Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

29 July - 02 August 2019

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

Name of registrant:	Martha Motadi
NMC PIN:	04A0556O
Part(s) of the register:	RN1 – Registered Nurse Adult Sub part 1 16 April 2004
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Ian Luder (Chair, Lay member) Kim Bezzant (Registrant member) Chris Thornton (Lay member)
Legal Assessor:	David Clark
Panel Secretary:	Amira Ahmed
Ms Motadi:	Not present and not represented
Nursing and Midwifery Council:	Represented by Sophie Stannard, NMC Case Presenter
Facts proved:	**1, 2, 3 (a), (b), 4 (a), (b), 5, 7 and 8**
Facts not proved:	**6, 9 (a), (b)**
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim Order:	**Interim suspension order – 18 months**

Details of charge:

That you, a Registered Nurse:

1. On 1st September 2018 held the door to Resident A's room closed to prevent her from leaving her room on one or more occasions. **(PROVED)**

2. On 1st September 2018 held Resident A in an inappropriate manner when you and a Care Worker held her by her arms and forcibly moved her to her room. **(PROVED)**

3. On 1st September 2018 following an unwitnessed fall by Resident A:- **(PROVED)**

   (a) failed to carry out any or any adequate assessment to check Resident A for injuries; and/or **(PROVED)**

   (b) failed to carry out any or any adequate neurological and/or other observations. **(PROVED)**

4. On 1st September 2018 following an unwitnessed fall by Resident A you moved Resident A in an inappropriate manner by:- **(PROVED)**

   (a) lifting and/or permitting Resident A to be lifted manually from the floor, and/ or **(PROVED)**

   (b) failing to use a hoist. **(PROVED)**

5. On 1st September 2018 following an unwitnessed fall by Resident A you lifted Resident A into a chair instead of her bed. **(PROVED)**

6. On 1st September 2018 you inaccurately recorded in the Accident Report Form and Key Events Diary that Resident A's fall occurred at 2 a.m. **(NOT PROVED)**

7. On 1st September 2018 you recorded information on a Vital Signs Monitoring Chart which was separate to the one already in use for Resident A. **(PROVED)**

8. On 1st September 2018 you did not complete the Vital Signs Monitoring Chart to an adequate standard. **(PROVED)**

9. Your conduct at Charge 6 above was:- **(NOT PROVED)**

   (a) misleading and/or **(NOT PROVED)**
   (b) dishonest in that you knew that Resident A had not fallen at 2 a.m. and sought to conceal the actual time you discovered that she had fallen. **(NOT PROVED)**

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

Decision on Service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Motadi was not in attendance and that written notice of this hearing had been sent to Ms Motadi's registered address by recorded delivery and by first class post on 28 June 2019.

The panel took into account that the notice letter provided details of the allegations, the time, dates and venue of the hearing and, amongst other things, information about Ms Motadi's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Ms Stannard submitted the NMC had complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules").

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Ms Motadi has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34. It noted that the rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up-to-date registered address.

Decision on proceeding in the absence of Ms Motadi

The panel next considered whether it should proceed in the absence of Ms Motadi. The panel had regard to Rule 21 (2) which states:

> (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—

(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;

(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or

(c) may adjourn the hearing and issue directions.

Ms Stannard invited the panel to continue in the absence of Ms Motadi on the basis that she had voluntarily absented herself. Ms Stannard submitted that there had been very limited engagement by Ms Motadi with the NMC in relation to these proceedings. On 21 March 2019, Ms Motadi wrote to the NMC and said she was returning to her home country and that she was unlikely to receive any communication sent to her UK address. However, she did not provide any alternative address despite being asked to do so. Ms Stannard further submitted that there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised "*with the utmost care and caution*" as referred to in the case of *R.* v *Jones (Anthony William), (No.2) [2002] UKHL 5*. The panel further noted the case of *General Medical Council v Adeogba; General Medical Council v Visvardis [2016] EWCA Civ 162.*

The panel also reminded itself that Rule 16(1) of the NMC (Education, Registration and Registration Appeals) Rules 2004 places an obligation on registrants to notify the NMC in writing within one month of any change in their address.

