Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
11 – 13 January 2021

Virtual Hearing

Name of registrant:	Mrs Precila Natividad Pinguel
NMC PIN:	01G1315O
Part of the register:	Registered Nurse – Sub Part 1 Adult Nursing – July 2001
Area of registered address:	Kent
Type of case:	Misconduct
Panel members:	Paul Powici (Chair, lay member) Helen Chrystal (Registrant member) Sue Davie (Lay member)
Legal Assessor:	Nina Ellin
Panel Secretary:	Melissa McLean
Nursing and Midwifery Council:	Represented by Claire Stevenson, Case Presenter
Mrs Pinguel:	Not present and not represented in absence
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Pinguel was not in attendance, nor was she represented in her absence. The panel was informed that Notice of this Hearing had been sent to Mrs Pinguel's registered email address on 30 November 2020.

Ms Stevenson, on behalf of the Nursing and Midwifery Council (NMC), informed the panel that the Notice of Hearing provided details of the allegations, the time, dates and the video conferencing details required to join the hearing. The Notice also included information about Mrs Pinguel's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

The panel accepted the advice of the legal assessor.

The panel noted that under the recent amendments made to the Rules during the Covid-19 emergency period, a Notice of Hearing may be sent to a registrant's registered address by recorded delivery and first class post or to a suitable email address on the register.

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

Proceeding in the absence of Mrs Pinguel

The panel next considered whether it should proceed in the absence of Mrs Pinguel. It had regard to Rule 21 and heard the submissions of Ms Stevenson who invited the panel to continue in the absence of Mrs Pinguel.

Ms Stevenson referred the panel to an email from the Royal College of Nursing (RCN), Mrs Pinguel's representative at the time, dated 1 October 2020 in which they stated:

> *"Please note that we are no longer acting for Precila Pinguel. Please ensure that our name is removed from the record and that all future correspondence is sent direct to the registrant.*
>
> *Ms Pinguel has instructed me to inform you that she will not be attending the Fitness to Practise hearing and she will not be represented in her absence."*

Ms Stevenson told the panel that following this email, the NMC emailed Mrs Pinguel to confirm if she wishes to submit further documents or if she wishes to attend today's hearing. Ms Stevenson drew the panel's attention to an email from Mrs Pinguel to a case officer at the NMC dated 2 October 2020 in which she stated:

> *"Good morning .*
> *As Ive mentioned to my RCN representative and it's very clear. And I don't want to attend any NMC hearing (sic)."*

Ms Stevenson submitted that whilst Mrs Pinguel had previously engaged with the NMC, since her last email on 2 October 2020, there has been no further engagement. Ms Stevenson submitted that Mrs Pinguel had voluntarily absented herself. She further submitted that Mrs Pinguel has not requested an adjournment and therefore it would be unlikely that an adjournment would secure her attendance at a future date. Ms Stevenson submitted that that there is a strong public interest in the expeditious disposal of the case

and that it is in the interests of justice to proceed in the absence of Mrs Pinguel. She therefore invited the panel to proceed in Mrs Pinguel's absence.

The panel accepted the advice of the legal assessor. She referred the panel to the cases of *General Medical Council v Adeogba* [2016] EWCA Civ 162 and *R v Jones (Anthony William)* (No.2) [2002] UKHL 5.

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.*

The panel has decided to proceed in the absence of Mrs Pinguel. In reaching this decision, the panel has considered the submissions of Ms Stevenson, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- There has been a significant amount of time passed since the incidents in the charges;
- Mrs Pinguel has indicated clearly that she does not wish to attend this hearing;
- No application for an adjournment has been made by Mrs Pinguel;
- Since 2 October 2020 Mrs Pinguel has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Pinguel in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Mrs Pinguel, she will not be able to challenge the evidence relied upon by the NMC via video link and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Pinguel's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence on her own behalf.

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

Details of charge:

That you, a registered nurse:

1) During a nightshift which commenced on 28 August 2018 went to sleep whilst on duty between approximately 2am and 6am. **[PROVED]**
2) On 9 September 2018 you were verbally abusive towards Colleague 1 in that you shouted at her "fucking liar" and/or "fine, fuck you, I don't want to work with you again anyways" or words to that effect. **[PROVED]**

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

Background

The NMC received a referral from Ami Group - Ami Lodge Rehabilitation Unit and Ami Court Nursing Home ("the Group") on 30 October 2018 in relation to Mrs Pinguel. Ms Pinguel began working at the Group on 25 July 2018.

