Conduct and Competence Committee

Substantive Hearing

23 – 27 January 2017

Nursing and Midwifery Council, Temple Court 13a Cathedral Road, Cardiff, CF11 9HA

Name of Registrant Nurse:	Diana Veronica Skeats
NMC PIN:	78I4074E
Part(s) of the register:	RN1, Registered Nurse – Sub part 1 Adult – 1 December 1981
Area of Registered Address:	Wales
Type of Case:	Misconduct
Panel Members:	Helen Potts (Chair Lay member) Christopher Morrow-Frost (Registrant member) Hilary Nightingale (Lay member)
Legal Assessor:	John Bromley-Davenport QC
Panel Secretary:	Sarah Burton
Registrant:	Mrs Skeates present and represented by Chris Green, Counsel instructed by the Royal College of Nursing
Nursing and Midwifery Council:	Represented by Tania Murshed, Counsel, NMC Regulatory Legal Team.
Facts proved by admission:	**1.1, 1.2 and 2**
Facts not proved:	**3 (no case to answer)**
Fitness to practise:	**Impaired**
Sanction:	**Suspension order – 6 months**
Interim Order:	**Interim suspension order – 18 months**

Details of charge as read:

That you, whilst employed as a Registered Nurse at the Rhiwlas Care Home:

1. On 12 April 2014 did not perform CPR on Patient A:

1.1 When DNR was not in place;
1.2 Without conducting an appropriate assessment of Patient A's condition;
1.3 Without exercising any appropriate clinical judgment;

2. Did not keep your CPR training up to date in that your CPR training had expired on 8 February 2014;

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

Background

You were employed as a nurse working at the Rhiwlas Care Home (the Home). You were responsible for leading shift teams, supervising staff, performing patient assessments and providing patient care. You mostly worked day shifts and were line managed by the Home's deputy manager, Ms 2.

The allegations arise from the cardiac arrest and subsequent death of Patient A on 12 April 2014. Patient A had been at the Home for approximately five weeks and suffered from dementia and required physical care as a result of a fractured hip. Latterly she did not like to leave her room, remaining in her bedroom for most of the day and had started on occasion declining to eat food.

On the evening of 12 April 2014, a care assistant, Ms 1, noticed that her door was shut at around 20:20 which caused her to check on Patient A. On finding that Patient A was unresponsive Ms 1 called for assistance from you and another nurse. You both attended but neither of you performed CPR.

The Coroner's report of Patient A's death noted that the cause of death was:

a) a pulmonary embolism
b) deep vein thrombosis in the right leg
c) immobility following a fracture of the neck of femur (operated)
d) dementia
e) old stroke.

The Coroner concluded that the death was accidental.

Following Patient A's death on 12 April 2014 her Notification of Death form was reviewed by the acting Home Manager who noted that CPR was not listed as having been carried out. Subsequently an investigation was carried out.

Decision and reasons on application to amend charge

The panel heard an objection made by Mr Green, on your behalf, pursuant to Rule 24(2) and Rule 24(4) and a subsequent application to amend the wording of charge 2 pursuant to Rule 28.

The amendment requested by Mr Green was to clarify the charge and the misconduct within it. He submitted that the charge as currently drafted is ambiguous and that the proposed amendment would provide clarity and enable you to either admit or deny the charge.

Ms Murshed submitted that it is the NMC's position that you did not keep your training up to date in accordance with the company policy and the NMC's Code of Practice. Ms Murshed submitted that it is the NMC's position that charge 2 should not be amended and such an application is opposed.

Mr Green submitted that in light of the NMC's position, charge 2 should be clarified by adding the words 'in accordance with company policy and the NMC's Code of Practice.' Mr Green submitted that without such an amendment you may defend the charge on one basis but the charge be found proved on another basis.

Mr Green submitted that the proposed amendment should be as follows:

"2. Did not keep your CPR training up to date in accordance with company policy in that you had not attended training since 8 February 2013"

The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

28 (1) At any stage before making its findings of fact …

(i) … the Conduct and Competence Committee, may amend

(a) the charge set out in the notice of hearing …

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

The panel determined that Charge 2 as drafted was unambiguous. It required the NMC to prove that your Cardio Pulmonary Resuscitation (CPR) training was not up to date in that it had in some way expired on 8 February 2014.

The panel was of the view that such an amendment, as applied for, was not necessary for the interests of justice. The panel was satisfied that there would be no prejudice to you and that no injustice would be caused to either party by refusing the proposed amendment. It was therefore not appropriate to allow the amendment, as applied for.

