Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 8 January 2024 – Wednesday 24 January 2024

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

Name of Registrant:	Ruth Dzvengwe
NMC PIN	00D0256E
Part(s) of the register:	RNA: Adult nurse, level 1 (29 September 2003)
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Nicholas Rosenfeld (Chair, Lay member) Jillian Claire Rashid (Registrant member) Lorraine Wilkinson (Lay member)
Legal Assessor:	Michael Levy (8 – 16 January 2024, 22 – 24 January 2024) Ian Ashford-Thom (17 January 2024)
Hearings Coordinator:	Anya Sharma
Nursing and Midwifery Council:	Represented by Ryan Ross, Case Presenter
Ms Dzvengwe:	Not present and self-representing (8 – 19 January 2024) Present and self-representing (22 and 24 January 2023)
Facts proved:	Charges 1a, 1b, 2i, 2ii, 2iv, 2v, 2vi, 2vii, 2viii, 2ix, 2x, 2xi, 3, 5a, 5b, 6, 7a, 7b, 8a, 8b, 8c, 9b, 9c and 10
Facts not proved:	Charges 2iii, 4 and 9a
Fitness to practise:	**Impaired**
Sanction:	**Striking-off Order**

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 Ms Dzvengwe was not in attendance and that the Notice of Hearing letter had been sent to Ms Dzvengwe's registered address by recorded delivery and by first class post on 8 December 2023.

The panel had regard to the Royal Mail 'Track and Trace' printout which showed the Notice of Hearing was delivered to Ms Dzvengwe's registered address on 9 December 2023. It was signed for against the printed name of 'Ruth Dzvengwe'.

Mr Ross, on behalf of the Nursing and Midwifery Council (NMC), 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 and drew reference to the NMC Guidance document entitled 'Notice of hearings and meetings' reference PRE-6 last updated 14 October 2022.

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

In the light of all the information available, the panel was satisfied that Ms Dzvengwe 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 Ms Dzvengwe

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

Mr Ross referred the panel to the Proceeding in Absence (PIA) NMC bundle, which includes email correspondence with the NMC and Ms Dzvengwe between September 2023 and January 2024. Mr Ross told the panel that Ms Dzvengwe had informed the NMC via email on more than one occasion that she is unable to attend the hearing and cited [PRIVATE], and work and family responsibilities for the reasons why she would not be in attendance.

Mr Ross submitted that the panel can see from the email correspondence within the PIA bundle that Ms Dzvengwe is engaging to some extent with the NMC, has received the hearing papers, was aware of the substantive hearing dates, has informed the NMC that she will not be attending the substantive hearing and was made aware by the NMC via email that an application would be made on day one of the substantive hearing for the panel to proceed in her absence.

Mr Ross informed the panel that the NMC had also offered to cover Ms Dzvengwe's travels costs so that she could attend the substantive hearing. Mr Ross submitted that Ms Dzvengwe has voluntarily absented herself, and that the panel should proceed in her absence, as there was no reason to believe that an adjournment would secure Ms Dzvengwe's 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 also had regard to the NMC Guidance document entitled 'Proceeding with hearings when the nurse, midwife or nursing associate is absent' reference CMT- 8, last updated 13 January 2023.

The panel has decided to proceed in the absence of Ms Dzvengwe. In reaching this decision, the panel has considered the submissions of Mr Ross, the PIA bundle including Ms Dzvengwe's email correspondence with the NMC 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* [2016] EWCA Civ 162 and 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 Dzvengwe;
- The panel was satisfied that Ms Dzvengwe was aware of when the proceedings were due to commence, and despite continued correspondence between her and the NMC, where she was offered travel and accommodation expenses, the option of attending via a virtual link or by telephone, she chose not to engage in the hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A number of witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, who are all registered nurses currently in employment, the NHS trusts that employ them, and as they are involved in clinical practice, the patients who require their care;
- Given the dates of the allegations and the nature of the concerns, it would be in the public interest in the expeditious disposal of the case to proceed; and
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events

There is some disadvantage to Ms Dzvengwe in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to Ms Dzvengwe at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person 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 allowances 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 Ms Dzvengwe's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Ross, on behalf of the NMC, to amend the wording of charges 2, 5 and 6. Mr Ross submitted that none of the proposed amendments by the NMC involve substantive changes to the charges and there is no change to the seriousness or to the severity of the allegations.

Mr Ross set out that the most significant change is in respect of what is now charge 2(iii), whereby a date is being moved by four days. He submitted that it is not the case that the date of these events carries weight but the mischief to which the charges point are the issue. Mr Ross submitted that that dates in the charges had erroneously reflected the dates that they had been reported rather than the dates which they had occurred. Ms Dzvengwe was made aware of the correct dates in this case when she received the exhibits from the NMC.

In relation to charge 2, Mr Ross submitted that bullet points be replaced by roman numerals, '[on]' be added to the start of each sub-charge, and the word and/or be inserted after charge 2d) to assist with clarity.

Mr Ross submitted that no injustice or prejudice would be caused to Ms Dzvengwe by way of these charges being amended. Mr Ross submitted that these amendments would correct some typographical and stylistic errors, and that the proposed amendments would provide clarity and more accurately reflect the evidence.

That you, a Registered Nurse

2. On one or more occasions as set out ~~in Schedule 1~~ **below**, acted in a manner towards colleagues which was,
    a. Argumentative

b. intimidating
c. disrespectful
d. interruptive **and/or**
e. uncooperative

in that on the following dates you:

i. **On** 24 October 2019 deliberately ignored Colleague A.
ii. **On** 24 October 2019 deliberately pushed Colleague A twice.
iii. **On** ~~15~~ **11** September 2020 refused to answer questions.
iv. **On** 8 May 2021 attended work despite not being allocated a shift and refused to leave when asked by Colleagues B and C.
v. **On** 10 May 2021 repeatedly interrupted and refused to listen to Colleague C, in a meeting.
vi. **On** 2 July 2021 refused to engage in a capability discussion with Colleague C.
vii. **On** 8 July 2021 continued to interrupt and talk over others in a discussion.
viii. **On** 12 July 2021 continually interrupted Colleague C at a capability meeting.
ix. **On** 23 July 2021 refused to engage in a capability discussion with Colleague C putting your hand in his face stating talk to the hand.
x. **On** 9 September 2021 continued to interrupt Colleagues C and D, at a meeting.
xi. **On** 10 October 2021 walked out of meeting with Colleague C.

5. On ~~12~~ **11** May 2021 administered IV fluids to Patient D
   a. not at the prescribed rate of 83mls/hour
   b. without an IV pump

6. On ~~12~~ **11** May 2021 gave incorrect discharge medication advice

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). The panel also considered the NMC Guidance: How a charge becomes final, Reference PRE-2c, last updated 23 June 2021.

The panel considered the proposed amendments as set out by Mr Ross. The panel, of its own volition, decided that in relation to charge 2, the words ‘and/or’ would need to be placed at the end of each sub-charge 2a) – 2d), rather than solely at the end of 2d).

The panel determined that amendments in relation to charges 2, 5 and 6, as applied for and proposed by the panel, were fair, having regard to the panel’s overarching objectives to protect the public and would not impact the nature of the proceedings. The panel was satisfied that there would be no prejudice to Ms Dzvengwe and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for by the NMC and proposed by the panel, to ensure clarity and accuracy.

Schedule of Charge (as amended)

That you, a Registered Nurse

1. Between 29 September 2021 and May 2022, refused a management instruction to work under a performance improvement plan by
    a. Refusing to follow colleagues’ instructions.
    b. Refusing to accept medication administration supervision.

2. On one or more occasions as set out below, acted in a manner towards colleagues which was,
    a) Argumentative and/or
    b) intimidating and/or
    c) disrespectful and/or
    d) interruptive and/or
    e) uncooperative

in that on the following dates you:

i. On 24 October 2019 deliberately ignored Colleague A.
ii. On 24 October 2019 deliberately pushed Colleague A twice.

iii. On 11 September 2020 refused to answer questions.
iv. On 8 May 2021 attended work despite not being allocated a shift and refused to leave when asked by Colleagues B and C.
v. On 10 May 2021 repeatedly interrupted and refused to listen to Colleague C, in a meeting.
vi. On 2 July 2021 refused to engage in a capability discussion with Colleague C.
vii. On 8 July 2021 continued to interrupt and talk over others in a discussion.
viii. On 12 July 2021 continually interrupted Colleague C at a capability meeting.
ix. On 23 July 2021 refused to engage in a capability discussion with Colleague C putting your hand in his face stating talk to the hand.
x. On 9 September 2021 continued to interrupt Colleagues C and D, at a meeting.
xi. On 10 October 2021 walked out of meeting with Colleague C.

3. On 22 May 2020 catheterised Patient E when you were not competent to do so

4. On 14 May 2021 administered intravenous paracetamol to Patient C without it being checked by another nurse

5. On 11 May 2021 administered IV fluids to Patient D
    c. not at the prescribed rate of 83mls/hour
    d. without an IV pump

6. On 11 May 2021 gave incorrect discharge medication advice

7. On 7 September 2021 removed Patient F's a nasal pack
    a. without clinical justification
    b. when you were not competent to do so

8. Refused to transfer patients when requested to do so on
    a. 31 August 2021 (Patient A)
    b. 3 February 2022 (Patient B)

9. Between May 2020 and May 2022 did not provide adequate patient care in that you
    a. Did not hand your patient over either verbally or in writing to the night shift, on 4 June 2021
    b. Did not answer patient call bells.
    c. Refused to provide patient care.

10. On various dates during a shift, you left the ward without communicating with colleagues.

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

Decision and reasons on application for hearing to be held in private

At the outset of Colleague C's witness evidence, the panel made a request that this case be held partly in private on the basis that proper exploration of Ms Dzvengwe's case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Ross indicated that he supported the application.

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 drew reference to the NMC Guidance Hearings in private and in public Reference CMT-10 Last Updated 8 August 2023.

The panel determined to go into private session in connection with Ms Dzvengwe's []as and when such issues are raised.

Background

Ms Dzvengwe entered the NMC register on 29 September 2003, and worked at London North West University Healthcare NHS Trust ('the Trust') as a bank nurse from September 2004. Ms Dzvengwe worked as a band 5 nurse from 1 October 2017 in the Trust urology department.

In October 2019, Ms Dzvengwe was redeployed to the surgical assessment unit (SAU), which stretched across three floors and dealt with patients that were both pre-surgery and post-surgery.

For various reasons, Ms Dzvengwe was placed under a formal assessment program. Ms Dzvengwe was unhappy with this process and was allegedly uncooperative.

The NMC received a referral from the Trust on 5 July 2022 regarding Ms Dzvengwe's attitude and her nursing practice. Ms Dzvengwe's line manager, Colleague C, had sought to deal with these issues at a local level, but that proved unsuccessful.