On 28 August 2018 Mrs Pinguel was working a night shift at Ami Lodge and was allegedly sleeping from 2:00am to 6:00am. It is alleged that Mrs Pinguel laid down and went to sleep on two chairs pushed together in the lounge with a blanket and pillows. This was seen by Colleague 1 and another healthcare assistant, Colleague 2. Mrs Pinguel did not respond to patient bells or to the noise made by the two healthcare assistants throughout this period. Mrs Pinguel woke at around 6:00am due to an alarm set on her mobile phone.

On 9 September 2018 Mrs Pinguel was working a shift at Ami Lodge and was allegedly verbally abusive to healthcare assistant Colleague 1 in front of patients about the fact that Colleague 1 had told a colleague that Mrs Pinguel had slept whilst on duty. It is alleged that Mrs Pinguel shouted at her "*fucking liar*" and/or *"fine, fuck you, I don't want to work with you again anyways*" or words to that effect. These comments were made in the lounge in front of patients.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC.

Decision and reasons on Facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Stevenson on behalf of the NMC. The panel also had regard to the RCN letter sent on behalf of Mrs Pinguel dated 8 October 2019 which set out a number of arguments and submissions and also to Mrs Pinguel's reflective piece in which she set out her account in relation to the

incidents in question. The panel has drawn no adverse inference from the non-attendance of Mrs Pinguel.

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

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

- Colleague 1: Healthcare Assistant at Ami Group at the time of incident – witnessed Mrs Pinguel sleeping and was verbally abused by her.

- Colleague 2: Senior Healthcare Assistant at Ami Group – witnessed Mrs Pinguel sleeping.

- Colleague 3: Registered Manager of Ami Group – was informed that Mrs Pinguel was sleeping on shift and had verbally abused a colleague.

The panel considered the evidence of the witnesses and made the following conclusions:

The panel was of the view that Colleague 1 was a credible witness. The panel noted that Colleague 1 was clear in her answers and was consistent between what she had written in her local statement, NMC witness statement and her oral evidence. The panel was of the view that Colleague 1 provided a clear description of what she witnessed. The panel found Colleague 1 to be a clear, reliable and honest witness.

The panel considered the evidence of Colleague 2 to be credible. The panel was of the view that Colleague 2's evidence was extremely clear and consistent. It noted that Colleague 2 was confident in answering questions and was able to provide a clear and detailed explanation of Ami Lodge and of Mrs Pinguel's posture when she was sleeping. The panel found Colleague 2 to be a consistent and reliable witness.

The panel considered the evidence of Colleague 3 to be credible. The panel took into account that Colleague 3 was not a direct witness to the incidents, however the panel noted that she was clear when explaining her account. The panel took into account Colleague 3's evidence in relation to Ami Group's policies and procedures and noted that she was clear and concise about the matters she was able to give evidence on. The panel found Colleague 3 to be helpful in respect of the areas within her knowledge.

When considering the overall evidence, the panel took into account Mrs Pinguel's response documentation provided prior to 2 October 2020 which was provided by the NMC. It bore in mind her response to the allegations, the RCN's submissions and the arguments put forward. The panel was of the view that as Mrs Pinguel has not attended this hearing, nor has she instructed a representative to act on her behalf, it has been unable to test her evidence. The panel therefore cannot establish her credibility against the three witnesses or the evidence of the NMC.

The panel noted that there was a difference in the accounts of Colleague 2 and Colleague 3 in relation to one matter. It noted that the evidence of Colleague 2 was that she was approached by Colleague 3 to write a statement regarding her observations of the nightshift on 28 August 2018. However the evidence of Colleague 3 was that she was first informed by Colleague 2 on 28 October 2018 that Mrs Pinguel was caught sleeping on the nightshift. The panel was of the view that although there is a difference in the accounts in relation to that matter, it is not an issue that goes to whether the incident occurred at all and it does not alter the core of the evidence nor does it weaken the evidence of the charge that Mrs Pinguel was caught sleeping.

