Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 8 November - Wednesday 10 November 2021

Virtual Hearing

Name of registrant:	**Jonathan Reyes**
NMC PIN:	03J0268O
Part(s) of the register:	Registered Nurse – Adult Nursing (October 2003)
Area of registered address:	Southend On Sea
Type of case:	Misconduct
Panel members:	Adrian Smith (Chair, Lay member) Lisa Punter (Registrant member) Robert Fish (Lay member)
Legal Assessor:	Marian Gilmore QC
Panel Secretary:	Jasmin Sandhu
Nursing and Midwifery Council:	Represented by Vanya Headley, Case Presenter
Mr Reyes:	Not present and not represented
Facts proved:	Charges 1 and 3
Facts not proved:	Charge 2
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Reyes was not in attendance and that the Notice of Hearing letter had been sent to his registered email address by secure email on 14 September 2021.

The panel considered whether notice of this hearing had been served in accordance with the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (the Rules). It 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.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and virtual nature of the hearing and, amongst other things, information about Mr Reyes' right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Ms Headley, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34.

The panel accepted the advice of the legal assessor.

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

Decision and reasons on proceeding in the absence of Mr Reyes

The panel next considered whether it should proceed in the absence of Mr Reyes. It had regard to Rule 21 and heard the submissions of Ms Headley who referred the panel to the cases of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5, *Tait v Royal College of*

Veterinary Surgeons (RCVS) [2003] UKPC 34*,* and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

Ms Headley submitted that Mr Reyes has voluntarily absented himself from these proceedings. She stated that Mr Reyes has informed the NMC on a number of occasions that he does not wish to participate in these proceedings. Ms Headley further stated that three witnesses are scheduled to be heard today, and therefore adjourning would be an inconvenience to them. Ms Headley invited the panel to continue in the absence of Mr Reyes.

The panel accepted the advice of the legal assessor who reminded it of its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21. The panel was reminded that this power 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 Mr Reyes. In reaching this decision, the panel considered the submissions of Ms Headley and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* as well as to the overall interests of justice and fairness to all parties. It noted that:

- Mr Reyes has informed the NMC that he has received the Notice of Hearing and confirmed on a number of occasions that he would not be attending and is content for the hearing to proceed in his absence;
- No application for an adjournment has been made by Mr Reyes;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Three witnesses are scheduled to attend today to give live evidence, and not proceeding may inconvenience these witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;

- The charges relate to events that occurred in 2017 and 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.

The panel noted that there is some disadvantage to Mr Reyes in proceeding in his absence. Although the evidence upon which the NMC relies upon will have been sent to his registered email address, Mr Reyes will not be able to challenge this evidence or give his own evidence at this virtual hearing. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Reyes' decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge

That you, a registered nurse, whilst employed at Marlborough Court Care Home on 1 April 2017:

1) *Without clinical justification and/or in the absence of you having made a clinical decision, failed to carry out cardio-pulmonary resuscitation ("CPR") on Resident 1 when they were found to be unresponsive; or* **[FOUND PROVED]**

2) *In the event that you made a clinical decision not to carry out CPR failed to record that decision in Resident 1's daily notes.* **[FOUND NOT PROVED]**

3) Failed to record any details relating to Resident 1's death in their daily notes.
[FOUND PROVED]

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

Background

In May 2018, the NMC received a referral from the Head of Care Improvement at Four Seasons Health Care, who raised a concern regarding Mr Reyes' fitness to practise. At the time of the concern raised, Mr Reyes was working as a Registered General Nurse at Marlborough Court Care Home (the Home). He was employed at the Home from 11 July 2016 to 22 August 2017.

On 1 April 2017, Mr Reyes was the nurse in charge on the nursing unit at the Home. It is alleged that a Health Care Assistant (HCA) found Resident 1 unresponsive at around 19:00 on that day and informed Mr Reyes, who then advised that the emergency services should be called.

The 111 emergency services were called by a senior HCA, and it is said that the call handler identified this to require an emergency response, thus escalating it to a 999 call. The call handler advised that CPR should be carried out on Resident 1 until the paramedics arrive.

