Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 2 January 2024 – Friday 12 January 2024

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Nsa Ita**
NMC PIN	95D0061O
Part(s) of the register:	Nurses part of the register Sub part 1 RN1: Adult nurse, level 1 (12 April 1995)
Relevant Location:	Stoke-on-Trent
Type of case:	Misconduct/Lack of competence
Panel members:	Dale Simon (Chair, lay member) Janine Ellul (Registrant member) Asmita Naik (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Opeyemi Lawal
Nursing and Midwifery Council:	Laurence Harris, Counsel instructed by NMC
Ms Nta:	Present and unrepresented
No Case to Answer:	Charges 2a and 2b
Facts proved:	Charges 1a, 1b, 1c, 4a, 4b, 4c, 5, 6, 7a, 7b, 7c, 7d and 8
Facts not proved:	Charges 3
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months with a review)**

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

Details of charges

That you, a registered nurse, between 04 February 2019 and 05 May 2019, whilst working in a supernumerary capacity:

1. On or around 20 March 2019, during a morning shift:
    a. failed to feed a baby, who had vomited overnight, within a reasonable period of having been instructed to do so.
    b. failed to make any/any accurate record of how many feeds the baby referred to at charge 1a had taken.
    c. shouted ‘make your mind up’ and/or whispered ‘for Christ’s sake’ in response to a colleague who was talking through the creation of a feeding plan or shouted/whispered words to that effect.

2. On 22 March 2019:
    a. inaccurately completed records in respect of a baby to suggest they hadn’t received a review.
    b. amended the records referred to at charge 2a without making clear the amendment was retrospective.

3. On 05 April 2019, were unable to operate an incubator despite having received training.

4. On 22 April 2019:
    a. drew up IV antibiotics in a manner which did not comply with the principles for aseptic non-touch technique.
    b. inaccurately suggested that 0.6ml in a 5ml syringe was a different amount when drawn up in a 1ml syringe.
    c. repeatedly asked a colleague to sign off your IV competency after they had told you they were not satisfied you had sufficient competence to be signed off.

5. On 23 April 2019, used a neopuff on a baby when there was no clinical need to do so.

6. On one or more occasions failed to respond to monitor alarms and/or turned off monitor alarms without ascertaining why they had alarmed.

7. On an unknown date(s):
    a. gave pre-term formula milk to a baby who was full-term.
    b. required repeated prompting to document in a baby's special care chart.
    c. failed to record hourly observations of cannula line pressure, despite being instructed to do so.
    d. inaccurately recorded that a baby had experienced desaturations when they had not.

8. Failed to engage constructively with feedback from colleagues.

AND, in the light of the above, your fitness to practise is impaired by reason of your misconduct at charge 1c and/or 4c and/or your lack of competence in respect of the remaining charges.

Decision and reasons to hear NMC witnesses at the hearing centre

At the outset of the hearing the panel were made aware that the NMC witnesses were attending the hearing remotely.

Upon sending your Case Management Form (CMF), you emailed your NMC case officer on 12 October 2023, stating:

> *'I would like all the witnesses to be present in person during the hearing for cross examination.'*

However, on the first day of the hearing, you learned that all the witnesses were attending remotely despite your requests, and you still wished for them to be present at the hearing centre.

Mr Harris submitted that the hearing should proceed as the witnesses are ready to give evidence via video link. He also submitted that you were made aware of the NMC stance on your request and had been told that the witnesses would not be attending the hearing centre and will only be attending remotely.

Mr Harris referred the panel to the NMC guidance DMA-6, specifically;

> *'Evidence can be given to a panel in several different ways. What is important is that the panel can fairly consider the case before them.*
>
> *…*
>
> *A decision to hold a hearing at a hearings centre does not mean that a person needs to attend to give evidence 'in-person'. How a person gives evidence will be a separate decision.*

In most circumstances, there is no disadvantage in someone giving evidence by video-link compared to appearing in the same room as the panel. In some cases, it may be better to give evidence by video-link rather than over the telephone, although telephone evidence may still be considered a fair way for the witness to give their evidence.'

Mr Harris submitted that if the witnesses attend remotely, you will still have a fair hearing despite your concerns about technology about the technology as the technology is known to work and is used regularly for NMC hearings.

Mr Harris submitted that the interests of justice lean towards allowing the witnesses to continue remotely.

You submitted that your concerns relating to technology and collusion by those giving evidence were allayed, and as such you agreed to proceed with the witnesses attending remotely.

The panel heard advice from the legal assessor.