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

Charge 1

1) *During a nightshift which commenced on 28 August 2018 went to sleep whilst on duty between approximately 2am and 6am.*

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it of Mrs Pinguel, Colleague 1 and Colleague 2 all being on duty. It also took into account the policy at that time which clearly stated that staff should not sleep whilst on duty.

The panel took into account the witness statements and oral evidence of Colleague 1 and Colleague 2. The panel noted that both witnesses were clear and consistent and provided credible oral evidence. It took into account that both witnesses described how Mrs Pinguel slept and provided detailed accounts of the level of noise on the unit at that time.

The panel took into account Colleague 1's witness statement in which she stated:

> *"A bit later in the shift, though I do not recall what time, I was cleaning the kitchen and noted that the Registrant had created a "bed" for herself in the lounge. She had pushed two chairs together so that they faced each other, and she had gotten a blanket and pillows from empty beds to make herself comfortable".*
> *[…]*
> *"Around 02:00hrs I noticed that the Registrant had fallen asleep in her makeshift bed. I knew she was asleep as her eyes were closed and though I was moving around washing the tables and chairs in the lounge (except for the two that the Registrant was asleep in), she remained undisturbed and asleep."*
> *[…]*

"The Registrant did not wake up at the sound of the patient bells, and in fact was snoring when I left to attend the patients."

This was supported in Colleague 1's evidence in which she was able to describe how Mrs Pinguel was sleeping and stated that when she was hoovering, Mrs Pinguel did not move or flinch. The panel accepted this evidence.

The panel also took into account Colleague 2's witness statement in which she stated:

"Around 2:00am I walked over to Ami Lodge to get the hoover as I needed to use it over at Brook Lodge. As soon as I opened the front door of Ami Lodge, I looked down the hall way and saw the Registrant laying in two chairs which had been pushed together as described as above, and which were situated in the doorway leading towards the lounge. I noted that the Registrant was asleep as she was slouched down in these chairs with her eyes shut and her mouth open."
[…]
"Therefore, it appeared to me that the Registrant had been asleep from the first time I saw her sleeping around 2:00am, all the way through until the last time I saw her sleeping around 5:30am."

Colleague 2's statement was supported with her oral evidence in which she stated that Mrs Pinguel was snoring, her mouth was wide open and that she did not flinch when she entered Ami Lodge or when she got the hoover out. The panel also noted Colleague 2's oral evidence in which she stated that she entered the building where Mrs Pinguel was sleeping three times and Mrs Pinguel did not move even when she passed close by. The panel accepted this evidence.

The panel noted that Mrs Pinguel denies that she was asleep. The panel took account of the matters raised in the RCN's letter dated 8 October 2019 but preferred the evidence of the witnesses who described what they did and the fact that Mrs Pinguel was asleep.

The panel therefore concluded that during a nightshift which commenced on 28 August 2018 Mrs Pinguel went to sleep whilst on duty between approximately 2am and 6am and therefore find this charge proved.

Charge 2

2) *On 9 September 2018 you were verbally abusive towards Colleague 1 in that you shouted at her "fucking liar" and/or "fine, fuck you, I don't want to work with you again anyways" or words to that effect.*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of all three witnesses. The panel noted that there is no corroborative evidence with the account of Colleague 1, however the panel heard evidence of Mrs Pinguel's general attitude and behaviour. The panel took into account that it is accepted by Mrs Pinguel and by Colleague 1 that a conversation took place, but the content of the discussion is disputed.

The panel bore in mind Colleague 1's witness statement which states:

> *"The Registrant was upset and asked me why I had told a colleague that she had slept for four hours on our last shift together, being 28 August 2018. I confirmed that I had told a colleague that because it was true..."*
> *[…]*
> *"The Registrant became angry and was shouting and moving her hands around. She told me that I was a "fucking liar"…"*
> *[…]*
> *"I left the lounge to collect the cleaning supplies that I had come for and I was leaving, the Registrant remained in the lounge but shouted loudly, "fine fuck you, I don't want to work with you again anyways."*

The panel noted that although there is no other evidence that Mrs Pinguel verbally abused Colleague 1, the panel noted Colleague 2's oral evidence in which she stated that Mrs Pinguel had approached her to complain about Colleague 1 saying she had been sleeping during her shift. Colleague 2 stated that Mrs Pinguel was aggressive and that she felt intimidated by her. The panel noted that in Colleague 2's oral evidence, she also stated that she had previously witnessed Mrs Pinguel being confrontational towards Colleague 3. This evidence was supported by Colleague 3 in which she stated in her oral evidence that Mrs Pinguel had argued with her and that she gave her the impression that she could easily lose her temper. The panel accepted this evidence.