The paramedics arrived at the Home at 19:22 and allegedly found Resident 1 up-right in a chair, with onset riga-mortis in her jaw and hands. At 19.30 they confirmed her death. The paramedics became concerned that CPR could not have been undertaken with Resident 1 in the position in which she was found.

In addition to this, on 7 September 2017, it is apparent that Resident 1's daughter conveyed her distress to the Home after learning that her mother had received CPR when she believed there was a Do Not Attempt to Resuscitate (DNAR) order in place.

An internal investigation into these events was undertaken and led to concerns being raised about Mr Reyes' actions. It is said that by the time the investigation began, Mr Reyes had left his employment at the Home for reasons unconnected to this matter.

Decision and reasons on application to admit written statement of Ms 2

The panel heard an application made by Ms Headley under Rule 31 to allow the written statement of Ms 2 into evidence. Although Ms 2 was available to give oral evidence during the course of this hearing, the NMC submit that her attendance was not required given that her written statement provided was sufficient.

In the preparation of this hearing, the NMC had indicated to Mr Reyes that it was the NMC's intention for Ms 2 to provide oral evidence to the panel. Despite knowledge of the nature of the evidence to be given by Ms 2, Mr Reyes made the decision not to attend this hearing. On this basis Ms Headley advanced the argument that there was no lack of fairness to Mr Reyes in allowing Ms 2's written statement into evidence.

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

The panel noted that Ms 2's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph: '*This statement is true to the best of my knowledge and belief. I confirm that I am willing to attend a hearing if required*.' This statement was signed by Ms 2 on 28 August 2020.

The panel considered whether Mr Reyes would be disadvantaged by the change in the NMC's position of moving from reliance upon the oral testimony of Ms 2 to that of a written statement. It took into account that Mr Reyes had been provided with a copy of Ms 2's

statement and he had not raised any issues. The panel also accepted that none of Ms 2's evidence went directly to the charges in this case. It further noted that as Mr Reyes has chosen to voluntarily absent himself from these proceedings, he would not have been able to cross-examine this witness in any case. The panel also bore in mind that there was a public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In all the circumstances, the panel concluded that it would be fair and relevant to accept the written statement of Ms 2 into evidence. It determined that there was no additional information which could be provided by Ms 2 at this hearing which was not already contained in her written statement. The panel decided that it would give what it deemed appropriate weight to this statement once it had heard and evaluated all the evidence before it.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence adduced in this case together with the submissions made by Ms Headley. The panel has drawn no adverse inference from the non-attendance of Mr Reyes.

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 oral evidence from the following witnesses called on behalf of the NMC:

- Ms 1: Head of Care Improvement at Four Seasons Health Care at the time of events.

- Mr 1: Registered Paramedic with the Health and Care Professions Council (HSPC).

As previously decided, Ms 2 would not be giving oral evidence at this hearing.

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

Charge 1

That you, a registered nurse, whilst employed at Marlborough Court Care Home on 1 April 2017:

1) *Without clinical justification and/or in the absence of you having made a clinical decision, failed to carry out cardio-pulmonary resuscitation ("CPR") on Resident 1 when they were found to be unresponsive; or*

This charge is found proved.

The panel was of the view that on the balance of probabilities, Mr Reyes did fail to carry out CPR without clinical justification.

In reaching this decision, the panel first considered whether the duty to carry out CPR was on Mr Reyes himself. It was the view of the panel that although it is not formally set out in the Home's policy, the expectation at the Home at the time was that the registered nurse on duty was responsible for carrying out CPR. The panel took into account the oral evidence of Ms 1 who confirmed that as Mr Reyes was the only nurse on shift at the time, it was his duty to either carry out the CPR to Resident 1 himself, or alternatively, delegate this duty to one of the HCAs. The panel considered Ms 1's evidence to be reliable and noted that there was no other evidence before it to refute her account. The panel also

noted that although Mr Reyes was said to have been working on the nursing unit rather than the residential unit at the time of events, he was called onto the scene by an HCA. The panel had regard to the oral evidence of Ms 1 who confirmed this, as well as to Mr Reyes' response form dated 22 September 2019 where he states: '*I was probably called to help…*'. Taking all the above into account, the panel was satisfied that as the only nurse present at the time, it was Mr Reyes' duty to carry out CPR on Resident 1.