The panel took into account the submissions, NMC and PSA guidance and the public interest in the expeditious disposal of the hearing. The panel determined that there is no real benefit in causing a delay by requiring the witnesses to attend the hearing centre and that there was no unfairness to you in hearing the witnesses via video link.

The panel determined to proceed with the witnesses attending remotely.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Harris under Rule 31 to allow the hearsay evidence relating to charge 3, which states:

> *'On 05 April 2019, were unable to operate an incubator despite having received training.'*

Mr Harris submitted that the evidence that relates to this charge is within Ms 7's referral to the NMC and meeting notes, which states:

> *'Some staff concerns raised regarding her clinical ability were; unable to operate incubator (after receiving training)…'*

Mr Harris submitted that these two references are the sole pieces of evidence in respect of charge 3 and that attempts were made by the NMC to establish who witnessed the incubator incident but the individual could not be identified.

Mr Harris submitted that he acknowledged that anonymous hearsay cannot be fairly admitted but the panel should consider whether the overall allegations allow the reliability of this allegation to be tested.

You opposed the application to admit hearsay evidence and stated that you deny charge 3.

The panel heard and accepted the legal assessor's advice and referenced Rule 31.

The panel considered that the evidence is relevant as it relates to the charge. However, the panel determined that if the evidence was admitted, you will not be able to challenge the evidence as you deny the charge and the panel have no way of testing it.

The panel concluded that the anonymous hearsay has been presented as the sole and decisive evidence for charge 3.

In these circumstances the panel refused the application.

Mr Harris offered no evidence on charge 3.

Background

The charges arose whilst you were employed as a registered nurse by University Hospital of North Staffordshire.

You were a band 5 staff nurse on the neonatal 2 unit and in your application to the Trust it outlined that you had previously worked as a senior sister on a neonatal unit.

On commencing your employment, you received the standard induction package and support for new starters with previous neonatal experience and training.

You were assigned mentors, had a supernumerary period of 6 weeks and a new starter competency package to complete. You received regular input from the senior staff nurse and from the clinical educator to shape your supernumerary period individually as appropriate.

Concerns were raised by colleagues because it was felt that your clinical ability did not reflect someone with your level of experience in neonatal nursing.

You were closely supported in your nursing practice because of the concerns raised about your clinical skills but you did not demonstrate an improvement in your clinical practice. This was evident by both comments and concerns from those working with you, your mentors and by the fact that you were failing to get your competency packages completed.

As a result, your supernumerary period was extended from 6 weeks to 10 weeks to provide you with more opportunity to have your competency package signed off, but you still did not complete it.

The senior staff nurse, unit matron and clinical educator all highlighted concerns about your ability in meetings with you during your supernumerary period. However, when asked what help you needed to complete your competency package, you believed that you were

fit to practice and needed no further support or intervention to help you to get your competency package signed off.

Decision and reasons on application of no case to answer

At the close of the NMC case.

The panel of its own volition initiated the application that there is no case to answer in respect of charges 2a and 2b. This application was made under Rule 24(7).

In relation to this application, Mr Harris submitted that the panel should consider that the charges are separate and should be addressed separately.

In relation to charge 2a, Mr Harris submitted Ms 7 gave evidence about the concerns raised by the doctor in respect of your record keeping. However, Ms 7 could not give direct evidence of the inaccuracies that the doctor informed her of.

Mr Harris accepted that Ms 7's evidence is hearsay and the doctor has not given evidence.

In relation to charge 2b, Mr Harris submitted that Ms 7 exhibits a contemporaneous note for a patient but whilst giving oral evidence she was unable to remember what was amended or identify it on the face of the document.

Mr Harris submitted that there might be sufficient evidence to prove this charge, if the panel take into account the contemporaneous note, Ms 7 statement and oral evidence.

Mr Harris submitted that this charge should be allowed to remain before the panel.

You submitted that there is no evidence to support these charges.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented to find the facts proved.

In relation to charge 2a, the panel considered the hearsay evidence relied upon and took the view that the sole and decisive evidence in respect of this charge. The NMC has not provided a statement from the doctor and without this the panel cannot test his evidence. The panel determined that there is no admissible evidence to allow the panel to properly find the facts of the charge proved.

In relation to charge 2b, the panel accepted that there is some evidence in respect of this charge. The panel noted Ms 7 remembers that an amendment was made but she could not remember what the amendment was when now looking at the note. The panel could not identify what was amended as there were no obvious markings on the document. As such the panel could not determine whether any such amendment was retrospective. The panel determined that in the absence of the doctor, who could tell the panel of what was changed, there is insufficient evidence to find the facts of this charge proved.