Taking all of the above into account, and noting that the panel found all three witnesses to be credible and consistent, the panel was of the view that on the balance of probabilities, it is more likely than not that Mrs Pinguel was verbally abusive towards Colleague 1 as alleged. The panel therefore find this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Pinguel'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.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the

facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Pinguel's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Ms Stevenson provided the panel with written submissions. In her written submissions she referred the panel to the case of *Calhaem v GMC* [2007] EWHC 2006 (Admin) in which Mr Justice Jackson commented on the definition of misconduct: '*it connotes a serious breach which indicates that the doctor's fitness to practise is impaired'.* She also referred the panel to the case of *Nandi v GMC* [2004] EWHC 2317 (Admin) in which Mr Justice Collins stated: '*the adjective 'serious' must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners'.*

In her written submissions, Ms Stevenson submitted that the facts found proved amount to misconduct. She submitted that falling asleep on duty is a serious breach on the basis that Mrs Pinguel placed patients at serious risk of harm by leaving them unattended when she went to sleep for a lengthy period during a nightshift. She further submitted that Mrs Pinguel was the only nurse on duty and therefore solely responsible for the patients' wellbeing. Ms Stevenson also stated that it was against Ami Group's Night Staff Policy to sleep on duty. She submitted that Mrs Pinguel had not followed the basic tenets of the nursing profession but instead followed an unsafe level of practice that was likely to cause a serious risk of harm.

Ms Stevenson submitted that Mrs Pinguel being verbally abusive towards a colleague is a serious breach on the basis that through her actions, there are serious concerns present and that as a registered nurse, Mrs Pinguel's colleagues should be able to trust and respect her and that she should be a role model for students and aspiring nurses.

Ms Stevenson submitted that Mrs Pinguel's actions as proven, fall far short of what would be expected of a registered nurse. She further submitted that the public would expect that the profession would be dependable and properly care for friends, relatives and members of the public. She stated that the public would expect nurses to uphold a professional reputation. Ms Stevenson referred the panel to the 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") and stated that the following areas have been breached:

1 Treat people as individuals and uphold their dignity
2 Listen to people and respond to their preferences and concerns
8 Work cooperatively
19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
20 Uphold the reputation of your profession at all times

Submissions on impairment

Ms Stevenson moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581 (Admin). Ms Stevenson in her written submissions stated that the panel may be

assisted by the following questions posed by Dame Janet Smith in her Fifth Shipman Report, as endorsed by Mrs Justice Cox.

> *'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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

Ms Stevenson submitted that Mrs Pinguel's fitness to practise is impaired and that the first three limbs of *Grant* are engaged. In her written submissions, Ms Stevenson referred the panel to three previous referrals made against Mrs Pinguel which resulted in sanctions. These were; a 3 year caution order imposed on 2 October 2009, a 1 year caution order imposed on 15 January 2016 and a 3 month suspension order imposed on 22 March 2018.

Ms Stevenson invited the panel to consider that the first charge in this matter occurred only one month after the expiry of the suspension order originally imposed on 22 March 2018. She also invited the panel to consider that the charges in relation to the 3 year caution order imposed on 2 October 2009 are very similar in nature. Ms Stevenson

submitted that Mrs Pinguel has repeated her misconduct by falling asleep on duty, when she was the nurse in charge and placing patients at serious risk of harm.

Ms Stevenson submitted that in light of the previous and the current findings, Mrs Pinguel has in the past and/or is liable in the future to act as so as to put a patient or patients at unwarranted risk of harm. She further submitted that the behaviour of Mrs Pinguel as found proven, plainly brings the profession into disrepute, she stated that it is an unsatisfactory level of care, and an unsatisfactory way to communicate with her colleague raising attitudinal concerns.