The panel has decided to proceed in the absence of Ms Motadi. In reaching this decision, the panel has considered the submissions of the case presenter, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *Jones.* It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- no application for an adjournment has been made by Ms Motadi;
- Ms Motadi has not engaged recently with the NMC and has not responded to any of the letters or emails sent to her about this hearing;
- Ms Motadi has not provided the NMC with accurate details of how she may be contacted;
- there is no reason to suppose that adjourning would secure her attendance at some future date;
- one witness has attended today to give live evidence, and another witness is due attend the hearing; not proceeding may inconvenience the witnesses, their employer and their clients who need their professional services;
- there is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Motadi in proceeding in her absence. She would not be able to challenge the evidence relied upon by the NMC and would not be able to give evidence on her own behalf. However, in the panel's judgment, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Any prejudice to Ms Motadi must be seen in the context of her decision not to engage in the process.

The panel also took account of the considerable efforts made by the NMC to give Ms Motadi the opportunity to attend the hearing. In addition to sending notices and documents in accordance with the Rules, the NMC attempted to make contact with Ms Motadi through a number of email addresses and telephone numbers, and instructed tracing agents to try to identify her address.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Ms Motadi.

Decision and reasons on application under Rule 19

In the opening of the NMC's case, Ms Stannard made a request that the hearing should be held in private whilst the panel view the CCTV recording. The application was made pursuant to Rule 19 of the Rules. The grounds for the application were that the CCTV recording could contain images showing Resident A in her nightwear, and also that as the CCTV also recorded sound, her name might be referred to during the footage.

Rule 19 states:

> 19.—(1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.
>
> (2) Not relevant
>
> (3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied—
>
> (a) having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and
>
> (b) having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.
>
> (4) In this rule, "in private" means conducted in the presence of every party and any person representing a party, but otherwise excluding the public.

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

The panel bore in mind that the name and location of the Home had already been referred to by Ms Stannard in her opening. The panel acknowledged that the CCTV recording covered a period of time where Resident A could be in her nightwear and that the entrance to her room could be seen in the recording. The panel also recognised the risk of her name being referred to by Ms Motadi or other members of staff. The panel was satisfied that the need to protect Resident A's dignity and identity justified its viewing the CCTV recording in private. Therefore, the panel granted the application under Rule 19(3).

The panel revisited this issue following the evidence of Ms 1. When it came to view parts of the CCTV recording again, the panel determined that those particular passages of the recording could be viewed in public as they did not risk compromising Resident A's dignity or identity.

Background

The charges arose whilst Ms Motadi was employed as a Registered Nurse through an agency by The Grange Chertsey (the Home). The Home had capacity for 62 residents across three floors. Ms Motadi was covering one and a half floors on the night of the allegations. She was caring for Resident A, a vulnerable elderly person who suffers from dementia and had a history of falls.

On 1 September 2018, it is alleged that Ms Motadi held the door to Resident A's room closed to prevent her from leaving her room on one or more occasions. It is also alleged that Ms Motadi and a Care Worker held Resident A in an inappropriate manner by her arms and forcibly moved her back to her room after she had walked from her room to another part of the Home.

It is alleged that, shortly afterwards, following an unwitnessed fall by Resident A, Ms Motadi failed to carry out any or any adequate assessment to check Resident A for injuries. It is also alleged that Ms Motadi failed to carry any or any adequate neurological and/or other observations.

Ms Motadi is alleged to have moved Resident A in an inappropriate manner following the fall, by lifting and/or permitting her to be lifted manually from the floor rather than using a hoist, and then by putting her in a chair instead of her bed.

As a result of injuries sustained following the fall Resident A was subsequently hospitalised for ten days, and diagnosed with fractures to her left shoulder and left hip.

It is further alleged that Ms Motadi inaccurately recorded in the Accident Report Form and Key Events Diary that Resident A's fall occurred at 2am. Ms Motadi's conduct in this regard is alleged to have been misleading and/or dishonest in that she knew that Resident A had not fallen at 2 am. It is alleged that she sought to conceal the actual time she discovered that Resident A had fallen.