The panel concluded that, taking account of all the evidence before it the evidence was both tenuous and weak, and is insufficient to support the charges.

Application to admit rebuttal evidence

Following your evidence in chief and response to panel questions. Mr Harris made an application to introduce rebuttal evidence.

Mr Harris' rebuttal evidence consisted of:

- A letter from Newham University Hospital NHS Trust regarding the outcome of your disciplinary hearing dated 12 January 2011
- A letter from St Barts NHS Trust regarding your dismissal on grounds of incapability dated 20 August 2012

Mr Harris submitted that these documents were relevant to clarifying the chronology of the gap in your work history, particularly neonatal nursing. Mr Harris further submitted that the documents were relevant in that they served to clarify and correct the impression given by you in your evidence that you had worked clinically in 2012.

Mr Harris invited the panel to consider the letter from Ms 7 dated 28 February and further correspondence from Newham University Hospital NHS Trust dated 3 January 2010, which detailed three disciplinary allegations.

Mr Harris submitted that the documents were both relevant and fair in that they addressed your evidence which suggested that the allegations are a result of a conspiracy and not a misunderstanding or dispute.

When shown the documents you confirmed that you were unable to remember the specific dates contained within them but accepted that these events had taken place and could not remember the exact duration of your absence from work.

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

The panel took into account the documentation provided by Mr Harris. The panel noted that in response to its questions about your career history you had stated that you had last practiced clinically in a neonatal unit in 2012 and that you had left nursing in 2012 because you did not want to be “restricted” to neonatal nursing.

Based on your answers, the panel determined that the admission of these documents is both fair and relevant to clarify the timeline and further serves to correct any misapprehension or inaccuracies of your recollection of your career history. In addition, the panel were of the view that admitting these letters, will not be unfair to you as you knew about the disciplinary hearing and were aware of the general nature of the contents.

The panel confirm that the factual contents within the letters will not be considered when determining the facts of the charges raised against you.

In all the circumstances, the panel admits the rebuttal evidence.

Decision and reasons on facts

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

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

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

- Ms 1: Clinical Educator at Trust
- Ms 2: Staff nurse at Trust
- Ms 3: Band 6 Senior staff nurse
- Ms 4: Band 7 Sister on neonatal unit
- Ms 5: Band 5 staff nurse on neonatal unit
- Ms 6: Band 5 staff nurse on neonatal unit
- Ms 7: Senior sister and Ward manager on neonatal intensive care unit

The panel also heard evidence from you under affirmation.

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 and your own witness statement.

The panel noted your written witness statement in particular:

'I would like to bring to the attention of the panel the following;

- *The allegations made against me are pre meditated with the intent to destroy my career*
- *People were sent on a mission to spy on me on strategic places*
- *They ganged up against me*
- *Incident report was not written as per policy*
- *Risk assessment which is mandatory was not done*
- *UHNM did not carry out internal investigation*
- *I was not aware of the allegations made against me*
- *It is unfair to be punished for what I did not know*
- *According to NMC guidelines, all incidents must be recorded but it was not done*
- *According to health and Safety at work Acts 1974, all employers must document incidents and carry out risk assessment. None of this was done by UHNM and NMC which indicates that the allegations made against me are false*
- *The case is too long hence, leading to a lot of inconsistency in the witness statements*

I carried out my duties to the best of my ability throughout my stay at UHNM.

I am safe. No harm came to any baby, staff or any member of the public while working at UHNM.

I would like the panel to take note that I have been informing the NMC and the UHNM continually for almost five years now that the allegations made against me are malicious and false but nothing has been done about it.

Please take note that I am a victim of a conspiracy.

I have been labelled and also stigmatized by a group of staff in NICU at UHNM.'

The panel considered the witnesses called by the NMC to be credible, consistent and compelling. Their evidence was measured and balanced. The panel also found no evidence to suggest that they had been acting in collusion as part of a conspiracy against you.

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

Charge 1)

"On or around 20 March 2019, during a morning shift:

a) failed to feed a baby, who had vomited overnight, within a reasonable period of having been instructed to do so.
b) failed to make any/any accurate record of how many feeds the baby referred to at charge 1a had taken
c) shouted 'make your mind up' and/or whispered 'for Christ's sake' in response to a colleague who was talking through the creation of a feeding plan or shouted/whispered words to that effect."

These charges are found proved.

