left open. The bedroom was situated by the entrance to the home and all visitors to the home had view of the person. There was no evidence the person's privacy and dignity had been considered and addressed.”

The panel found that there is evidence to satisfy that Mr Ramanah, more likely than not, did fail to ensure the privacy and dignity of Resident C by leaving the door open.

Charges j(ii), j(iii) and j(iv)

j) Failed to ensure the privacy and dignity of residents including:
   i)[...]
   ii)Failing to ensure staff provided adequate reassurance and support to residents;
   iii)Failing to ensure the wishes and preferences of residents were sought and acted upon.
   iv)Failing to ensure information was provided to residents in formats suitable for their needs.

These charges are found NOT proved.

In relation to a failure to ensure adequate reassurance and support was provided to residents, the panel considered the CQC inspection report dated 2020 which stated:

“During the inspection we observed positive and negative engagement with people. At the mealtime we heard staff regularly tell people to "Sit down", without any reassurance or support to do that”

The panel could not determine, on the balance of probabilities, that the evidence in support of this charge is enough to constitute inadequate reassurance.

In relation to a failure to ensure the wishes and preferences of residents were sought and acted upon, the panel found that there was at least one example of the wishes and preferences of a resident were sought and acted upon which was outlined in the CQC report dated 2020 which stated:

> *"The registered manager sent us evidence of monthly hymn singing and advised that people have said they did not wish to attend a church service every week."*

The panel therefore concluded that there is evidence of Mr Ramanah ensuring the wishes and preferences of a resident were sought and acted upon.

In respect of a failure to ensure information was provided to residents in formats suitable for their needs, the panel had regard to the CQC inspection report dated 2020 which states:

> *"People were not provided with information in a format suitable to their needs for example on choosing activities or how to make a complaint. Pictorial menus were on the notice board however, these were not routinely used to promote choices and inform people what was on the menu. On day two of the inspection pictorial menu cards on display were not reflective of the meal on offer and provided"*

The panel noted that there were pictorial menus on display. It considered that on day two the pictorial menu picked by the resident could have been provided and the panel did not hear or receive any evidence contradicting this.

The panel therefore concluded, that on the balance of probabilities, it could not be satisfied that Mr Ramanah had failed to ensure staff provided adequate reassurance and support to residents, to ensure the wishes and preferences of residents were sought and

acted upon or to ensure information was provided to residents in formats suitable for their needs.

Charges k(i), k(iii) and k(iv)

k) In relation to Resident E:

i) Failed to ensure adequate hydration;
ii) […]
iii) Failed to put in place adequate procedures in place to maintain the resident's skin integrity and condition;
iv) Failed to ensure the resident was positioned appropriately in order to avoid tissue injury.

These charges are found proved.

In relation to the failure to ensure adequate hydration for Resident E, the panel took into account the written statement of Witness 3 in which she stated:

> *"Res E also appeared dehydrated. Their skin looked quite dry and we conducted a test (pulling their skin and if it flips back it means the person is hydrated […] Resident E's skin did not return to its position quickly…*
>
> *… Res E urine was concentrated (I could see this through the catheter) which is another indication of dehydration. From what I could see on the notes […] there was no monitoring of actual liquids input and output over 24 hours"*

This was supported by the comments from [TT] who saw the resident on 13 March 2020, and stated:

"his urinary catheter was full and the urine was quite dark, indicating that he was dehydrated…

…He was showing signs dehydration. His mouth and tongue were very dry and red, his skin was dry and in poor condition"

The panel therefore concluded that there was consistent evidence from more than one source which is sufficient to conclude that Mr Ramanah did fail to ensure that Resident E was adequately hydrated.