The concerns in this case include the failure to work cooperatively (charges 1, 2 and 8), poor medical practice/acting beyond one's competency (charges 3, 4 and 7) and poor patient care (charges 5, 6 and 9). Ms Dzvengwe has repeatedly denied the charges in correspondence to the NMC. However, she has not advanced an alternative explanation to the allegations beyond her general denial.

On the evidence before the panel, Ms Dzvengwe frequently appears to confuse the charges with other unrelated matters that the Trust had addressed with her. Ms Dzvengwe has informally raised issues of harassment and bullying by the Trust.

Decision and reasons on application to admit hearsay evidence on 11 January 2024

The panel heard an application made by Mr Ross under Rule 31 to allow the written statement of Ms 6 and hearsay evidence of Colleague A into evidence. Mr Ross referred the panel to his written submissions in relation to the hearsay application as well as the supporting hearsay bundle, which included a telephone note between Ms 6 and the NMC Case Coordinator on 19 December 2023 which sets out that Ms 6 will be abroad in Ethiopia and indicated that she could give evidence virtually on 15 January 2024, but the Wi-Fi quality may be intermittent.

The panel also took into account email correspondence from the NMC to Ms 6 providing details in relation to the substantive hearing. The bundle also included emails from Ms 6 to the NMC dated 19 December 2023 and 22 December 2023 indicating that she will be abroad between 3 and 26 January 2024 and therefore unable to attend the hearing, and that after considering the situation she thought it would not be appropriate for her to attend a hearing whilst on holiday abroad.

The panel heard and accepted the advice of the legal assessor. It had regard to the NMC Guidance on evidence, in particular the section on hearsay Reference DMA-6, last updated 1 July 2022, Rule 31(1) of The Nursing and Midwifery Council (Fitness to Practise) Rules 2004, the principles in the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)* and the case of *Mansaray v Nursing and Midwifery Council [2023] EWHC 730 (Admin).*

The panel determined that if Ms 6 were available and could potentially give evidence on 15 January 2024, then those enquiries should be made by the NMC to facilitate this. The panel was of the view that if this were to prove impossible, then the panel will determine the issue of the hearsay application once those enquiries/attempts have been made in relation to Ms 6. The panel noted from the hearsay bundle that Ms 6 has indicated that she would be available on 15 January 2024 to give evidence and noted that there may be internet issues. The panel indicated that it would be their preference if

Ms 6 could give evidence on 15 January 2024 and requested that the NMC make the necessary enquiries.

Mr Ross submitted that he would ensure that the NMC make the necessary further enquiries, but is mindful that the email correspondence within the hearsay bundle sets out that communication will be difficult whilst Ms 6 is abroad, and that Ms 6 will not be able to check emails regularly.

The panel determined to make a decision in relation to the hearsay application in respect of both Colleague A and Ms 6 once the NMC had made those further enquiries.

On 15 January 2024, Mr Ross updated the panel that there had been no further contact from Ms 6 and, accordingly, invited the panel to proceed with the hearsay application.

Panel's decision and reason in relation to hearsay application on 16 January 2024

In relation to Colleague A, the panel had sight of the Datix, which is a contemporaneous document where Colleague A reported the incident. Colleague A also reported the incident to other more senior nurses, who corroborate this in their witness statements. One of the senior nurses was Colleague C, who also corroborated this in his oral evidence to the panel. Ms 3 also spoke to this in her witness statement and said that the incident had been reported to her at the time. The panel took into account that there does not appear to be any challenge from Ms Dzvengwe in relation to that charge. It also considered that it has no evidence before it to suggest that this allegation was fabricated. The panel noted that this is a serious charge (charges 2i and 2ii), and it is relevant and fair to admit the hearsay evidence of Colleague A, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

In relation to Ms 6, the panel considered that the allegations relate to incidents which occurred on 11 September 2022, and that Ms 6's hearsay evidence is the sole and decisive evidence in relation to that date (charge 2iii). The panel considered that Ms 6's evidence relates to matters that were reported to her from a staff nurse and a student

nurse, neither of which have provided witness statements nor provided oral evidence before the panel at the hearing. The panel noted that it had been provided with no good reason for the non-attendance of those witnesses and no information to the steps taken by the NMC to secure their attendance, if any. Given the nature of the charge and the quality of the evidence in the statement, the panel was decided it would be unjust to admit it as hearsay.

Panel's reasons and decision to not revisit proceeding in absence application on Monday 15 January 2024

The panel was made aware of correspondence between the NMC and Ms Dzvengwe on Friday 12 January 2024, and additional email correspondence from Ms Dzvengwe received on Monday 15 January 2024. The panel had regard to the NMC correspondence, which reiterates to Ms Dzvengwe that her fitness to practise substantive hearing is ongoing and that she is welcome to engage by attending at 2 Stratford Place. The panel noted that the NMC have reiterated this in a number of emails sent to Ms Dzvengwe and was therefore not minded to revisit its decision to proceed in the absence of Ms Dzvengwe.

Decision and reasons on facts

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

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

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

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

- Ms 1: Matron of Outpatients at the Trust
- Ms 2: Nurse in Charge at the Trust
- Colleague C: Clinical Nurse Manager at the Trust
- Ms 3: Band 6 Sister at the Trust
- Ms 4: Advanced Nurse Practitioner at the Trust
- Colleague B: Band 6 Nurse at the Trust
- Mr 1: Charge Nurse at the Trust
- Ms 5: Specialist Nurse Practitioner at the Trust

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.

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

Charge 1a)

1. Between 29 September 2021 and May 2022, refused a management instruction to work under a performance improvement plan by

a) Refusing to follow colleagues' instructions

This charge is found proved.

In reaching this decision, the panel referred to the improvement action plan which was sent by Colleague C to Ms Dzvengwe on 28 September 2021. The panel noted that the improvement action plan included the sub-heading *'communication'*, as well as the bullet point *'demonstrate ability to communicate verbally in an intellectual and in professional manner'*. From this, the panel inferred that it was incumbent on Ms Dzvengwe to 'follow Colleagues' instructions'.

The panel took into account an email which was sent on 25 February 2022 from Ms 2 to Colleague C, with the subject ' [Ms Dzvengwe] feedback':

> *'I worked with [Ms Dzvengwe] yesterday 24/02/2022 and I found her very difficult because she refused to follow reasonable instructions (refused to look after) C bay patients under my supervision which I will be doing all the IV and meds and as a result I had to call the nurse in charge in.'*

The panel also considered an email which was sent on 8 February 2022 from Ms 4 to Colleague C, with the subject ' [Ms Dzvengwe] performance':

> *'the start of the shift with [Ms Dzvengwe] has been again in tension as she got upset when after the allocation… she said why am I asking her to look after inpatients when she can't give medications and I answered that we will perform this task together, but she was not happy to follow my instructions. She does not accept to be with someone else but to look after her patients independently as she is an RN and knows what she does is her answer always to me*
>
> *…*
>
> *She repeated many times during the shift the phrase I do my job and you do yours'*

The panel found the evidence of Ms 4 and Ms 2 to be consistent and supported by near-contemporaneous accounts of the events. Accordingly, the panel determined that this charge was found proved on the balance of probabilities.

Charge 1b)

1. Between 29 September 2021 and May 2022, refused a management instruction to work under a performance improvement plan by
   b) Refusing to accept medication administration supervision

This charge is found proved.

In reaching this decision, the panel took into account the improvement action plan which details expectations around medication administration supervision and specifically where it states the following objectives:

> *Safe administration of oral and IV medication to patients*
>
> - *Supervised drug rounds throughout the shift*
> - *Demonstrate ability to safely administer medications*
> - *Demonstrate ability to monitor the patient throughout, recognising any adverse effects to the medication and takes appropriate action without delay*
> - *Demonstrates safe documentation and appropriate handling of medication*

The panel then considered an email from Mr 1 which was sent on 13 October 2021 to Colleague C, with the subject *'Feedback for [Ms Dzvengwe] 12/10/2021 Night Shift'* :

> *' When I asked [Ms Dzvengwe] to do the oral medication under my supervision, she refused. I asked her why, she said she had so many things to do. I did encourage her to do it, she said she will join me on the drug rounds but in the end, she never did.'*

The witness statement of Ms 4 set out the following:

> *'[Ms Dzvengwe] asked "Why did you put me on that bay with patients that need medication when you know I can't do them" and I explained to her that I am here to support her but in the end we did not do anything together because she did not want to be supervised. Ruth would also mention that I was much younger than her and I should not be giving her instructions. Ruth also commented 'you do your job I'll do mine.'*

In oral evidence, Ms 4 told the panel *'She was avoiding me. I was saying something to her… she was not responding or giving any answers… she was trying to avoid me'.*

The panel considered that Ms 4 and Mr 1 have provided consistent and reliable evidence, supported by a near-contemporaneous email from Mr 1 and reinforced in oral evidence. Therefore, having considered all of the evidence before it, the panel was satisfied that it was more likely than not, that Ms Dzvengwe whilst subject to the performance improvement plan, refused to accept medication administration supervision.

The panel therefore found this charge proved.

Charges 2i) and 2ii)

2. On one or more occasions as set out below, acted in a manner towards colleagues which was,
   a) Argumentative [and/or]
   b) intimidating [and/or]
   c) disrespectful [and/or]
   d) interruptive [and/or]
   e) uncooperative

   in that on the following dates you:

i. [On] 24 October 2019 deliberately ignored Colleague A.

ii. [On] 24 October 2019 deliberately pushed Colleague A twice.

These charges are found proved.

In reaching this decision, the panel took into account Ms Dzvengwe's email response to the regulatory concerns dated 22 August 2023, the Datix dated 24 October 2019 and the witness statements and oral evidence of Colleague C and Ms 3.

The panel considered the following extract from Ms Dzvengwe's email response to the regulatory concerns dated 22 August 2023:

> *'I work responsibly and work as a team member… I am competent in the nursing skills I have undertaken and preserved safety and promote professionalism and trust… I have treated people with respect and I am accountable for my work, patients care and safety and well being of my colleagues and my family and profession.'*

The panel considered the Datix report dated 24 October 2019, which is contemporaneous to the date of the incident. It noted that the Datix refers to Colleague A speaking to the nurse in charge about the incident, and the description of the incident was recorded as *' I was in the Doctors area to look for a patient's notes and* [Ms Dzvengwe] *deliberately pushed me. I told her that this is not professional and she just ignored me. Again around 17:0 hours as I was coming out of clean utility she came forwarded face to face with me an then turned her back to me and pushed me to the door.'*

The panel took into account that this is also referenced in Colleague C's and Ms 3's witness statements.

Colleague C's witness statement sets out:

> *'There were ongoing issues with* [Ms Dzvengwe]*'s attitude, communication and teamwork. In October 2019, a HCA named [Colleague A] alleged that [Ms*

Dzvengwe] had deliberately ignored her and pushed her twice. I spoke to [Ms Dzvengwe] but the matter did not proceed any further from an HR perspective as [Colleague A] left the Trust.'