In reaching this decision, the panel took into account Ms 6's NMC witness statement, oral evidence and her contemporaneous note dated 25 March 2019. The panel also took into your account your statement and oral evidence.

In Ms 6's NMC witness statement she stated:

‘There was a baby on the unit that needed feeding because he had vomited. The night shift nurses who handed over said the baby vomited overnight. Nsa asked if she could look after that baby for practice and I agreed. At around 8:15 am, the nurse in charge came in and I told her about Baby A and she asked me to bottle feed the baby as sometimes they are less likely to vomit if they take a bottle instead of feeding via NGT (nasogastric tube).

I therefore asked Nsa to bottle feed Baby A and I got on with my work looking after other babies. After an hour, I went back to check on Nsa and she said she hadn’t fed Baby A. She added that she was cleaning. Baby A was crying, and I was concerned so I told Nsa to clean later and to feed the baby as this was priority. At around 12pm, I went to see Baby A’s feeding chart to try and create a feeding plan for the baby. I tried to involve Nsa with this by talking out loud for us to brainstorm (as she said that she had previous Neonatal experience) but after a few minutes, Nsa shouted “make up your mind” at me. I looked at her in shock and stated that I just wanted to include her. She just smiled at me and did not say anything. Following this, I reported my concerns to the ward manager Esther, and I emailed her with what I had witnessed.’

Ms 6’s oral evidence in respect of charge 1a and 1b was consistent with what she had written in her NMC witness statement.

In Ms 6’s contemporaneous note dated 25 March 2019, she stated:

‘…her reaction was whispering “for Christ sakes” and roll her eyes.’

However, during Ms 6’s oral evidence she conceded that her contemporaneous note was more accurate than her statement which had been written some time after the event and without the benefit of her contemporaneous note.

In both your oral evidence and written statement, you emphasised that these were false allegations with no evidence, and that you were not aware of the incidents.

The panel noted that Ms 6 was concerned about the tone used in speaking the words as they made her feel disrespected.

The panel preferred the evidence of Ms 6 to your evidence and determined that the incidents did occur, and that you had whispered the words “for Christ’s sake”.

Therefore, the panel found these charges proved.

Charge 4)

“On 22 April 2019:

a) drew up IV antibiotics in a manner which did not comply with the principles for aseptic non-touch technique.
b) inaccurately suggested that 0.6ml in a 5ml syringe was a different amount when drawn up in a 1ml syringe.
c) repeatedly asked a colleague to sign off your IV competency after they had told you they were not satisfied you had sufficient competence to be signed off.”

These charges are found proved.

In reaching this decision, the panel took into account Ms 2’s NMC witness statement, oral evidence and an email from Ms 2 to Ms 7 dated 24 April 2019. The panel also took into account your oral evidence, statement and your supervised practice assessment – IV medications document.

In Ms 2’s NMC witness statement she stated:

‘On the nightshift of 22 April 2019, Nsa kept asking me to sign off her IV antibiotic competencies. I told Nsa that I could not do this as I had never seen her prepare antibiotics. I said to Nsa that I would go through antibiotics with her and if she was competent, I would sign that she had done that one. Amber, the staff nurse who was working with us in room 2 that night, said to me that I wouldn’t want to sign off on Nsa’s IV competencies when I saw how she draws them up. When we draw up antibiotics on the unit, we do not touch ' key parts' to ensure the end of syringe remains non contaminated to ensure no bacteria enters the IV site. Once we have drawn up the antibiotics, we put the syringe back into the packet and into a clean blue tray. Nsa, however, kept putting the syringe on the side. I told her to she couldn't do that as she needed to keep the field clean. As Nsa had many weeks of support and had previous nursing experience, I felt that I should have been more happy with what I observed. I could go into any hospital and the principles for aseptic non touch technique would remain the same.

On the unit amount of drug we draw up into the syringe is usually a small amount. When I observed, Nsa's understanding was that 0.6ml in a 5ml syringe was different to the amount if this amount was drawn up into a 1ml syringe (as stated in original email). I explained that whatever size syringe we use- the measurement is the same, she become quite defensive and aggressive in her manner. I would not of felt comfortable signing any staff nurses IV competency package had I of witnessed them drawing up IV's the way that I observed Nsa. I said to Nsa, that she should try to draw up more IV's to get more confident, but she continued to ask me all night to sign her off, which I obviously didn't do.’