A second application to amend the charges was made by the parties during the facts stage of the hearing. It was proposed by both parties to make the following changes:

That you, whilst employed as a Registered Nurse at the Rhiwlas Care Home:

1. On 12 April 2014 did not perform CPR on Patient A:

1.1 When DNR was not in place;

1.2 ~~Without conducting an appropriate assessment of Patient A's condition;~~ When your employer's DNA CPR policy required you to do so;

1.3 ~~Without exercising any appropriate clinical judgment;~~ And did not contact paramedic services as required by your employer's DNA CPR policy.

Ms Murshed submitted that this application was made in light of the evidence that was now before the panel; the witness evidence and a full copy of Policy 51. She told the panel that it was conceded by Mr Green that you accept that you did not follow the Home's policy in that you were required to carry out CPR and to contact the paramedic

services. Ms Murshed submitted that it would, therefore, be sensible to amend the charges to reflect this information. Mr Green confirmed that this application is agreed. He submitted that such an amendment would be in the public interest and could be made without injustice being caused to you.

The panel agreed that the amendments proposed by the parties identified the 'mischief' reflected by the evidence that the panel had heard so far. However, the panel considered a slightly different form of wording to set out the charges, whilst keeping the spirit of the changes proposed by both parties.

The panel was of the view that such an amendment was in the interests of justice. The panel was satisfied that no prejudice and no injustice would be caused to either party by accepting the spirit of the amendment proposed by both parties. The panel concluded that it was therefore appropriate to allow an amendment to the charge and the amended charge should read as follows:

Amended charge:

That you, whilst employed as a Registered Nurse at the Rhiwlas Care Home:

1. On 12 April 2014 did not perform CPR on Patient A:

1.1 When there was no DNACPR decision in place; and

1.2 When your employer's DNACPR policy required you to do so.

2. On 12 April 2014 did not contact the paramedic services as required by your employer's DNACPR policy.

3. Did not keep your CPR training up to date in that your CPR training had expired on 8 February 2014.

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

Decision and Reasons on Application of no case to answer

The panel considered an application from Mr Green, on your behalf, that there is no case to answer in respect of charge 3. This application was made under Rule 24 (7) of the Rules. This rule states:

24 (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –

(i) either upon the application of the registrant …

the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.

In relation to this application Mr Green submitted that there was a paucity of evidence in respect of charge 3. Mr Green drew the panel's attention to the document setting out the Home's training requirements which stipulates that there was an expectation that nurses would carry out annual CPR training. Mr Green also drew the panel's attention to your training record which states that your CPR training expired on 8 February 2014.

Mr Green noted that Mr 3 stated in his oral evidence that a nurse's CPR training is valid for three years. Mr Green also reminded the panel of the oral evidence of Mr 3 who said that it was company policy for nurses to undertake CPR training annually, but that there may be acceptable circumstances in which this is delayed. Mr Green submitted that no disciplinary proceedings were raised against you by your employer in respect of a delay in your 2014 CPR training.

Mr Green further noted the oral evidence of Ms 2, who stated that it was not the responsibility of the nurse to source their training, but rather the Home should provide it. Mr Green also referred to the witness statement of Ms 4, which states that you were

booked to attend CPR training on 20 April 2014. Furthermore, Ms 4 stated that the lack of CPR update training did not affect your understanding of CPR. Mr Green submitted that the statement further says that it only becomes a disciplinary matter if a nurse is invited to training, it is put in place, and the nurse does not attend. Mr Green submitted that there was no disciplinary investigation regarding the expiry of your CPR training, which was as a result of there being no trainer at the Home at the relevant time.

Mr Green submitted that the panel must consider whether the available evidence could be sufficient to prove the charge. He submitted that the evidence in this case does not prove that there was a strict rule to the effect that CPR training must be undertaken every year. Mr Green noted that Mr 3 stated during his oral evidence that there was an expiry date and the CPR training would become out of date, but that this was 3 years after the training had been undertaken, namely February 2016 and not February 2014. Mr Green submitted that all of the evidence in the round was not capable of proving charge 3.

Ms Murshed, on behalf of the NMC, submitted that the NMC's case relied on the expiry date as given by the Home. She accepted that Mr 3 said in his oral evidence that there was no rigid rule at the Home for nurses to have CPR training every 12 months and that the evidence available shows that there was an expectation for you to keep training up to date. Ms Murshed also noted that Ms 2 and Mr 3 said that it was the responsibility of the Home to provide CPR training. However, she submitted that if the panel considered charge 3 in its strict sense, the training at the Home had expired as the Home required nurses to undertake CPR training annually, rather than every three years.

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

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

sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel was of the view that this is not a case where there is no evidence available to it in respect of charge 3. The panel noted that there is some evidence which is of a tenuous and contradictory nature. In particular the panel noted the conflicting evidence concerning the frequency and expiry of CPR training.