Ms Motadi is also said to have recorded information on a Vital Signs Monitoring Chart which was separate to the one already in use for Resident A, and to have not completed the Vital Signs Monitoring Chart to an adequate standard.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Ms Stannard on behalf of the NMC.

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

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 the facts will be proved if the panel is satisfied that it was more likely than not that the incidents occurred as alleged.

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

The panel heard oral evidence from two witnesses called on behalf of the NMC.

Witnesses called on behalf of the NMC were:

Ms 1 – Manager at the Grange Chertsey Home at the time of allegation. She began working at the home on 29 August 2018, shortly before the events involving Resident A;
Ms 2 – Clinical Lead Nurse at the relevant time. She had been working at the Home since August 2013 and is now the Deputy Manager.

Ms Motadi did not make any written submissions but the panel was provided with two references which spoke positively about her professionalism and dedication. The panel also saw various training certificates. The panel took this information into account, to the extent that it was relevant, when making its determination on the facts.

The panel first considered the overall credibility and reliability of both the witnesses it had heard from.

The panel found Ms 1 to be a credible and reliable witness, who was cooperative and confident. Her oral evidence was consistent with her detailed written statement. The panel heard that Ms 1 was a registered nurse with a long standing career.

The panel found Ms 2 to be a credible and reliable witness. The panel noted that Ms 2 was the Moving and Handling Training Coordinator in the Home at the time of the allegations. The panel found her oral evidence to be clear and consistent with her written statement. In one part of her oral evidence, where she relayed information given by Resident A's daughter about the injuries Resident A had sustained by virtue of the fall, and of Resident A's subsequent deterioration, the panel considered that Ms 2 appeared more emotional and perhaps less objective. This is understandable, but it led the panel to treat those parts of her evidence with caution.

The panel found the CCTV footage presented by the NMC as evidence to be clear. It was in colour and there was audio recording. For most of the time the CCTV provided good sound recording of Resident A and Ms Motadi.

Ms 1 gave evidence that the CCTV system is maintained by an external firm but that at the beginning of all her shifts she would check that the correct date and time were displayed. Ms 1 said she had done so from the start of her role at the Home, continuing her practice from another establishment. She also explained to the panel that an administrator monitored the screens and would know if the time on the recordings was inaccurate. The panel was satisfied that it could rely on both the content of the recording and the accuracy of the time that was displayed.

The panel considered each charge and made the following findings:

Charge 1:

1. On 1st September 2018 held the door to Resident A's room closed to prevent her from leaving her room on one or more occasions

This charge is found proved.

In reaching this decision, the panel took into account the CCTV recording in which Ms Motadi is seen holding the door closed on three different occasions. From 00:31.45 to 00:40.22, Ms Motadi held the door for a prolonged period of time. The panel determined that Resident A was likely to have been trying to open the door as she could be heard shouting from within her room, and in a seemingly distressed state. Ms Motadi appeared to be bracing herself to hold the door closed with force. Ms 1 and 2 both explained that holding the door closed on residents was against policy in these circumstances. Ms 2 explained in her oral evidence that she would keep the doors to residents' rooms ajar, so as to be able to monitor them easily.

Ms 1 in her written statement dated 21 January 2019 stated:

"My concern with them holding the door shut is that this is abusive and amounts to a deprivation of Resident A's liberty as she should be allowed to come and go as she pleases. There are strict restraint rules which provide that restraint of a resident's liberty requires written authority…"

The panel determined that Ms Motadi had held the door closed to prevent Resident A from leaving on three occasions. This action was not in accordance with the Home's policy or Resident A's care plan, both of which the panel had seen.

Therefore the panel found this charge proved.

Charge 2:

2. On 1st September 2018 held Resident A in an inappropriate manner when you and a Care Worker held her by her arms and forcibly moved her to her room.

This charge is found proved.

In reaching this decision, the panel took into account the Assessment of Care Needs for Resident A dated 29 August 2018, which stated that staff should:

"…steer Resident A gently by the arm and walk at her pace. If she objects to you holding her arm let go but stay close by..."

