Conduct and Competence Committee

Substantive Hearing

5 - 9 June 2017

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

17 July 2017

Nursing and Midwifery Council, 61 Aldwych, London, WC2B 4AE

Name of Registrant Nurse:	Yvonne Foley
NMC PIN:	05J0341E
Part(s) of the register:	Registered Nurse- Sub Part 1 Adult Nursing- 15 February 2006
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	David Boden (Chair, Lay member) Michael Murphy (Registrant member) Sylvia Dean (Lay member)
Legal Assessor:	Kate Cornell (5 June 2017) Nicholas Wilcox (6 - 9 June 2017) John Donnelly (17 July 2017)
Panel Secretary:	Rebekah Isaacs
Mrs Foley:	Not present and not represented
Nursing and Midwifery Council:	Represented by Nazmeen Imambaccus (5 – 9 June 2017) and Siobhan Caslin (17 July 2017),

	Case Presenters instructed by NMC Regulatory Legal Team
Facts proved:	1.1, 1.2, 2.1, 3.1, 3.2, 4.1, 4.2, 5, 6.1, 6.2, 6.3, 6.4, 8, 9, 10, 11, 12, 13, 14, 15, 16.1, 16.3
Facts proved by admission:	None
Facts not proved:	1.3, 3.4, 7
Facts not considered by virtue of other facts proved:	2.2, 3.3, 4.3, 16.2
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim Order:	Interim suspension order – 18 months

Details of charge:

That you, whilst employed by Peninsula Community Health as a registered nurse:

1. On 23rd October 2012 in relation to Patient A:

1.1 failed to administer a controlled drug, namely Zomorph;

1.2 failed to administer two 'once only' drugs

1.3 Failed to document that you had not administered the drugs as described in 1.1 and/or 1.2 above

2. In respect of the drug round due to commence at or around 17:30 hours you:

2.1 Commenced the drug round late namely at 19:00 hours; or in the alternative

2.2 knowing that you were unable to commence the drug round at the designated time, failed to allocate the drug round to an appropriate colleague

That you, whilst employed by Cornwallis Care Services Limited as a band 5 staff nurse at Cornwallis Care Home during the period 14 January 2014 and 17 March 2015:

3. During the night shift commencing on 5 June 2014 and in relation to Patient A1, you failed to do the following:

3.1 Regularly monitor the patient during the night;

3.2 Identify that the patient's high grade mattress had deflated; or in the alternative

3.3 Take appropriate action in respect of the deflated mattress;

3.4 Change the patient's incontinence pad;

4. On or around 4 February 2015 failed to:

4.1 Identify signs of patient deterioration

4.2 Compile a list of patients that required assessment by a General Practitioner

4.3 Escalate patients for review by a General Practitioner

5. On an unknown date, during handover to a new member of staff, told them "*not to bother with Patient E because he will just tell you to fuck off*', or words to that effect;

6. On 5 February 2015:

6.1 Failed to administer medication, namely Lorazepam, to Patient E1

6.2 Recorded that you had administered Lorazepam, to Patient E1 when you had not;

6.3 Failed to escalate Patient F for review of her unstable diabetes by a General Practitioner despite being asked to do so by Colleague C;

6.4 In the presence of other members of staff referred to Colleague A as a '*bitch*' or words to that effect;

7. Your actions in relation to Charge 6.2 was dishonest in that you intended to conceal the fact that you had not administered the medication set out in Charge 6.1

8. On 13 February 2015 said to Patient E1 "*you are walking like you've shat yourself*" or words to that effect

9. On an unknown date refused to provide care to Patient G;

10. On an unknown date said to Colleague B '*you sound like a paki'* or words to that effect

11. On one or more occasions on an unknown date or dates referred to Patient H as '*mable the table'* or words to that effect;

That you, whilst employed by Nursefinders Limited as a registered nurse:

12. On or around 23 April 2015, informed Nursefinders Limited that you had left Cornwallis Care Services Limited, your previous employer, on your own terms due to the treatment that you had received from management when you had in fact been dismissed by Cornwallis Care Services Limited for gross misconduct.

13. Your actions in relation to Charge 12 were dishonest, in that you intended to conceal the fact that you had been dismissed for gross misconduct from Nursefinders Limited

14. Between 23 April 2015 and 1 October 2015, did not inform Nursefinders Limited that you were being investigated by the Nursing and Midwifery Council ("NMC")

15. Your actions in relation to Charge 14 was dishonest in that you intended to conceal that you were being investigated by the NMC from Nursefinders Limited

That you, whilst employed by Amberley Care Home as a registered nurse:

16. On 30 September 2015 between the hours of 07.45 and 21.15 and in relation to Patient I, you failed to do the following :

16.1 change the dressing on the PEG feed site of the patient; or alternatively

16.2 did not delegate changing the dressing on the patient's PEG feed site to another member of staff

16.3 record that you had not changed the dressing on the patient's PED feed site

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

Decision on Service of Notice of Hearing:

The panel was informed at the start of this hearing that Mrs Foley was not in attendance and that written notice of this hearing had been sent to Mrs Foley's registered address by recorded delivery and by first class post on 31 March 2017. Royal Mail "Track and Trace" documentation confirmed that the notice of hearing was sent to Mrs Foley's registered address by recorded delivery on that date.

The panel took into account that the notice letter provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mrs Foley's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence. The "Track and Trace" documentation also indicated that the notice was signed for at Mrs Foley's registered address on 1 April 2017. Ms Imambaccus submitted the NMC had complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules").

The panel accepted the advice of the legal assessor.

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

Decision on proceeding in the absence of the Registrant:

The panel had regard to Rule 21 (2) (b) which states:

> *"Where the registrant fails to attend and is not represented at the hearing, the Committee...may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant...*"

Ms Imambaccus invited the panel to continue in the absence of Mrs Foley on the basis that she had voluntarily absented herself. Ms Imambaccus presented the panel with copies of communication that the NMC had with Mrs Foley and her husband. She asked the panel to consider this evidence and submitted that there had been little previous engagement by Mrs Foley with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor. The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is one that should be exercised "*with the utmost care and caution*".

The panel noted a communication note detailing a telephone call between the NMC and Mrs Foley's husband on 9 May 2017 which states as follows:

> "*….she does not wish to participate whatsoever…*".

The panel also noted the correspondence from Mrs Foley's husband on 10 May 2017 in which he stated;

> "*….my wife is not well enough to attend and feels no need to use video facilities…*"

The panel has decided to proceed in the absence of Mrs Foley. In reaching this decision, the panel has considered the submissions of the case presenter, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R.* v *Jones (Anthony William), (No.2) [2002] UKHL 5.* It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Foley has expressly communicated (through her husband) that she is aware of the hearing and does not wish to attend;
- no application for an adjournment has been made by Mrs Foley;
- Mrs Foley has not consistently engaged with the NMC and has not responded to any of the letters sent to her about this hearing;

- there is no reason to suppose that adjourning would secure her attendance at some future date;
- three witnesses have attended today to give live evidence, others are due to attend;
- not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- the charges relate to events that occurred some years ago, in particular; 2012, 2014 and 2015;
- further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- there is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Foley in proceeding in her absence. Although the evidence upon which the NMC relies was sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the panel's judgment, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Foley'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 Mrs Foley. The panel will draw no adverse inference from Mrs Foley's absence in its findings of fact.

Decision and reasons on application to amend charge

The panel heard an application made by Ms Imambaccus, on behalf of the NMC, to amend a number of charges.

The proposed amendment was to clarify which patient was involved in each incident. It was submitted by Ms Imambaccus that the proposed amendment would provide clarity and more accurately reflect the evidence.

The panel was invited to substitute the letters which corresponded with anonymised patients as follows:

- In Charge 3, the reference to 'Patient A1' was to be replaced with 'Patient B'
- In Charge 5, the reference to 'Patient E' was to be replaced with 'Patient C'
- In Charges 6.1, 6.2 and 8, the reference to 'Patient E1' was to be replaced with 'Patient D'
- In Charge 6.3 the reference to 'Patient F' was to be replaced with 'Patient E'
- In Charge 9 the reference to 'Patient G' was to be replaced with 'Patient F'

3. During the night shift commencing on 5 June 2014 and in relation to Patient B, you failed to do the following:

5. On an unknown date, during handover to a new member of staff, told them "not to bother with Patient C because he will just tell you to fuck off', or words to that effect;

6.1 Failed to administer medication, namely Lorazepam, to Patient D

6.2 Recorded that you had administered Lorazepam, to Patient D when you had not;

6.3 Failed to escalate Patient E for review of her unstable diabetes by a General Practitioner despite being asked to do so by Colleague C;

8. On 13 February 2015 said to Patient D "you are walking like you've shat yourself" or words to that effect

9. On an unknown date refused to provide care to Patient F;

Ms Imambaccus further invited the panel to amend the wording in charge 16.3 which she said had a typographical error. She submitted that the word 'PED' should be substituted with the word 'PEG' and should read as follows:

16.3 record that you had not changed the dressing on the patient's PEG feed site

The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

28 (1) At any stage before making its findings of fact …

(i) … the Conduct and Competence Committee, may amend

(a) the charge set out in the notice of hearing …

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

The panel was of the view that such amendments, as applied for, would bring clarity to the charges. The panel considered that Mrs Foley had already had notice of the evidence to be relied upon by the NMC and that these amendments did not alter the evidence which had been served. Therefore, the panel was satisfied that there would be no prejudice to Mrs Foley 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, to ensure clarity and accuracy.