Ms 3's witness statement sets out:

'In the first month of [Ms Dzvengwe] joining the unit, I had to have a conversation with her following an incident between [Ms Dzvengwe] and a HCA. I do not recall the HCA's name. Two HCAs approached me and reported that [Ms Dzvengwe] had pushed one of them with her bottom to move them out of the way and was rude, loud and shouted at her. When I spoke to [Ms Dzvengwe] she denied everything. [Ms Dzvengwe] believes she is very capable and knows what she is doing.'

The panel also took into account Colleague C's oral evidence, in that when asked by the panel whether Colleague A had previously made similar allegations, Colleague C said that she had not, and further that there was no reason to believe that Colleague A would have fabricated this. In his oral evidence he told the panel:

She had a disagreement with one of the health care assistants, where she had pushed her… The health care assistant left the Trust… unable to take it further;

The panel gave considerable weight to the contemporaneous Datix. Considering the Datix report, the written evidence of Colleague C, the written evidence of Ms 3 combined with the oral evidence of Colleague C, on the balance of probabilities the panel was satisfied that Ms Dzvengwe did deliberately ignore Colleague A and deliberately pushed Colleague A twice.

As a result of its findings in relation to the facts of the charge, in relation to charge 2i), the panel was satisfied that Ms Dzvengwe acted in a way which was intimidating, disrespectful and uncooperative.

Following the panel's determination on the facts of the charge, in relation to charge 2ii), the panel was satisfied that Ms Dzvengwe acted in a way which was both intimidating and disrespectful.

Charge 2iii)

2. On one or more occasions as set out below, acted in a manner towards colleagues which was,
   a) Argumentative [and/or]
   b) intimidating [and/or]
   c) disrespectful [and/or]
   d) interruptive [and/or]
   e) uncooperative

   in that on the following dates you:

iii. [On] 11 September 2020 refused to answer questions.

This charge is found NOT proved.

The panel determined that there was no evidence before it to find this charge proved.

Given that the panel has not admitted RT's statement by way of hearsay evidence, the NMC has failed to provide the panel with any evidence which supports 2iii) and in view of this, the panel found charge 2iii) not proved.

Charge 2iv)

On one or more occasions as set out below, acted in a manner towards colleagues which was,
a) Argumentative [and/or]
b) intimidating [and/or]
c) disrespectful [and/or]
d) interruptive [and/or]
e) uncooperative

in that on the following dates you:

iv. [On] 8 May 2021 attended work despite not being allocated a shift and refused to leave when asked by Colleagues B and C.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague C and Colleague B.

The panel noted that within your response to the regulatory charges, you set out that:

> *My character is that I am quite, alert, respectful, communicative, pro-active, problem solver, decision maker, self starter lead within the framework I am working with.*

The panel considered Colleague B's feedback dated 8 May 2021, which is contemporaneous to the incident, where it is stated:

> *'On Saturday 8th May 2021 at around 07:45 I informed [Ms Dzvengwe] that she is not scheduled to work. Her name was written in the staffing book but MAPS indicates that she is off on that day.*
>
> *…*
>
> *Later on during that morning I heard [Ms Dzvengwe] shouting, while talking [Colleague C] on the telephone. I spoke with [Colleague C] afterwards. He informed me to asked [Ms Dzvengwe] to leave and if she refuses to ask security to ask her to leave the ward.*
>
> *…*

After listening to her, I kindly asked her to leave and can discuss her issues with [Colleague C] on Monday. She said ti was no my fault and she has no problem with me. She insisted that she will stay until 13:00 because she had discussion about her shift with [Colleague C]. I told her that I do not want to call security to talk to her, can she leave please.'

The panel also took into account Colleague C's witness statement

'… I was concerned about [Ms Dzvengwe]'s behaviour and wellbeing following an incident on 8 May 2021. I was at home at the time but I received an email from the Sister-in-Charge, [Colleague B], advising that [Ms Dzvengwe] had turned up for work despite not being rostered on and was refusing to go home. I called SAU and spoke to [Ms Dzvengwe] and told her she needed to go home but she continued to refuse and told me that if she went home she would go missing before hanging up on me. I called [Colleague B] again and told her to seek advice from the Psychiatric Liaison Nurse Specialist on duty. Eventually, two site managers came and spoke to [Ms Dzvengwe] and she went home.'

The panel in particular noted Colleague C's witness statement in relation to Ms Dzvengwe from the investigatory meeting:

'08/05/206 [Colleague B] feedback re [Ms Dzvengwe] turning up for duty when not rostered to work:

- *[Ms Dzvengwe] turned up for duty when not rostered to work. Refused … instruction to leave and go home, in spite of being shown Health roster.*
- *I spoke to her over the phone and she refused to go home saying that she would go missing and call the police*
- *… sought assistance from Psychiatric Liaison Team and Clinical Site Practitioners*
- *[Ms Dzvengwe] eventually agreed to leave, having been spoken to by the two Clinical Site Practitioners on duty.'*

The panel also took into account a letter to Ms Dzvengwe from Colleague C dated 27 May 2021:

> *'[Colleague B] has logged onto the SAU Health roster to show you your rota and the fact that you had not been rostered to work. Despite this, you still refused to go home and refused to listen to a clear management instruction form your line manager to go home.'*

The following extract from Colleague B's witness statement corroborates this:

> *'On Saturday 8 May 2021 I attended a day shift at work. At around 07:45am I informed [Ms Dzvengwe] that she was not scheduled to work. Her name was written in the staffing book but she was not scheduled to work on the MAPS system. I told [Ms Dzvengwe] she should go home but [Ms Dzvengwe] said she wanted to do some work first since she already made the journey to work. [Ms Dzvengwe] did not mention what the work was and she did not say whether the work was important. I reported this incident to my manager by calling him as it was his day off.*
>
> *[Colleague C] is our ward manager and he spoke to [Ms Dzvengwe] about the situation. He asked her to leave because she was not scheduled to work and that she would not be paid for the shift. [Ms Dzvengwe] told [Colleague C] she would go home once she had finished doing her work. After speaking to [Ms Dzvengwe] [Colleague C] called me to say I should call security if she did not leave. I spoke to [Ms Dzvengwe] privately asking her to leave but she refused to. I told her I would have to call security if she did not leave and she said she would call the Police as she felt this was a safeguarding issue.'*

Having considered all of the evidence before it, the panel on the balance of probabilities was satisfied that you attended work despite not being allocated a shift and refused to leave when asked by Colleague B and Colleague C.

In relation to charge 2iv), the panel determined that Ms Dzvengwe acted in a way which was argumentative, intimidating, disrespectful and uncooperative.

Charge 2v)

2. On one or more occasions as set out below, acted in a manner towards colleagues which was,
   a) Argumentative [and/or]
   b) intimidating [and/or]
   c) disrespectful [and/or]
   d) interruptive [and/or]
   e) uncooperative

   in that on the following dates you:

v. [On] 10 May 2021 repeatedly interrupted and refused to listen to Colleague C, in a meeting.

This charge is found proved.

The panel referred to a letter sent by Colleague C on 27 May 2021 to Ms Dzvengwe, which recounts a meeting which took place on 10 May 2021. During the course of that meeting, Colleague C reports:

> *' … You kept interrupting me and not listening to what I had to say. After repeated warnings, the meeting was terminated and I informed you that I would put what I had wanted to discuss with you in writing.'*

The panel also noted that this is corroborated in Colleague C's witness statement:

> *'… the meeting had to be terminated as [Ms Dzvengwe] would not listen and kept interrupting…'*

Colleague C in his oral evidence to the panel set out:

'She would talk over me and raise her voice in terms of volume. You had to terminate the meeting as she was not listening…. I would say shouting… this was not just in meetings; this would sometimes happen at the nursing station in front of patients… she was not happy to be challenged'

The panel found Colleague C's evidence to be consistent, reliable, credible and supported by the letter sent to Ms Dzvengwe two weeks after the incident.

On considering the evidence before it, the panel was satisfied that on 10 May 2021, Ms Dzvengwe did repeatedly interrupt and refused to listen to Colleague C in a meeting. In relation to 2v), the panel determined that given that Colleague C was Ms Dzvengwe's line manager, she acted in a way which was disrespectful, interruptive and uncooperative.

The panel therefore found this charge proved.

Charge 2vi)

2. On one or more occasions as set out below, acted in a manner towards colleagues which was,
   a) Argumentative [and/or]
   b) intimidating [and/or]
   c) disrespectful [and/or]
   d) interruptive [and/or]
   e) uncooperative

   in that on the following dates you:

vi. [On] 2 July 2021 refused to engage in a capability discussion with Colleague C.

This charge is found proved.

The panel considered the email sent by Colleague C to Ms Dzvengwe dated 27 July 2021 in relation to the incident which took place on 2 July 2021:

> *'[Ms Dzvengwe] said that she was a capable nurse and started speaking in Shona (mother tongue) and as she was not engaging with me nor willing to listen to what I had to say and frequently kept interrupting me when I was speaking, the meeting was terminated.'*

The panel further considered the following extract from Colleague C's witness statement:

> *' I had a meeting with [Ms Dzvengwe] in my office on 2 July 2021 to discuss the capability proceedings with her. [Ms Dzvengwe] did not think the capability proceedings were necessary and accused me and HR of being unsupportive. The meeting ended without much success as [Ms Dzvengwe] was unwilling to engage in discussion or listen to what was being said.'*

The panel had regard to the consistency of the evidence, finding Colleague C's evidence to be both reliable and credible in relation to this point. On the balance of probabilities, the panel found the charge proved and that Ms Dzvengwe's refusal to engage in a capability discussion with Colleague C was both disrespectful and uncooperative.

Charge 2vii)

2. On one or more occasions as set out below, acted in a manner towards colleagues which was,
   a) Argumentative [and/or]
   b) intimidating [and/or]
   c) disrespectful [and/or]
   d) interruptive [and/or]
   e) uncooperative

   in that on the following dates you:

vii. [On] 8 July 2021 continued to interrupt and talk over others in a discussion.

This charge is found proved.

In reaching this decision, the panel referred to the internal statement from Colleague C dated 27 January 2022:

'08/07/2021 Appraisal meeting with [Ms Dzvengwe]:

- *I met with [Ms Dzvengwe] in my office with Matron… present to do [Ms Dzvengwe]'s appraisal.*
- *We were unable to agree and set any objectives as [Ms Dzvengwe] disagreed that she had any areas for development.*
- *[Ms Dzvengwe] said that she could teach me about communication as I needed to improve this according to her. She made a comment about babies and preceptorship whose meaning was unclear*
- *It has been pointed out to [Ms Dzvengwe] that her constant interruptions when I was talking did not demonstrate listening and therefore did not show effective communication*
- *Meeting again had to be terminated due to [Ms Dzvengwe]'s constant interruption and talking whilst I was talking*
- *[Ms Dzvengwe] therefore remains non-compliant with her Appraisal'*

The panel considered Colleague C's witness statement:

'On 8 July 2021 I had an appraisal meeting with [Ms Dzvengwe] and the matron,… However, we were unable to agree to a set of objectives as [Ms Dzvengwe] continued to interrupt and denied having any areas for improvement and said that she could teach me about communication. This meeting had to be terminated as [Ms Dzvengwe] continued to interrupt and talk over me.'