Ms Stevenson stated that Mrs Pinguel has provided evidence in relation to impairment, which demonstrates her acknowledgement to the seriousness of the concerns and referred to the NMC Code. However she submitted that Mrs Pinguel has denied the allegations and has therefore shown no acceptance or remorse. She stated that Mrs Pinguel has disengaged with the NMC, has not attended this hearing to provide evidence, and there is no explanation as to why Mrs Pinguel acted as she did or how she would act differently in a similar situation in the future. Ms Stevenson therefore invited the panel to consider Mrs Pinguel's evidence in relation to insight as being limited.

Ms Stevenson submitted that there is very limited evidence from Mrs Pinguel that could convince the panel that she is not at risk of repeating this behaviour and as such she invited the panel to find that Mrs Pinguel's fitness to practise is impaired.

Decision and reasons on misconduct

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

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

The panel was of the view that Mrs Pinguel's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Pinguel's actions amounted to a breach of the Code. The panel considered each charge separately when considering which areas of the Code was breached.

For charge 1, the panel was of the view that the following areas of the Code were breached:

1.2 make sure you deliver the fundamentals of care effectively
8.2 maintain effective communication with colleagues
8.5 work with colleagues to preserve the safety of those receiving care
19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

For charge 2, the panel was of the view that the following areas of the Code were breached:

8.2 maintain effective communication with colleagues
20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Pinguel falling asleep on duty is a serious breach of the Code and amounted to misconduct. The panel was of the view that as Mrs Pinguel was asleep she would have been unable to attend to patients, and therefore could have placed patients at serious risk of harm by leaving them unattended and by not being able to respond properly to any situation that arose. The panel also noted that Mrs Pinguel was the sole nurse on the shift, and therefore solely responsible for the patients' wellbeing.

The panel was of the view that Mrs Pinguel verbally abusing her colleague is a serious breach of the Code and amounted to misconduct. The panel noted that any other professional would find this behaviour to be deplorable. It took into account section 20.2 of the Code which states "*act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*". The incident in question arose because one of the HCA's reported her sleeping on duty to a manager, it therefore showed a level of intimidation and bullying which is not acceptable. The panel was of the view that aggressive behaviour is not appropriate and is serious enough to amount to misconduct. Taking all the information into account, the panel found that Mrs Pinguel's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Pinguel'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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; …*

The panel found that limbs (a), (b) and (c) were all engaged in this case. The panel was of the view that sleeping on a nightshift and verbally abusing colleagues placed patients' at an unwarranted risk of harm, brought the nursing profession into disrepute and breached fundamental tenets of the profession.

In reaching this decision, the panel considered Mrs Pinguel's response documentation provided by the RCN which included a number of training certificates, a written reflective piece from Mrs Pinguel and a number of testimonials. The panel took into account the various different training courses that Mrs Pinguel had undertaken but was of the view that only one of the courses, conflict management, is related to the facts found proved.

The panel also bore in mind the number of testimonials provided on Mrs Pinguel's behalf. It noted that although the majority of testimonials are supportive, they are not up to date. The panel noted that the most recent testimonial is dated 28 May 2020 and the majority are dated February 2020. Within the testimonials there is a "statement of general working practices" dated 11 May 2020. It raises issues including around Mrs Pinguel's attitude and demeanour. The panel took into account Mrs Pinguel's undated written reflective piece provided by the RCN in October 2019. The panel noted that Mrs Pinguel has continued her denial of sleeping on duty, acknowledges that a nurse should not be sleeping whilst on duty but made no reference to the language used in a conversation with Colleague 1.

The panel was not in possession of any updated evidence from Mrs Pinguel herself and therefore was unable to determine her insight into her misconduct. The panel did not have any information from Mrs Pinguel regarding how her actions put patients at a risk of harm, an understanding of why what she did was wrong or how this impacted negatively on the

reputation of the nursing profession. The panel noted that although Mrs Pinguel appeared to acknowledge that a nurse should not be sleeping on duty, she maintained her denial of this throughout her reflective piece and the panel did not have any further information as to any insight or remorse. The panel also bore in mind that Mrs Pinguel has not attended this hearing and has actively disengaged from the NMC since October 2020.