In the email from Ms 2 to Ms 7 dated 24 April 2019, she stated:

‘Nsa asked me numerous times to sign off her competency folder, but I do not feel I am able to do this as there were a few issues along the way whilst maing [sic] up the antibiotics… I don’t want the email to come across petty, but it was very simple things, one being locating the actual antibiotic she needed (Gent) in the draw,

another was understanding that 0.6ml being the same if it was drawn up un a 5ml or 1ml syringe, and she did become quite defensive when either of us tried to point anything out that wasn't ANTT.'

Ms 2's oral evidence was consistent with her NMC statement, and she clarified during her oral evidence that you asked her to sign your competency folder less than five times on that same shift.

The panel had regard to Ms 1 and Ms 7 evidence describing the process for completing the competency package. The panel heard about the procedure for signing off the package, and that it was the responsibility of the individual concerned to work through it and ensure it was completed. The nurses observing the individual carrying out the procedures would sign off the competency if they felt it was adequately completed.

You stated that these allegations were false with no evidence and Ms 2 did not follow the due process. You also stated that that you had no reason to ask Ms 2 to sign your competency pack as it was already signed off, before this shift.

You provided the panel with your signed supervised practice assessment – IV medications document.

The panel noted the IV medications document indicated that you needed your fifth signature to complete this competency as the first four signatures were dated 20 April 2019, the shift Ms 2 referred to was on 22 April 2019 and the fifth signature was dated 24 April 2019. The panel determined that it was more likely than not that you repeatedly asked Ms 2 to sign you off during the shift on 22 April 2019 as you still required a signature to be fully signed off.

The panel preferred the evidence of the NMC.

The panel found these charges proved.

Charge 5)

> "On 23 April 2019, used a neopuff on a baby when there was no clinical need to do so."

This charge is found proved.

In reaching this decision, the panel took into account Ms 2's NMC witness statement, oral evidence, an email from Ms 2 to Ms 7 dated 24 April 2019 and a local statement dated 23 April 2019. The panel also took into account your statement and oral evidence.

In Ms 2's NMC witness statement she stated:

> *'On the nightshift of 23 April 2019, I was also working in room 2 with Nsa. Bed spaces 6, 7 and 8 are all alongside one wall. The curtains around space 7, where Nsa was looking after a baby, were drawn and I was in space 6 with the baby I was looking after. I could hear the other staff nurse we were working with shouting for me to help from space 7. I quickly went into the space to see if everything was okay; Nsa didn't say anything to me. What concerned me the most was that the baby's mum was there and it just looked like mayhem. Nsa got the neopuff we use to resuscitate babies when they are not breathing and she began to give the baby rapid 'breaths', which is not part of the Newborn Life Support Algorithm. I asked Nsa to stop as I could see the baby was breathing.'*

Ms 2's local statement was written before she went off shift and also reported the incident to the manager on duty. Ms 2 emailed her concerns to Ms 7 on 24 April 2019.

Ms 2's oral evidence was consistent with her statements.

In your statement and oral evidence, you accepted that Ms 2 was present but gave an account that indicated the incident had ended before Ms 2 came into the room.

The panel considered the contemporaneous note and preferred the evidence of NMC.

The panel found this charge proved.

Charge 6)

> "On one or more occasions failed to respond to monitor alarms and/or turned off monitor alarms without ascertaining why they had alarmed."

This charge is found proved.

In reaching this decision, the panel took into account Ms 3's NMC witness statement, oral evidence and Ms 7's notes of meetings between you and Ms 7 from 24 March 2019 to 20 April 2019. The panel also took into account your statement and oral evidence.

In Ms 3's NMC witness statement she stated:

> *'I am not able to confirm the date of this concern, but I experienced that Nsa didn't monitor alarms quite regularly. When working on the unit you have the babies you were allocated to care for, but you work the room alongside your colleagues and would collaborate to ensure the safety of all the babies in the room. Therefore, if the monitor for a baby you were not caring for was alarming, you would attend to it to see if there were any concerns about the baby's condition. An alarm will monitor to indicate a change in the baby's vital signs, including changes in oxygen levels (desaturations), heart rate and respiratory rate.*
>
> *It would be usual for Nsa not to attend to the alarm, or to just turn it off and walk away without considering why the monitor had alarmed. If I did shout up to ask Nsa*

to check an alarm, she would look at the baby of concern but if she wasn't asked, Nsa didn't appear to recognise an alarm was sounding or would just turn it off and walk away. Parents would have been present and may have observed Nsa not attending to alarms.'

Ms 3's NMC witness statement is not contemporaneous and was written four years after the incident. However, Ms 7 started to note the concerns that were raised to her by other staff and in a contemporaneous note she recorded:

'Conversation with Ms 3 on 12 April 2019
NI not paying attention to alarms/attending alarms in the room wither for her own babies or others even when it was explained that this was necessary.'