The panel found Colleague C to be consistent, reliable and credible on this point. The panel determined that Ms Dzvengwe's continued interruption and talking over others in an discussion on 8 July 2021 was argumentative, disrespectful, interruptive and uncooperative. The panel therefore found this charge proved.

Charge 2viii)

2. On one or more occasions as set out below, acted in a manner towards colleagues which was,
   a) Argumentative [and/or]
   b) intimidating [and/or]
   c) disrespectful [and/or]
   d) interruptive [and/or]
   e) uncooperative

   in that on the following dates you:

viii. [On] 12 July 2021 continually interrupted Colleague C at a capability meeting.

This charge is found proved.

In reaching this decision, the panel referred to an internal statement from Colleague C dated 27 January 2022:

> *12/07/2021 Informal Capability Meeting:*
>
> - *Purpose of meeting explained, I started talking about communication but due to [Ms Dzvengwe]'s constant interruptions and inability to listen, meeting had to be terminated…*

The panel also drew reference to Colleague C's witness statement dated 16 May 2023:

> *On 12 July 2021, I held an informal capability meeting with [Ms Dzvengwe]. However, the meeting had to be terminated as [Ms Dzvengwe] continuously*

interrupted and spoke over me and discussed the outcome of the disciplinary hearing as opposed to the capability process.

The panel found Colleague C to be consistent, reliable and credible on this point. Given that Ms Dzvengwe had continually interrupted Colleague C at the capability meeting, the panel found this to be argumentative, disrespectful, interruptive and uncooperative. On the balance of probabilities, given all of the evidence before it, the panel found the charge proved.

Charge 2ix)

2. On one or more occasions as set out below, acted in a manner towards colleagues which was,
   a) Argumentative [and/or]
   b) intimidating [and/or]
   c) disrespectful [and/or]
   d) interruptive [and/or]
   e) uncooperative

   in that on the following dates you:

ix. [On] 23 July 2021 refused to engage in a capability discussion with Colleague C putting your hand in his face stating talk to the hand.

This charge is found proved.

In reaching this decision, the panel considered the email from Colleague C addressed to Ms Dzvengwe dated 17 August 2021, where Colleague C recounted what had occurred during the informal capability meeting on 23 July 2021:

'[Ms Dzvengwe] said talk to the hand and made a hand gesture towards me. [Colleague C] said to [Ms Dzvengwe] that this was disrespectful.'

The panel also noted Colleague C's internal statement dated 27 January 2022:

‘ I attempted to discuss what the issues were and [Ms Dzvengwe] made a talk at the hand gesture, questioned my management skills and why I had not done any management courses. I explained to [Ms Dzvengwe] that this meeting was about her and not me.’

Colleague C’s witness statement sets out the following:

‘ When I tried to reiterate to [Ms Dzvengwe] that there were issues, she put her hand up in front of my face and told me to talk to her hand which I pointed out was disrespectful of her.’

In response to panel questions during his oral evidence on 9 January 2023, Colleague C said that he felt disrespected, and that he had found Ms Dzvengwe’s behaviour to be challenging. Colleague C further told the panel that he had been trying to support Ms Dzvengwe and address the issues. The panel determined that Colleague C was consistent in his evidence and his evidence was supported by an email sent less than a month after the incident had occurred. Given all the evidence before it, on the balance of probabilities, the panel found that Ms Dzvengwe acted in the manner alleged in the charge.

In relation to charge 2ix), the panel found that Ms Dzvengwe acted in a manner which was argumentative, disrespectful and interruptive. The panel therefore found the charge proved.

Charge 2x)

2. On one or more occasions as set out below, acted in a manner towards colleagues which was,
    a) Argumentative [and/or]
    b) intimidating [and/or]
    c) disrespectful [and/or]
    d) interruptive [and/or]
    e) uncooperative

in that on the following dates you:

x. [On] 9 September 2021 continued to interrupt Colleagues C and D, at a meeting.

This charge is found proved.

The panel considered Colleague C's internal statement dated 27 January 2022:

09/09/2021 Meeting with HoN Surgery requested by RD:

- *Meeting became very difficult as RD kept talking over HoN Surgery and was informed that if she did not stop meeting would be terminated.*

- *[Ms Dzvengwe] asked by HoN to reflect on her communication style as she often did not listen to what another person had to say, especially if she disagreed with it.*

The panel noted that this is consistent with Colleague C's witness statement:

'Due to the ongoing issues [Ms Dzvengwe] and I were having, [Ms Dzvengwe] requested a meeting with the Head of Nursing for Surgery, … alleging there was conflict between me and her. A meeting took place between me, [Ms Dzvengwe] and [Head of Nursing for Surgery] on 9 September 2021 to attempt to resolve the issues, but [Ms Dzvengwe] was arguing and talking over [Head of Nursing for Surgery] so much that [Head of Nursing for Surgery] threatened to terminate the meeting if [Ms Dzvengwe] didn't stop. [Head of Nursing for Surgery] told [Ms Dzvengwe] she needed to reflect on her communication style.'

The panel was of the view that Colleague C's evidence was consistent, credible and reliable on this point. Based on the evidence before it, the panel found this charge proved and determined that Ms Dzvengwe acted in a manner which was argumentative, disrespectful, interruptive and uncooperative.

Charge 2xi)

2. On one or more occasions as set out below, acted in a manner towards colleagues which was,
   a) Argumentative [and/or]
   b) intimidating [and/or]
   c) disrespectful [and/or]
   d) interruptive [and/or]
   e) uncooperative

   in that on the following dates you:

xi. [On] 10 October 2021 walked out of meeting with Colleague C.

This charge is found proved.

The panel considered Colleague C's internal statement dated 27 January 2022:

> *'10/10/2021 Improvement Action Plan Review Meeting:*
>
> *RD became increasingly angry, raised her voice and pointed her finger at me, RD terminated the meeting and left.'*

The panel also considered Colleague C's witness statement in relation to capability review meetings:

> *'A review meeting was held on 10 October 2021 to discuss [Ms Dzvengwe] 's progress and the issues her supervisors had raised. At this stage, [Ms Dzvengwe] was not consistently meeting the objectives of her improvement action plan. However, when the issues and incidents were discussed with [Ms Dzvengwe] she did not demonstrate any insight or awareness and became increasingly angry, raising her voice and pointing her finger at me. I told [Ms Dzvengwe] if she was unhappy with her improvement plan she should speak to*

[Head of Nursing for Surgery] and [Ms Dzvengwe] ended up walking out of the meeting.'

The panel found Colleague C to be credible, reliable and consistent on this point and found this charge proved on the balance of probabilities. The panel determined that Ms Dzvengwe acted in a manner that was argumentative, intimidating, disrespectful, interruptive and uncooperative.

Charge 3

3. On 22 May 2020 catheterised Patient E when you were not competent to do so

This charge is found proved.

The panel took into account Ms Dzvengwe's explanation in her response to the regulatory concerns, where she accepted that she had catheterised a male patient after verbal consent using aseptic techniques. She submitted that she had completed a workbook for male catheterisation in March 2017.

However, the panel considered the Datix report which was generated on 26 May 2020 in relation to the incident on 22 May 2020. It noted that the description of the incident stated the following:

'Male patient underwent traumatic and incorrect urethral catheterisation by SAU nurse.

The nurse involved does not possess any male catheterisation competency. She stated that she had been doing male catheterisation and cystoscopies previously but when asked if she had competency certificates, she said that she did not have them when questioned afterwards by the Clinical Nurse Manager.

…

The Urology Registrar said that he had not instructed any nurse to re-catheterise the patient, as the patient had come to NPH for him, to re-catheterise following traumatic catheterisation in the community.

The Urology Registrar alleges that following the female SAU nurse, catheterising the patient incorrectly, the nurse tried to obstruct him from deflating the urethral catheter using a needle as the catheter balloon the SAU Nurse had inserted was inflated inside the patient's urethra again. He said that the urine present was bloody'

The panel also considered Colleague C's witness statement in relation to *'acting outside of competence – catheterising a patient'*:

'There was another incident on 22 May 2020 where [Ms Dzvengwe] had catheterized a urology male patient by the name of Patient E who had been brought from Ealing Hospital. The urology consultant examined the patient afterwards and reported that the patient had suffered a "traumatic catheterization by an inexperienced nurse". The patient suffered harm in that there was blood in his urine and he was not able to go home that day as planned. He had to be recatheterized and kept for observations. By catheterizing the patient, [Ms Dzvengwe] acted outside of her competence. When I spoke to [Ms Dzvengwe] about the issue she said that she had worked on a urology ward so she thought she could do the catheter, but unless she had done the relevant training and been assessed as competent, she shouldn't have done it. [Ms Dzvengwe] could not provide any evidence that she had completed the training and was competent and she had also jeopardized a Health Care Assistant's ("HCA") career as well as she had asked the HCA to assist her with the catheter. It was also noted by the urology registrar that [Ms Dzvengwe]'s attitude was unacceptable.'

The panel also took into account Colleague C's oral evidence, in particular:

‘ [Ms Dzvengwe] attempted to catheterise the patient… the man had to stay another day… he could have gone home the same day…. There was some harm… it was traumatic…;

There was no insight or awareness as to why she should not have catheterised the patient…. Lack of self-awareness or self-reflection as to what could have happened;

The risks… by someone without the relevant training… can cause damage to the patient…

The urology registrar was not happy with her attitude… There was a reason why this gentleman was transferred to us. They had already tried to catheterise him… it would have been up to the urology team… We would not have attempted to catheterise this gentleman ourselves;

She did not provide evidence of her male catheterisation competency… she could have done that to myself;

However, based on the evidence before the panel, it was clear that this patient had been admitted by the urology team after an initial failed attempt. Colleague C made clear in his oral evidence that a nurse should not have attempted a catheterisation in these circumstances. The panel found that you had catheterised Patient E, when you were not competent to do so, despite your claim to the contrary.

Based on the evidence before it, and on the balance of probabilities, the panel found this charge proved.

Charge 4

4. On 14 May 2021 administered intravenous paracetamol to Patient C without it being checked by another nurse

This charge is found NOT proved.

The NMC submits that the Trust's policy implies that a second checker is required to administer IV medicines. The panel had regard to the Trust's intravenous (IV) medicines policy issued 15 January 2020, which does not explicitly state that two nurses are required to administer IV medicines.