During the course of the hearing, it was noticed that there were typographical errors in charges 7 and 15, in that 'was' appeared rather than 'were'. These charges were amended accordingly under the 'slip rule'.

Charges as amended:

That you, whilst employed by Peninsula Community Health as a registered nurse:

1. *On 23rd October 2012 in relation to Patient A:*

1.1 failed to administer a controlled drug, namely Zomorph;

1.2 failed to administer two 'once only' drugs

1.3 Failed to document that you had not administered the drugs as described in 1.1 and/or 1.2 above

2. In respect of the drug round due to commence at or around 17:30 hours you:

2.1 Commenced the drug round late namely at 19:00 hours; or in the alternative

2.2 knowing that you were unable to commence the drug round at the designated time, failed to allocate the drug round to an appropriate colleague

That you, whilst employed by Cornwallis Care Services Limited as a band 5 staff nurse at Cornwallis Care Home during the period 14 January 2014 and 17 March 2015:

3. During the night shift commencing on 5 June 2014 and in relation to Patient B, you failed to do the following:

3.1 Regularly monitor the patient during the night;

3.2 Identify that the patient's high grade mattress had deflated; or in the alternative

3.3 Take appropriate action in respect of the deflated mattress;

3.4 Change the patient's incontinence pad;

4. On or around 4 February 2015 failed to:

4.1 Identify signs of patient deterioration

4.2 Compile a list of patients that required assessment by a General Practitioner

4.3 Escalate patients for review by a General Practitioner

5. On an unknown date, during handover to a new member of staff, told them "not to bother with Patient C because he will just tell you to fuck off', or words to that effect;

6. On 5 February 2015:

6.1 Failed to administer medication, namely Lorazepam, to Patient D

6.2 Recorded that you had administered Lorazepam, to Patient D when you had not;

6.3 Failed to escalate Patient E for review of her unstable diabetes by a General Practitioner despite being asked to do so by Colleague C;

6.4 In the presence of other members of staff referred to Colleague A as a 'bitch' or words to that effect;

7. Your actions in relation to Charge 6.2 were dishonest in that you intended to conceal the fact that you had not administered the medication set out in Charge 6.1

8. On 13 February 2015 said to Patient D "you are walking like you've shat yourself" or words to that effect

9. On an unknown date refused to provide care to Patient F;

10. On an unknown date said to Colleague B 'you sound like a paki' or words to that effect

11. On one or more occasions on an unknown date or dates referred to Patient H as 'mable the table' or words to that effect;

That you, whilst employed by Nursefinders Limited as a registered nurse:

12. On or around 23 April 2015, informed Nursefinders Limited that you had left Cornwallis Care Services Limited, your previous employer, on your own terms due to the treatment that you had received from management when you had in fact been dismissed by Cornwallis Care Services Limited for gross misconduct.

13. Your actions in relation to Charge 12 were dishonest, in that you intended to conceal the fact that you had been dismissed for gross misconduct from Nursefinders Limited

14. Between 23 April 2015 and 1 October 2015, did not inform Nursefinders Limited that you were being investigated by the Nursing and Midwifery Council ("NMC")

15. Your actions in relation to Charge 14 were dishonest in that you intended to conceal that you were being investigated by the NMC from Nursefinders Limited

That you, whilst employed by Amberley Care Home as a registered nurse:

16. On 30 September 2015 between the hours of 07.45 and 21.15 and in relation to Patient I, you failed to do the following :

16.1 change the dressing on the PEG feed site of the patient; or alternatively

16.2 did not delegate changing the dressing on the patient's PEG feed site to another member of staff

16.3 record that you had not changed the dressing on the patient's PEG feed site

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

Decision and Reasons on application pursuant to Rule 31

The panel heard an application made by Ms Imambaccus, on behalf of the Nursing and Midwifery Council (NMC), under Rule 31 of the Rules to allow Ms 6, Mr 8 and Ms 9 to provide their evidence via telephone.

In relation to Ms 6, Ms Imambaccus informed the panel that she is unable to attend this hearing due to staff shortages and a close friend suffering from a serious illness and she was providing care and support. Ms Imambaccus stated that Ms 6 has confirmed that she is willing to give evidence via telephone.

In relation to Mr 8, Ms Imambaccus informed the panel that he is employed as a firefighter and is unable to attend the hearing in person due to these work commitments. Ms Imambaccus told the panel that Mr 8 is willing and able to give his evidence via telephone. She submitted that whilst Mr 8 is a sole and decisive witness relating to charge 13, his evidence is limited and relates to the documents which he exhibits with his witness statement. She highlighted that these documents have already been served on Mrs Foley and therefore to allow this application would be fair and would cause no prejudice to Mrs Foley.

In relation to Ms 9, Ms Imambaccus submitted that Ms 9 is currently out of the country and is due to return to the United Kingdom (UK) on day 3 of the hearing (Wednesday, 7 June 2017). She is willing and able to give evidence via telephone if the panel accedes to this application. Ms Imambaccus told the panel that whilst the matters Ms 9 speaks to, are factually disputed matters, she is not the sole and decisive witness, save with

respect of charge 3, and the panel has heard from other witnesses on these matters. Ms Imambaccus also highlighted that the NMC had written to Mrs Foley on 5 May 2017 proposing for Ms 9's evidence to be heard by video link and she had not objected to this proposal. Ms Imambaccus submitted that in all the circumstances there is no prejudice to Mrs Foley for Ms 9's evidence to be given by telephone.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included Rule 31 which provides that, so far as it is '*fair and relevant,'* a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He also referred the panel to the case of *Thorneycroft v NMC [2014] EWHC 1565 (Admin)* and the factors it should take into account when deciding whether to allow the application.

The panel took into account that Ms 6 was originally due to give evidence in person however due to her personal and work circumstances she is unable to attend in person but she is willing to engage with the process.

The panel considered that the scope of Mr 8's evidence was limited and considered that it would be appropriate for him to give evidence by telephone, particularly in light of his work commitments and the distance he would be required to travel to attend the hearing in person.

The panel accepted that Ms 9's ability to give evidence would be adversely effected were she required to travel to London having just arrived in the UK from a long haul flight. It determined that the quality of Ms 9's evidence would be superior if she were permitted to give evidence via telephone. It considered that there would be no substantial unfairness to Mrs Foley if Ms 9 were allowed to give evidence via telephone, and that it could cross-examine her evidence on Mrs Foley's behalf.

The panel considered the extent to which its assessment of each witness might be disadvantaged if each witness gave evidence via telephone rather than in person. The panel accepted that it is preferable for a witness to attend to give evidence but concluded that it would in this case be placed at no real disadvantage by each witness

concerned giving evidence via telephone as it will be able to hear their voices. It determined that the expeditious disposal of this case is important given the age of the charges. The panel could not identify any prejudice to Mrs Foley as the legal assessor or the panel itself would be able to pose questions to any witnesses on her behalf. In these circumstances, the panel came to the view that Ms 6, Mr 8 and Ms 9's evidence was crucial and important and that it would be fair to receive it via telephone.

Application to admit additional documentary evidence

Ms Imambaccus, on behalf of the NMC made an application under Rule 31 of the NMC Fitness to Practice Rules 2004, to receive documentary evidence, a further record relating to the incident involving Patient A.

Rule 31 states:

> *"Upon receiving the advice of the legal assessor, and subject only to the requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings."*

Ms Imambaccus, submitted that the evidence was relevant to charge 1.1 and it is the best available evidence which fills a gap. She submitted that it would be fair to admit this evidence as it would be useful to all parties involved.

The panel heard advice from the legal assessor, which included reference to the case of *R (Hill) v Institute of Chartered Accountants in England and Wales, [2013] EWCA Civ 555*. The panel were informed of the approach recommended in this case, to panels considering whether evidence should be admitted; *"the right question to ask of any procedure adopted should therefore be not whether it is permitted but whether it is prohibited".* The case indicated that fairness is the critical issue.

The panel considered the application carefully. With regard to relevance the panel was satisfied that the documentary evidence was relevant as it would help the panel to contextualise some of the other information it had been provided, in particular the drug

that should have been administered to Patient A. It would therefore assist the panel in reaching an informed decision on the allegations, in particular charge 1.1.

The panel next considered whether it was fair to grant the application. In considering what is entailed by the requirements of a fair hearing, the panel considered this application thoroughly and had regard to all of the relevant factors known to it. The panel noted that Mrs Foley was not present and may not have seen the Datix report. However, the panel considered that the available documentation was a clear and contemporaneous document which would be of assistance in determining the facts and would not prejudice Mrs Foley. The panel determined that it would attach the weight it deems appropriate. The panel therefore determined that it was fair to grant the application.

Accordingly, the panel granted this application to adduce the incident investigation form from Peninsula Community Health.

Decision and reasons on application to amend charge

The panel heard an application made by Ms Imambaccus, on behalf of the NMC, to amend charge 2.1.

Ms Imambaccus invited the panel to delete the word ‘or in the alternative’ from charge 2.1 as she submitted that these were unnecessary in light of the evidence.

The panel heard and accepted legal advice.