In your statement and oral evidence, you stated that you did not know Ms 3 and the allegations were false with no evidence and denied that this incident happened.

The panel preferred the evidence of the NMC.

On the balance of probabilities, the panel found this charge proved.

Charge 7a)

"On an unknown date(s):
a) gave pre-term formula milk to a baby who was full-term."

This charge is found proved.

In reaching this decision, the panel took into account Ms 3 NMC witness statement and oral evidence. The panel also took into account your statement and oral evidence.

During Ms 3's oral evidence she was detailed about the events of the incidents and made it clear that no actual harm was caused to the baby.

You stated that this did not happen, and you have never worked with Ms 3.

The panel prefer the evidence of the NMC.

The panel found this charge proved.

Charge 7b,c,d)

"On an unknown date(s):

b) required repeated prompting to document in a baby's special care chart.
c) failed to record hourly observations of cannula line pressure, despite being instructed to do so.
d) inaccurately recorded that a baby had experienced desaturations when they had not."

These charges are found proved.

In reaching this decision, the panel took into account Ms 5's NMC witness statement and oral evidence. The panel also took into account your statement and oral evidence.

Ms 5's NMC witness statement and oral evidence was consistent and clear.

You accepted that Ms 5 was your mentor and that you worked alongside her. However, during your oral evidence you stated, "Ms 5 was forced to give evidence and that she had been pinned against you."

The panel determined that your assertion lacked credibility. Ms 5's testimony was clear and balanced and she gave evidence willingly. Ms 5 made no reference nor was she asked about being forced to make a statement.

Therefore, the panel preferred the evidence of the NMC.

The panel found these charges proved.

Charge 8)

"Failed to engage constructively with feedback from colleagues."

This charge is found proved.

In reaching this decision, the panel took into account your statement and oral evidence. The panel also took into account the following:

Ms 2's NMC witness statement she stated:

'I explained that whatever size syringe we use- the measurement is the same, she become quite defensive and aggressive in her manner.'

Ms 2's email to Ms 7 dated 24 April 2019 she stated:

'…she did become quite defensive when either of us tried to point anything out that wasn't ANTT.'

In Ms 4's witness statement she stated:

'However, Nsa had this blocking attitude. When you tried to engage with her, it was like she almost put her hand up and said she was doing it her way. She was

positively hostile when staff tried to provide her with help and guidance, or would ignore and argue, and this is what made me feel that Nsa could potentially be dangerous. In all my years of nursing, I have never met anyone like Nsa.'

In Ms 7 NMC witness statement she stated:

'Both Nsa's ability and attitude was a concern. I found that Nsa was very evasive, dismissive, hostile and difficult to engage with. It was difficult to maintain eye contact with her and she didn't like to be challenged. She didn't understand why we were doing what we were doing. Even when she had not demonstrated her competency in a certain task, she was asking staff to sign her off. We explained to her that we could not sign her off until we had done the tasks with her. She did not like that at all. People tried to befriend Nsa and talk to her about things other than work, but she refused to speak with anyone. She would say "why are you asking me about this?" It was not just about Nsa being private, she was quite hostile about it. She would often give short abrupt answers so there was not much to go off as to whether she knew anything.'

In your witness statement, you stated that you are unaware of this incident and that this is a false allegation with a lack of evidence.

The panel determined that a number of witnesses had raised concerns and felt that there was a common theme; failure to respond to feedback, a failure to turn up to feedback meetings and a lack of progress despite extensive support. The lack of progress in your clinical practice and growing concerns suggests that your engagement with the feedback offered was not constructive.

The panel found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether those facts found proved in charges 1c and 4c amount to misconduct and whether the remaining charges amount to a lack of competence and, if so, whether your fitness to practise is currently impaired by reason of lack of competence and/or misconduct. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Your evidence under affirmation

You told the panel that charges 1c and 4c do not amount to misconduct, because asking a colleague to sign-off cannot be regarded as misconduct.

You said that you had accepted that there was a gap in your nursing practice, but you were working towards closing that gap by seeking employment at the Trust and getting your competencies signed off.

You told the panel that since the referral to the NMC in 2019, you have been doing some ‘studies’ online as you have difficulties in gaining employment in a nursing capacity because of your NMC restrictions and lack of references. When further questioned about the nature of these studies, you stated that you have been receiving information circulars from a nursing agency you once worked for. However, you were unable to provide any details of your learning or provide any certificates. You further told the panel that all of your previous studies such as your MBA were to back up your nursing knowledge.