The panel also noted Ms 1's statement in which she explained that:

"Martha should have followed Resident A's Assessment of Care Needs to Prevent Agitation and chatted with her and walk her back to her room."

Ms 1 also stated in her written statement that:

"Martha should not have put her hands on Resident A because she can easily be reasoned with and responds to being spoken to respectfully."

The panel also considered the CCTV recording which showed Ms Motadi and a Care Worker holding Resident A by her arms and forcibly moving her at pace to her room. The panel noted that in the CCTV recording Resident A appeared to be distressed and objected to being forcibly taken to her room.

The panel therefore found this charge proved.

Charge 3:

3. On 1st September 2018 following an unwitnessed fall by Resident A.

The panel considered the Care Plan for Resident A in Maintaining a Safe Environment, dated 20 December 2017 and noted that she:

"… has a history of falls and is a high risk of falls."

The panel also noted from the CCTV recording that there was no one in the room at the time with Resident A to witness the fall. Therefore the panel was satisfied that the fall was unwitnessed.

3 (a). failed to carry out any or any adequate assessment to check Resident A for injuries;

This charge is found proved.

The panel considered Ms 1's written statement that explained there was a duty to undertake an adequate assessment to check Resident A for injuries following an unwitnessed fall.

Ms 1 states in her witness statement dated 21 January 2019 that:

"Whenever a resident has a fall that has not been witnessed, the resident should be checked for any pain and/ or fractures and to see whether their mobility has changed compared to before the fall. The Home's Policy on Falls states that the nurse should check *'for pain, loss of sensation (feeling), loss of movement in arms and/or legs, swellings, visible injury and deformity, which might indicate a fracture' AIso, check for sickness, confusion, drowsiness, delirium and agitation.'*

"To carry out this assessment, I would expect a nurse to work their way down the spine and press to see if there was a reaction. All of the resident's limbs should then be checked. This assessment is especially important with regard to someone you did not see fall because you do not know what parts of the body they may have injured. You have to assume they may have hurt everything until you can find out what did happen."

The panel determined that this clearly demonstrated the duty for Ms Motadi to have undertaken an adequate assessment of Resident A after the fall. Ms 1 in her written statement also explains that:

“Martha would have been aware of her duty to carry out an assessment and observe Resident A following her fall, as a result of basic nursing training and the Home's Policy on Falls.”

The panel noted that Ms Motadi left Resident A’s room within two minutes of having found her lying on the floor. The panel agreed with Ms 1 that this was insufficient time to have enabled an adequate assessment of Resident A for injuries. In any event, had an adequate assessment been carried out, Ms Motadi should have determined that Resident A had suffered injuries.

The panel therefore found this charge proved.

3 (b). failed to carry out any or any adequate neurological and/or other observations.

This charge is found proved.

Ms 1’s evidence stated:

“If it is suspected that a resident has hit their head or if the fall was not witnessed, neurological observations must also be carried out. This includes checking for pupil reactions to light, confusion, bruising to the head, and bleeding from the eyes or ears. These neurological observations should be carried out every 15 minutes from the time of the fall for up to 24 hours after the fall (although this timeframe depends on the circumstances, the resident and the findings of the observations). This is general nursing knowledge and standard practice for a nurse treating a patient who has had a fall.”

The panel considered that Ms Motadi had not taken any observations of Resident A after 02:15am, and the 02:15am recording did not include any Neurological observations. The panel did note that there was a duty to carry out an adequate assessment which is shown in both the Home policy and described earlier in Ms 1's written statement.

Therefore the panel found this charge proved.

Charge 4:

4. On 1st September 2018 following an unwitnessed fall by Resident A you moved Resident A in an inappropriate manner

The panel noted that the Home has policies in place on moving residents following a fall. Ms 1 drew the panel's attention to the following paragraph from the Homes policy on Falls. It states that:

"…if it is safe to move an injured service user from the floor it is important that staff have the expertise and equipment to do so and can comply with moving and transferring procedures."