The panel noted that the same wording in charge 2.1 appears in both charges 3.1 and 16.1. The panel considered the evidence it had heard and considered it unnecessary to amend the charge in the manner proposed by the Case presenter. It determined that it would consider the facts and come to the conclusions it deemed necessary in relation to the charges as they appear in their current form.

The panel therefore determined to reject the application to amend charge 2.1.

Background

Mrs Foley qualified as a registered nurse in February 2006 and was employed by Cornwallis Care Services Ltd. from January 2014 until her dismissal on 17 March 2015.

As a result of concerns Mrs Foley was subject to supervision and her probation period was extended by three months. Mrs Foley then successfully completed her probation.

In June 2014, Ms 9 raised concerns surrounding Mrs Foley's inability to identify deteriorating patients and escalate appropriately. There were also concerns regarding Mrs Foley's failure to care for a patient who was bed bound; the patient was on a specialised mattress to elevate her and reduce the pressure that she placed on severe bed sores. Whilst on a night shift Mrs Foley failed to monitor the patient adequately so that it was not noticed that the mattress had been switched off at the wall and had subsequently deflated. The patient had sunk down onto the base of the bed resulting in no pressure relief being afforded and she consequently developed a further pressure sore.

On 5 February 2015, during a staff handover, Mrs Foley maligned another registered nurse whom she worked alongside by calling her a 'bitch'.

On 6 February 2015 a complaint was made by Ms 9, a registered nurse who worked alongside Mrs Foley, regarding a controlled drug that had not been administered and dressings that had not been completed.

On 7 February 2015 a further complaint was received from Ms 5, a registered nurse who also worked alongside Mrs Foley. Ms 5 raised concerns regarding Mrs Foley's attitude and her interaction with patients. On one occasion Ms 5 observed Mrs Foley completing a handover, when discussing a patient she said to a new care worker 'don't bother with him he will just tell you to fuck off'. Mrs Foley had also refused to assist one vulnerable patient who had exhibited challenging behaviour, [PRIVATE] Concerns were also raised regarding the Mrs Foley's medicine administration, she had pre-signed a medication chart to reflect that Lorazepam had been administered to a patient but then

Mrs Foley informed Ms 5 that she had not actually administered it and ‘it was free to be administered’. Mrs Foley had also failed to arrange a review by a GP of a patient with unstable diabetes despite acknowledging that this was necessary.

On 13 February 2015 it is alleged that Mrs Foley ridiculed a patient by telling her to ‘stop walking like you’ve shat yourself’.

It is also alleged that Mrs Foley used a racial slur and referred to a member of staff at Cornwallis Care Home as a ‘paki’.

On 17 March 2015, following a local investigation Mrs Foley was dismissed by Cornwallis for gross misconduct. The decision to dismiss was given to Mrs Foley at a disciplinary hearing and subsequently confirmed to her in writing.

On 23 April 2015 Mrs Foley commenced employment with an agency called Nursefinders Limited. Mrs Foley informed the agency of the incident at Cornwallis Care Home where she had told a patient to ‘stop walking like you’ve shat yourself’ but failed to inform the agency that she had been dismissed for gross misconduct. Mrs Foley stated that she had left as she was unhappy with the hostile environment and working conditions at Cornwallis. Mrs Foley did not inform the agency that she was subject to an NMC investigation. Much later Mrs Foley disclosed this information to another member of staff during a handover at Trewartha Nursing Home and this was subsequently reported to Nursefinders.

A further complaint was received from Amberley Care Home as Mrs Foley had failed to change the dressing on a PEG feed site on a patient. Following these concerns Mrs Foley’s employment with Nursefinders Limited was terminated on 5 October 2015.

As part of this investigation it also came to light that Mrs Foley was previously dismissed from Peninsula Community Health. Mrs Foley was investigated following concerns regarding the omission of a controlled drug, Zomorph - Morphine Sulphate and two ‘once only’ drugs. Concerns were also raised regarding Mrs Foley’s time management and handover skills.

Decision on the findings on facts and reasons

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

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

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

The panel has drawn no adverse inference from the non-attendance of Mrs Foley.

The panel heard oral evidence from nine witnesses called on behalf of the NMC:

Ms 1, Human Resources Manager at Peninsula Community Health

Ms 2, Staff Nurse at Cornwall Foundation Trust

Ms 3, Hospital Sister at Cornwall Foundation Trust

Ms 4, Activities Co-ordinator at Cornwallis Care Services Ltd

Ms 5, Bank Nurse at Cornwallis Care Services Ltd

Ms 6, Registered Manager at Nursefinders Limited

Ms 7, Home Manager at Amberley House Care Home

Mr 8, Operations Manager at Cornwallis Care Services Ltd

Ms 9, Bank Nurse at Cornwallis Care Services Ltd

The panel found Ms 1 to be credible and clear. She could not provide much detail of the incident due to the passage of time, however she sought to assist and respond to questions to the best of her ability. She confirmed the findings of her investigation and was honest about the uncertainty surrounding the 'once only' drugs referenced in charge 1.2.

In respect of Ms 2 the panel found her evidence to be honest and precise. She did not seek to embellish her evidence by adding additional information. She spoke with conviction when she told the panel that she was certain that the controlled drug and once only drugs had not been given to Patient A. She told the panel why it was Mrs Foley's responsibility to give these drugs to Patient A and how she would have known she was required to give these drugs at the relevant times. She also detailed the consequences of a drug not being administered at the correct time and described the impact this would have on patient care.

The panel found Ms 3 to be a credible, knowledgeable and compelling witness. It found that she had good clinical knowledge and a clear recall of the events, procedures and what was expected of nursing staff at the time. Ms 3 gave the panel details about the workings of the Home, the shift patterns, medication rounds and what was expected of a nurse when medication is not given on time. The panel were impressed by her professionalism and found her evidence helpful in contextualising the allegations in charge 2 in particular.

The panel found Ms 4 to be open, honest and credible. She spoke frankly about Mrs Foley's behaviour and actions and did not appear to have an axe to grind. Ms 4 provided details about the patient's demeanour and the impact of Mrs Foley's remarks on the patient and on herself. She provided details of how she addressed matters and confirmed that initially she did not report the incident with Patient D but sought to

discuss it with Mrs Foley directly. The panel found her evidence helpful in considering charges 8 and 10 in particular.

As regards Ms 5, the panel found her to be credible and consistent. She gave factual answers and was honest in her recollection of the events. She provided the panel with details about the residents and the home. She also explained the situations in which these incidents arose and the impact of Mrs Foley's remarks and actions on residents and other staff. The panel found Ms 5's evidence helpful in that she was consistent and provided detailed responses to the best of her knowledge.

The panel found Ms 6 to be clear and unambiguous. She confirmed what Mrs Foley did and did not say and clarified the context in which she had contact with Mrs Foley. The panel found that whilst Ms 6's evidence was limited, it was helpful as it went to the heart of charges 12, 13, 14, and 15.

The panel considered Ms 7's evidence to be credible and compelling. She explained the PEG feed process and the responsibilities of the carers and the qualified nurses. The panel found that her evidence contextualised charge 16 and confirmed Mrs Foley's awareness of her obligation to change Patient I's dressing and her experience in carrying out these activities. She described standard practices at the Home and the patient's pattern of behaviour and compliance. The panel found Ms 7's evidence extremely helpful in filling in the evidential gaps.

In respect to Mr 8, the panel found his evidence credible and clear. He had a good recall of the circumstances of Mrs Foley's dismissal and his interactions with her. He asserted his conviction that Mrs Foley knew that she had been dismissed and the reasons for her dismissal. He told the panel that Mrs Foley had apologised at the time and that a copy of the contemporaneous disciplinary hearing minutes were sent to her, thereby giving her an opportunity to correct any misstatements. He confirmed that Mrs Foley did not dispute the dismissal or the record of the disciplinary meeting.

The panel found Ms 9 to be a caring, professional and credible witness. She provided details about the patients and their care regimes. She spoke extensively about patient

B, about her care routine, her history and her disposition. She told the panel that she found the mattress completely deflated and explained how the mattress functions and how malfunctions would present themselves. Ms 9 told the panel about the harm that Patient B suffered as a consequence of the deflated mattress namely a further serious pressure sore. She denied that she had personal issues with Mrs Foley and made clear that Mrs Foley was disposed to using abusive language.

The panel also took into account the notes of Mrs Foley's meeting with Ms 1 on 21 December 2012 and Mrs Foley's responses in the Disciplinary Hearing held on 17 March 2015 as well as her email to the NMC dated 12 October 2015.

The panel considered each charge and made the following findings:

That you, whilst employed by Peninsula Community Health as a registered nurse:

Charge 1

1. On 23rd October 2012 in relation to Patient A:

Charge 1.1

1.1 failed to administer a controlled drug, namely Zomorph;

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular the evidence of Ms 2.

The panel had sight of the incident investigation form which was completed by Ms 2. The drug noted on this form is 'zomorph' and this document is dated 31 October 2012 which is eight days after the incident itself.

Ms 2 told the panel that Mrs Foley had been the nurse on the day shift on the 23 October 2012 therefore she was responsible for administering the medication to Patient A during that shift. She further told the panel that when Mrs Foley handed over to her for

the night shift, Mrs Foley did not appear aware that she had missed the medication out and did not hand this information over to Ms 2.