In relation to the adequate maintenance of Resident E's skin integrity and condition, it had regard to the photographic evidence of Resident E's skin condition. The panel also had regard to the written statement of Witness 3 which stated:

"sacrum was red and sore with an area about four inches that had exudate (a term for fluid that can come from a wound which may or may not be infected… We also noted a deep tissue injury on his heel (I cannot recall which one although, at the hospital it was noted to be the left heel) which we would grade as four given the colour. Pressure areas are graded from 0-4 with the higher score indicating the severity of the problem area"

Further, the panel had regard to the comments from [TT] who stated:

"He was showing signs of dehydration., His mouth and tongue were very dry and red, his skin was dry and in poor condition"

In relation to a failure to ensure the resident was positioned appropriately in order to avoid tissue injury, the panel considered, a written statement by Witness 3 which stated:

"and I needed to check his pressure areas and I advised the carers I wanted to look at under the covers. I checked his buttocks and saw a wound to his sacrum, this was superficial but looked very sore: The top of the buttocks were pink in colour

with some breaks in the skin. I call this slough. The affected area was about 4" in length. This can be caused by pressure, lying in one position for a long time and moisture from being hot…

…Resident E was on an ordinary standard mattress not an air mattress. If it is known a patient has a sore bottom the plan of care is to provide a softer mattress."

The panel therefore finds, based on the evidence before it, it was satisfied that Mr Ramanah did fail to ensure Resident E was adequately hydrated, failed to put in place adequate procedures in place to maintain the resident's skin integrity and condition and failed to ensure the resident was positioned appropriately in order to avoid tissue injury.

Charge k(ii)

k) In relation to Resident E:

i) […]
ii) Failed to escalate deterioration of the resident's condition in a timely manner;
iii) […]
iv) […]

This charge is found NOT proved.

The panel noted that in an email from the social worker dated 12 April 2020 she states:

"No out of hours contact for the GP surgery

I phone 111 and shared my concerns and requested palliative nursing care for Resident E

…. Doctor 1's advice is to keep Resident E comfortable and she has acknowledged the rapid deterioration in Resident E and not being able to swallow tablets and high risk of choking.

However the Dr has prescribed tablet form of antibiotics for possible Pneumonia. Due to the high risk of COVID 19 in the hospital environment the Dr has

recommended Resident E to stay at the home and see the GP in 2 weeks if he is still alive"

The panel had regard to a further email from the social worker dated 13 April 2020 which stated:

"The latest update is that the GP has made a video phone call to Resident E and the carers.
GP has made referral for the palliative nurses so that they would visit Resident E and do the needful and assess to see how best they could support Resident E…
… The next of kin is updated with the current situation
The home will let me know once the nurses have been to see Resident E…"

The panel noted that there was the involvement of a number of individuals in Resident E's care and there is a clear audit within the emails of escalation and what actions have been taken and what advice has been received from the Doctor. The panel therefore finds that it could not be satisfied that there was a failure to escalate deterioration of Resident E's condition in a timely manner.

[This hearing went part heard on 24 May 2023 due to a lack of time. The hearing resumed on 27 November 2023].

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 Mr Ramanah'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 ability to practise kindly, safely and professionally.

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

Submissions on misconduct

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

Mr Way addressed the panel on misconduct. He reminded the panel that the failures relate to Mr Ramanah's conduct whilst acting in a managerial role in the Home. He outlined the conduct found proved and submitted that the concerns in this case are wide ranging in that they relate to issues both of management within the Home, but also issues of patient safety and patient harm.

Mr Way submitted that Mr Ramanah was a registered nurse working in a key management role within a home which cared for vulnerable residents. He submitted that the conduct found proved fell below the required standards of a registered nurse and the failings in this case do amount to misconduct.

Mr Way referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision. He highlighted that the values and principles set out in the Code can be applied to a range of different practice settings, but they are not negotiable or discretionary. He outlined that the code covers four key topics, namely Prioritise People, Practise Effectively, Preserve Safety and Promote Professionalism. He identified the specific, relevant standards where Mr Ramanah's actions amounted to misconduct.

Mr Way specifically identified to the panel that whilst Mr Ramanah was working in a managerial role which did not require him to be a nurse, he is a registered nurse and for that reason he should practise in accordance with the Code and the fundamental tenets of nursing.

Mr Way submitted that Mr Ramanah has failed to uphold the code on multiple counts and the conduct which has been found proven falls far below the standards of what would be proper in the circumstances. He submitted that Mr Ramanah failed to fulfil his management responsibilities, and this has the potential to impact directly on the care of the Home's residents. He submitted that residents of the home were put at risk by a lack of action taken to effectively address serious concerns that were being raised. He therefore invited the panel to find that the charges proven amount to misconduct.