The Datix report in relation to this incident on 14 May 2021 states that Ms Dzvengwe's actions were in breach of the Trust's medicines policy. Having had sight of the Trust's IV medicines policy, the panel was satisfied that it would not be fair to infer that a second checker for the administration of IV medicines was required in these circumstances. This was a formal policy document from the Trust, which the panel would have expected to detail the requirement. Having decided not to make this inference, the panel found this charge not proved.

The panel also took into account that Colleague C's witness statement refers specifically to a breach of policy rather than a breach of accepted practice and procedure. There is a subtle difference between Trust policy and accepted practice. The gravamen of this charge is not stated in the policy document. The panel therefore found this charge not proved.

Charge 5

5. On 11 May 2021 administered IV fluids to Patient D
    a) not at the prescribed rate of 83mls/hour
    b) without an IV pump

This charge is found proved (in its entirety).

The panel considered the internal statement of Colleague C dated 27 January 2022, which states:

12/05/2021 [Ms 3] shift feedback:

- *Urology patient with known renal failure had drip set up to run stat, instead of 12 hourly via infusion pump. [Ms Dzvengwe] denied having done this when questioned.*

The panel also considered an email from Ms 3 sent to Colleague C on 12 May 2021:

> *'At 1900hrs, urology doctor came to the nurses station after checking on patient in A2 [Patient D] . He wanted to know who prepared the iv fluids of [Patient D], and I mentioned [Ms Dzvengwe] prepared and administered it. He said that it was set up to full drip, which is dangerous for patient as he has renal failure. I then went to [Ms Dzvengwe] to clarify and to also inform the night team about the incident. She explained that since the patient bends his arm, I would not flow fast, I mentioned to her that this is not the case. It should be according to the prescribed rate which was 12hour/litre or 83 mls/hr. and that this should be in a IV Pump. She then denied saying she did not put in full drip.*
>
> *…*
>
> *With regards to the IV fluid preparation and administration, I clearly heard … telling her to put IV fluids in IV pump. This was not done, resulting to urology doctor complaint.'*

The panel took into account Ms Dzvengwe's explanation that as Patient D *'bends his arm, [it] would not flow fast'.* The panel rejected this explanation, and in Ms 3's oral evidence she explained to the panel '*In [Ms Dzvengwe]'s case, we said it is better to use the pump. Having a pump would be the safest way, particularly as the patient had renal failure… if you think the canula is not working properly… the best way to do it is to put the canula where there is no bending;'.*

The panel considered Ms 3's witness statement:

> *'When the doctor came to check on Patient D he saw that [Ms Dzvengwe] had put the IV drip on full, fast drip mode but the drip was not dripping, so the patient*

had not received enough fluid that hour and there was the risk that the patient could have received too much fluid. [Ms Dzvengwe] should have checked she had put the drip on correctly and that it was set to a regulated pump and not full.

When I asked [Ms Dzvengwe] why she had prepared a full drip when Beatrice had told her to prepare the drip with a pump, Ruth said that she used the fast drip as Patient D was bending his arm and when his arm is straight, the fluid would flow and when he bends it, it will stop. I didn't understand why she would give that excuse as it didn't make sense and it was not safe as you cannot guarantee when the patient will bend and straighten their arm. I told [Ms Dzvengwe] this was not correct and the fluid should be given at the prescribed rate. [Ms Dzvengwe] then denied putting the drip on full. I don't think [Ms Dzvengwe] would deliberately prepare the wrong IV drip, but her excuse didn't make any sense.'

In her oral evidence to the panel, Ms 3 confirmed that through the actions of Ms Dzvengwe, Patient D could have come to harm.

The panel rejected Ms Dzvengwe's explanation and preferred the evidence of Ms 3 on this point. The panel determined that Ms 3's evidence was credible, consistent and reliable and was supported by a near-contemporaneous email on this point.

On the balance of probabilities, the panel considered that Ms Dzvengwe did administer IV fluids to Patient D not at a prescribed rate via an IV pump. In view of the above, the panel found the charge proved.

Charge 6

6. On 11 May 2021 gave incorrect discharge medication advice

This charge is found proved

In reaching its decision, the panel took account of the email from Ms 3 to Colleague C sent on 12 May 2021 in relation to feedback regarding Ms Dzvengwe during a shift. The panel noted that this was sent the day after the shift in question.

> *'When the patient asked SN [Ms Dzvengwe] where his medicine is to take home, SN [Ms Dzvengwe] replied that it should be his GP to give this medicine. I happened to be next to them and explained to her that it was prescribed as ward stock and it should be us giving this to patient before discharge.*
>
> *I find it worrying that she would advise patient to get medicine from GP when it is clearly in the discharge summary that we dispense medicine for patient.'*

The panel also considered Ms 3's witness statement in relation to incorrect patient advice:

> *'A patient (I do not recall their name) was being discharged from the unit and had been prescribed antibiotics. The patient asked where the medication was and [Ms Dzvengwe] replied that the patient needed to get the antibiotics from their GP. I interrupted and told [Ms Dzvengwe] that we will give the patient the antibiotics from the pharmacy or our ward stock and then I went and got the medication for the*
> *patient.*
>
> *I was alarmed by this as [Ms Dzvengwe] had told the patient incorrect information which would have resulted in the patient leaving the unit without his antibiotics if I hadn't overheard. Even newly qualified nurses know the unit has ward stock we can give to patients. I don't know why [Ms Dzvengwe] responded in the way she did. If she was unsure, she should have checked the discharge letter but she didn't.'*

During her oral evidence, Ms 3 told the panel:

'It would have delayed the antibiotics by a day or so… she could have missed two doses. You have to follow a course of antibiotics… might not have the full effect of the antibiotics… could affect the future health of the patient… if the patient had an infection, that infection could get worse in the delay in getting the antibiotics'

Considering all of the evidence before it, on the balance of probabilities, the panel found it more likely than not that Ms Dzvengwe gave the incorrect discharge medication advice on 11 May 2021.

Charge 7

7. On 7 September 2021 removed Patient F's a nasal pack
   a) without clinical justification
   b) when you were not competent to do so

This charge is found proved (in its entirety)

In reaching its decision, the panel considered the Datix report dated 7 September 2021, with the description of the incident as follows:

' patient came with epistaxis, ENT team inserted a nasal pack with balloon, they didn't instruct to remove or change the pack but our staff remove the pack and tried to reinsert the pack but patient refused reinsert early this morning. Doctor informed me that patient does not require for pack change, somehow staff tried to change, it could be affect if he start to bleed but fortunately his bleeding stopped.'

The panel also had regard to Ms Dzvengwe's explanation in her written response to the regulatory concerns:

'[Patient] 's nasal pack was out when I responded to the call bell , he also sneezed where mucus was pink and clear I cleaned the nose and I applied a nasal bolster patient, refer to ENT patient notes I documented. ENT team was

called to review and informed of change, night doctor attended and documented in the note.'

The panel also heard oral evidence from Colleague C

…always removed by the ENT team. They had not asked the nursing staff to remove the rapid rhino [nasal pack]. She has not received the necessary training, or provided us with any evidence of inserting or removing rapid rhino's. ….some come in and take blood thinners… may have needed to be taken to theatre & cauterized…

A sneeze would not dislodge a rapid rhino…

…

In our hospital trust, a rapid rhino is removed by a Ear, Nose and Throat (ENT) Doctors… it was not a written policy but it was accepted practice that everyone knows…'

The panel also noted Colleague C's witness statement in relation to the removal of the nasal pack:

' … Patient F had come to the SAU with epistaxis and the ENT team had inserted a nasal pack with balloon and instructed that the nasal pack remain in situ, but [Ms Dzvengwe] had removed it without there being any clinical justification for doing so… [Ms Dzvengwe] had then attempted to reinsert the nasal pack but Patient F refused.

Patient F didn't come to any harm but there was the potential for there to be internal bleeding as a result of [Ms Dzvengwe] removing the nasal pack against the ENT team's instructions. The patient could have also suffered internal bleeding and trauma if [Ms Dzvengwe] had attempted to reinsert the nasal pack as she had not completed the necessary training and assessment and was therefore not competent to remove and reinsert the nasal pack.

I completed a Datix regarding the incident on 7 September 2021 which was then updated and completed on 20 September 2021 after I had spoken to [Ms Dzvengwe] . When … Surgical Head of Nursing, and I spoke to [Ms Dzvengwe] she admitted that she had removed the nasal pack and made one unsuccessful attempt to reinsert it. [Ms Dzvengwe] did not say why she had removed the rapid rhino as the ENT doctors had not documented anything to that effect. It was reiterated to [Ms Dzvengwe] that she shouldn't have done that as she was not trained or been assessed as competent. [Ms Dzvengwe] was argumentative and did not see what she had done wrong. There was no self-awareness or reflection on this incident.'

The panel was satisfied that the Datix report confirms that there was no clinical justification to remove the nasal pack and that Ms Dzvengwe was not competent to do so.

The panel rejected Ms Dzvengwe's explanation and preferred the Datix report which was prepared at the time and the corroborative evidence which was before the panel. On the balance of probabilities, the panel found this charge proved.

Charge 8a)

8. Refused to transfer patients when requested to do so on
   a) 31 August 2021 (Patient A)

This charge is found proved

The panel considered Ms Dzvengwe's response to the regulatory concerns in which she stated that she had not refused to move patients.

However, the panel considered an email from Ms 2 sent on 14 February 2022 to Ms 1 in respect of feedback about Ms Dzvengwe:

'I worked with [Ms Dzvengwe] on 31/08/2021… The patient was stable therefore I requested porter for patient transfer and nurse informed about it. When porter

came [Ms Dzvengwe] looking after patient said 'patient not stable to be transferred' therefore porter went and nurse in charge informed about it.'

The panel also had sight of the transcript of notes from the formal investigation meeting on 17 February 2022 with Ms 1 and Ms 2, in particular the following:

' [Ms Dzvengwe] said the patient is not ready to be transferred. I asked her to be specific and tell me why the patient isn't ready. Maybe the patient is bleeding or disorientated. You cannot just say they are not ready. That is the reason the porter went back because [Ms Dzvengwe] was stopping the patient from being transferred.'

The panel also took into account MS 2's witness statement, which is consistent with the transcript of notes:

' I checked Patient A's vital signs and everything was ok, so I told Patient A they were ready to be transferred and then let [Ms Dzvengwe] know. [Ms Dzvengwe] told me Patient A wasn't ready. I asked her to elaborate and she said she had looked at the patient and they weren't ready. I told her that Patient A was fine and that I had checked their vital signs, but we would wait and monitor the patient to make sure there were no issues. I waited a bit of time and checked Patient A again and there were no issues. I therefore booked the porter for the patient transfer and told [Ms Dzvengwe] that Patient A was ready to be transferred.