You informed the panel that you had previously applied for the return to practise course but were rejected twice as your PIN had not expired but had been suspended due to the ongoing NMC proceedings.

You outlined to the panel that the NMC proceedings have had a detrimental impact on your mental, physical and spiritual wellbeing and your family. You informed the panel that you have not worked in a nursing capacity since 2019 and due to your dismissal from the Trust, you are unable to get a reference. You confirmed that you had not practiced as a neonatal nurse since 2011 to the present day except for the 10 weeks of employment with the Trust. Furthermore, you confirmed you had no other nursing experience since 2011 except for one partially completed shift with a nursing agency in adult care setting, which you undertook at some point before you commenced employment with the Trust. When questioned you indicated that you had no interest in anything other than neonatal work.

You told the panel that if you had the chance to go back to practice you will be fit to do so, as you will have the support of colleagues. You also told the panel that in future you would inform your employer of previous concerns raised about your practice to give a clearer picture of the support you need.

Submissions on lack of competence

The NMC has defined a lack of competence as:

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

Mr Harris invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of ‘The Code: Professional standards of practice and behaviour for nurses and midwives (2015)’ (“the Code”) in making its decision.

Mr Harris identified the specific, relevant standards where your actions amounted to a lack of competence. Mr Harris submitted that lack of competence needs to be assessed using a three-stage process:

- Is there evidence that you were made aware of the issues around your competence?
- Is there evidence that you were given the opportunity to improve?
- Is there evidence of further assessment?

Mr Harris submitted that your lack of competence involved wide ranging areas that are fundamental to nursing practice. The facts found proved occurred within a short period of time and despite extensive support being provided to you by your employer and staff members, you demonstrated an unwillingness to engage with support. He submitted that the facts found proved show that your competence at the time was below the standard expected of a band 5 registered nurse.

Submissions on misconduct

Mr Harris then addressed the panel on misconduct. He referred the panel to the Code and identified the relevant standards where the NMC say your actions amounted to misconduct, in particular 9.3, 8 and 19.

Mr Harris submitted your conduct towards Ms 6 demonstrates a lack of respect for colleagues and ineffective communication.

Mr Harris invited the panel to take the view that your behaviour at charges 1c and 4c should be regarded as misconduct.

Submissions on impairment

Mr Harris moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Harris submitted that limbs a, b and c are engaged in the *Grant* test.

Mr Harris submitted that all of the charges occurred over a three-month period, which was the first time in a neonatal clinical capacity since 2011. He further submitted that steps were taken by the Trust to help you make improvements.

Mr Harris referred the panel to Ms 4's evidence in which she stated that *'…Nsa could potentially be dangerous.'* Mr Harris submitted that public protection and public interest grounds are engaged.

Mr Harris therefore invited the panel to find that your fitness to practice currently impaired by your lack of competence and misconduct.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

The panel determined that your actions at charges 1c and 4c were single isolated instances and did not fall significantly short of the standards expected of a registered nurse.

In relation to charge 1c, in light of Ms 6's description of the incident and the overall context, the panel was satisfied that your actions in whispering 'for Christ's sake' were not so serious as to be considered misconduct.

In respect of 4c, in light of the context that you still required your IV competency package to be signed off and that you needed to ask colleagues you were working with to complete this task, the panel determined that your actions were not so serious as to be considered misconduct.

The panel found that your actions did not amount to misconduct.

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, the following standards:

> *'**1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***6 Always practise in line with the best available evidence***

To achieve this, you must:

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

8 Work cooperatively

To achieve this, you must:

8.4 work with colleagues to evaluate the quality of your work and that of the team

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
13.4 take account of your own personal safety as well as the safety of people in your care
13.5 complete the necessary training before carrying out a new role

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable band 5 registered nurse and not by any higher or more demanding standard.

The panel had regard to the number of witnesses who explained that you were practicing at a standard far below that of an experienced neonatal nurse and also with regard to basic nursing skills.

The panel determined that the facts found proved provided a fair sample of instances of lack of competence; there are 13 charges in a 10-week period, most of the errors relate to basic nursing practice while you were supernumerary and closely supervised and supported by colleagues. The instances cover a variety of situations in which staff working alongside you felt that your practice fell far below standards expected of a band 5 neonatal nurse. The panel noted that your supernumerary period had been extended to support you but you did not meet the standards required.

The panel determined that your lack of competence was compounded by your attitude as you are not open to feedback, you resisted and blocked any support given to you and you are unable to identify your own shortfalls and seek appropriate support.