The panel found that Mrs Foley had a duty to administer zomorph to Patient A on 23 October 2012 as she was the nurse responsible for his care on that shift. Having found that Mrs Foley had a duty of care for Patient A, in light of Ms 2's evidence and the incident report, it found that Mrs Foley failed to administer the controlled drug of zomorph to Patient A.

Accordingly, the panel found this charge proved.

Charge 1.2

1.2 failed to administer two 'once only' drugs

This charge is found proved

In reaching this decision, the panel took into account all the written and oral evidence, in particular the evidence of Ms 2.

Ms 2 told the panel that when she commenced her shift at 20:00 hours on 23 October 2012, she checked the drugs against the medication administration charts for each patient. She stated that she checked whether the drugs for the day shift had been given in order to ascertain whether and when night medication was to be administered. Ms 2 told the panel that in the process of checking the medication against the medication charts, she discovered that Patient A's 'once only' medication had not been administered. She said that by the time she identified this error, it was part way into her shift and Mrs Foley had left the building, therefore she did not ask her about this omission.

The panel found that Mrs Foley had a duty to administer the two 'once only' drugs to Patient A on 23 October 2012 as she was the nurse responsible for his care on that shift. Having found that Mrs Foley was responsible for the care of Patient A, in light of Ms 2's evidence, the panel found that Mrs Foley failed to administer the 'once only' drugs to Patient A.

Accordingly, the panel found this charge proved.

Charge 1.3

> *1.3 Failed to document that you had not administered the drugs as described in 1.1 and/or 1.2 above*

This charge is found NOT proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular the evidence of Ms 2.

Ms 2 told the panel that Mrs Foley appeared to have forgotten to administer the medication to Patient A as per charges 1.1 and 1.2. She stated that Mrs Foley appeared to be unaware that she had not administered Patient A's medication.
The panel had regard to Mrs Foley's remarks made during an investigation meeting held by Peninsula Community Hospital on 21 December 2012:

> *"SG:* ***Q. Tell me about the drugs round & how you came to omit a controlled drug & 2 other once only drugs***
> *YF: Not being familiar with once only drug charts was a factor. I recall a male patient, room 10 wanted his drug later. On previous shifts staff had told me "don't give it to him until later" "He won't want his unit later".*

In light of this account the panel considered that there is insufficient evidence to explain why Mrs Foley did not administer the drugs to Patient A. It concluded that a nurse who forgets to administer medication, cannot have a duty to record their omission as they would need to have known that they did not administer the medication for the duty to arise. The panel considered whether or not Mrs Foley knew she had not administered the medication to Patient A and whether she therefore had a duty to document her omission of this medication. The evidence is inconclusive and Ms 2's evidence suggests that Mrs Foley had forgotten to administer the medication to Patient A.
In considering the evidence available, the panel was not satisfied that Mrs Foley had a responsibility to record that she had not administered the medication to Patient A.

Accordingly, the panel found this charge not proved.

Charge 2

2. In respect of the drug round due to commence at or around 17:30 hours you:

Charge 2.1

2.1 Commenced the drug round late namely at 19:00 hours; or in the alternative

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular Mrs Foley's remarks during the disciplinary hearing of 21 December 2012:

> *"SG:* ***Q. Can you explain to me what happened during the shift you were in charge of on the 23/10/12 at Helston Hospital?***
> *YF: …..I started the round at 7pm because I was looking for drug charts & busy getting more drugs as they had run out. Several Doctors had been in that day & I had to look for some of the charts. I checked the trolley, treatment room, notes, they weren't in the tray. I never found them."*

The panel found that Mrs Foley admitted starting the drug round late during the disciplinary hearing. Also, Ms 2 told the panel that when she started her shift at 20:00 hours, Mrs Foley was still completing the evening drug round.

The panel had heard evidence from Ms 3 about the shift patterns and that drug rounds occur in the morning and in the evening.

In light of all the evidence, the panel found that Mrs Foley commenced the drug round at 19:00 hours instead of at 17:30 hours as required.

Accordingly, the panel found this charge proved.

Charge 2.2

2.2 knowing that you were unable to commence the drug round at the designated time, failed to allocate the drug round to an appropriate colleague

This charge was not considered

In the light of its findings on charge 2.1, the panel did not consider it necessary to consider 2.2.

That you, whilst employed by Cornwallis Care Services Limited as a band 5 staff nurse at Cornwallis Care Home during the period 14 January 2014 and 17 March 2015:

Charge 3

3 During the night shift commencing on 5 June 2014 and in relation to Patient B, you failed to do the following:

Charge 3.1

3.1 Regularly monitor the patient during the night;

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence in particular the evidence of Ms 9.

The panel had regard to Ms 9's evidence that Mrs Foley was the nurse on duty and should have checked Patient B during the night. Ms 9 confirmed that patients are required to be checked every two hours. She told the panel that Patient B was particularly vulnerable and should therefore have been checked regularly. Ms 9 explained that even if a nurse conducted a cursory check of the patient at night they would have been able to identify any issues with the mattress due to its functionality and the sound it makes. She further explained that if the power to the mattress fails there is a warning sound and a light flashes and an absence of its normal sound.

The panel accepted Ms 9's evidence and found that Mrs Foley had a duty to monitor Patient B as she was the nurse on duty during that night shift. In considering all the evidence available, the panel found that Mrs Foley had not regularly monitored Patient B during the night shift of 5 June 2014.

Accordingly, the panel found this charge proved.

Charge 3.2

3.2 Identify that the patient's high grade mattress had deflated; or in the alternative

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence in particular the evidence of Ms 9. The panel had regard to Ms 9's evidence that when she attended shift on the morning of 6 June 2014 she discovered Patient B's mattress completely deflated.

Ms 9 told the panel that there was no other mattress supporting Patient B and that she would have been lying on a thin layer of plastic, therefore it would have been obvious that the mattress had deflated. Ms 9 further told the panel that even in night conditions, anyone monitoring or checking the patient would have been able to easily and immediately identify that the mattress had deflated.

Ms 9 told the panel that she had received handover from Mrs Foley and that Mrs Foley was the nurse on duty during the night shift of 5 June 2014. Ms 9 explained the steps she took once she identified that Patient B's mattress had deflated and the impact this incident had on Patient B's health.

The panel accepted Ms 9's evidence that the mattress was completely deflated on her arrival at the home and that Mrs Foley had been the nurse on duty during the night shift. The panel therefore found that Mrs Foley had a responsibility to care for Patient B and that she should have identified the deficiencies with the mattress and taken steps to safeguard Patient B accordingly. In considering the evidence, the panel found that Mrs Foley had failed to identify that Patient B's high grade mattress had deflated.

Accordingly, the panel found this charge proved.

Charge 3.3

3.3 Take appropriate action in respect of the deflated mattress;

This charge was not considered

In the light of its findings in charge 3.1 and 3.2, the panel did not consider it necessary to consider 3.3.

Charge 3.4

3.4 Change the patient's incontinence pad;

This charge is found NOT proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 9.

Ms 9 informed the panel that patient incontinence pads are typically changed by health care assistants. However, she stated that it is the qualified nurses' responsibility to ensure that patients receive personal care as and when required.

The panel had regard to the wording of the charge which states 'change the patient's incontinence pad' and interpreted this to mean that Mrs Foley was being charged with not changing Patient B's incontinence pad herself. Therefore, in light of the evidence proffered by Ms 9, the panel found that Mrs Foley did not have a duty to change Patient B's incontinence pad, and therefore there was no failure by Mrs Foley.

The panel concluded that whilst Mrs Foley was required to ensure that Patient B's incontinence pad was changed, in view of the specific wording of the charge, there is insufficient evidence to impose a responsibility on Mrs Foley to change it herself.

Accordingly, the panel found this charge not proved.

Charge 4

4. On or around 4 February 2015 failed to:

Charge 4.1

4.1 Identify signs of patient deterioration

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 9.

Ms 9 informed the panel that during her shift, she identified a number of patients who had chest infections and required referral to their General Practitioners ('GP'). She told the panel that Mrs Foley was the nurse on duty at the relevant time (on or around 4 February 2015) and she should have identified the signs of deterioration in the patients concerned.

The panel had regard to the typed letter from Ms 9 with a handwritten date of 6 February 2015 which states:

> *"B 2 patients were put on the GP list. I had ot [sic] add 4 more patients at 0800 Wednesday 3 of whom had serious chest infections. I was informed that she had been told by Carers that the patients were unwell".*

The panel noted the date of 6 February 2015 is handwritten on the letter, however it heard evidence from Ms 9, the author of the letter, that the document was produced close to the time of the incident and was a contemporaneous account.

The panel accepted Ms 9's evidence and found that Mrs Foley did have a duty to identify signs of patient deterioration. It considered the evidence of Ms 9 that Mrs Foley had been informed by care assistant colleagues that a number of patients were unwell.

In light of all the evidence, the panel found that Mrs Foley failed to identify the signs of the patients' deterioration.

Accordingly, the panel found this charge proved.

Charge 4.2

4.2 Compile a list of patients that required assessment by a General Practitioner

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 9.

Ms 9 told the panel about the General Practitioners (GP) list and explained its purpose. She explained that nurses should add patients to the list if they require a review or if their condition has changed. The panel noted that there is no evidence of Mrs Foley having put the patients on the GP list, in particular given Ms 9's evidence that she herself put a number of patients on the GP list following Mrs Foley's shift.