The panel next considered whether Mr Reyes failed to carry out CPR on Resident 1. It had regard to the oral evidence of Mr 1 who stated that when he arrived at the Home, there was no evidence that CPR had been carried out on Resident 1. Resident 1 was fully clothed, found up-right in her chair, with no suggestion that CPR had been commenced or attempted. The panel took the view that Mr 1 was a credible witness, being a registered professional paramedic who arrived on the scene. It therefore considered Mr 1's evidence to be reliable and in the absence of any contrary evidence, the panel determined that it was more likely than not that Mr Reyes failed to carry out CPR on Resident 1.

The panel subsequently considered whether Mr Reyes' failure to carry out CPR was without clinical justification. It took into account all the evidence before it and noted that there was no suggestion that a DNAR notice was in place for Resident 1, there was nothing to suggest that Resident 1 was suffering from a terminal illness which would render CPR clinically inappropriate, and that there was no indication that Resident 1 had been in that state for a prolonged period of time before being found by the HCA. Furthermore, the panel noted that there was no record in Resident 1's daily notes from 1 April 2017 to suggest that the decision to not carry out CPR was a clinical decision. In all the circumstances, the panel found that Mr Reyes failed to carry out CPR without clinical justification, thus finding this charge proved.

Charge 2)

That you, a registered nurse, whilst employed at Marlborough Court Care Home on 1 April 2017:

2) *In the event that you made a clinical decision not to carry out CPR failed to record that decision in Resident 1's daily notes.*

This charge is found NOT proved.

The panel considered that charge 2 was in the alternative to charge 1. As such, given its finding in the previous charge that Mr Reyes' failure to carry out CPR was not clinically justified, the panel finds this charge not proved. The panel also noted that there is no evidence in Resident 1's daily notes from 1 April 2017 to suggest that the failure to carry out CPR by Mr Reyes was a clinical decision.

Charge 3)

That you, a registered nurse, whilst employed at Marlborough Court Care Home on 1 April 2017:

3) Failed to record any details relating to Resident 1's death in their daily notes.

This charge is found proved.

The panel had regard to Resident 1's daily notes as contained in the documentary evidence provided by Ms 1. The panel noted that these daily notes contain undocumented days, specifically 28 March 2017, 30 March 2017, and 31 March 2017. However, as 1 April 2017 was accounted for, the panel was satisfied that this would have been where details of Resident 1's death would be recorded. The panel also considered that if the absence of details relating to Resident 1's death was attributable to missing pages, it was a reasonable inference that Mr Reyes would have referred to this in his response to the concerns.

Having regard to Resident 1's daily notes for 1 April 2017, the panel determined that Mr Reyes did not record any details relating to Resident 1's death. It noted that the notes state that Resident 1 '*slept all through the night'* and '*she had her checks done hourly, and remains in bed*'. The panel also noted that a line had been drawn under this daily note, with the word '*discontinued*' written. However, the panel did not have sight of any further details recorded in Resident 1's daily notes for that day and nothing relating to her death.

Taking all the above into account, the panel was satisfied that on the balance of probabilities, this charge is found 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 Mr Reyes' fitness to practise is currently impaired. Whilst there is no statutory definition of fitness to practise, 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, Mr Reyes' fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Ms Headley submitted that whilst there is no statutory definition of misconduct, guidance has been provided by various case law authorities, including: *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, *Remedy UK Ltd R (on application of) v General Medical Council* [2009] EWHC 2294 (Admin), and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Ms Headley referred the panel to the terms of 'The NMC code of professional conduct: standards for conduct, performance and ethics (2015)' (the Code) and outlined the specific standards which she submitted have been breached by Mr Reyes. She submitted that whilst breaches of the Code do not automatically warrant a finding of misconduct, Mr Reyes' actions and omissions fell far short of the standards expected by a registered nurse and are sufficiently serious to amount to misconduct. She submitted that Mr Reyes' failures go to the heart of the nursing profession, in that he failed to assist in an emergency situation, failed to provide basic life support, and failed to keep an adequate record of events. She further stated that Mr Reyes' lack of record keeping added distress to the family of Resident 1, who were not provided with an explanation of the events surrounding the death of their relative. As such, Ms Headley invited the panel to take the view that the facts found proved do amount to misconduct.

