Regina Mumbuluma

Members present
Antony Townsend (in the Chair), Board Member, Professional Standards Authority
Mark Stobbs, Director of Scrutiny and Quality, Professional Standards Authority
Kisha Punchihewa, Head of Legal/ Senior Solicitor, Professional Standards Authority

In attendance
Peter Mant, Legal Advisor, 39 Essex Chambers

Observers
Sophie Joseph, Senior Scrutiny Officer (Legal), Professional Standards Authority
Alexandra Taylor, Senior Scrutiny Officer, Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny and Quality, Professional Standards Authority
Remi Gberbo, Lawyer, Professional Standards Authority
Michael Warren, Policy Adviser, Professional Standards Authority
Bolanle Omoyinmi, Data Administrator, Professional Standards Authority

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members’ consideration of the relevant decision about the Registrant made by the regulator’s panel, and the Authority’s decision whether or not to refer the case to the court under Section 29 of the Act.
3. **The Authority's powers of referral** under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:
   - to protect the health, safety and well-being of the public
   - to maintain public confidence in the profession concerned, and
   - to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscllo*1).

4. **Conflicts of interest**

4.1 The Members did not have any conflicts of interest.

5. **Jurisdiction**

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of England and Wales and the statutory time limit for an appeal would expire on Monday 8 April 2019.

6. **The relevant decision**

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 1 February 2019.

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. **Documents before the meeting**

7.1 The following documents were available to the Members:

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1 CRHP v Ruscllo [2004] EWCA Civ 1356
7.2 The Members and the Legal Advisor were provided with a copy of a response from the NMC to the Authority’s notification of the s.29 Meeting.

8. Background

8.1 The Registrant was employed as a nurse at Sonnet Care Homes (the Home).

8.2 The allegations and findings are as detailed below at Appendix 1 and arose in the context of the Registrant’s employment at Sonnet Care Homes (‘the Home’) and her actions during the night shift on 13 August 2017.

8.3 The Registrant worked the nightshift on 13 August 2017 at the Cedar Nursing Unit. It was a 30-bed residential nursing unit for patients with complex nursing needs including end of life patients and those with dementia. Resident A had complex needs including advanced dementia, depression and bipolar disorder and required 1:1 care between 10:00 and 22:00. Resident A was at high risk of falls and had suffered a fall 10 days prior to the incident giving rise to the allegations.

8.4 On 13 August 2017, the Registrant was the registered nurse on duty with four Healthcare Assistants. The Registrant commenced the night shift at 20:00 but, as alleged in the charges, she failed to allocate appropriate 1:1 care for Resident A and Resident B, as detailed in their care plans. Health Care Assistant A (HCA A) was looking after both these residents. HCA A told the Registrant that she was taking Resident B back to his room, thus alerting her to the need to supervise Resident A whilst she was out of the room. At around 20:50, the Registrant left Resident A in the dining room unsupervised, knowing that there was no member of staff present; Resident A fell and suffered a fracture. Following the incident, the Registrant provided misleading/false information about the incident and encouraged Care Assistant A to provide a
report which corresponded with her account. The Panel did not find that the
Registrant’s actions were dishonest.

8.5 The failure to arrange 1:1 care was not found to amount to misconduct. The
Registrant’s fitness to practise was found to be impaired on public interest
grounds only and a caution order was imposed for a period of 2 years.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal
advice.

9.2 The Members discussed the following concerns about the decision:

(a) Whether the findings made by the panel were open to it on the charges
brought and the evidence.
  - Whether the finding of no dishonesty was wrong;
  - Whether the finding of no misconduct in relation to the failure to allocate
    1:1 care was wrong; and
  - Whether the overall sanction was insufficient.

(b) Whether the case was under-prosecution.
  - Failure to charge that 1:1 care was required for patient safety;
  - Failure to bring any charge in respect of reporting to the next of kin; and
  - Failure to charge, or raise, the duty of candour (in relation to next of kin
    or more generally).

Whether the findings made by the panel were open to it on the charges

9.3 The Members noted that charge 6 alleged that the Registrant’s actions in
charge 4 were dishonest in that the Registrant sought to mislead the reader of
the report as to the circumstances surrounding the incident.

9.4 The Panel found that:

there may have been a lack of clarity as to the circumstances
surrounding Registrant A’s fall, and there may have been a
miscommunication between [the Registrant] and Care Assistant A. It
considered that whilst it was more likely than not that Care Assistant A
did have a conversation with [the Registrant] regarding leaving the dining
room to attend Resident B, it was also more likely than not that this
conversation would have been brief, and took place whilst [the
Registrant] were engaged in other duties, namely the medicines round.
In these circumstances, the panel did not consider that [the Registrant]
had a deliberate intention to mislead, and that your actions would not be
regarded as dishonest according to the standards of ordinary decent people.