The panel found that Mrs Foley did have a duty to compile a list of patients whom it appeared required assessment by a General Practitioner during her shift. The panel accepted Ms 9's evidence that a number of patients had severe chest infections and would have required assessment by a GP. In light of this evidence, the panel found that Mrs Foley failed to compile a list of patients requiring assessment by their GP.

Accordingly, the panel found this charge proved.

Charge 4.3

4.3 Escalate patients for review by a General Practitioner

This charge was not considered

Having made its findings on charges 4.1 and 4.2, the panel did not consider it necessary to deal with charge 4.3 which addressed the same issues as charge 4.2.

Charge 5

5. *On an unknown date, during handover to a new member of staff, told them "not to bother with Patient C because he will just tell you to fuck off', or words to that effect;*

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 5 and Ms 9.

The panel had regard to the evidence of Ms 5 who had stated that she was present when Mrs Foley made the remark as charged. Ms 9 told the panel that she was also present when Mrs Foley told a new member of staff "*not to bother with Patient C because he will just tell you to fuck off'.* She told the panel that the patient had been at Cornwallis Care Home for twenty seven years and Patient C had never sworn at her. She explained that Patient C could be irritable and had been known to kick a door in the past.

The panel believed the evidence of Ms 5 and Ms 9. In considering all the evidence available, the panel found that it was more likely than not that Mrs Foley had told a new member of staff "*not to bother with Patient C because he will just tell you to fuck off'.*

Accordingly, the panel found this charge proved.

Charge 6

6. On 5 February 2015:

Charge 6.1

6.1 Failed to administer medication, namely Lorazepam, to Patient D

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular the medication administration record ('MAR') of Patient D and Ms 5's evidence.

The panel considered that the MAR confirmed that Patient D was due Lorazepam on the 5 February 2015 in the evening. Ms 5 informed the panel that Mrs Foley was responsible for Patient D's care on the date concerned. The panel therefore concluded that Mrs Foley had a duty to administer Lorazepam to Patient D.

In considering whether or not Mrs Foley did in fact administer the Lorazepam to Patient D or not, the panel had regard to Ms 5's statement dated 7 February 2015 where she states: *"In the past Mrs Foley has said, again in front of witnesses that she would refuse client [sic] care because she believed that he might become aggressive and was not prepared to compromise her own safety".* Whilst giving live evidence at the hearing, Ms 5 confirmed that Mrs Foley had made these comments to her and she found it difficult to deal with Patient D. Furthermore, Ms 5 told the panel that when she started her shift on 5 February 2015, Mrs Foley informed her that she had not administered the Lorazepam to Patient D and that she could give it to him if she wanted to.

In considering all the evidence available, the panel found that Mrs Foley had not administered Lorazepam to Patient D on 5 February 2015 as she should have done.

Accordingly, the panel found this charge proved.

Charge 6.2

6.2 Recorded that you had administered Lorazepam, to Patient D when you had not;

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular Patient D's MAR and Ms 5's written and oral evidence.

The panel had regard to Patient D's MAR where they noted Mrs Foley's signature on 5 February 2015 beside the evening medication entry. Ms 5 confirmed that it was Mrs Foley's signature on the MAR. Ms 5 also told the panel that during handover, Mrs Foley informed her that she did not administer the Lorazepam to Patient D but had signed to say she had.

The panel found that Mrs Foley had a duty to administer Lorazepam to Patient D as she was the nurse on duty and was responsible for his care.

In considering all the evidence, the panel found that Mrs Foley had signed Patient D's MAR to say that she had administered the Lorazepam and had not administered the Lorazepam as the signature suggests.

Accordingly, the panel finds this charge proved.

Charge 6.3

6.3 Failed to escalate Patient E for review of her unstable diabetes by a General Practitioner despite being asked to do so by Colleague C;

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular Ms 5's written statement of 7 February 2015 and her written statement dated 11 February 2016 and oral evidence.

Ms 5 told the panel that she had asked Mrs Foley to arrange for Patient E to have a medical review due to her concerns that the patient's diabetes was unstable. She further confirmed that Mrs Foley acknowledged this instruction yet did not take any steps to escalate Patient E's condition for medical review. Ms 5 explained to the panel what actions she had taken in order to establish whether or not Mrs Foley had carried out her instruction and escalated the patient for medical review. She told the panel she had checked with the Patient's GP and also checked the team diary where the nurses recorded GP referrals, both enquiries confirmed that Mrs Foley had not escalated Patient E's condition to her GP.

The panel accepted Ms 5's evidence and found that Mrs Foley had a duty to escalate Patient E's care for medical review, as Patient E's care had effectively been handed over to her by her colleague Ms 5.

The panel found that there is no evidence that Mrs Foley escalated Patient E's care for medical review.

Accordingly, the panel finds this charge proved.

Charge 6.4

6.4 In the presence of other members of staff referred to Colleague A as a 'bitch' or words to that effect;

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 5 and Mr 8.

The panel had regard to the disciplinary hearing meeting dated 17 March 2015 where Mrs Foley stated:

"At handover MP made a cutting remark and left the table, I don't know what I did to upset her. So I said "She is really being a bitch lately and I don't know why".

Ms 5 told the panel that she had heard Mrs Foley make this remark at the time.

In light of Mr 8's evidence about the disciplinary hearing, the panel considered that Mrs Foley had then admitted to calling her colleague a 'bitch'.

In considering all the evidence, the panel found that Mrs Foley had referred to her colleague A as a 'bitch'.

Accordingly, the panel found this charge proved.

Charge 7

7. Your actions in relation to Charge 6.2 were dishonest in that you intended to conceal the fact that you had not administered the medication set out in Charge 6.1

This charge is found NOT proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 5.

In oral evidence, Ms 5 informed the panel that Mrs Foley had told her that she had not administered the medication to Patient D. The panel noted that the same is described in Ms 5's statement dated 7 February 2015.

Considering the evidence available, the panel found that Mrs Foley had declared her failure to administer the Lorazepam to Ms 5 and therefore could not have been seeking to conceal the fact that it had not been administered. The panel determined that a reasonable and honest nurse would not consider Mrs Foley's actions to be dishonest.

Accordingly, the panel found this charge not proved.

Charge 8

> 8. *On 13 February 2015 said to Patient D "you are walking like you've shat yourself" or words to that effect*

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 4, Ms 5 and Mr 8.

The panel had regard to the disciplinary hearing meeting notes dated 17 March 2015, where you stated:

> *"DE: Verbal abuse- addressing a resident in an inappropriate manner?*
> *You were leading [sic] to the toilet and you said "don't walk like you've shit yourself"*
> *YF: "shat"*
> *MMcD knows I love [sic] to bits, I didn't mean it in that manner."*

In light of this evidence, the panel considered that Mrs Foley had admitted to the charge.

Ms 4 and Ms 5 told the panel that they had heard Mrs Foley making this comment to Patient D. Ms 4 told the panel how Patient D's responded to Mrs Foley's comment and that she looked embarrassed and put her head down.

In considering all the evidence, the panel found that you did state to Patient D *"you are walking like you've shat yourself" or words to that effect.*

Accordingly, the panel found this charge proved.

Charge 9

9. *On an unknown date refused to provide care to Patient F;*

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 5.

Ms 5 informed the panel that Mrs Foley had told her that she would not deal with Patient F as she found him aggressive. Mrs Foley also gave her personal reasons for her refusal including that she was not prepared to compromise her own safety.

The panel accepted and believed Ms 5's evidence and found that it is more likely than not that Mrs Foley refused to care for Patient F.

Accordingly, it finds this charge proved.

Charge 10

10. *On an unknown date said to Colleague B 'you sound like a paki' or words to that effect*

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 4.

Ms 4 told the panel that Mrs Foley had told her 'you sound like a paki'. She explained that in response she told Mrs Foley that she was not a "paki" she was Indian and asked Mrs Foley not to use that word. She told the panel that she later sought to resolve the matter by taking Mrs Foley aside and telling her that she found her remarks racist and unacceptable. She stated that Mrs Foley did not apologise for her comments and instead asserted that she was not racist.

The panel accepted Ms 4's evidence and found that she gave an honest account.

In light of the evidence, the panel, therefore, found that Mrs Foley had said to Colleague B 'you sound like a paki' or words to that effect.

Accordingly, it finds this charge proved.

Charge 11

11. On one or more occasions on an unknown date or dates referred to Patient H as 'mable the table' or words to that effect;

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 5.

Ms 5 told the panel that Mrs Foley referred to Patient H as *'mable the table'*. She described Patient H's response and stated that Patient H did not appear to receive Mrs Foley's comment as a joke. Ms 5 emphasised that Mrs Foley's comment was not said in jest and that she frequently referred to patients in a degrading or demeaning manner.

The panel accepted Ms 5's evidence and found that Mrs Foley had referred to Patient H as 'mable the table' or words to that effect.

Accordingly, the panel finds this charge proved.

That you, whilst employed by Nursefinders Limited as a registered nurse:

> *12. On or around 23 April 2015, informed Nursefinders Limited that you had left Cornwallis Care Services Limited, your previous employer, on your own terms due to the treatment that you had received from management when you had in fact been dismissed by Cornwallis Care Services Limited for gross misconduct.*

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 6 and Mr 8.