The panel considered the Manual Handling Policy of the Home which states:

"Where a specific risk of injury is identified and manual handling is unavoidable, then measures to reduce the risk must be introduced. Examples of these are the use of mechanical aids"

The policy further states that:

*"*Staff should never in any circumstances, attempt to lift a service user or a weight where they believe that there is a significant risk of injury involved."

The panel also took account of Ms 1's written statement in which she states:

"Although I cannot be certain that moving her without a hoist made her injuries more severe, it is a breach of the care home's policy on falls and it can potentially cause more harm."

She further states in her written statement that:

"Martha's actions in lifting Resident A are serious as it goes against the policy of the Home and breaches the 'no lifting' policy. Martha would have been aware of this because she had worked at the Home for a long time and all nursing homes have a policy of 'no lifting'. This is because of the risk of causing or exacerbating injuries to the resident and could cause injury to the nurse or staff member. Once Martha had conducted a full assessment of Resident A, she should have discovered the hip fracture and the shoulder break and then kept Resident A laying still until an ambulance could arrive. However, if she had carried out the assessment and not found any injury, she should have gone to get a hoist to lift Resident A back into bed."

4 (a). Lifting and/or permitting Resident A to be lifted manually from the floor

This charge is found proved.

The panel took account of the Key Events Diary where an entry was made at 2am on 1 September 2018. It also noted Ms Motadi's written statement made by her at the request of Ms 2 after the incident. In this statement Ms Motadi states that:

"At 2am I Martha Motadi found Resident A on the floor, Both myself and HealthCare Assistant… tried to put her in bed, she refused and preferred to sit on her chair." [sic]

Ms 2 in her witness statement also stated that:

“Martha informed me that her and a carer had stood up and put her in the chair.” [sic]

In the Key Events Diary Ms Motadi wrote:

“…managed to take 2 steps and walk to her chair and she fell asleep.”

The panel was of the view that Ms Motadi had inappropriately lifted Resident A or permitted her to be lifted manually from the floor, and therefore found this charge proved.

4 (b) failing to use a hoist.

This charge is found proved.

The panel noted Ms 1’s detailed evidence that hoists were not kept in residents’ bedrooms but that one hoist was present on each floor. Ms Motadi would have had to get the hoist and bring it into Resident A’s room. At no stage did Ms Motadi state that she used the hoist.

The panel determined that from the CCTV recording Ms Motadi was not seen to bring a hoist into the room. The panel therefore concluded that charge 4 (b) is found proved.

Charge 5:

5. On 1st September 2018 following an unwitnessed fall by Resident A you lifted Resident A into a chair instead of her bed.

This charge is found proved.

The panel noted that there was no factual dispute that Resident A was put into a chair instead of into her bed. This was the position in which she was found in by the day staff the next morning. The panel also considered the Key Events Diary in which Ms Motadi wrote at 07:10am that morning:

"Resident A still fast asleep as a result of lorazepam given at 22 hours. Attempted to wake her and walk her but remained fast asleep"

The panel also noted that both witnesses advised that Resident A should have been kept on the floor and medical assistance sought, or hoisted to her bed, which would be following the correct Manual Handling Policy.

The panel therefore found this charge proved.

Charge 7:

7. On 1st September 2018 you recorded information on a Vital Signs Monitoring Chart which was separate to the one already in use for Resident A.

This charge is found proved.

The panel had sight of two Vital Signs Monitoring Charts. It noted that the first chart had its first entry on 11 June 2017 and its last entry on 1 September at 12h30 and that entry had been made by a member of staff other than Ms Motadi.

The panel noted that the previous entry to that one had been made on 28 August 2018. The panel also noted that there was space on this Vital Signs Monitoring Chart sheet for 13 more entries. The panel was of the view that the entries made by Ms Motadi at 2.15am were on a new sheet when that was not necessary.

Ms 1 corroborated this in her witness statement and explained that:

"…this is against the Home's policy. The policy is to record all observation checks on the same chart in order that it can be clear to see if there is deterioration in the resident's observations so the next nurse can see at a glance the condition of the patient. This is very serious because it prevents another nurse easily seeing what has happened and makes it harder to compare if there have been changes in a resident's vital signs."