…

When the porter arrived, [Ms Dzvengwe] told the porter Patient A wasn't ready to be moved… she just kept saying Patient A wasn't ready but did not provide any further explanation… she did not accept that she had been mistaken.

Patient A did not suffer any harm as a result of the delay in the transfer, but the delay caused further delays for other patients… there is a ripple effect…'

The panel noted that Ms 2 substantiated the allegation during the course of her formal investigation meeting on 17 February 2022 and maintained her position in her oral evidence before the panel. The panel preferred Ms 2's evidence to the account advanced by Ms Dzvengwe.

Given the evidence before it, the panel was satisfied that it was more likely than not that Ms Dzvengwe refused to transfer patients when requested to do so on 31 August 2021 (Patient A).

Charge 8b)

8. Refused to transfer patients when requested to do so on
    b) 3 February 2022 (Patient B)

This charge is found proved

The panel considered the email from MS 2 sent on 14 February 2022 to Ms 1 in respect of feedback about Ms Dzvengwe:

> *' long day, [Ms Dzvengwe] refused to take patient to angio suite for her procedure this was escalated to nurse in charge as she was on break to pass on information to [Ms Dzvengwe] but [Ms Dzvengwe] still refused to take the patient to Angio, very unprofessional by shouting in front of patient and in the nursing station as well.'*

The panel determined that Ms 2's evidence was consistent, credible and reliable in relation to this incident and on the balance of probabilities Ms Dzvengwe did refuse to transfer Patient B on 3 February 2022. The panel therefore found this charge proved.

Charge 9a)

9. Between May 2020 and May 2022 did not provide adequate patient care in that you
    a) Did not hand your patient over either verbally or in writing to the night shift, on 4 June 2021

This charge is found NOT proved

The panel, in reaching this decision, considered that the charge does not specify a particular time frame for the handover of the patient. The panel took into account that it had heard evidence that you did ultimately hand over the patient and acted appropriately in the circumstances.

In reaching this determination, the panel considered the following evidence:

On 15 January 2023, the panel heard oral evidence from Colleague B. During the course of her oral evidence, she stated the following:

‘ She just missed one. I called her. She sent me a text saying that she would call back the ward. She called the ward and came back. She came back, realised that she had made a mistake and came back to do the handover’

Colleague B further confirmed during her oral evidence that there was no patient harm as nothing was missed.

This is corroborated in an email from Colleague B sent to Colleague C on 4 June 2021 with the subject *‘Feedback – [Ms Dzvengwe]’*

> *‘[Ms Dzvengwe] did not give hand over of one of her patients to the night staff. I called her and left a message on her mobile to call the ward. She said she will call me later.’*

In view of Colleague B’s evidence, the panel found that on Ms Dzvengwe’s return to the ward, she undertook a handover in June 2021. The panel therefore found this charge not proved.

Charge 9b)

9.Between May 2020 and May 2022 did not provide adequate patient care in that you b)Did not answer patient call bells.

This charge is found proved

The panel considered an email from Mr 1 sent to Colleague C on 21 September 2021 with the subject: *Feedback for [Ms Dzvengwe] on 16/09/2021 Long Day' :*

> *'She does not answer call bells, she waits for the HCA to answer. I asked her why – she answered so many reasons every time – she said she is busy and the HCA needs to attend to that patient. – I told her clearly that answering call bells is a shared responsibility and it should be attended to the soonest for patients' safety.'*

The panel considered Ms 5's witness statement:

> *' For example, during the shift one of [Ms Dzvengwe] 's patients rang for assistance with toilet and mobilising. The student on shift called out for [Ms Dzvengwe] and she did not respond so I had to help the student assist [Ms Dzvengwe] 's patient. When I asked [Ms Dzvengwe] why she did not respond she said she was completing a datix for a door… Instead of assisting a patient [Ms Dzvengwe] was writing emails to report an issue with a door that did not interfere with us performing our nursing duties. This door presented no risk to anybody which is why it was not a priority at the time.'*

The panel also took into account Ms 5's oral evidence, which was that it was everyone's responsibility to answer call bells for all the patients and that this was a priority:

> *'We answer everybody's call bells… should answer as soon as possible… call bells highest priority because of the need of what we are doing…*
>
> *She answered call bells when she answered them, in her own time… call bells are the most important thing… the patients suffer distress;*

The panel determined that Ms 5 and Mr 1's evidence was broadly consistent with each other, credible and reliable. The panel found this charge proved.

Charge 9c)

9.Between May 2020 and May 2022 did not provide adequate patient care in that you

c) Refused to provide patient care.

This charge is found proved

The panel considered an email from Ms 5 sent to Colleague C on 2 August 2021 with the subject: *My concerns about [Ms Dzvengwe]'* :

> *' From what I witnessed she prioritises non-essential things above patients. For example, there was a patient in a1 who needs assistance for toilet and mobilising. The student working that day called out for her and she didn't respond. I helped the student and when I questioned why she was not helping she responded and said that she was doing something (which was not a priority at that moment) which was writing a datix for a door.*
>
> *When the student informed her on two occasions that the same patient asked for urgent pain relief, she was still writing the datix and that she will do it after'*

A further email from Ms 5 sent to Colleague C on 28 September 2021 with the subject: '*Concerns Re [Ms Dzvengwe]'* also set out:

> *'She will start to look after her patients within her limit and in the middle of it she calls someone else to finish her work still within her limit or will refuse to continue to care for her patient, I have tried addressing this issues with her and explaining that it is not acceptable however she continues to dismiss what I am addressing to her.'*

The panel took account that Ms 5's witness statement is consistent with her emails:

> *' When [Ms Dzvengwe] returned back to the ward she argued with me as she was not happy that I attended to her patient. [Ms Dzvengwe] told me that it was not my patient to take care of and that it was her patient. Once [Ms Dzvengwe] saw that I was helping her patient she refused to help that patient again. [Ms Dzvengwe] refused to assist that patient by not giving them medication.'*

The panel considered an email from Mr 1 sent to Colleague C on 21 September 2021 with the subject: *Feedback for [Ms Dzvengwe] on 16/09/2021 Long Day':*

> *'If you ask her about other patients not allocated to her, she tells that its not her patient even though her colleague is already on break and handed over the patient to her. – I told [Ms Dzvengwe] , she should know about other patients as well as we are working as a team.'*

Given all the evidence before it, the panel on the balance of probabilities found this charge proved, in that between May 2020 and May 2022 you did not provide adequate patient care in that you refused to provide patient care.

Panel's proposed amendment in relation to charge 1c) on 16 January 2024

On 16 January 2024, the panel moved out of private session, having been deliberating on the facts stage and invited Mr Ross to make submissions in relation to a proposed amendment in relation to charge 1c). The panel accepted the advice of the legal assessor.

Pursuant to rule 28, the panel proposed an amendment to charge 1c) to better reflect the evidence that the panel heard. The amendment to charge 1c) is that on various dates during a shift you left the ward without informing colleagues. Considering the merits of the case and the fairness of the proceedings, the panel was satisfied that the amendment could be made without injustice, that it would be fair and in accordance with the panel's overarching objective to protect the public.

The original charge 1c) related to specific dates that the evidence did not support. However, the panel heard evidence that during the course of various shifts on various dates, Ms Dzvengwe left the ward without communicating with colleagues. The gravamen of the charge is leaving the ward without communicating with colleagues, and this is a charge that was already in the schedule of charges and known by Ms Dzvengwe. The panel also considered that Ms Dzvengwe voluntarily absented herself and is aware of the charges and determined that there would be no injustice caused in amending the charge accordingly.

Mr Ross indicated that he had no observations in relation to the proposed amendment, and that it would be a matter for the panel's discretion.

The amendment is to delete charge 1c) and replace with charge 10.

That you, a Registered Nurse

1. Between 29 September 2021 and May 2022, refused a management instruction to work under a performance improvement plan by
   ~~c. Leaving the ward without communicating with colleagues~~

10. On various dates during a shift, you left the ward without communicating with colleagues.

Having made the amendment, the panel then returned back to private session to continue with its deliberations on the facts stage.

Charge 10

10) On various dates during a shift, you left the ward without communicating with colleagues

This charge is found proved

The panel considered an email from Mr 1 sent to Colleague C on 21 September 2021 with the subject: *Feedback for [Ms Dzvengwe] on 16/09/2021 Long Day' :*

> *'She does not tell is she goes out from the ward. – I told her that this is very unprofessional practice and again its against the teamwork effort.'*

The panel also noted the following from Ms 2's witness statement in relation to Ms Dzvengwe leaving the ward without notice:

> *On approximately 6 or 7 occasions over various shifts, I would try to find [Ms Dzvengwe] but she would not be on level 3. When she would eventually reappear, I would ask where she had been but she would not provide a reason why she left or where she had been. She would just brush it off like it wasn't an issue. I had to reiterate to [Ms Dzvengwe] several times that there always needs to be two nurses on duty on level 3 so it was important that she not leave unless it was her break and someone was there to cover her. It is not ideal to work with someone who disappears. When you go on break, you need to hand over everything so patient safety can be maintained. If there is an issue with a patient and you're not there and the other nurse doesn't know what's happening with the patient, there is a significant risk for potential patient harm as the other nurse wouldn't know what to do.*

The panel considered the following extract from an email from Ms 5 sent on 2 August 2021 to Colleague C, with the subject *'my concerns about [Ms Dzvengwe]':*

> *'She goes off the ward and does not inform other nurses.'*

This is also corroborated in Ms 5's witness statement:

> *'[Ms Dzvengwe] continued to leave the ward for long periods of time, from 30 minutes to up to an hour without telling anyone where she was going. This was a risk to patient safety as this meant there was only 1 nurse taking care of 12 high*

risk patients. This was stressful on the team as someone would be alone and I would often have to find a replacement whilst she had disappeared.'

The panel also had regard to the witness statement of Ms 3:

*' **Missing from the unit between 8:00 and 12:30***

At some stage during the morning, [Ms Dzvengwe] disappeared. There is always so much to do, so it was impossible for me to keep track of her movements at all times, but she didn't tell me or any other member of staff where she was going. I had previously received complaints from staff that Ruth would go missing on the unit so I was wary of this issue.

Missing from the unit at 14:00

… However, when the porter came to take the patient in A4 (I do not recall the patient's name) for surgery, I couldn't find [Ms Dzvengwe]. I looked everywhere and it is quite a small single levelled floor, so if you can't find somebody it means they deliberately don't want to be found.'

Having had regard to all the evidence before it, the panel determined that Ms Dzvengwe on various dates whilst on shift left the ward without communicating with colleagues. The panel therefore found this charge proved.