Ms 6 confirmed that she had received the application from Mrs Foley's at Nursefinders.

The panel had regard to Mrs Foley's Nursefinders undated application form, in particular the employment history section where the applicant is asked 'position held, duties undertaken and reason for leaving'. It noted that in that section, Mrs Foley has stated *'unhappy with environment, working conditions'*.

The panel also considered Ms 6's Interview questions record dated 15 April 2015, where under the question "why are you leaving your current employer", she had documented *'already left. Hostile environment'.*

The panel considered that although the charge suggests that Mrs Foley informed Nursefinders of her reasons for leaving Cornwallis Care Home on 23 April 2015, she was in fact interviewed on 15 April 2015 and would have completed her application form before that date. The panel noted that the 23 April 2015 is the date that Mrs Foley started her work at Nursefinders. It is satisfied that the wording of the charge covers the relevant period of time of when Mrs Foley informed Nursefinders of her reason for leaving Cornwallis.

The panel heard from Mr 8 who confirmed that Mrs Foley had been told at the disciplinary hearing on 17 March 2015 and in writing thereafter that she had been dismissed for gross misconduct.

The panel found that in her application form Mrs Foley had cited working conditions and environment as her reason for leaving her previous employment at Cornwallis Care Services Ltd and had maintained this reason at her interview. It considered that she had numerous opportunities to inform Nursefinders that she had in fact been dismissed from her previous employer, and would be expected to do so, but she in fact had not informed them of the reason for her leaving, which was dismissal for gross misconduct.

Accordingly, the panel found this charge proved.

Charge 13

> *13. Your actions in relation to Charge 12 were dishonest, in that you intended to conceal the fact that you had been dismissed for gross misconduct from Nursefinders Limited*

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 6 and Mr 8.

Mr 8 told the panel that Mrs Foley was informed of her dismissal from Cornwallis Services Ltd on 17 March 2015. He stated that she would have been in no doubt that she had been dismissed. He further explained that in response to being informed of the dismissal, Mrs Foley apologised, which demonstrates her understanding that she knew she was being dismissed for gross misconduct. Mrs Foley was also informed of the decision in writing and sent notes of the disciplinary hearing of the 17 March 2015.

Ms 6 told the panel that Mrs Foley did not inform Nursefinders that she was dismissed from her previous employers Cornwallis Services Ltd. The panel believed Ms 6's evidence. It considered that Mrs Foley had had numerous opportunities to inform Nursefinders of her dismissal from Cornwallis. The panel noted the documentary

evidence of the application form and interview note of Nursefinders and found that Mrs Foley had given other reasons for her leaving Cornwallis in an attempt to conceal the fact that she had in fact been dismissed for gross misconduct.

Therefore in considering all the evidence, the panel found that Mrs Foley had been dishonest, and had intended to conceal the fact that she had been dismissed for gross misconduct from Nursefinders Limited. Mrs Foley was specifically asked her reason for leaving Cornwallis in her application form and in interview by Nursefinders, and she would have known that the dismissal was relevant and that she had a duty to disclose information about the dismissal at that stage. The panel also noted that it was only one month before being interviewed by Nursefinders, that Mrs Foley had been dismissed from Cornwallis, therefore the dismissal would have been fresh in her mind.

In light of the evidence, the panel found that Mrs Foley would have known she was being dishonest in not declaring her dismissal to Nursefinders and in giving other reasons for leaving.

Accordingly, the panel finds this charge proved.

Charge 14

> *14. Between 23 April 2015 and 1 October 2015, did not inform Nursefinders Limited that you were being investigated by the Nursing and Midwifery Council ("NMC")*

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 6.

The panel noted that Mrs Foley was informed of the Nursing and Midwifery Council's investigation on 11 May 2015.

The panel had regard to the letter by Ms 6 dated 5 October 2015 where she states:

"Yvonne disclosed during a telephone conversation with myself on 1/10/2015 that she was being investigated by the NMC. She expressed she thought it was her previous employers who had instigated the investigation and said "they are being spiteful – this is what they are like".

In evidence Ms 6 further confirmed that Foley did not disclose to Nursefinders that she was being investigated by the NMC until 1 October 2015.

The panel considered that as a registered nurse of over ten years' experience, Mrs Foley would have known that she had a duty to inform her employer that she was subject to an NMC investigation.

In considering all the evidence, the panel found that between 23 April 2015 and 1 October 2015, Mrs Foley had not informed Nursefinders Limited that she was being investigated by the NMC.

Accordingly, the panel found this charge proved.

Charge 15

15. Your actions in relation to Charge 14 were dishonest in that you intended to conceal that you were being investigated by the NMC from Nursefinders Limited

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 6.

Ms 6 informed the panel that Mrs Foley had not disclosed the NMC investigation to Nursefinders until 1 October 2015.

The panel found in relation to charge 14 that Mrs Foley would have known that she had a duty to disclose to Nursefinders that she was under investigation by the NMC.

The panel noted that Mrs Foley has not proffered any explanation for her late disclosure of the NMC investigation.

In considering all the evidence, the panel found that there is no other reasonable explanation for Mrs Foley's late disclosure to Nursefinders, other than that she was being dishonest and intended to conceal that she was being investigated by the NMC.

Accordingly, it finds this charge proved.

That you, whilst employed by Amberley Care Home as a registered nurse:

Charge 16

16. On 30 September 2015 between the hours of 07.45 and 21.15 and in relation to Patient I, you failed to do the following:

16.1 change the dressing on the PEG feed site of the patient; or alternatively

This charge is found proved.

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 7.

Ms 7 told the panel that when she left the shift on the morning of the 30 September 2015, she had informed Mrs Foley that Patient I's dressing needed to be changed after she had been showered. Ms 7 stated that Mrs Foley was responsible for Patient I on 30 September 2015 during the day time and that when Ms 7 returned in the evening Mrs Foley had not changed the dressing and informed her of the same. Ms 7 also told the panel of the adverse impact that Mrs Foley's failure to change Patient I's dressing had had on the patient in that her skin had become excoriated in that area.

The panel believed Ms 7's evidence and found that Mrs Foley did have a duty to change Patient I's dressing even though the patient had not had a shower. Mrs Foley had been advised of the need for Patient I to have her dressing changed and was the nurse in charge of the shift.

Therefore, in considering all the evidence, the panel found that Mrs Foley had failed to change Patient I's dressing on 30 September 2015 as required.

Charge 16.2

16.2 did not delegate changing the dressing on the patient's PEG feed site to another member of staff

This charge was not considered

In the light of its findings in charge 16.1 the panel did not consider it necessary to consider 16.2.

Charge 16.3

16.3 record that you had not changed the dressing on the patient's PEG feed site

This charge was found proved

In reaching this decision, the panel took into account all the written and oral evidence, in particular that of Ms 7.

Ms 7 told the panel that Mrs Foley had a duty to record that she had not changed Patient I's dressing and her reasons for not doing so. Ms 7 confirmed that there was no record of Patient I's dressing being changed.

The panel had regard to the Wound Assessment Chart and the Amberley House Daily Comment Sheet which both confirms that Mrs Foley did not change Patient I's dressing on her PEG feed site as there is no entry on 30 September 2015 where Mrs Foley should have recorded her actions.
The panel noted that the Daily Comment Sheet's sheet shows that Ms 7 changed Patient I's dressing on 29 September 2015 and on 30 September 2015 and no one changed it in between.

The panel found that it was Mrs Foley's responsibility to change Patient I's dressing on 30 September 2015 whilst she was the nurse on duty. It further found that there was no evidence of Mrs Foley having changed Patient I's dressing as required.

Accordingly, the panel finds this charge proved.

Submission on misconduct and impairment:

Having announced its finding on all the facts, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Foley's fitness to practise is currently impaired. The NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

Ms Imambaccus, invited the panel to find that Mrs Foley's actions amounted to serious misconduct and fell far below what is expected of a registered nurse. She highlighted that the misconduct was wide ranging and occurred in three different places of employment affecting a number of vulnerable patients.

In her submissions, Ms Imambaccus invited the panel to take the view that Mrs Foley's actions as charged in 1 - 11 amounted to breaches of *The Code: Standards of conduct, performance and ethics for nurses and midwives 2008* (*"the 2008 Code*") and that Mrs Foley's actions as charged in charges 12 – 16 amounted to breaches of *The Code: Professional standards of practice and behaviour for nurses and midwives 2015 ("the 2015 Code")*. She then directed the panel to specific paragraphs and identified those which, in the NMC's view, Mrs Foley had breached, and which amounted to misconduct.

Ms Imambaccus then moved on to the issue of impairment, and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and uphold proper standards and uphold public confidence in the profession and in the NMC as a regulatory body. Ms Imambaccus referred the panel to the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).*

Ms Imambaccus highlighted that there has been no engagement from Mrs Foley and that the panel may wish to consider the partial admissions Mrs Foley had made to some of the charges during the local disciplinary hearing as evidence of insight.

Ms Imambaccus submitted that there was no evidence of remediation, remorse or insight from Mrs Foley. She added that the incidents of misconduct were repeated in different contexts and therefore the panel may find that there is a real risk of repetition. Ms Imambaccus told the panel that Mrs Foley had made a number of clinical errors, neglected patients, failed to identify patient deterioration and had demonstrated an unacceptable attitude towards the health and wellbeing of both patients and her colleagues. She submitted that Mrs Foley's actions would undermine confidence in the profession.