In light of the facts found proved, the panel has concluded that your practice was far below the standard that one would expect of a reasonable registered nurse acting in your role.

In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on impairment

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

The panel recognised that you have robustly defended this case and maintain your innocence. The panel accepts that you are entitled to do so. The panel recognises that it would be unfair to penalise you for any perceived lack of insight or remorse arising from your defence. The panel however noted the nature of your defence which went beyond mere denial and suggested that you were a victim of a malicious and false conspiracy. The panel also considered that there was clear evidence of attitudinal concerns throughout your case.

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

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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 found that limbs a, b and c of the *Grant* test are engaged. The panel found that no patient was caused physical harm as you were being directly and closely supervised. However, vulnerable patients were put at risk of harm as a result of your lack of competence. The panel found that your failings breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel had regard to whether the lack of competence identified is easily remediable, whether it has been remedied and the risk of repetition. The panel was satisfied that the lack of competence in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel noted that you worked one nursing shift between 2011 – 2019 through an agency on an adult ward before seeking employment at the Trust and that since 2019 you have not worked in any nursing capacity. Therefore, the panel concluded that you have been unable to strengthen your practice. You have not

provided any evidence of training or nursing/health related work or volunteering that could have played a part in strengthening your practice in the last 5 years.

The panel determined that you have demonstrated a lack of insight into your readiness to practice in a neonatal unit after such a long period of absence. You also lack insight into your responsibility to ensure that you are competent to practice safely as you rely on the fact that you will be supervised by others to ensure the safety of your patients, who if on a neonatal unit. would be extremely vulnerable. This shows a continued lack of insight which greatly increases the risk of repetition.

The panel is of the view that, based on the lack of evidence that you have strengthened your practice there is a risk of repetition. 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 public confidence in the profession and the NMC as a regulator would be undermined if a finding of impairment were not made in this case, given the nature of the charges around basic nursing tasks and the vulnerability of the patients in neonatal care.

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

Sanction

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

Submissions on sanction

Mr Harris informed the panel that the NMC had advised you that it would seek the imposition of a 12-month suspension order with a review if it found your fitness to practise currently impaired.

Mr Harris submitted that concerns about your practice are wide-ranging and not on the lower end of impairment. He further submitted that you have clear attitudinal problems and lack any sense of responsibility for your actions.

Mr Harris submitted that a conditions of practice order needs to be workable and appropriate and outlined factors that would undermine the appropriateness of a conditions of practice order such as;

- Being out of practice for a number of years and returning for a short period of 10 weeks
- No conditions placed on your clinical practice can adequately protect vulnerable patients
- No willingness to engage with support the Trust put in place.

Mr Harris submitted that for these reasons a conditions of practice order would not be workable.

Mr Harris invited the panel to impose a 12-month suspension order with a review.

You submitted that you had no preference, and that the decision is up to the professional judgement of the panel.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Extremely vulnerable patients were put at risk of harm
- Pressure and burden placed on colleagues due to the level of your lack of competence
- Your unwillingness to respond appropriately to feedback
- Lack of insight into your personal responsibility to ensure your readiness to return to neonatal nursing.

The panel were unable to identify any mitigating factors.

The panel acknowledged your full participation in the hearing and your daily attendance.

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.

The panel found a caution order would not adequately address the public protection and public interest concerns in this case.

The panel next considered whether placing conditions of practice order on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The shortfalls in your practice are wide-ranging and the level of your practice is far below the standard of a band 5 registered nurse, therefore the panel felt that you will require extensive retraining in basic nursing skills before you are able to return safely to practice. The panel therefore determined that a conditions of practice order will not be proportionate or workable.

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

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate in cases of lack of competence where the following factor is apparent:

- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, a suspension order will sufficiently mitigate the risks and address the public protection and public interest.

As no allegations of misconduct have been found proved, the imposition of a striking-off order is not available to the panel.

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

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

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

The panel determined that a suspension order for a period of 12 months with a review was appropriate in this case.

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

Any future panel reviewing this case would be assisted by:

- Your attendance at any future hearings
- A reflective piece from you demonstrating your insight into your lack of competence and the impact on patients, colleagues and the profession
- References and testimonials from employers and others who are able to comment on your clinical practice and/or character
- Copies of any relevant training certificates

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Harris. He submitted that an interim order is necessary to the grounds of public protection and in the wider public interest to cover the period of appeal.

Decision and reasons on interim order

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

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

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

That concludes this determination.