Panel's decision to adjourn proceedings on Thursday 18 January 2024 until Monday 22 January 2024

Following the handing down of the determination on facts on Wednesday 17 January 2024, the panel sent a copy of its decision to Ms Dzvengwe's email address. Ms Dzvengwe was informed that the panel would be resuming the hearing at 9:30am on Thursday 18 January 2024 at 2 Stratford Place, moving onto the next stage of proceedings, namely misconduct and impairment. Also included in the email were the options of Ms Dzvengwe attending the hearing virtually via MS Teams, or alternatively

writing in with any submissions she would like to present before the panel in relation to misconduct and impairment before the hearing resumed.

Ms Dzvengwe responded to the email sent by the hearings coordinator on Wednesday 17 January 2024, requesting to reschedule for Monday 22 January 2024 as she is self-representing and was unable to change her work arrangement at short notice. The panel had sight of the email correspondence between Ms Dzvengwe and the hearings coordinator.

On Thursday 18 January 2024, Mr Ross addressed the panel in relation to this. He submitted that it was entirely a matter for the panel to consider, but the panel will have seen from the PIA bundle that Ms Dzvengwe was notified of the substantive hearing dates in September 2023. Mr Ross submitted that the NMC has made a number of attempts for Ms Dzvengwe to engage with the substantive hearing, including continued support in understanding the substantive hearing process and offering to pay for her travel expenses to the hearing centre.

Mr Ross submitted that the NMC was not supportive of adjourning proceedings until Monday 22 January 2024.

The panel heard and accepted the advice of the legal assessor. It referred to the NMC Guidance ‘When we postpone or adjourn hearings’ Reference CMT-11 Last Updated 13 July 2023.

The panel had sight of the correspondence between the NMC and Ms Dzvengwe and noted that Ms Dzvengwe is self-representing. It inferred from the correspondence that Ms Dzvengwe was requesting an adjournment until Monday 22 January 2024.

In reaching its decision, the panel considered the following factors:

Public interest in the expeditious disposal of the case

The panel was of the view that, given that Ms Dzvengwe had requested a relatively short adjournment, there would be little detriment to the public interest in the expeditious disposal of the case.

Potential inconvenience

There were no NMC witnesses that would be inconvenienced by the hearing being adjourned until Monday 22 January 2024. The panel noted that there may be some inconvenience caused to the NMC in delaying this matter until Monday. However, given that there was no further live evidence to be called by the NMC, the panel determined that the inconvenience to the regulator would be limited in the circumstances.

Fairness to Ms Dzvengwe

Ms Dzvengwe is self-representing and may not be familiar with regulatory proceedings. Ms Dzvengwe was emailed the panel's determination in relation to the facts stage in the late afternoon on Thursday 18 January 2024. The panel determined it would be unfair to proceed without allowing Ms Dzvengwe the opportunity to consider the panel's determination, have an opportunity to collate evidence and relevant documentation for the next stage of the process, namely the misconduct and impairment stage. In addition, this would provide Ms Dzvengwe with an opportunity to rearrange her work commitments accordingly.

The panel determined to adjourn proceedings until Monday 22 January 2024. It was of the view that by granting the adjournment, no injustice would be caused to the parties.

On Monday 22 January 2024, the hearing resumed with Ms Dzvengwe in attendance at 2 Stratford Place.

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 Ms

Dzvengwe'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 ability to practise kindly, safely and professionally.

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, Ms Dzvengwe'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.'*

Mr Ross invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

Mr Ross identified the specific, relevant standards where Ms Dzvengwe's actions amounted to misconduct. He submitted that Ms Dzvengwe's actions fall seriously short of the standard expected of a registered nurse, and invited the panel to conclude that misconduct has been established.

Ms Dzvengwe told the panel that she was of the view that her actions did not amount to misconduct. She told the panel that she had followed policies, procedures and protocols and reminded it that she had never been involved in disciplinary proceedings before.

Submissions on impairment

Mr Ross 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).

Mr Ross submitted that it is the NMC's case that Ms Dzvengwe's fitness to practise is impaired by reason of her misconduct. He submitted that Ms Dzvengwe has no insight into her regulatory failings, nor has she demonstrated any ownership of her mistakes. Ms Dzvengwe's conduct was not a one-off incident, but rather a pattern of conduct which put patients at harm and/or created a risk of potential harm. Mr Ross further submitted that there are significant attitudinal concerns in relation to Ms Dzvengwe, and it can be seen that she often fails to engage with the issue being put to her. This is despite Ms Dzvengwe already being on a performance improvement plan at the time, and also being an experienced nurse who qualified in 2003.

Mr Ross submitted that Ms Dzvengwe has, however provided the NMC with some evidence of mandatory NHS training she had undertaken, and has continued to have limited engagement with the NMC. On 9 May 2023, Ms Dzvengwe notified the NMC that she had accepted a job offer with Dapplemere Nursing Home Ltd, though the NMC is not aware if she ever took up the post.

Mr Ross submitted that the panel will want to carefully consider whether there is a risk of repetition in this case, and how Ms Dzvengwe would address any future incidents if she were to work in a hospital ward setting in the future. He submitted that the panel

may wish to further consider whether Ms Dzvengwe has the ability to respond appropriately to future situations, whether she has an attitude that is conducive to self-reflection and learning, and whether she has the training, knowledge, support network and tools to respond appropriately.

In relation to public protection, Mr Ross submitted that the panel will want to weigh up whether the public would be put at risk by a potential repetition of Ms Dzvengwe's conduct. In relation to public interest, he submitted that the panel will also want to consider whether an informed member of the public would be troubled by the charges and findings of the panel, and if there would be an adverse effect on the regulator and profession more widely if Ms Dzvengwe's fitness to practise were not found to be impaired.

Ms Dzvengwe provided the panel with a background to her employment history and referred the panel to her response to the regulatory concerns included in her registrant response bundle. She explained that whilst she is not currently working in a healthcare setting, she wishes to return to nursing practice given her experience. She said that there is always an opportunity in life to improve but did not accept that she had a communication problem, stating *'I don't have a problem with communication.. it is about being clear and understood as a nurse… I always say good morning…*'.

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* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

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

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

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

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:
9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance
9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
13.5 complete the necessary training before carrying out a new role

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
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
To achieve this, you must:
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

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 your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 1a)

The panel determined that charge 1a) constitutes serious professional misconduct. The performance improvement plan was put in place to assist Ms Dzvengwe and to support her in areas which had been identified as deficient. In view of its findings on facts in relation to this charge, the panel noted that Ms Dzvengwe had refused to follow reasonable instruction, refused to look after patients under the nurse's supervision, and this had the potential to put patients at risk of harm.

This misconduct breached the fundamental tenets of the nursing profession of practising effectively and preserving safety.

Charge 1b)

The panel determined that charge 1b) constitutes serious professional misconduct. It was of the view that safe medication administration is vital to safe nursing practice, and by Ms Dzvengwe failing to comply with this, she fell far short of what was expected of a registered nurse.

This breached the fundamental tenets of the nursing profession of practising effectively, preserving safety and promoting professionalism and trust.

Charges 2i and 2ii)

The panel determined that Charges 2i and 2ii) constitutes serious professional misconduct and falls far short of the standards expected of a registered nurse. The panel considered that Ms Dzvengwe was in a position of responsibility, and a healthcare assistant should expect to attend to work and not be subjected to such behaviour from a nurse who was in a position of greater authority. Ms Dzvengwe should have been setting an example to a far more junior member of staff and would not be expected to behave in such a manner.

This misconduct breached the fundamental tenets of the nursing profession of prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

Charge 2iv)

The panel determined that charge 2iv) constitutes serious professional misconduct. The panel considered that whilst Ms Dzvengwe could have attended work as a result of a genuine misunderstanding, she had subsequently been asked to leave by more senior colleagues and then by her supervisor on the phone. It was of the view that Ms Dzvengwe refusing to leave, despite these requests from her line managers, represents a disregard for the management structure of the hospital, which is there to protect patients and to ensure the efficient running of the hospital. The panel determined that Ms Dzvengwe's refusal to leave when she was told that security would have to be called, combined with her comments about her threatening to go missing, falls far short of what is expected of a registered nurse.

This breached the fundamental tenets of the nursing profession of prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

Charges 2v) – 2xi)

The panel determined that charges 2v) – 2xi) constitute serious professional misconduct.

It was important for Ms Dzvengwe to understand, respect and adhere to the supervision of those more senior to her. These processes were in place to support and help her, and for Ms Dzvengwe to repeatedly interrupt and not listen to her manager, Colleague C, falls far short of what is expected of a registered nurse and what would be appropriate in the circumstances. The panel noted that Colleague C was trying to support Ms Dzvengwe, and she rejected that support, demonstrating poor behaviour during meetings and capability discussions. This demonstrates a complete lack of respect and a disregard for the management structures and processes of the hospital, which are in place to ultimately protect, promote and maintain the health, safety and wellbeing of the public, and to maintain professional standards of conduct for the nursing profession within the hospital.

This misconduct breached the fundamental tenets of the nursing profession of prioritising people, practising effectively, preserving safety and promoting professionalism and trust both individually and collectively for these sub-charges.

Charge 3

The panel determined that charge 3 constitutes serious professional misconduct. The panel noted that a patient did come to harm and was placed at an unwarranted risk of more serious harm as a result of your actions. There was blood in the patient's urine and the patient had to remain in the hospital for an extra day when he could have been discharged. Ms Dzvengwe acted outside of her competency and did not follow instructions from a more senior colleague. The panel considered that Ms Dzvengwe in this regard demonstrated a lack of self-awareness and a lack of self-reflection as to why she should not have done this.

This misconduct breached the fundamental tenets of the nursing profession of prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

Charges 5a) and 5b)

The panel determined that charges 5a) and 5b) constitute serious professional misconduct. The panel noted that Ms Dzvengwe did not follow instructions, she undertook her own course of conduct with complete disregard to the instruction of others, in particular the urology doctor. The panel was of the view that it was incumbent on Ms Dzvengwe to follow the instructions of those who had prescribed appropriate care for this patient, as opposed to completely disregarding their clinical judgement. The patient had known renal failure, and Ms Dzvengwe's actions put this patient at risk of harm.

This misconduct breached the fundamental tenets of the nursing profession of, practising effectively, preserving safety and promoting professionalism and trust.

Charge 6)

The panel determined that charge 6) constitutes serious professional misconduct. It noted that Ms Dzvengwe's actions might have delayed the patient receiving their antibiotics, thereby potentially missing two doses. The panel considered that the patient not receiving their full course of antibiotics could have had a detrimental effect on their health. As an experienced senior nurse, Ms Dzvengwe would have known that the hospital would have had a stock of the required medication and gave the incorrect advice in any event.

This misconduct breached the fundamental tenets of the nursing profession of practising effectively and preserving safety.

Charge 7a) and 7b)

The panel determined that charges 7a) and 7b) constitute serious professional misconduct. There was no clinical justification for removing the patient's nasal pack, and Ms Dzvengwe provided no certificates to demonstrate her competency in doing so. The panel took into account that it heard oral evidence that the nasal pack ought to have been removed by the ENT doctors in any event, and that Ms Dzvengwe should not have been removing it in the first place, even if she had competency to do so. The consequence of Ms Dzvengwe's actions was that the patient was put at risk of harm, in that he may have suffered further bleeding, requiring cauterisation in theatre.