The panel has accepted the advice of the legal assessor who referred to the cases of *Roylance v GMC (No. 2) [2000] 1 AC 311*, *Calhaem v GMC [2007] EWHC 2606 (Admin)* and *Walker v Bar Standards Board [2013] PC 2011/0219.*

The panel adopted a two-stage process in its consideration. First, the panel had to determine whether the facts found proved amounted to misconduct. Secondly, only if the facts found proved amounted to misconduct, did the panel then have to decide whether, in all the circumstances, Mrs Foley's fitness to practise is currently impaired as a result of that misconduct.

Decision on misconduct

In determining whether the facts found proved amount to misconduct the panel had regard to the terms of the Codes.

The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

The panel was of the view that Mrs Foley's actions fell significantly short of the standards expected of a registered nurse, and that her actions amounted to breaches of the Code. The panel found that the following parts of the preamble for the 2008 Code are applicable in this case:

> *"The people in your care must be able to trust you with their health and wellbeing*
>
> *To justify that trust, you must:*
>
> *• make the care of people your first concern, treating them as individuals and respecting their dignity*
>
> *• work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community*
>
> *• provide a high standard of practice and care at all times*
>
> *• be open and honest, act with integrity and uphold the reputation of your profession.*
>
> *As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions*."

The panel considered that in respect to charges 1 – 11 the following standards of the 2008 Code were engaged:

> ***1*** *You must treat people as individuals and respect their dignity.*
>
> ***2*** *You must not discriminate in any way against those in your care.*
>
> ***3*** *You must treat people kindly and considerately.*
>
> ***24*** *You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues.*
>
> ***27*** *You must treat your colleagues fairly and without discrimination.*

42 *You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.*

48 *You must demonstrate a personal and professional commitment to equality and diversity.*

61 *You must uphold the reputation of your profession at all times.*

The panel considered that in respect to charges 12- 16 the following standards of the 2015 Code were engaged:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Foley's actions were a serious departure from the standards expected of a nurse. It considered that Mrs Foley's clinical conduct fell into the following categories namely;

- administration of medication and timing
- neglecting patients
- failing to identify deterioration in patients
- unacceptable attitude towards patients and colleagues

The panel also took into account the dishonesty charges in respect of the attempts to conceal the real reasons for leaving her previous employer and her subsequent referral to the NMC.

The panel found that Mrs Foley's actions were serious and affected a number of particularly vulnerable patients some of whom suffered actual harm as a result of her failings. Furthermore the panel noted that Mrs Foley's misconduct was wide-ranging and repeated in a number of places of employment over a sustained period of time. It considered that the incidents concerned issues which go to the heart of the fundamental tenets of the nursing profession. The panel was of the view that, in all the circumstances, Mrs Foley's actions amounted to serious misconduct and that she failed to declare and uphold proper standards of care and propriety.

Decision on impairment

The panel next went on to decide if as a result of the misconduct Mrs Foley's fitness to practise is currently impaired. In doing so the panel accepted the advice of the legal assessor who referred it to the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).*

The panel was mindful that nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries and to act with honesty and integrity. Patients and their families must be able to trust nurses to make their health and wellbeing their priority. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' trust and public's trust in the profession. In this regard the panel considered the judgement of Mrs Justice Cox in the case of *Council for Healthcare Regulatory Excellence* v *(1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) in reaching its decision, in paragraph 74 she said:

> *In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the*

public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.

Mrs Justice Cox went on to say in Paragraph 76:

I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a. *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
b. *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
c. *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
d. *has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

The panel found that limbs a – d are engaged as to the past and as to the future. The panel's reasons are as follows.

In relation to limb a, the panel finds that Mrs Foley's conduct caused actual harm to patients B and I.

In relation to limb b, the panel is satisfied that Mrs Foley brought the nursing profession into disrepute by her actions and in particular her discriminatory behaviour towards patients and colleagues.

In relation to limb c, the panel is satisfied that Mrs Foley has breached a number of the fundamental tenets of the nursing profession; Mrs Foley's honesty and integrity has been called into question. The panel finds that not only was her behaviour repeated over a long period of time, but that such behaviour compromised the safety of patients. The panel considers this to be a serious departure from the standards expected of a Registered Nurse. The panel finds that such conduct undermines the function of the NMC as a Regulator, whose primary function is to protect the public.

The panel finds that limb d is engaged. In its findings on facts, the panel determined that Mrs Foley had acted dishonestly. Her cause of conduct was clearly deliberate in that she was fully aware that she had been dismissed and that she was under investigation by the NMC yet she did not inform the agency Nursefinders of her previous dismissal for gross misconduct or of the NMC investigation until it was discovered in October 2015.

In considering whether Mrs Foley's conduct is likely to be repeated in the future, the panel took into account any evidence of her insight, remorse and remediation.

The panel took into account the very limited engagement from Mrs Foley with respect to the NMC fitness to practice proceedings and the fact that she has not provided any evidence of insight, remorse or remediation.

In terms of remediation, the panel accepted that whilst the clinical misconduct may be remediable it is more difficult to remediate dishonesty. It noted that there was no evidence before it of any attempts by Mrs Foley to remediate her other failings despite opportunities to do so.

The panel had regard to Mrs Foley's responses during the Peninsula Community Health investigation meeting held on 21 December 2012 and during the disciplinary hearing at Cornwallis Nursing Home on 17 March 2015. It considered that even when she admitted incidents of misconduct Mrs Foley expressed no remorse and neither did she apologie for her action or demonstrate an understanding of the seriousness of her behaviour and the impact it had on patients, her colleagues and the nursing profession.

In considering all of the above, the panel concluded that there is a significant risk in the future that Mrs Foley will put patients at risk of harm and display an unacceptable attitude towards patients and others. The panel therefore determined that a finding of impairment is necessary on the ground of public protection.

The panel went on to consider whether a finding of impairment was also necessary in the wider public interest. The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding proper professional standards for members of those professions. Mrs Foley's actions were serious and in some cases dishonest and caused harm in certain cases to patients. In so doing she brought her profession into disrepute and breached the fundamental tenets of the nursing profession.

The panel determined that, in this case, a finding of impairment on public interest grounds is required in order to uphold proper professional standards and maintain public confidence in the profession. There is a strong public interest in this case as Mrs Foley put vulnerable patients at significant risk of harm, was demeaning in her conduct towards patients and colleagues and dishonest to her employer. The panel finds that confidence in the profession and the NMC as regulator would be undermined should a finding of impairment not be made.

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

Determination on Interim Order

The panel concluded that the hearing would go part-heard at sanction stage on the afternoon of Friday 9 June 2017. It therefore invited submissions on an interim order.

The hearing will reconvene on 17 July 2017.

The panel considered the submissions made by Ms Imambaccus on behalf of the NMC, that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The panel accepted the advice of the legal assessor. It has also had regard to the NMC's guidance to panels in considering whether to make an interim order. The panel has taken into account the principle of proportionality, bearing in mind the interests of the public and your own interests.

The panel was satisfied that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. To do otherwise would be incompatible with its earlier findings.

The panel has determined to impose an interim suspension order for a period of 18 months or further order.

Resuming Hearing: 17 July 2017

Decision on Service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Foley was neither in attendance nor was she represented in her absence.

The panel was also informed that written notice of this hearing had been sent to Mrs Foley's address on the NMC register by recorded delivery and by first class post on 16 June 2017. The Track and trace indicates that the notice was delivered and signed for on the 17 June 2017 and there has been no email correspondence from Mrs Foley since then.

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

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mrs Foley had been served with notice of this hearing in accordance with Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules"). It noted that the rules do not require delivery and that it is the responsibility of any registrant to maintain an effective and up to date registered address.

Decision on proceeding in the absence of the Registrant

The panel had regard to Rule 21(2)(b) which states:

> *"Where the registrant fails to attend and is not represented at the hearing, the Committee...may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant...*"

Ms Caslin reminded the panel that its discretion 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. She invited the panel to proceed in the absence of Mrs Foley on the basis that she had voluntarily absented herself. Ms Caslin submitted that there has been minimal engagement from Mrs Foley with the NMC in relation to these

proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that it's discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 and took account of the guidance given in the case of *Adeogba v GMC* [2016] EWCA Civ 162.

In reaching its decision, the panel considered the submissions of the case presenter, and the advice of the legal assessor. It had regard to the principles set out in the decision of *Adeogba*, and to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Foley's engagement with the NMC had been minimal and that she had not responded to any of the letters sent to her about this hearing;
  Mrs Foley had sent a clear message prior to the hearing of 5 - 9 June 2017 stating expressly her intention to disengage from these proceedings;
- no application for an adjournment had been made by Mrs Foley;
- there was no reason to suppose that adjourning would secure her attendance at some future date;
- a finding of impairment has been made with respect to the charges against Mrs Foley and a copy of the decision was sent to her shortly afterwards;
- there is a strong public interest in the expeditious disposal of this case.

The panel had regard to the fact that there could be some disadvantage to Mrs Foley in proceeding in her absence. She would not be able to give evidence on her own behalf. However, in the panel's judgment, Mrs Foley has had ample opportunity to provide any further evidence she may wish the panel to consider.