Therefore the panel found this charge proved.

Charge 8:

8. On 1st September 2018 you did not complete the Vital Signs Monitoring Chart to an adequate standard.

This charge is found proved.

The panel noted that Ms Motadi made an entry into the Vital Signs Monitoring Chart at 02.15am, and there was also a second, untimed, entry where she wrote:

"Could not obtain vital datae appeared very drowsy as a result of lorazepam given". [sic]

The panel accepted Ms 1's evidence that because Resident A had had an unwitnessed fall a record of regular vital signs monitoring was important, to check whether there was any deterioration to her condition. The panel considered that the reported drowsy state of Resident A reinforced this need. Without expressing any view as to whether there was monitoring of vital signs, the panel found that no such observations were recorded by Ms Motadi. She had either not taken any vital signs monitoring or, if she had done so, she had failed to record it. The panel concluded that in either circumstance the Vital Signs Monitoring Chart had not been completed to an adequate standard.

The panel therefore found this charge proved.

Charge 6 and 9 (a) and (b):

6. On 1st September 2018 you inaccurately recorded in the Accident Report Form and Key Events Diary that Resident A's fall occurred at 2 a.m.

9. Your conduct at Charge 6 above was:
   (a) misleading and/or
   (b) dishonest in that you knew that Resident A had not fallen at 2 a.m. and sought to conceal the actual time you discovered that she had fallen.

Both charges found NOT proved.

The panel has already found that on the balance of probabilities the time shown on the CCTV recording was correct. The CCTV shows that Resident A was found on the floor in her bedroom at 01:26:40 and that clearly the fall had occurred sometime before then.

In the accident report form Ms Motadi recorded the time and date of the accident as:
"date: 1/9/18 Time: 2am"

She also wrote on the form:
"I Martha RGN was doing unit rounds when I found [Resident A] on the floor".

In the statement Ms Motadi prepared at the request of Ms 2 she wrote:
"I Martha Motadi found [Resident A] on the floor".

In the Key Events Diary Ms Motadi wrote:
"Resident A was found at 2am".

The CCTV is clear that Resident A was already on the floor at 01:26:40 and that Ms Motadi found her in that position very shortly afterwards. The panel determined that Ms Motadi was in error in writing on three separate occasions that Resident A was 'found' on the floor at 2am. However, she only recorded on one occasion that Resident A's fall 'occurred' at 2am, and this was immediately qualified in the text referred to above.

The panel considered that charge 6 had not been framed in a manner which was consistent with the evidence and the rest of the NMC case. It therefore gave careful consideration as to whether to invite the NMC to make representations to amend the charge namely that Resident A had been 'found' at 2am. To enable it to reach a decision on that the panel considered whether, if charge 6 were to be amended and then found proved, there was a basis on which it could have found charge 9 proved.

The panel concluded that while Ms Motadi's conduct could at its highest have been found to have been "misleading", it did not consider, taking into account the judgement of Lord Hughes in *Ivey v Genting Casinos* [2017] UKSC 67, that it was likely to have been found to have been dishonest. In the panel's view, there was insufficient evidence to disprove Ms Motadi had simply made a mistake as to the time she found Resident A on the floor.

In the circumstances the panel decided not to invite representations from the NMC to amend charge 6. It therefore found charge 6, and consequently charge 9, not proved.

Submission 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 Ms Motadi's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

Ms Stannard referred the panel to the case of *Roylance v GMC (No. 2) [2000] 1 AC 311* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

In her submissions Ms Stannard invited the panel to take the view that Ms Motadi's actions amount to breaches of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) (the Code), the various policies at the Home, and the care plans of Resident A. She then directed the panel to specific paragraphs of the Code and submitted that Ms Motadi's actions were serious and amounted to misconduct.

She 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 maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Ms Stannard referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).*

Ms Stannard brought to the panel's attention previous regulatory findings against Ms Motadi. She submitted they should be taken into consideration if the impairment stage were to be reached. She then referred the panel to the conditions of practice order that was made on 18 May 2012 and the four subsequent reviews. She explained that the last review took place on 13 November 2015.