The panel was satisfied that the misconduct in this case is in principle capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Pinguel has remedied her practice. The panel had no evidence before it that Mrs Pinguel has remediated, the panel took into account the numerous training courses she has undertaken, but was of the view that only one course relates to the charges in this matter.

The panel took into account the three previous fitness to practice hearings in respect of Mrs Pinguel. The charges found proved in those proceedings were generally of a different nature to those found proved in these proceedings with the exception of one instance of sleeping on duty at a hearing in October 2009. The panel was of the view that Mrs Pinguel has not remediated and has repeated her behaviour. The panel is of the view that there is a real risk of repetition due to the lack of insight and remediation from Mrs Pinguel. The panel was also concerned that these incidents occurred shortly after a 3 month suspension order imposed in March 2018.

In the panel's view, for the reasons set out, misconduct and current impairment is found based solely on the current charges. The panel are however of the opinion that the previous matters strengthen its view that Mrs Pinguel is liable in the future to put patients at unwarranted risk of harm, bring the profession into disrepute, and breach the fundamental tenets of the code.

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

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

The panel determined that a finding of impairment on public interest grounds is required. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Pinguel's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Submissions on sanction

At the panel's request, Ms Stevenson informed the panel of the reviewing panel's decision of the suspension order originally imposed on 22 March 2018. She informed the panel that the review of the order took place on 14 June 2018 and the order was due to expire on 23 July 2018 and the order was allowed to expire.

Ms Stevenson provided the panel with written submissions in relation to sanction.
She invited the panel to consider the NMC's guidance Factors to consider before deciding on sanctions' when making its decision. She submitted what the NMC consider to be the aggravating and mitigating factors in Mrs Pinguel's case.

The aggravating factors submitted were:

- Serious misconduct;
- Attitudinal concerns;
- Level of intimidation and bullying;
- Mrs Pinguel's conduct put patients at a serious risk of harm;
- Limited evidence of insight and acceptance and remorse;
- There have been three previous referrals or findings by the NMC regarding Mrs Pinguel.

The mitigating factors submitted were:

- Some level of insight;
- Positive testimonials (albeit dated);
- Evidence of remediation.

Ms Stevenson submitted that the appropriate and proportionate sanction in this case is a striking-off order. She referred the panel to the NMC Guidance in relation to a striking-off order, specifically:

> *"This sanction is likely to be appropriate when what the nurse, has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:*
>
> *i. Do the regulatory concerns about the nurse, raise fundamental questions about their professionalism?*

ii. *Can public confidence in nurses, be maintained if the nurse, is not removed from the register?*

iii. *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?"*

Ms Stevenson submitted that those three key considerations can be answered in the affirmative. She further submitted that Mrs Pinguel placed patients at serious risk of harm by leaving them unattended, when she went to sleep for a lengthy period during a shift, where she was the only nurse on duty and therefore responsible for the patients' wellbeing. Ms Stevenson submitted that this showed a blatant disregard for the safety of those in Mrs Pinguel's care. Ms Stevenson further submitted that Mrs Pinguel had also been verbally abusive towards a colleague which demonstrates attitudinal issues.
Ms Stevenson submitted that a suspension order would have been appropriate where there has been a single instance of misconduct and there was no evidence of harmful deep-seated or attitudinal problems. She submitted that neither of which apply in the current case.

Finally, Ms Stevenson submitted that this matter may have been able to be dealt with by way of a mid-length suspension order but when it is considered in the context with the previous three regulatory findings, the NMC submit that the appropriate and proportionate sanction would be a striking-off order. Ms Stevenson submitted that this is justified due to the fact that the concerns in this case raise fundamental concerns about Mrs Pinguel's professionalism and that her conduct is fundamentally incompatible with continued practice.

Decision and reasons on sanction

Having found Mrs Pinguel's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful

regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Serious misconduct;
- Attitudinal concerns;
- Level of intimidation and bullying;
- Mrs Pinguel's conduct put patients at a serious risk of harm;
- Limited evidence of insight and no acceptance or remorse;
- There have been three previous findings by the NMC regarding Mrs Pinguel, one of which is a similar charge; sleeping on duty;
- The incidents in the charges occurred within a matter of weeks after a suspension order had expired.