The panel considered that the most compelling evidence was that of Mr 3 who is an experienced nurse manager of a home operated by the same company. The panel noted that in his role as a home manager he has overall responsibility and accountability for the training of his staff. The panel accepted Mr 3's evidence that CPR training is a statutory requirement and that the validity of the training is for 3 years but that the Home required its nurses to undertake annual update training. The panel also accepted his evidence that there was some flexibility as to when this annual training was carried out and that he stated that in his view your training had not expired and was up to date at the relevant time. The panel noted that the NMC had placed no evidence before it that contradicts this assertion. The panel also noted that the evidence of Mr 3 was consistent with that of Ms 2, in that it was not up to the individual to source the CPR training but it was the responsibility of the Home. The panel also accepted the evidence of Ms 2, Mr 3 and the statement of Ms 4 that a nurse had the responsibility to attend training and that it is only a disciplinary matter when they do not attend and they have been sent reminders.

The panel was therefore of the view that, taking account of all the evidence before it, there was no realistic prospect that it would find the facts of charge 3 proved.

Decision on the findings on facts and reasons

The panel considered all the evidence adduced in this case together with the submissions made by Ms Murshed, on behalf of the NMC, and those made by Mr Green, on your behalf.

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

The panel took into account all the oral and documentary evidence in this case. The panel heard oral evidence from three witnesses called on behalf of the NMC:

Ms 1, Carer at the Home
Ms 2, Deputy Manager of the Home
Mr 3, Manager of a Home operated by the same company.

The panel found each of these witnesses to be credible, consistent and balanced.

The written statements of Ms 4, Registered Nurse and General Manager of another care home, and Ms 5, Home Administrator**,** were agreed by the parties and read into the evidence.

During the course of this hearing, following a late amendment to the charges, you admitted the following charges:

That you, whilst employed as a Registered Nurse at the Rhiwlas Care Home:

1. On 12 April 2014 did not perform CPR on Patient A:

1.1 When there was no DNACPR decision in place; and

1.2 When your employer's DNACPR policy required you to do so.

2. On 12 April 2014 did not contact the paramedic services as required by your employer's DNACPR policy.

These charges were therefore announced as proved by reason of your admissions.

The panel had already considered the remaining charge during an application for no case to answer (see decision above).

Charge 3:

3. Did not keep your CPR training up to date in that your CPR training had expired on 8 February 2014;

No case to answer.

Submissions on misconduct and impairment:

Having announced its findings on all the facts, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. The NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

At the start of this stage of the hearing Mr Green informed the panel that you were unwell and would not attend today. The panel were mindful that you should be granted the opportunity to provide evidence on impairment which could assist the panel in establishing your current insight, remorse and remediation. The panel offered you, through Mr Green, the opportunity to request an adjournment or to provide evidence through alternative means, for example by telephone. Mr Green having taken instructions from you was content for the proceedings to continue.

Mr Green informed the panel that you admit impairment and that you will not be providing any further evidence at this stage other than a copy of a training certificate and a letter from your former employer, Clarence Medical Centre, where you were employed from October 2014 to February 2015, before you left on health grounds.

Mr Green informed the panel that there are current health considerations which would prevent you from working full time and from working 12 hour shifts. However, he told the panel that you do hope to return to nursing practice on a part time basis. Mr Green submitted that it is accepted by you that upon a return to nursing practice, you would require a period of time working under supervision as you have not worked since 2015.

In her submissions Ms Murshed invited the panel to take the view that your actions amount to a breach of *The Code: Standards of conduct, performance and ethics for nurses and midwives 2008* ("the Code"). She then directed the panel to specific paragraphs and identified where, in the NMC's view, your actions amounted to misconduct.

Paragraph 21 – “You must keep your colleagues informed when you are sharing the care of others.”

Paragraph 38 – “You must have the knowledge and skills for safe and effective practice when working without direct supervision.”

Paragraph 42 – “You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.”

Ms Murshed submitted that misconduct is defined as a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. She stated that failure to follow procedures and failure to attempt CPR is clearly misconduct.

Ms Murshed then 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 uphold proper standards and to maintain public confidence in the profession and in the NMC as a regulatory body.

Ms Murshed noted that since this incident you have only worked as a nurse for a short period, before resigning on health grounds. She submitted that there is no evidence as to how you would deal with a similar situation in the future and that there is no evidence that you have taken any steps to remediate your misconduct.

Ms Murshed submitted that you have shown some level of insight when you stated during the Home’s investigation that you regretted not discussing a Do Not Attempt to Resuscitate (DNACPR) with the patient and her family. However, Ms Murshed submitted that this insight is limited given your apparent justifications for not carrying out CPR on the patient. In the documentation before the panel you repeatedly state that the patient had a low mood and had appeared to have given up on life. You considered that

the patient did not want to live, despite there being no DNACPR form in place. During the investigation, you said that you considered that carrying out CPR on the patient would have been disrespectful of her wishes. You also stated that you saw the spirit of the patient looking down on you saying, ‘don’t you dare’. Ms Murshed submitted that there were no patient notes to show that the patient wanted to die and whilst the patient’s mood was low, a doctor had assessed her as not being depressed and had made a referral to a dietician about her eating.