Ms Stannard submitted that Ms Motadi had not shown any remorse or insight relating to this case, nor had she shown any reflections on the harm she may have caused to Resident A, Resident A's family and the profession. She also submitted that Ms Motadi's actions on 1 September 2018 resulted in the restriction of Resident A's liberty, and to a delay in her receiving medical treatment. Ms Stannard therefore invited the panel to make a finding of current impairment in this case.

The legal assessor gave general advice to the panel on how to approach its decision on misconduct and impairment. More specifically, the legal assessor advised the panel on the extent to which it could take account of the previous regulatory findings against Ms Motadi. In summary, the advice on this issue was that:

- the panel should not take account of the previous regulatory findings when considering the question of misconduct. That decision should be taken solely on the basis of the findings of fact made in this case;
- if the panel finds misconduct, the previous findings could be relevant to its decision on current impairment;
- the panel could take the previous findings into account when considering the extent to which, if at all, Ms Motadi presents a risk to patients or the public;
- the panel could also take the previous findings into account when considering the extent to which Ms Motadi has remediated any errors she may have made;
- the weight to be given to the previous regulatory findings is a matter for the panel's judgement.

The panel accepted the advice of the legal assessor.

The panel adopted a two-stage process in its consideration, as advised. First, the panel determined whether the facts found proved amount to misconduct. Second, only if the facts found proved amount to misconduct, would the panel decide whether, in all the circumstances, Ms Motadi's 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.

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 Ms Motadi's actions did fall significantly short of the standards expected of a registered nurse, and that her actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

2 Listen to people and respond to their preferences and concerns

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

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

4.2 make sure that you get properly informed consent and document it before carrying out any action

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

8 Work co-operatively

To achieve this, you must:

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

10 Keep clear and accurate records relevant to your practice

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.2 make a timely referral to another practitioner when any action, care or treatment is required

20 Uphold the reputation of your profession at all times

Whilst the panel appreciated that breaches of the Code do not automatically result in a finding of misconduct, the panel found that collectively the proven charges were indicative of conduct that fell far below the standard expected of a registered nurse. In the panel's view Ms Motadi's conduct in relation to charges 1, 2 and 4(a) was particularly reprehensible. The panel also determined that Ms Motadi had failed to act as a role model for a junior colleague, which the panel considered to be an aggravating factor.

Therefore, the panel found that Ms Motadi's actions fell far below the conduct and standards expected of a nurse, and amounted to misconduct.

Decision on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. Nurses 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 *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."

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 finds that the first three limbs of Dame Janet Smith's Fifth Report from Shipman in the case of *Grant* are engaged.

Regarding insight, the panel considered that Ms Motadi had not shown any evidence of reflection on her actions. In its consideration of whether Ms Motadi has remedied her practice the panel took into account the training she had undertaken but it concluded that this was superficial and that there is no evidence of the assessment of competence.

The panel is of the view that there is a risk of repetition based on Ms Motadi's lack of insight and remediation. 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 are 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, which 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, in this case, a finding of impairment on public interest grounds was required.

The panel considered that a vulnerable elderly lady suffering with dementia was mistreated and it was of the view that the public would be appalled by this. It therefore determined Ms Motadi's actions would undermine public confidence in the profession. Furthermore, a finding of current impairment was required in order to demonstrate to the profession that this type of behaviour would not be tolerated

Having regard to all of the above, the panel was satisfied that Ms Motadi's fitness to practise is currently impaired.

The panel initially reached its conclusions on current impairment solely on the facts in this case. However it then reviewed the previous regulatory findings against Ms Motadi when her fitness to practice was determined to have been impaired. The panel noted that some of the previous findings related to record keeping, failure in assessing a patient and checking charts. The panel further noted that these findings correlated with three of the charges found proved in this case. The previous history reinforced the panel's concern about the risk of repetition.

In its determination of 13 November 2015, when deciding that Ms Motadi's fitness to practice was no longer impaired in relation to the previous findings, the then panel said that she was 'highly unlikely to repeat the failings in this case.' This panel considers that the confidence of the previous panel was, regrettably, misplaced. Events since 2015 reinforce this panel's conclusions regarding the risk of repetition and potential further damage to public confidence, and therefore the necessity of a finding of current impairment.