Submissions on impairment

Mr Way 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).

Mr Way reminded the panel that when determining whether fitness to practise is currently impaired, there is no burden of proof on either party and that it is a matter for the panel's professional judgement.

Mr Way submitted that impairment is a forward-looking exercise, and the panel will need to consider impairment as of today's date. He submitted that there are serious concerns about Mr Ramanah's past conduct and that there is no evidence before the panel today that any of these concerns have been addressed.

Mr Way submitted that Mr Ramanah failed to ensure safe care was being provided to the residents of the Home and in doing so placed them at an unwarranted risk of harm.

Mr Way submitted that there is no evidence that any real steps have been taken by Mr Ramanah to strengthen his practice, to remediate any concerns or any particular insight that the Mr Ramanah has gained.

Mr Way acknowledged that Mr Ramanah has indicated that he has retired from practice and therefore the panel might conclude he has not had the opportunity to strengthen his nursing practice. He submitted that the panel can have no real confidence that any concerns have been addressed. He submitted that Mr Ramanah's actions breached aspects of the Code and fundamental tenets of nursing.

Mr Way acknowledged that in its consideration of impairment, the panel will consider the personal component. He submitted that there is no evidence before the panel which suggests any personal mitigation was present at the time resulting in Mr Ramanah acting in the way that he did. He reminded the panel that the incident involving Resident E was so serious that the Police were involved and whilst this did not lead to any legal action taken against Mr Ramanah, the incident in itself was sufficiently serious to escalate to that level.

Mr Way reiterated that the panel does not have evidence of insight or steps taken by Mr Ramanah to strengthen his practice. Further, he stated that the concerns in this case do not relate to isolated incidents. He submitted that the panel could not be satisfied that, if Mr Ramanah did return to unrestricted practice, it would be highly likely that the conduct would be repeated.

Mr Way therefore invited the panel to make a finding of impairment on public protection and public interest grounds.

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. In its considerations of whether or not the charges found proved amount to misconduct the panel drew reference to the NMC guidance document entitled 'Misconduct', Ref: FtP – 2a last updated 29 November 2021, which sets out:

> *"The Code sets the professional standards of practice and behaviour for nurses, midwives and nursing associates, and the standards that patients and public tell us they expect from nurses, midwives and nursing associates. While the values and principles can be interpreted for particular practice settings, they are not negotiable."*

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

‘1 Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

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

1.5 respect and uphold people’s human rights

3 Make sure that people’s physical, social and psychological needs are assessed and responded to

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

8 Work co-operatively

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

8.6 share information to identify and reduce risk

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

9.4 support students’ and colleagues’ learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

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

10.5 take all steps to make sure that records are kept securely

11 Be accountable for your decisions to delegate tasks and duties to other people

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

13 Recognise and work within the limits of your competence

13.4 take account of your own personal safety as well as the safety of people in your 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

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

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

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

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

18.4 take all steps to keep medicines stored securely

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered whether Mr Ramanah's actions as set out in each of the charges were so serious to amount to serious professional misconduct.

In respect of charge 1a(i) the panel noted that some staff inductions had taken place and it considered whether the extent of the lack of 'adequate' staff inductions in respect of agency staff was sufficiently serious to constitute misconduct. The panel noted that similarly to charge 1a(i), charges 1a(iv) and 1a(vi) relate to a failure to ensure safe care was being provided by not supervising staff appropriately and by not assessing staff understanding on training and guidance. The panel determined that Mr Ramanah would have had a duty as a registered nurse acting in a managerial role to work cooperatively with colleagues to preserve the safety of those receiving care. The panel found that Mr Ramanah's actions as set out in charges 1a(i), 1a(iv) and 1a(vi) could have the potential for a gap in their skillset or knowledge to be unidentified and would effectively place limitations on their ability to provide safe and effective care to the vulnerable residents of the Home. In consequence of his actions as set out in these charges, Mr Ramanah did breach the fundamental tenet of preserving safety and therefore the panel determined that this is sufficiently serious to amount to serious professional misconduct.

In respect of charge 1a(ii), the panel found that Mr Ramanah's actions as set out in this charge demonstrate a failure on his part to preserve the safety of the residents. A failure to ensure adequate staffing levels impacts directly on the quality of care provided. Further, the panel found that in the event of an emergency, for example a fire, the number of staff available to manage this would have been insufficient to ensure the residents were safe. It therefore determined that this does amount to serious professional misconduct.