The panel also took into account the following mitigating features:

- Some positive testimonials (albeit dated);
- Limited evidence of remediation (one course on conflict management completed in October 2019).

The panel first considered whether to take no action but concluded that this would be inappropriate in this case. The panel was of the view that taking no action would be insufficient to mark the seriousness of the charges, as well as the previous findings which demonstrates repeated behaviour. To take no further action would fail to address the public protection concerns in this case. In addition, it would be inadequate to address the wider public interest considerations arising from the nature and circumstances of the misconduct. The panel was also of the view that taking no action would undermine the public confidence in the NMC as a regulator.

For the same reasons, the panel considered that imposing a caution order would not mark the seriousness of the charges or address the wider public interest considerations
The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Pinguel's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Pinguel's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel also noted that the concerns in this matter are attitudinal and behavioural in nature. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mrs Pinguel's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. Again, the panel had regard to the SG, and the indicative factors which may suggest that a suspension order may be appropriate.

The panel noted that Mrs Pinguel had previously been subject to three separate sanctions, one of which included a 3 month suspension order which expired on 23 July 2018. The panel bore in mind the caution order that was imposed on 2 October 2009 due to charges found proved which included Mrs Pinguel sleeping on a nightshift.

The panel was of the view that Mrs Pinguel had ample opportunity to demonstrate remediation and to change her behaviour. The panel bore in mind that the incidents in the charges occurred shortly after her suspension order had expired which demonstrates that she did not learn or develop from previous referrals. The panel took into account the facts

found proved and noted that sleeping on duty and being verbally abusive and aggressive towards a colleague are attitudinal and behavioural in nature. The panel was concerned that, although the previous findings occurred over a period of time and relate to different issues with the exception of the sleeping charge, they indicate attitudinal issues.

The panel noted that although the charges in this matter are single incidents, taking into account the previous findings, there is a pattern of misconduct and a pattern of Mrs Pinguel putting patients at risk of harm. The panel was of the view that this demonstrates a lack of insight and that Mrs Pinguel has chosen to behave in a way that is not consistent with the NMC Code. In the panel's view, a member of the public would be extremely concerned to hear that a nurse repeatedly is acting outside of the NMC Code. The panel was of the view that the conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Pinguel's actions is fundamentally incompatible with Mrs Pinguel remaining on the register. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel took into account the charges and was of the view that sleeping on a nightshift whilst being the sole nurse in charge and verbally abusing a colleague demonstrates a lack of professionalism. The panel noted that Mrs Pinguel's actions of sleeping on a

nightshift were deliberate in that she arranged chairs in a way for her to go to sleep. The panel also noted that this happened shortly after she had assured the reviewing panel of her suspension order on 14 June 2018 that she would be “patient focused”.

The panel was of the view that the public confidence in nurses would not be maintained should Mrs Pinguel not be removed from the register. Finally, the panel concluded that a striking-off order is the only sanction that would sufficiently protect patients, members of the public and maintain professional standards. It was of the view that Mrs Pinguel’s actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel’s findings in this particular case demonstrate that Mrs Pinguel’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 effect of Mrs Pinguel’s actions in 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 took into account that it had no information from Mrs Pinguel in relation to her employment. It noted that the imposition of the striking-off order may have a negative financial impact on her. However, in applying the principle of proportionality, the panel determined that, in any event, the need to protect the public, maintain professionalism and the wider public interest outweighs Mrs Pinguel’s interests in this regard.

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

This will be confirmed to Mrs Pinguel in writing.

Interim order

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

Submissions on interim order

Ms Stevenson submitted that given the panel have found impairment on both public protection and public interest grounds and have now imposed a striking-off order an interim order should be imposed in order to allow for the possibility of an appeal to be brought and determined. She submitted that an interim suspension order for a period of 18 months should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

Decision and reasons on interim order

The panel had regard to the seriousness of the facts found proved and the reasons for its findings on the issues of misconduct, impairment and sanction set out in its substantive determination. The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest.

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

was necessary to impose an interim suspension order. It considered that the appropriate duration of the interim suspension order was for a period of 18 months, because of the length of time likely to be required for any appeal, if brought, to be determined or otherwise finally disposed of.

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

That concludes this determination.