Ms Murshed submitted that these statements show that you were trying to justify your decision not to carry out CPR and that it was not a decision that you, as a nurse, should have been making in any event. Ms Murshed noted that during the investigation you told the Home that you thought that the patient had been dead for too long and that CPR would have been futile.

Mr Green informed the panel that you admit misconduct and impairment at this stage. He invited the panel to take account of your statements and the minutes of the Home’s investigatory, disciplinary and appeal meetings which were contained in the hearing bundle. Mr Green submitted that the panel may wish to consider whether your decision not to carry out CPR on the patient was inappropriately influenced by your beliefs about the patient’s wishes and/or your personal religious beliefs. Mr Green submitted that these questions are not matters of the panel’s judgement but are matters of fact. He submitted that the panel does not need to resolve these questions of fact but if it chooses to do so, then the panel must apply the same burden and standard of proof applicable at the facts stage of the hearing, namely that it was for the NMC to prove these matters on the balance of probabilities.

With regard to the Code, Mr Green submitted that the paragraph concerning a nurse communicating with colleagues is not applicable as this is not at the centre of the charge and is speculation. Furthermore, he submitted that there is no charge concerning record keeping and therefore it is again not appropriate to find this paragraph of the Code breached. However, Mr Green accepted that the other articles of

the Code highlighted by Ms Murshed have been breached and are serious enough to amount to misconduct.

Mr Green invited the panel to consider the mitigation in this case including that there is no evidence before the panel that your misconduct caused the death of the patient and that the incident involved two nurses and not just yourself.

Mr Green submitted that there is no evidence before the panel other than your own statements as to why you did not carry out CPR. He submitted that the spiritual experience you had was not the driving force behind your decision not to carry out CPR, as the clinical decision that CPR was futile had already been made. Mr Green submitted that your spiritual encounter is not given in your statements as the reason for not carrying out CPR on the patient, as it occurred after the decision not to carry out CPR. He noted that during the Home's investigation you said that if CPR had been needed you would have done it, even if it was against your spiritual belief. Mr Green submitted that this shows you are able to draw a distinction between your feelings and your duties. Mr Green accepted that you appeared to have an emotional reaction to the death of the patient and responded to this in terms of your religion, but again this is not why you did not carry out CPR.

Mr Green also drew the panel's attention to your statement in which you said you asked your colleague, another more experienced nurse, whether you should carry out CPR and she replied, 'No'. Mr Green submitted that it would not have been appropriate for you to argue with her. Mr Green further submitted that whilst you accept that neither you nor your colleague should have made the decision not to carry out CPR, you should not be criticised for accepting the lead of a more experienced nurse.

Mr Green outlined your nursing career for the panel. The panel heard that you qualified in 1981 and then took a long break from nursing between 1999 and April 2012 and then completed a return to practise course. He also told the panel that you have taken some steps to remediate your misconduct as you have completed a first aid course. However,

he stated that it is accepted that this does not constitute full remediation and that a period of supervision would be needed upon your return to nursing practice. Mr Green submitted that therefore impairment is admitted by you.

With regard to insight, Mr Green submitted that you were confused at the time of the investigation as to what was required of you in respect of CPR and the Home's policy. However, he submitted that you are no longer confused and you now know what is required of you. The panel heard that such misconduct would not happen again as you understand that you must carry out CPR in such circumstances. Mr Green also informed the panel that you apologise for this incident.

The panel has accepted the advice of the legal assessor which included reference to a number of judgments, these included: *Roylance* v *General Medical Council (No 2) [2000] 1 A.C. 311; Nandi* v *GMC [2004] EWHC 2317 (Admin); GMC v Meadow [2007] QB 462 (Admin)*; *Cheatle v General Medical Council [2009] EWHC 645 (Admin)* and *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).*

The panel adopted a two-stage process in its consideration, as advised. 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, your fitness to practise is currently impaired as a result of that misconduct.

Decision on misconduct

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of *The code: Standards of conduct, performance and ethics for nurses and midwives 2008* (the Code).

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

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

“Preamble - …provide a high standard of practice and care at all times…”

Paragraph 17 “You must be able to demonstrate that you have acted in someone’s best interests if you have provided care in an emergency.”

Paragraph 35 “You must deliver care based on the best available evidence or best practice.

Paragraph 61 “You must uphold the reputation of your profession at all times.”

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel noted that you have admitted that you failed to follow the Home’s policy, did not carry out CPR when there was no DNACPR decision in place and did not contact paramedics when you were required to do so.