The panel considered charge 1a(iii). The panel found that by not ensuring that staff were working shifts that would enable them to have adequate rest, he was compromising the level of care provided to residents of the Home who were vulnerable. The panel determined that without adequate rest, staff members concentration levels and attention to detail could be compromised and the likelihood of mistakes occurring would be increased. The panel determined that Mr Ramanah in failing to implement systems to ensure staff were having adequate rest between shifts, failed to ensure the safety of the residents in the Home. The panel therefore determined that this does constitute serious professional misconduct.

In respect of charges 1a(vii), and 1i(iv), the panel noted that these all relate to Mr Ramanah's failures to ensure a safe and clean-living environment was maintained, including failing to ensure safe and serviceable fittings, furniture and equipment. The panel determined that Mr Ramanah's conduct as set out in these charges failed to prioritise people and preserve the safety of the residents of the Home, both being fundamental tenets of the profession. The panel noted that the code explicitly states:

> *"The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in* ***clean and hygienic conditions [For emphasis added]****. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided."*

The panel found that Mr Ramanah's conduct as set out in charges 1a(vii) and 1i(iv) were serious breaches of the fundamental tenets of nursing and fell seriously short of what would be expected of a registered nurse acting within a managerial role. The panel therefore concluded that these charges are sufficiently serious to amount to serious professional misconduct.

The panel considered the charges which relate to safeguarding concerns, namely charges 1a(viii), 1b(i), 1b(ii) and 1c. The panel determined that Mr Ramanah failed to preserve the safety of the vulnerable residents of the Home by not ensuring that the appropriate safeguarding measures were in place, thereby breaching a fundamental tenet of the profession. Further, the panel found that Mr Ramanah's failures to escalate accidents in the home via the appropriate safeguarding channels demonstrate a serious departure from the proper standards of conduct which would be expected of a registered nurse, particularly whilst acting in a managerial role. The panel concluded that Mr Ramanah's conduct was sufficiently serious to amount to serious professional misconduct.

The panel considered charge 1a(ix) which relates to Mr Ramanah's failure to ensure adequate care planning. The panel noted that the care plans would have outlined the residents' nutritional requirements and any risks associated with nutrition. The panel further noted that the failure to ensure adequate care planning impacted on whether person centred care was provided to the residents. The panel had regard to the Code which sets out:

> *"The fundamentals of care include, but are not limited to, nutrition, hydration, […] It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided."*

The panel concluded that Mr Ramanah's actions in respect of Charge 1a(ix) demonstrate a serious falling short of what would have been expected of a registered nurse. It concluded that this amounted to serious professional misconduct.

In respect of charges 1d(i), d(iv), d(v), 1g(ii), and g(iii), which all relate to failures to ensure adequate records were kept and record storage systems were in place and being followed, the panel found that Mr Ramanah's actions to amounted to serious professional misconduct. The panel determined that Mr Ramanah did not ensure he practiced effectively (one of the fundamental tenets), nor did he identify the risks as a result of failing to keep adequate records or take steps to make sure that the records were being kept securely in line with the provisions of the Code. Mr Ramanah's actions had the potential to interfere with the continuity of patient care, which gives rise to a risk of harm. The panel determined that this amounted to serious professional misconduct.

In respect of charges 1e(i), e(ii), the panel determined that Mr Ramanah's actions as set out in these charges amounted to serious professional misconduct. The panel found that infection control processes are an integral part of nursing and in failing to manage this, Mr Ramanah breached the fundamental tenet of preserving safety. Further, the panel noted that these failures occurred during the Covid-19 pandemic when infection control procedures should have prioritised and increased, especially given the impact that the pandemic had on care homes. The panel concluded that these charges amounted to serious professional misconduct.

In respect of charges 1e(iii), e(iv) and 1i(vi), which relate to Mr Ramanah's failure to mitigate fire risks, maintain sufficient staffing levels to carry out fire evacuations and provide clear fire escape routes, the panel determined that his actions do amount to serious professional misconduct. The panel found that this gave rise to a real risk of harm to residents of the Home in that if a fire were to occur, there would not be the appropriate measures in place to preserve their safety. The panel therefore concluded that Mr Ramanah's actions amounted to serious professional misconduct.