In these circumstances, the panel decided that it would be fair, appropriate and proportionate to proceed in the absence of Mrs Foley. The panel determined to draw no adverse inference from her absence in reaching its decision on sanction.

Determination on sanction:

Having determined that Mrs Foley's fitness to practise is currently impaired, the panel considered what sanction, if any, it should impose in relation to her registration.

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case. The panel heard the submissions of Ms Caslin.

Ms Caslin invited the panel to consider all the sanctions available. She referred the panel to the NMC's Indicative Sanctions Guidance ("ISG") and submitted that sanction was a matter for the panel's own judgement. She invited the panel to consider the aggravating and mitigating factors in this case, some of which she detailed. She further commended the judgement in the case of *Ali Abbas v General Medical Council [2017] EWHC 51 (Admin)* for the panel's consideration.

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel took account of the ISG and the need to protect the public as well as the wider public interest. This includes maintaining public confidence in the profession and the regulatory process, and declaring and upholding proper standards of conduct and behaviour. The panel applied the principle of proportionality, weighing the interests of the public with Mrs Foley's interests, and carefully considered the mitigating and aggravating factors in this case. It acknowledged that in deliberating on sanction it should start with the least restrictive sanction and work upwards where appropriate. The panel also bore in mind that the purpose of a sanction was not to be punitive, although it might have that effect. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The aggravating factors which the panel found to be present were as follows:

- The misconduct was wide-ranging and involved actual harm to two vulnerable patients and posed a potential risk of harm to a number of other patients;
- The misconduct was sustained over a three year period, involving seven patients, two colleagues and three employers;
- Mrs Foley's dishonest conduct was repeated and indicative of deep-seated attitudinal problems;
- The misconduct also involved racial remarks made to a colleague whilst at work;
- Mrs Foley has demonstrated no insight and no remorse into the potential gravity of her actions;
- There is no evidence of remediation;
- Mrs Foley's actions represented a course of conduct which was persistent and adversely affected patients, colleagues and the wider public.

The mitigating factors which the panel found to be present were these:

- There was no evidence that Mrs Foley had previously, or has subsequently, been the subject of any adverse regulatory proceedings during her career;
- She made partial admissions in respect of some the charges during the local disciplinary hearing;

The panel then went on to consider what, if any, sanction was appropriate in this case.

The panel first considered taking no action. Mrs Foley's misconduct warrants the imposition of a sanction to mark her serious departure from the professional standards set out in the NMC Code and to protect the public and the wider public interest. In addition to the risk of repetition identified in its findings on impairment, the panel has concluded that the facts in this case were far too serious for it to take no action.
The panel then considered whether a caution order would be appropriate. It took into account the relevant paragraphs of the ISG. It bore in mind that a caution order would not impose any restriction on Mrs Foley's practice rights. The panel has determined that

the misconduct in this case was at the higher end of the spectrum of impaired fitness to practise. In all the circumstances, the panel concluded that a caution order would not be sufficient to protect the public as there is a real risk of repetition and a need to uphold proper professional standards and to maintain public trust and confidence in the nursing profession and the efficacy of its regulation.

The panel next considered the imposition of a conditions of practice order. It noted the factors set out in the relevant paragraphs of the ISG which indicated when such an order might be appropriate - in particular where identifiable areas of nursing practice required assessment or retraining. There are several identifiable areas of Mrs Foley's practice which might be capable of being addressed by such an order, in particular the issues concerning the administration and recording of medication. However, the dishonesty is indicative of a deep-seated attitudinal problem which would not be easily addressed by imposing conditions. As there has been limited engagement by Mrs Foley, no evidence of insight and no evidence of willingness on her part to engage or comply with possible conditions, the panel was not satisfied that the nature of the misconduct found in this case could properly be addressed by such an order. Taking all these factors into account, no conditions of practice could be devised which would be relevant, proportionate, workable and measurable, or sufficient to protect the public. Accordingly, the panel determined that a conditions of practice order would not be an appropriate or proportionate sanction.

The panel then went on to consider whether a suspension order was an appropriate and proportionate order to impose. In so doing, the panel took account of the guidance in the ISG, in particular, paragraphs 36-38, which deal with the issue of dishonesty, and paragraphs 66-70, which deal with relevant factors to bear in mind when considering whether to impose a suspension order.

The panel is mindful that the misconduct identified was not isolated. It amounted to a number of wide-ranging failings by Mrs Foley involving patients and colleagues, in different settings over a period of three years. Mrs Foley's dishonest conduct was repeated and her behaviour towards patients and colleagues is in the panel's view, indicative of a deep-seated attitudinal problem which resulted in distress and harm to two vulnerable patients and a colleague. The misconduct also involved failings in basic

areas of nursing practice, such as the failure to escalate a deteriorating patient, administer medication and maintain accurate records.

Mrs Foley has expressed no remorse for her actions, nor has she demonstrated insight. She has persistently refused to accept responsibility for her actions and has sought to deflect blame to others. In the circumstances, the panel is concerned that she poses a significant risk of repeating her misconduct. Although there is no information before the panel to suggest a repetition since these incidents, the panel had regard to the length of time in which the misconduct occurred which suggests a pattern of behaviour on the part of Mrs Foley and a lack of insight, a failure to accept responsibility and a tendency to deflect blame.

The panel has borne in mind that honesty, integrity and trustworthiness are considered to be the bedrock of any nurse's practice. It has also borne in mind that dishonesty is particularly serious because it can undermine the trust the public place in the profession. Mrs Foley has not engaged in these proceedings or provided evidence to the panel that she acknowledges that she behaved dishonestly and has given no assurances that there would be no repetition of this behaviour in future.

The panel also had regard to the case of *Ali Abbas v General Medical Council [2017] EWHC 51 (Admin)* in particular the following:

> *49 "As the authorities I have cited make clear, where, as in this case, there has been persistent dishonesty, erasure is a likely sanction. It may be otherwise if there is insight or some other combination of circumstances which would mean a lesser sanction would be appropriate. However, as Mr Mant said, in the present case the Tribunal found that the Appellant lacked any insight into his errors. Putting the matter at its lowest, I could not possibly say that erasure was not a sanction open to the Tribunal. The Appellant argued that there may be different degrees of wrongdoing, meriting different levels of sanction. Of course that is right. It is also right, as the Tribunal acknowledged, that the Appellant was previously of good character. However, on the findings that the Tribunal made and was entitled to come to, he had been dishonest, not just on one occasion,*

but on a number of them and over a considerable period. He had dishonestly misled the IOP and he had dishonestly breached conditions on his registration. In those circumstances, it would have been surprising if the Tribunal had concluded that a lesser sanction than erasure was appropriate".

Balancing all the above factors, the panel concluded that a suspension would be insufficient to protect the public and satisfy the public interest in the maintenance of public confidence in the nursing profession and the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

The panel has concluded that Mrs Foley's actions, her persistent dishonesty, lack of insight into the seriousness of her actions, coupled with her attitude and failure to accept any responsibility, is fundamentally at odds with her remaining on the NMC register. Her conduct is a serious departure from the relevant professional standards as set out in the Code. Her conduct caused harm to vulnerable patients and colleagues and her actions have seriously undermined the public's trust and confidence in the profession. In these circumstances, the panel has determined that the only appropriate and proportionate sanction that is sufficient to protect the public and satisfy the public interest is a striking-off order. The panel is satisfied that this sanction is necessary to mark the serious nature of Mrs Foley's misconduct, to maintain public confidence in the profession, and to send a clear message to the public and the profession about the standards expected of a registered nurse.

The panel was mindful of the potential impact that such an order would have on Mrs Foley. However, taking full account of the important principle of proportionality, the panel was of the view that the interests of the public outweighed Mrs Foley's interest.

The effect of this order is to remove Mrs Foley's name from the NMC Register. She may not apply for restoration until five years after the date that this order takes effect.

Unless subject to an appeal, this sanction will take effect 28 days from the date this decision is deemed to have been served upon Mrs Foley.

Decision and reasons on interim order:

The panel considered in accordance with Article 31(2) of the *Nursing and Midwifery Order 2001* whether an interim order should be imposed. The panel considered the submissions made by Ms Caslin, on behalf of the NMC, who sought an interim suspension order for a period of 18 months on the grounds of public protection and being otherwise in the public interest to allow for the 28 day appeal period and also to allow time for the possibility of any appeal to be lodged and determined.

The panel accepted the advice of the legal assessor. The panel has taken account of the guidance issued to panels by the NMC when considering interim orders and the appropriate test as set out at Article 31(2) of the *Nursing and Midwifery Order 2001.*

Having borne in mind its decision to impose a striking-off order, the panel is satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest in order to maintain public confidence in the profession and the regulatory process.

The panel has accordingly decided to make an interim suspension order. In reaching its decision, the panel had regard to the seriousness of the misconduct and the reasons outlined in its decision to make a striking-off order. To do otherwise would be inconsistent with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined. If no appeal is made then the 18 month interim suspension order will be replaced by the striking-off order 28 days after the decision of this hearing is deemed to have been served on Mrs Foley. If Mrs Foley does lodge an appeal, the 18 month interim suspension order will continue to run for the period imposed or until the appeal is decided.

This decision will be confirmed to Mrs Foley in writing.

That concludes this determination.