The panel was of the view that carrying out CPR is a fundamental nursing task and there is a clear expectation by the Home and by the public that a nurse would carry this

out should a patient suffer a cardiac arrest, unless there is a DNACPR in place. The panel noted the evidence before it in which you state that you were aware that there was no DNACPR in place. The panel also considered that you would have been aware that the patient's death was unexpected and that she was not receiving end of life care. Therefore, in light of all these circumstances, your failures to perform CPR as required by your employer's policy and to contact the paramedics did amount to conduct that falls seriously short of the conduct and standards expected of a nurse and amounts to misconduct.

Decision on impairment

The panel next went on to decide if as a result of this misconduct your fitness to practise is currently impaired.

The panel carefully considered the reasons as to why you did not carry out CPR on the patient, as the panel deemed it necessary to assess your motivation to enable it to determine your insight into the misconduct and any risk of repetition. The panel identified four potential motivations for your failure to carry out CPR:
a. A clinical decision that CPR was futile as the patient was dead.
b. You considered that the patient had wanted to die and that to carry out CPR would be disrespectful of her dignity.
c. You saw the patient's spirit in the room which said to you, "don't you dare", meaning do not try to carry out CPR.
d. You were influenced by a nursing colleague's decision not to carry out CPR.

The panel accepted, in so far as resolving the factual background and your motivation, it was deciding questions of fact and must do so on the basis that such facts must be proved by the NMC on the balance of probabilities. The panel carefully considered the documentation and events before it in chronological order. The panel made the following observations:

12 April 2014: Ms 1 said in her oral evidence, in response to panel questions, that at the time of the incident you appeared to take charge of the situation and you were the one to touch the patient to assess her temperature. However, Ms 1 heard no mention of discussion about CPR whilst she was in the room, which was only for about one minute.

13 April 2014 – In Ms 2's statement she says that, on the day following the incident, you and your colleague told her that you did not carry out CPR as you were sure the patient was dead and you thought it was futile.

10 May 2014 – In your statement to the Coroner you said that you considered at the time that CPR was extremely unlikely to be successful. You also stated that you did not believe that CPR is what the patient would have wanted and it would have disrespected her wishes, as she appeared to have given up on life. This assessment was made from what you had observed of the patient who had stopped eating, but without ever discussing it with her. You state that you regret not attempting to discuss the option of a DNACPR with the patient and her family. The panel noted that you did not express regret that you did not do CPR but rather that you did not have a DNACPR in place to support your decision. All of the oral and documentary evidence before the panel was clear that a nurse with basic training, working in a care home, was neither qualified to make an assessment as to whether a patient would wish to be resuscitated nor to make a DNACPR decision. The panel was concerned that you made this assessment of the patient's wishes without directly talking to her about it, when there was no reference in the patient's notes and there is no other evidence before the panel that the patient wished to die.

15 May 2014 – In an email of this date you sent the Home some comments to add to your statement. You stated that you twice asked your colleague if you should do CPR and you said that she said 'no.' You also explained how you believed that the patient would not have wanted CPR. You also felt that the spirit of the patient had left the body and you heard it telling you not to carry out CPR. The panel accept that you genuinely believed that the patient was dead and that CPR would have been futile, even though it was not your decision to make. The panel was of the view that while your clinical decision was the primary motivation in not carrying out CPR, this was also influenced by your belief that the patient wished to die and that her spirit was telling you not to do CPR.

16 June 2014 – During an investigatory meeting with Ms 4 you explained that you asked your nurse colleague whether you should do CPR and she said, 'No'. The panel noted that the decision not to do CPR appears to be based on your genuine belief that the patient was dead and that CPR would be futile. You also stated that you knew the

patient and that she wanted to die but that if your colleague had told you to do CPR you would have done so. When asked what you meant about disrespecting patients' wishes you said that it was a feeling, you knew you were right, and also that the patient wanted to go to heaven.

29 July 2014 – During the disciplinary meeting you displayed an awareness that you should have done CPR because you told the meeting you asked your nurse colleague if you should carry out CPR twice. You said that you were influenced by your colleague who you stated told you that CPR was not appropriate. In the meeting you also explained that the patient was refusing food which led you to believe that she no longer wished to live. However, you also knew that there was no DNACPR in place and that it was an unexpected death. The panel was of the view that this document shows that you made a decision not to call the paramedics as there was no pulse. Having made this clinical decision, you then immediately affirmed your decision with your belief that CPR would be against the patient's wishes. You then heard the spirit say, 'don't you dare' and you took this to mean that your decision not to carry out CPR was correct. As such, the panel was of the view that there was a spiritual element influencing your decision making at the same time as deciding whether or not to carry out CPR.

17 September 2014 – During your appeal meeting, some five months after the incident, when asked whether you would carry out CPR if someone collapsed in front of you, you stated that you would carry out CPR if you thought there was a chance of recovery but to do it otherwise could interfere with dignity and respect. You stated that you believed the patient in question wished to die. You also questioned why you would call out a paramedic to tell you what you already knew, namely that the patient was dead.