Ms Headley 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.

Ms Headley referred the panel to the Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011] EWHC 927 (Admin) and submitted that the first three limbs are engaged in this case. She submitted that failing to carry out CPR or make a clinical decision in relation to CPR put the resident at unwarranted risk of harm. She also submitted that Mr Reyes' failure to carry out basic fundamental nursing duties, namely omitting to carry out CPR

and the lack of record-keeping breached the fundamental tenets of the nursing profession and brought the profession into disrepute.

Ms Headley submitted that Mr Reyes' clinical failings are capable of remediation, such as through training, supervision, and development of insight. However, she submitted that Mr Reyes has not remediated the concerns in his practice. There is no evidence of training in either CPR or record keeping, he has not provided a reflective statement to demonstrate his insight into events, and there is nothing to suggest that he has sought the assistance of another registered nurse as a mentor. Ms Headley submitted that there is therefore a risk of repetition, and a finding of current impairment is necessary in order to protect the public.

Ms Headley also submitted that a finding of current impairment is in the public interest to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council*, and *General Medical Council v Meadow* [2007] QB 462 (Admin), and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Decision and reasons on misconduct and impairment

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 Mr Reyes' actions did fall significantly short of the standards expected of a registered nurse, and that his actions amounted to a breach of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.2 make sure you deliver the fundamentals of care effectively.*

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

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event…

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

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

20 Uphold the reputation of your profession at all times*.*

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code'

Whilst the panel appreciated that breaches of the Code do not automatically result in a finding of misconduct, it considered that Mr Reyes' failure to carry out fundamental nursing duties was a serious departure of the conduct and standards expected of a registered nurse. It also took into account the impact of Mr Reyes' actions and omissions on the family of Resident 1, in that his lack of record keeping meant that they were misinformed and were not provided with an explanation of events surrounding their relative's death. For

these reasons, the panel concluded that Mr Reyes' actions as found proved were sufficiently serious to warrant a finding of misconduct.

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

The panel bore in mind that nurses occupy a position of privilege and trust in society and are expected at all times to behave professionally. 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; and/or*

d) *....'*

The panel had regard to this test and found that the first three limbs were engaged in this case. In failing to carry out CPR, the panel was of the view that Mr Reyes put the resident at an unwarranted risk of harm. In addition, the panel considered that Mr Reyes' failure to carry out adequate patient care breached one of the fundamental tenets of the profession and therefore brought its reputation into disrepute.

In its consideration of whether Mr Reyes has remediated his practice, the panel had regard to the case of *Cohen v General Medical Council,* in which the court set out three matters which it described as being '*highly relevant'* to the determination of the question of current impairment:

'(a) Whether the conduct that led to the charge(s) is easily remediable?
(b) Whether it has been remedied?
(c) Whether it is highly unlikely to be repeated?'

While the panel was satisfied that the misconduct in this case is capable of remediation, it considered that there remains a risk of repetition. The panel did not have sight of any reflective statement by Mr Reyes to demonstrate his insight into events, nor did it receive any evidence to suggest that Mr Reyes has completed relevant training to address the

failings in his nursing practice. As such, the panel took the view that there was insufficient evidence before it to suggest that if faced with similar circumstances in the future, that Mr Reyes would act differently. 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 objective of the NMC is 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 also required. It considered that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Reyes' fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mr Reyes' registration has been suspended.

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.