The panel considered the charges in respect of failures to ensure adequate medication management, namely charges 1f(i), f(ii), f(iii), and f(v). In failing to provide adequate guidance to staff, Mr Ramanah allowed the potential for errors in relation to administering medications to occur. Further, in failing to ensure that medications were administered correctly to the residents, Mr Ramanah failed to preserve the safety of those residents and any errors would have been left unidentified. The panel found that failures to ensure medication records were completed impacts on the continuity of patient care and creates a real risk of harm to those residents of the Home. The panel found that Mr Ramanah's failures in respect of these charges relate to several aspects of medications management which is a core aspect of nursing care. The panel determined that these failures breached the fundamental tenets of the profession, were serious and amounted to serious professional misconduct.

In respect of charge 1j(i), the panel noted that all patients have the right to privacy. However, the panel did not have contextual information about this incident, specifically whether or not the resident was undergoing any treatment or procedure in order to determine whether or not it would have been inappropriate for Resident C's door to be left open. Further, the panel did not have any information which confirmed whether or not Resident C had consented to the door being left open or what their preferences were. The panel therefore determined that it did not have sufficient information to determine whether this amounts to serious professional misconduct.

In respect of charge 1k(i), k(iii) and k(iv), the panel found that Mr Ramanah's actions amounted to serious professional misconduct. The panel considered that Mr Ramanah failed to ensure adequate hydration of Resident E. It noted that the Code specifically sets out that the fundamentals of care include ensuring hydration of those being cared for and Mr Ramanah failed to fulfil his duty as a nurse in not doing so. Further, the panel found that the failures to maintain the patients skin integrity and condition and avoid tissue injury were so serious in that there was harm caused to Resident E.

The panel found that Mr Ramanah's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious professional misconduct. Mr Ramanah's actions demonstrate a serious departure from the Code, the fundamental tenets of nursing and the proper standards that would be expected of a registered nurse, particularly whilst acting in a managerial role where they would be expected to lead by example.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC guidance document entitled 'Impairment' Ref: DMA-1, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"'*

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, 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 – c of the "test" are engaged in this case. The panel concluded that residents were put at unwarranted risk of harm as a result of Mr Ramanah's misconduct. Mr Ramanah's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered whether there has been any evidence that Mr Ramanah has demonstrated insight. It noted that on 12 June 2023, after having been sent the panel's decision in relation to the facts, Mr Ramanah submitted an application for Agreed Removal. In response to the question:

> *"If you don't admit all the regulatory concerns, tell us which ones you dispute in the box below"*

He stated:

> *"ALL OF THEM BUT I ACCEPT THAT FINDINGS HAVE BEEN MADE AGAINST ME IN MY ABSENCE. THE MOST SERIOUS ALLEGATION HAS NOT BEEN PROVED EVEN IN MY ABSENCE THE ALLEGATION OF FAILING TO ESCALATE WHEN IT HAS ALWAYS BEEN KNOWN THAT THE DOCTOR WAS CALLED AND ATTENDED AND THE NEXT DAY WAS CALLED AGAIN BUT DID NOT ATTEND."*

The panel has not had any evidence that Mr Ramanah has demonstrated an understanding of how his failures put vulnerable residents at a risk of harm. Mr Ramanah has not demonstrated an understanding of how his failures impacted negatively on the reputation of the nursing profession nor has he demonstrated that he understands the proper standards of conduct that are expected of a registered nurse. The panel was therefore not satisfied that Mr Ramanah has demonstrated insight.

The panel noted that on his application for agreed removal, Mr Ramanah has indicated that he does not wish to return to nursing. It noted he has not been practising as a nurse nor has he provided evidence of any steps taken to strengthen his nursing practice.