This misconduct breached the fundamental tenets of the nursing profession of prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

Charges 8a) and 8b)

The panel determined that charges 8a) and 8b) constitute serious professional misconduct. The consequences of Ms Dzvengwe's actions could have potentially

caused delay to other patients, which can cause a ripple effect in the hospital and further delays to other patients, possibly impacting on patient safety.

This breached the fundamental tenets of the nursing profession of prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

Charges 9b) and 9c)

The panel determined that charges 9b) and 9c) constitute serious professional misconduct. The panel noted that it had heard in oral evidence that staff in the hospital should answer everyone's call bells and that answering call bells was the highest priority. Not answering call bells when a patient is potentially in distress, needs medical assistance or basic fundamental care puts patients at a serious risk of harm and does not uphold their dignity. A fundamental pillar of nursing is to provide patient care.

The panel in particular noted the requests from student nurses, which were ignored in the provision of post-operative patient care. The panel would have expected Ms Dzvengwe to act as a role model to the student nurses in providing timely care to those patients.

This misconduct breached the fundamental tenets of the nursing profession of prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

Charge 10

The panel determined that charge 10) constitutes serious professional misconduct. It was of the view that any professional registered nurse would find it deplorable that Ms Dzvengwe was missing on numerous occasions without anyone knowing where she was, and this resulted in a risk of serious harm to vulnerable patients who had just come out of theatre. The panel noted that the hospital had specific staffing levels to look after the number of patients it had, and when Ms Dzvengwe absented herself without telling anyone where she was, on at least one occasion a supervisor had been brought in to

assist with the shift. This put patients at risk and added stress on her colleagues, draining valuable resources from other areas of the hospital.

This misconduct breached the fundamental tenets of the nursing profession of prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

The panel also had regard to the NMC Guidance on Impairment, Reference DMA-1 Last Updated 27 March 2023.

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

In this regard the panel considered the 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 was satisfied that in the past, Ms Dzvengwe had acted so as to put a patient at an unwarranted risk of harm, has brought the nursing profession into disrepute and has breached the fundamental tenets of the nursing profession. Given the nature of the

concerns and the charges found proved, the panel is further satisfied that there was no evidence before it that could reassure it that Ms Dzvengwe was not liable in the future to put patients at an unwarranted risk of harm, bring the nursing profession into disrepute or breach the fundamental tenets of the nursing profession.

The panel took into account that Ms Dzvengwe did not provide the panel with any insight, remorse, reflection or relevant evidence of strengthening her nursing practice, beyond some basic mandatory training certificates in July 2022. Ms Dzvengwe's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

There has been limited engagement from Ms Dzvengwe during the substantive hearing process. Ms Dzvengwe had indicated that she had chosen not to read the panel's written determination in relation to the facts stage, despite being provided with the determination electronically three days in advance and refused to do so when offered a hard copy on a number of occasions by the Panel Chair. This indicated a worrying and deep-seated attitudinal concern.

The panel has no evidence before it to satisfy or reassure the panel that Ms Dzvengwe would not repeat the same conduct in the future. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 therefore determined that a finding of impairment on public interest grounds is also required.

Having regard to all of the above, the panel was satisfied that Ms Dzvengwe'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 Ms Dzvengwe off the register. The effect of this order is that the NMC register will show that Ms Dzvengwe 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

Mr Ross referred the panel to his written submissions in relation to sanction:

1. *The NMC seeks an order striking off the Registrant.*

2. *The Panel will be familiar with the task it has to undertake when imposing a sanction. The proper approach is to start with the least severe sanction and decide whether that outcome is right for the fitness-to-practise concerns that have been identified.*

3. *The sanction imposed by the Panel must be proportionate, striking a fair balance between the Registrant's rights and the overarching objective of public protection. The sanction should not go further than what is needed to meet that objective. The sanction is not about punishment.*

4. *At all times, the Panel will want to reflect carefully on public protection; public confidence in the profession and the NMC; and the upholding of proper standards of conduct and performance.*

5. *The Panel has already reflected in its determination the aggravating features of this case, including the lack of insight; the Registrant's limited engagement with the NMC; and the risk of patient harm posed by her actions.*

6. *The Panel may also take into account the frequency of the incidents captured in the Charges and that the Registrant was already receiving support from Band 6s under the performance improvement plan.*

7. *By way of mitigation, the Panel is already aware that:*

- ***a.*** *The Registrant has a clean disciplinary record;*
- ***b.*** *It cannot be said that the Registrant has not engaged at all, albeit her engagement has been patchy; and*
- ***c.*** *She has undertaken some CPD whilst she worked at St Mary's on the Isle of Wight, albeit it appears to be basic mandatory training.*

8. *In considering sanction, the Panel will need to consider whether the least severe sanction sufficiently addresses the concerns that have been identified.*

9. *Dealing with the options open to the Panel:*

10. *Take no action: We say this is not an appropriate case in which to take no further action. It is rare to take no further action after finding impairment. The Panel might think to itself that this case is so serious that it would be wrong not to act.*

11. *A caution order: This is only appropriate if the Panel decide there is no risk to the public or to patients requiring the Registrant's practice to be restricted, meaning the case is at the lower end of the spectrum of impaired fitness to practise, however the Panel wants to mark that the behaviour was unacceptable and must not happen again. Again, the Panel might think this case is fairly serious and that a caution order would not be appropriate.*

12. *A conditions of practice order: This might be best thought of as appropriate when there are no deep-seated attitude problems; no evidence of general incompetence; the nurse is willing to learn and improve; and there are identifiable areas for improvement. This is a matter for the Panel, but it will of course weigh up very*

carefully the issue of the seriousness of the impairment finding, in addition to the following factors:

- ***a.*** *The Registrant has shown no evidence of learning and improving.*
- ***b.*** *The Panel may think she has a deep-seated attitude problem.*
- ***c.*** *There are no identifiable areas of improvement – this is not simply an area of one or two specified clinical mistakes. Numerous transgressions have been found, and some of them relate to attitude.*

13. *A suspension order: As per the NMC Guidance, we know this would be appropriate where the misconduct is not fundamentally incompatible with nursing and the overarching objective of public protection remains satisfied:*

- ***a.*** *The core issue here is the seriousness of the findings.*
- ***b.*** *The Panel will want to ask itself whether suspension will be sufficient to maintain public confidence or professional standards in nursing.*
- ***c.*** *The Panel will also have one eye on the NMC guidance on suspension orders, which whilst not the final say on the matter does remind us that suspension orders can be thought appropriate where there is a single instance of misconduct but where a less sanction is not sufficient; there is no evidence of attitudinal problems; no evidence of repetition; insight has been shown; and there is no significant risk of repeat behaviour.*
- ***d.*** *Sadly, this is a case where there is evidence of attitude; there is a risk of repetition; and where there is no insight.*

14. *Finally, there is the option of strike off. For a strike off, the regulatory concerns need to be fundamental and where no lesser sanction is available. The Panel might agree with the NMC that this this is just such a case.*

The panel also bore in mind Ms Dzvengwe's submissions. Ms Dzvengwe told the panel that she would like to be put back onto the NMC register and return to work as a registered nurse.

Ms Dzvengwe told the panel that she did not think that she should be suspended, given that she has already been subject to an interim suspension order in the past. She informed the panel that she would be willing to comply with a conditions of practice order, and would like to go back to work with supervision and mentorship, with a focus on IV drug administration for example. Ms Dzvengwe informed the panel that she would also like to work as part of a management team.

Ms Dzvengwe explained to the panel that she loves nursing and that she originally came to the UK to train as a nurse. She told the panel that she loves to care for and nurture patients, and that she often misses the people that she looks after. Ms Dzvengwe explained that it is nice for her to come across previous patients in the supermarket and the church and see how they are doing.

Ms Dzvengwe informed the panel that she is currently studying and working part time in hospitality. She explained that she is currently finding her work difficult as the hours are long, she has to travel a lot, and given that the work is seasonal, the demand for work is less. [PRIVATE]

Decision and reasons on sanction

Having found Ms Dzvengwe'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:

- Lack of insight into failings
- Patient harm as a result of Ms Dzvengwe's actions
- A pattern of misconduct over a period of time
- No remorse

- Abuse of a position of trust
- Conduct which put patients at risk of suffering harm.
- Inability to accept supervision and reacting negatively to those trying to supervise her
- Unwillingness and/or inability to engage in the capability process

The panel also took into account the following mitigating features:

- Previous lengthy career in nursing
- There has been limited engagement from Ms Dzvengwe throughout the regulatory process

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.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Dzvengwe's practice would not be appropriate in the circumstances. 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 Ms Dzvengwe'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 Ms Dzvengwe's registration would be a sufficient and appropriate response. The panel took into account that whilst Ms Dzvengwe indicated that she would be willing to comply with a conditions of practice order, it was concerned that Ms Dzvengwe would not positively engage with a conditions of practice order. in respect of addressing the clinical and attitudinal concerns. Further, in response to panel questions on her willingness to be supervised

as part of conditions of practice, Ms Dzvengwe explained that she would wish to place pre-conditions on who would supervise her, as well as the supervisor's level of seniority. This did not reassure the panel that Ms Dzvengwe would comply with a conditions of practice order.

The panel is therefore 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 attitudinal misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Ms Dzvengwe'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. The SG states that 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 Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *…*

The panel was of the view that Ms Dzvengwe's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. Ms Dzvengwe's lack of insight into the regulatory failings, as well as the lack of evidence of any remorse or strengthening of practice and the significant clinical failings, compounded by the deep-seated attitudinal concerns, would render a suspension order neither proportionate nor appropriate. The panel determined that the serious breaches of the fundamental tenets of the profession evidenced by Ms Dzvengwe's actions are fundamentally incompatible with Ms Dzvengwe 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?*

Ms Dzvengwe'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 was of the view that the findings in this particular case demonstrate that Ms Dzvengwe'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 Ms Dzvengwe'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 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 Ms Dzvengwe in writing.

Hand down of sanction decision

Following the handing down of the panel's decision in relation to sanction, Ms Dzvengwe informed the panel that she would be leaving the hearing room, and accordingly did so. Ms Dzvengwe also indicated that she was not prepared to read the panel's written determination.

Mr Ross made an application to proceed in the absence of Ms Dzvengwe, given that she had voluntarily absented herself.

Given all the circumstances, the panel was content to proceed in the absence of Ms Dzvengwe.

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 in Ms Dzvengwe's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Ross. He submitted that imposing an 18-month interim suspension order is appropriate on the grounds of public protection and public interest to cover any appeal period until the striking-off order comes into place.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28 day appeal period.

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

That concludes this determination.