The panel considered the submissions of both parties and the above documentation very carefully. The panel was satisfied that you had checked the patient for signs of life and had the honest belief that the patient was dead. The panel however was of the view, that this clinical judgement was not one that you were required, trained or entitled to make and that you knew that you should have carried out CPR because you twice

asked your colleague if you should. The panel also concluded that it was clear from the evidence before it that you knew that there was no DNACPR in place having attempted to get a GP to make one earlier. Nonetheless, the panel was of the view that your primary motivation not to carry out CPR was your genuine belief that the patient was dead and it would be futile.

However, the panel also considered that another factor in your decision making during the incident was your belief that to carry out CPR would interfere with the patient's dignity and respect, as you believed that the patient wished to die. The panel noted that in her statement Ms 2 says that you treated the situation as if a DNACPR was in place. The panel was concerned that you inferred that this is what the patient had wanted when you had not had any conversation with the patient in respect of this. Rather, any decision you made purporting to suggest what the patient would have wished appears to flow from your own assumptions and from your observations that the patient did not want to eat. The panel noted that a GP had assessed the patient and had concluded that the patient had no psychological problems and was not suffering from depression. Instead, he referred the patient to a dietician with regard to concerns about her eating.

The panel also considered whether your spiritual beliefs had any impact in your decision making process. The panel was of the view that your beliefs reinforced what you thought were the patient's wishes: when the patient had previously told you that she wanted to 'go home' you took this to mean she wanted to die and go to heaven, rather than wanting to return to her place of residence. The panel was concerned that this inference was influenced by your own religious beliefs. In respect of you stating that you heard the patient's spirit saying 'Don't you dare', the panel was of the view that you used this to support your decision not to do CPR but again that this was not your primary motivation.

The panel also considered what, if any, influence your nursing colleague may have had on your decision making. The panel took into account the evidence of Ms 1 that you, rather than your nurse colleague, appeared to take control of the situation at the

patient's bedside. The panel also accepted the evidence of Ms 2 that you were both equal and that no nurse is more senior than the other within the Home. The panel was also mindful of the Code in that, 'As a professional you are personally accountable for actions or omissions in your practice' and that you must be able to justify those decisions.

Taking into account all of the above the panel was satisfied, on the balance of probabilities, that while in your own mind you thought that it was in the best interests of the patient not to carry out CPR, this was based on a very flawed decision making process. Although your primary decision was a clinical decision that the patient was already dead and CPR would have been futile, you were also influenced in your decision making by what you believed to be the patient's wishes, by your own religious beliefs, and to a lesser extent, by the advice of your nurse colleague.

The panel then went on to consider the issue of impairment. Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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 judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) 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.*

Mrs Justice Cox went on to say in Paragraph 76:

> *I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.*
>
> > *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 considered that whether CPR should be carried out and the paramedics be called, is not a decision for you, as a nurse who has not been specifically trained in this area, to make. You are required to carry out CPR even where you consider it to be futile. The panel therefore finds that, while there is no evidence of actual patient harm in this case, your misconduct had the potential to put a patient at risk of harm and would be liable to do so in the future should it be repeated. The panel also concluded that your misconduct has brought the profession into disrepute as a member of the public would

be extremely concerned by your flawed decision making. Furthermore, your misconduct breached a fundamental tenet of the nursing profession, namely to provide a high standard of practice and care at all times.

Regarding insight, the panel noted that you made admissions during the course of the hearing and that Mr Green apologised to this panel on your behalf. However, the panel was concerned that you have not provided evidence which directly addresses anything you may have learnt or how you would handle this situation differently in the future. Nor has the panel been provided with evidence that you have recognised and addressed just how flawed your decision making was. The panel also noted that the one point of learning you comment upon in the documentation produced for the Home's investigation, was that you will in future ensure that a DNACPR is put in place where appropriate.

The panel was concerned by the content of the Home's appeal meeting notes, which is the most recent evidence demonstrating your insight. During the meeting you were asked what you would do if someone collapsed in front of you and you replied, 'I would be happy to carry it (CPR) out if I thought there was a chance. If I thought there was no chance of recovery we are interfering with dignity and respect. Two people had clearly agreed that this lady had gone. There was no sensible chance of bringing her back. What do we do call paramedics out to tell us what we already knew.' The panel was of the view that this demonstrated that you have very limited insight into your misconduct in that you have failed to understand your obligation to perform CPR in accordance with policy, whether or not you consider that there is a chance of the patient recovering. The panel cannot therefore be satisfied that you do not currently pose a risk of harm to patients.