The panel determined there is no evidence before it, which could reassure it that Mr Ramanah would not be liable to repeat the conduct found proved in this case. Whilst Mr Ramanah has stated he is not currently practising and does not intend to return practice, the panel determined that in the event that he did return to nursing practice, there is a risk of repetition of the conduct found proved. The panel therefore determined that limbs a, b and c of the “test” were engaged both in the past and potentially in the future.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required. The panel concluded that, given the nature of the misconduct found proved, public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Ramanah’s fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Ramanah’s 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 Mr Ramanah's name off the register. The effect of this order is that the NMC register will show that Mr Ramanah has 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

The panel had regard to the Notice of Hearing, dated 27 March 2023, the NMC had advised Mr Ramanah that it would seek the imposition of a striking off order if it found Mr Ramanah's fitness to practise currently impaired.

In his submissions Mr Way informed the panel that the NMC's sanction bid is that of a striking off order.

Mr Way referred the panel to its findings in relation to misconduct and impairment.
He referred the panel to the parts of the Code which it identified were breached as a result of the misconduct. He submitted that the failings identified were serious, wide ranging and involved breaches of fundamental tenets of the profession.

Mr Way submitted that Mr Ramanah would have been expected to lead by example in his management role, and as determined by the panel, he clearly did not do so. Further, he submitted that the failings in this case do not relate to an isolated incident but instead a number of failings which persisted over a long period, despite CQC reports identifying areas of concern and support being offered by the local council.

Mr Way referred to the NMC's guidance on sanctions which sets out the factors to consider which included the concept of proportionality which is described as finding a fair balance between the nurse's rights and the overarching objective of public protection. The factors to consider as set out by the guidance also includes any aggravating and/or mitigating features, previous interim orders and their effect on sanctions and previous fitness to practise history.

In relation to aggravating factors, Mr Way submitted that this was a case where there was not only a risk of harm to the residents of the Home, but also actual harm was caused to Resident E as a result of Mr Ramanah's failures. Further, he added that the failures continued despite multiple previous CQC inspections. He also referred the panel to its findings in relation to the multiple areas of concern it has identified in Mr Ramanah's practice which it found amounted to serious professional misconduct.

In terms of mitigating features, Mr Way submitted that there is no real evidence that Mr Ramanah was attempting to follow good practice, and there's no evidence of personal mitigation that has been offered.

Mr Way referred to Mr Ramanah's application for agreed removal and stated that within this, Mr Ramanah attempted to deflect matters and stated that the most serious matter had not been found proven. He referred the panel to its findings in relation to the lack of insight demonstrated by Mr Ramanah.

Mr Way acknowledged that Mr Ramanah has been subject to an interim conditions of practice order since 21 May 2020. However, he informed the panel that as far as the NMC is concerned, Mr Ramanah has not been practising as a nurse for the duration of the interim order.

Mr Way submitted that the fact that no more actual harm was occasioned to residents than the panel had concluded was caused was not a good mitigating factor because residents were put at a real risk of suffering harm.

Mr Way submitted that Mr Ramanah could argue that there have been no previous fitness to practise concerns raised about him and may argue that this goes to mitigation. However, he submitted that the NMC's position is that limited weight ought to be attributed to this and that it is simply an overall neutral factor.

Mr Way submitted that the panel should consider the available sanctions starting at the least severe sanction and work upwards.

Mr Way submitted that taking no action and a caution order would be a wholly inappropriate given the panel's findings in relation to misconduct and impairment.

Mr Way addressed a conditions of practice order. He referred the panel to the guidance which sets out factors which may indicate a conditions of practice order is the appropriate sanction. He submitted this is not the appropriate sanction given that there are numerous and wide-ranging issues which amounted to serious professional misconduct. He submitted that it would be very difficult to frame a suitable package of conditions that would be workable. Further, given the seriousness of the case, a conditions of practice order would not be sufficient to satisfy wider public interest considerations.

Mr Way addressed a suspension order. He submitted that the panel should consider whether the seriousness of the case requires temporary removal and whether a period of suspension would be sufficient to protect patients, public confidence in nurses and professional standards. He referred the panel to the factors to consider when looking at a suspension order. He submitted that the panel may well consider that there are attitudinal problems, particularly where no insight has been demonstrated and therefore the panel could not be satisfied that he does not pose a risk of repeating the behaviour. He added that whilst there is no evidence of repetition of behaviour since the incident, Mr Ramanah has not attempted to practise as a nurse. He submitted that a suspension order is simply not sufficient to address the seriousness of the concerns identified and meet the NMC's overarching objectives in this case.