9.5 The Members noted that whilst the Panel had been advised as to the application of the test for dishonesty (per Ivey), it was not clear from the decision how this had been applied by the Panel.

9.6 The Members considered that there was a tension between the above reasoning and other parts of the panel's rationale in the decision, where the Panel found that HCA A had had a conversation with the Registrant in which she informed her that she was leaving with Resident B. There was no reference in the earlier parts of the decision to the Registrant not hearing/taking in what she was told. The members noted that no nurse or carer was in the room when Resident A fell, therefore it was not clear on what basis the Registrant was able to state “at 2125 hours the staff called for help. When checked found [Resident A] on the floor lying on the left side. The care staff said while she was attending to make another resident comfortable [Resident A] suddenly attempted to stand and slipped out of her wheelchair and fell on the floor on her left side.” The Panel concluded that the inaccuracy related to a discrete point and there was evidence that the Registrant was feeling distressed and stressed during the incident.

9.7 The members noted that the Panel had had the advantage of hearing and observing both witnesses and therefore its judgments as to what had occurred that evening were likely to be afforded a considerable degree of deference. Whilst the decision could have been drafted differently and in a more precise manner, the view taken by the Panel that there had been a “muddle” was one that was open to them. Finally, the Members concluded that when reading the decision as a whole, the view of the panel was that there had been an unfortunate set of events where although HCA A had said she was leaving the room, this information was not taken in by the registrant as she was undertaking other tasks.

9.8 The Members considered that the Panel took a very narrow approach when considering the Registrant’s duty to ensure 1:1 care for Resident A, but noted that the staffing levels at the home were not her ultimate responsibility. However, given the deference that was likely to be afforded to the panel, the Members concluded that the decision of the Panel was one that was open to them and was therefore sufficient.

Whether the case was under-prosecuted

9.9 The Members noted that on reviewing the case, concerns were raised as to whether all appropriate charges had been placed before the Panel. The Members considered the evidence that was available to the NMC and Case Examiners.
9.10 The Members considered that, on one view, the evidence supported an allegation that the registrant knew the particular vulnerabilities of Resident A, in particular that she had fallen previously, and so it was particularly important that she had 1:1 care.

9.11 The Members noted that there was evidence available that the Registrant provided the next of kin with the same account of what happened as was noted by her in the incident report, which had been considered to be untrue. The Members considered that this should have formed part of the allegations before the Panel since it affected the Registrant’s honesty. This had been noted by the Case Examiners.

9.12 The Members noted that the Registrant’s duty of candour was not alleged. The Members were most concerned that the Registrant made assumptions as to how the Resident A came to be on the floor even though she had not witnessed it. This could have been a breach of that duty. However, the Members considered that this was implicit in the allegation of dishonesty and it was not wrong to fail to allege it in its own right.

9.13 While the Members considered that these points were all relevant, it was not clear that their inclusion in the charges would have been likely to have made a difference to the outcome of the case.

**Conclusion on insufficiency for public protection**

9.14 The Members were concerned about the Panel’s approach, particularly the lack of clarity of reasoning in the substantive decision and the narrow approach taken by the Panel and the NMC following the Case Examiners’ referral. Nevertheless, for the reasons set out above they concluded that the decision was not one which no reasonable Panel could have made. In the circumstances, therefore, it was not insufficient for public protection.

10. **Referral to court**

10.1 Having concluded that the panel’s Determination was not insufficient for public protection, the Members were not required to consider whether they should exercise the Authority’s power under section 29 to refer the case to the relevant court.

\[Signature\]

Antony Townsend (Chair) Dated 10th June 2019
12. **Annex A – Definitions**

12.1 In this note the following definitions and abbreviations will apply:

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<thead>
<tr>
<th><strong>The Authority</strong></th>
<th>The Professional Standards Authority for Health and Social Care</th>
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<tbody>
<tr>
<td><strong>The Panel</strong></td>
<td>A Fitness to Practise Panel of the Health and Care Professionals Tribunal Service.</td>
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<tr>
<td><strong>The Registrant</strong></td>
<td>Regina Mumbulumua</td>
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<td><strong>The Regulator</strong></td>
<td>Nurse and Midwifery Council</td>
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<td><strong>NMC</strong></td>
<td>Nurse and Midwifery Council</td>
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<tr>
<td><strong>The Act</strong></td>
<td>The National Health Service Reform and Health Care Professions Act 2002 as amended</td>
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<td><strong>The Members</strong></td>
<td>The Authority as constituted for this Section 29 case meeting</td>
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<tr>
<td><strong>The Determination</strong></td>
<td>The Determination of the Panel sitting on 1 February 2019</td>
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<tr>
<td><strong>The Court</strong></td>
<td>The High Court of England and Wales</td>
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<tr>
<td><strong>The Code</strong></td>
<td>The HCPC’s <em>Standards of Conduct, Performance and Ethics</em></td>
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