In its consideration of whether you have remedied your practice the panel was of the view that your misconduct is remediable but that there is insufficient evidence before the panel to demonstrate that you have taken steps to do so. The panel noted that you have completed a first aid course and that Mr Green told the panel that you are now clear on

the policy requirement to carry out CPR. The panel noted that Ms 2 told Ms 4 during the Home's investigation that she did not think your religious beliefs would get in the way of your clinical professionalism again. The panel also accepted that you understand the imperative to have a DNACPR in place and that you would actively discuss this with patients. The panel had regard to the letter from your previous employer which stated that you were active in noting whether a DNACPR was in place for patients. However, the panel noted that you only worked there for a short period and therefore you had only very limited opportunity to remedy your misconduct.

The panel found that there was insufficient evidence as to what you would now do should you find yourself in the same situation again, namely that you would follow the Home's policy, carry out CPR and contact the paramedics.

The panel was of the view that there is a real risk of repetition given your lack of remediation and your lack of insight into your poor decision making. The panel concluded that there remained a risk that you would breach an employer's policy should it conflict with your thinking that CPR would interfere with a patient's dignity and respect, particularly in light of the comments you made during your appeal meeting (as set out above). In this case, even though you genuinely believed that the patient was dead, you knew that you should have carried out CPR but you did not do so. The panel was of the view that there is a risk of harm to patients as the decision about whether to carry out CPR in such circumstances is not one for you to make. The panel therefore decided that a finding of impairment is necessary on the ground of public protection.

The panel went on to consider whether a finding of impairment is also necessary in the wider public interest. The panel bore in mind the overarching objective of the NMC: to protect, promote and maintain the health safety and well-being of the public and patients and the wider public interest which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding proper professional standards for members of those professions. The panel was of the view that a member of the public would expect a nurse to carry out CPR when a DNACPR was not in place

and they would be very concerned if no finding of impairment were made in this case. Therefore, the panel determined that, in this case, a finding of impairment on public interest grounds is also required.

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

Determination on sanction:

The panel has considered this case very carefully and has decided to make a suspension order for a period of 6 months. The effect of this order is that the NMC register will show that your registration has been suspended.

You provided the following additional documents at the sanction stage:

1) A record of learning following your attendance on 12 April 2016 on an emergency first aid at work workshop (QCF level 2) run by the Wales Ambulance Service;
2) A document headed 'What I would do if someone collapsed or was found collapsed in front of me', which the panel was informed you had prepared overnight following the panel's decision on impairment the previous day.

In reaching its decision on sanction, the panel has had regard to all the evidence that has been adduced in this case together with the submissions of both parties. The panel accepted the advice of the legal assessor. 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 Indicative Sanctions Guidance ("ISG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel first considered the aggravating and mitigating factors in this case.

The panel identified the following aggravating factors in this case:

- You knew that you had a duty to carry out CPR and call the paramedics but you chose not to do so following a very inappropriate and flawed decision making process.
- You have demonstrated limited insight. In particular you continued to justify your flawed decision making throughout your employer's disciplinary and appeal processes.

- Although you have prepared an additional document since the panel's decision on impairment was made, it does not address how your decision making was flawed; this suggests an ongoing lack of both understanding and insight on your part.

The panel identified the following mitigating factors in this case:

- This was an isolated incident, at the end of a shift, in the context of an otherwise long and unblemished career.
- Your decisions, although flawed, were made in the genuine belief you were acting in the best interests of the patient.
- This was the first time you had experienced a sudden death at work.
- You immediately engaged in an open and honest way with both the Home's investigation and the NMC proceedings, admitting at an early stage that it was your duty to carry out CPR in the circumstances.
- You have accepted that you need supervision and training as part of your return to nursing.

The panel next went on to consider the available sanctions, starting with the least restrictive sanction first.

The panel 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 also noted that it had found that there is a risk of repetition and a risk of harm to the public. The panel was of the view that taking no action would not sufficiently protect the public as it would not restrict your nursing practice.

In considering whether a caution order would be appropriate in the circumstances, the panel took into account the ISG, which states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen*

again.' The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel was of the view that even though at the time of the incident you believed you were acting in the patient's best interests, you knew that you had a duty to carry out a potentially life saving measure (CPR) and you chose not to do so as a result of your flawed decision making. The panel concluded that this breached a fundamental tenet of the nursing profession to provide a high standard of care at all times and that you have not fully remediated your misconduct. Therefore, the panel decided that it would be neither proportionate nor in the public interest to impose a caution order. The panel also noted that it had found that there is a risk of repetition and risk of harm to the public due to your continued limited insight. The panel was of the view that a caution order would not sufficiently protect the public as it would not restrict your nursing practice.