In considering a striking off order, Mr Way referred the panel to the guidance which sets out the three key questions the panel should ask itself when considering whether or not to strike off the registrant. He submitted that the concerns raise fundamental questions about the professionalism of Mr Ramanah, public confidence would not be maintained if he remained on the register and that striking off is the only sanction which will be sufficient to protect patients, members of the public and maintain professional standards.

Mr Way submitted that there was a prolonged neglect of vulnerable service users, which put them at risk of serious harm despite required improvement ratings from the CQC for several years. He submitted that Mr Ramanah not only did not make the required improvements, but the service deteriorated and ultimately resulted in harm to resident E. He submitted that Mr Ramanah's actions and inactions are fundamentally incompatible with continued registration and on that basis invited the panel to strike Mr Ramanah's name off the register.

Decision and reasons on sanction

Having found Mr Ramanah'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 professional judgement.

The panel took into account the following aggravating features:

- Lack of insight and reflection on the concerns identified
- A pattern of misconduct over a period of time
- Conduct which put patients at risk of suffering harm.
- No evidence of steps taken to address the concerns

- The CQC inspections identified areas of concerns and there is no evidence to suggest that any improvements could be sustained

The panel also took into account the following mitigating features:

- The concerns arise from a period during which the Covid-19 pandemic was on-going.
- Previous history of good character over a 40 year nursing career

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Ramanah's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Ramanah's 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 next considered whether placing conditions of practice on Mr Ramanah's registration would be a sufficient and appropriate response. The panel considered that the concerns in this case do relate to clinical failings and areas which could potentially be addressed by retraining. However, the panel noted that the concerns in this case are wide-ranging and had no evidence before it that Mr Ramanah has demonstrated a potential and willingness to respond positively to retraining. In addition, given the seriousness of the failings in this case, and Mr Ramanah's lack of insight and lack of any steps taken to address the concerns, the panel was not satisfied that Mr Ramanah would engage with any conditions it could potentially impose. Given these factors, the panel determined that

there were no conditions which would workable. Furthermore, the panel concluded that the placing of conditions on Mr Ramanah's registration would not adequately address the public interest concerns.

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 Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel noted that the concerns in this case do not relate to a signal instance of misconduct but instead relate repeated failures which amounted to serious professional misconduct. The panel has already found that there is a risk of repetition in the future. Further, the panel noted having received the panel's decision in relation to the facts proved, whilst he indicated that he accepted the panel's findings, Mr Ramanah failed to demonstrate any insight or reflections as to the impact of his actions on the residents in his care, his colleagues, the nursing profession, and the wider public. The panel noted that whilst there has been no evidence of repetition since these incidents, Mr Ramanah has not been practising as a nurse so he has not been working in a setting in which there could be a recurrence of the failings found proved. Furthermore, Mr Ramanah has breached all four of the fundamental tenets of nursing by way of numerous failings over a significant period of time.

The panel found that Mr Ramanah had not reflected on the concerns or taken any opportunity to show insight, acceptance or remorse into his failures. As a result of his failures, Mr Ramanah was directly responsible through management of the Home for exposing residents to harm or neglect, additionally failing to ensure patient safety. The panel determined that the consequences of Mr Ramanah's misconduct could result in members of the public feeling reluctant to access health and care services. The misconduct was therefore so serious that it could affect the public's trust in nurses.

Given the above factors, 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 determined that its findings in respect of the facts, misconduct and impairment, together with Mr Ramanah's lack of insight or steps taken by him to strengthen his practice, render him fundamentally incompatible with remaining on the register.

The panel was of the view that striking off is the only sanction which would be sufficient to protect patients, members of the public and maintain professional standards.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Ramanah's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, 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 Mr Ramanah 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 Mr Ramanah's 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 Mr Way. He submitted that an interim order is necessary on the grounds of public protection and is otherwise in the public interest. He invited the panel to impose an interim suspension order for a period of 18 months to cover the 28-day appeal period. He reminded the panel that if no appeal is made, the interim order will lapse and be replaced by the substantive striking off order.

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 to cover the 28-day appeal period and the length of time during which any appeal may be dealt with.

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

That concludes this determination.