Determination on sanction:

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case. 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 Sanctions Guidance (SG) published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

Ms Stannard told the panel that the NMC had advised in the written notice of this hearing that it would ask the panel to make a striking-off order if it found Ms Motadi's fitness to practise currently impaired. Ms Stannard affirmed the NMC's position and invited the panel to make this sanction.

Ms Stannard set out what she considered to be the aggravating and mitigating features of this case. She submitted that, in light of Ms Motadi's previous fitness to practise history and the facts of this case, a suspension order would not be sufficient to protect patients and the public and maintain public confidence in the profession.

The panel identified the following aggravating factors:

- Ms Motadi's actions put an elderly and vulnerable patient at risk of harm;
- the missed opportunity to provide Resident A with adequate care;
- Ms Motadi persistently failed to follow Resident A's detailed care plans;

- Ms Motadi has abused her position of trust, both in relation to her duty to care to Resident A and in her failure to act as a role model for a junior colleague;
- Ms Motadi's lack of insight or remorse;
- the risk of repetition;
- Ms Motadi's lack of engagement.

With regard to mitigating factors, the panel did take into account the training undertaken by Ms Motadi but, for the reasons previously stated, it attached little weight to that training. The panel also took into account Ms Motadi's references. It noted that one referred to her work in 2016 and the second reference, which was more contemporaneous, lacked detail and it did not appear to the panel that the author had any significant personal knowledge of Ms Motadi's current practice.

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.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, 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, however the Fitness to Practise committee wants to mark that the behaviour was unacceptable and must not happen again.*'* The panel considered that Ms Motadi's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel is of the view that there are elements of the charges that could potentially be remediated through training and supervision, and therefore in theory could be addressed by way of a conditions of practice order. However, the panel considered that, overall, the misconduct was attitudinal and behavioural in nature. As such, it could not easily be addressed through the imposition of conditions.

The panel noted that conditions of practice were initially imposed in the previous case involving Ms Motadi. On a review, Ms Motadi did not provide any evidence of her compliance with those conditions, and so the conditions of practice order was replaced with a suspension order. A subsequent review panel did reinstate a conditions of practice order, which a later panel permitted to lapse. This implies that Ms Motadi was capable at that time of responding to conditions.

However, taking into account her subsequent failings, this current panel was of the view that, combined with Ms Motadi's lack of insight and remorse, and her explanation that she no longer wishes to practice as a nurse in the UK, a conditions of practice order is now inappropriate.

The panel noted that the SG states:

> "The Nurse's fitness to practice history…can be relevant to a decision on sanction. It's most likely to be useful in cases about similar kind of concerns. If problems seem to be repeating themselves this may mean, that previous orders were not effective…"

The panel concluded that the placing of conditions on Ms Motadi's registration would not adequately address the seriousness of this case and would not protect the public. Furthermore, the panel was not satisfied that she would be willing or able to comply with any conditions that may be imposed.

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

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

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

The panel determined that this was not a single instance of misconduct. Although the events occurred during one shift there were a number of serious breaches of the standards expected of a registered nurse. When considered alongside the previous regulatory history, in the panel's view this represents a pattern of misconduct. The panel noted that there is evidence of attitudinal problems and it was not satisfied that Ms Motadi would not repeat this sort of behaviour. As stated previously, Ms Motadi has not demonstrated any insight into her failings.

The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

The panel then considered a striking-off order. The panel considered the following questions as set out in the SG:

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

Ms Motadi's misconduct represented a significant departure from the standards expected of a registered nurse. The panel considered that her actions are fundamentally incompatible with her remaining on the register. The findings in this particular case demonstrate that Ms Motadi's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

Determination on Interim Order

The panel has considered the submissions made by Ms Stannard 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.

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. 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. To do otherwise would be incompatible with its earlier findings.

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 striking-off order 28 days after Ms Motadi is sent the decision of this hearing in writing.

That concludes this determination.