The panel next considered whether placing conditions of practice 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 panel took into account the ISG, in particular:

64 This sanction may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

64.1 No evidence of harmful deep-seated personality or attitudinal problems

64.2 Identifiable areas of nurse or midwife's practice in need of assessment and/or retraining

64.3 No evidence of general incompetence

64.4 Potential and willingness to respond positively to retraining

64.6 Patients will not be put in danger either directly or indirectly as a result of conditional registration

64.7 The conditions will protect patients during the period they are in force

64.8 It is possible to formulate conditions and to make provision as to how conditions will be monitored

The panel concluded that there were no practical or workable conditions of practice that it considered would address its concerns about your flawed decision making processes. The panel noted that the document you have produced overnight, whilst addressing what you would do if someone collapsed in front of you in the future, does not address the underlying factors that led to your flawed decision making as identified by the panel in its decision on impairment. The panel was concerned that your ongoing lack of insight as to your flawed decision making gives rise to a risk of repetition and therefore to a risk of harm to patients.

The panel is of the view therefore that there are no conditions that could be formulated at this stage without evidence of further insight from you. The flawed decision making in this case is not something that can be readily addressed through retraining, although the panel accepted that you would have had the willingness to respond positively to training. The panel considered that a CPR course would not assist because no concerns have been raised about your ability to carry out CPR. The issue in this case is that you chose not to carry out CPR, when you knew that you should have done it. Further in considering whether conditions could be appropriate the panel noted that there is no suggestion of general incompetence.

The panel considered that a conditions of practice order could have been appropriate in this case had there been evidence that you had full insight into your flawed decision making. However, without evidence that you have developed such insight, the panel considered direct supervision of all clinical duties would be required to sufficiently protect patients. The panel concluded that this would not be workable because it is not practicable to discuss every potential clinical decision or action in advance with a supervisor. Therefore, the panel considered that a conditions of practice order would not sufficiently protect patients from a risk of harm.

Furthermore the panel concluded that, whilst your limited insight persists, the placing of conditions on your registration would not adequately address the seriousness of this case. The panel concluded that a conditions of practice order would not uphold proper standards of the profession and maintain public confidence in the profession. The public would be rightly concerned about a nurse who failed to carry out CPR and to contact the paramedics when under a duty to do so.

The panel then went on to consider whether a suspension order would be an appropriate sanction. ISG paragraph 68 indicates that a suspension order may be appropriate where some of the following factors are apparent:

> *68 This sanction may be appropriate where the misconduct is not fundamentally incompatible with continuing to be a registered nurse or midwife in that the public interest can be satisfied by a less severe outcome than permanent removal from the register. This is more likely to be the case when some or all of the following factors are apparent (this list is not exhaustive):*
>
> *68.1 A single instance of misconduct but where a lesser sanction is not sufficient.*
>
> *68.2 No evidence of harmful deep-seated personality or attitudinal problems.*
>
> *68.3 No evidence of repetition of behaviour since the incident.*
>
> *68.4 The panel is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel determined that, although there had been a clear breach of a fundamental tenet of the profession, there are in your case mitigating circumstances. Therefore, the panel considered that, in your case, the misconduct was not fundamentally incompatible with remaining on the register.

The panel had no evidence before it that you had repeated this specific misconduct or that it had happened before. As such the panel was satisfied that this was a single incident. However, a lesser sanction is not appropriate in this case because you have neither demonstrated insight into nor remedied your flawed decision making processes. Whilst you now accept that you must carry out CPR unless a DNACPR is in place, you have not recognised and addressed just how flawed your decision making was. The panel considered that there remained a risk that your flawed decision making may be repeated until this has been remedied.

The panel further considered whether a striking-off order would be proportionate in your case. Taking account of all the information before it, and taking account of all the mitigation provided to the panel on your behalf, the panel concluded that it would be disproportionate and is not the only sanction available to the panel. Whilst the panel acknowledges that a suspension order may have a punitive effect, it would be unduly punitive in your case to impose a striking off order.

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 need to protect the public and the public interest in this case.

The panel considered that this order is necessary to enable you to develop full insight into the underlying reasons for your misconduct and to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 6 months was appropriate in this case to mark the seriousness of the misconduct. The panel considered that this would provide you with time to thoroughly reflect upon the incident and your decision

making and to produce an in-depth reflective piece. Such a step would enable you to remediate your misconduct and maintain public confidence in the profession.

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 may be assisted by evidence of:

- Your continued engagement with the NMC process.
- Hearing from you directly at the review hearing with particular reference to your insight and learning.
- A reflective piece addressing your flawed decision making, specifically in relation to your being influenced by your beliefs about a patient's wishes, your own religious beliefs and the advice from nurse colleagues.
- Any up to date references or testimonials from work colleagues, whether arising from paid or unpaid roles.

Determination on Interim Order

The panel has considered the submissions made by Ms Murshed that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest. Mr Green made no submissions on your behalf.

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. To do otherwise would be incompatible with its earlier findings. 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 period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.