Submissions on sanction

Ms Headley referred the panel to the NMC's SG. She stated that the aggravating factors in this case include:

- Mr Reyes' conduct put a patient at risk of significant harm
- Mr Reyes has a lack of insight into his failings

Ms Headley then moved onto the mitigating factors in this case, which she submitted to be:

- Previous good practice before this concern was raised

Ms Headley submitted that taking no action or imposing a caution order would not be appropriate in this case. She submitted that an order which does not restrict Mr Reyes' practice in some way would fail to offer sufficient safeguards against the identified risks in Mr Reyes' practice. Ms Headley submitted that taking no action or imposing a caution order would therefore not adequately protect the public, nor satisfy the public interest.

Ms Headley submitted that a conditions of practice order would also not be appropriate as there is no evidence to suggest that if conditions were imposed, that Mr Reyes would comply with them. He has not fully cooperated with the NMC, nor has he shown a willingness to engage in the process. Ms Headley further stated that there is no indication that Mr Reyes' has tried to remediate his practice, in that he has not provided any testimonials, evidenced any training, or written a reflective statement. Ms Headley submitted that in these circumstances, a conditions of practice order is neither workable nor appropriate.

Ms Headley moved on to the issue of a suspension order and submitted that this was an appropriate and proportionate order in the circumstances of this case. This is a single incident of misconduct which occurred over a short period of time. In addition, before this

incident took place, Mr Reyes had been practicing since 2003 with no prior regulatory concerns raised against him. Ms Headley invited the panel to consider imposing a suspension order for a period of 12 months with a review. This would allow time for Mr Reyes to consider whether he wishes to re-engage with the regulatory process and to evidence any remediation and/or insight.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr Reyes' 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:

- Mr Reyes' conduct put the resident at risk of significant harm
- Mr Reyes has a lack of insight into his failings

The panel also took into account the following mitigating feature:

- There have been no previous regulatory concerns raised since Mr Reyes started practising in 2003

The panel first considered whether to take no action or to impose a caution order but concluded that this would be inappropriate in view of the ongoing public protection issues identified. The panel decided that an order which does not restrict Mr Reyes' practice would not mitigate the ongoing risk in this case.

The panel next considered whether placing conditions of practice on Mr Reyes' practice would be a sufficient and appropriate response. The panel took into account the SG and was mindful that any conditions imposed must be proportionate, measurable and workable. The panel noted that there is no evidence of harmful deep-seated personality or attitudinal problems and that there are identifiable areas in Mr Reyes' practice which need to be addressed. However, it bore in mind that Mr Reyes has not shown a willingness to remediate the concerns in his practice or engage meaningfully with these proceedings. The panel therefore determined that a conditions of practice order was not workable as there is insufficient evidence before it to be satisfied that if conditions were imposed, that Mr Reyes would comply with them.

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

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

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register and that a suspension order would adequately protect the public, as well as meet the public interest.

It did go on to consider whether a striking-off order would be proportionate but concluded that the facts found proved and the level of impairment in this case does not render Mr Reyes incompatible with remaining on the register. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Reyes' case to impose a striking-off order.

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

The panel noted the hardship such an order may cause Mr Reyes, however it considered that this was outweighed by the public interest in this case. The panel determined that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 12 months in order to allow time for Mr Reyes to meaningfully engage with these proceedings, remediate his practice, and demonstrate insight.

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

Any future panel reviewing this case would be assisted by:

- Mr Reyes' attendance at his next hearing
- Evidence of re-training in CPR and record-keeping
- A reflective statement which demonstrates Mr Reyes' understanding of how his actions affected the resident's family, his colleagues, and the profession
- Testimonials from a line manager or supervisor that detail Mr Reyes' current work practices

This will be confirmed to Mr Reyes in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Headley who invited it to make an interim suspension order for a period of 18 months to cover the 28-day appeal period. She submitted that this order is necessary to protect the public and serve the public interest.

The panel heard and accepted the advice of the legal assessor who referred it to Article 31 of the 'Nursing and Midwifery Order 2001' (the Order).

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive suspension order. The panel therefore imposed an interim suspension order for a period of 18 months to allow sufficient time for an appeal to be made if Mr Reyes wishes to make one.

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

That concludes this determination.