Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

23 April – 7 June 2019 & 17 June – 31 July 2019

4 – 5, 7 – 8, 14 – 15, 18 – 21 & 25 – 28 November 2019

6 – 10 & 13 – 17 January 2020

10 – 14 February 2020

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

Name of registrant:	Helen Lockett
NMC PIN:	79B1258E
Part(s) of the register:	Registered Adult Nurse – July 1982 Registered Specialist Community Public Health Nurse – September 1993 Lecturer / Practice Educator – February 1998
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Emma Boothroyd (Chair, Lay member) Kitty Lamb (Registrant member) Eileen Skinner (Lay member)
Legal Assessor:	Nigel Mitchell
Panel Secretary:	Caroline Pringle
Ms Lockett:	Present and represented by Mary-Teresa Deignan, instructed by the RCN
Registrant B:	Present and represented by Leila Chaker, instructed by the RCN

Registrant C:	Present and represented by Claire Robinson, instructed by the RCN
Registrant D:	Present and represented by Anna Chestnutt, instructed by the RCN
Nursing and Midwifery Council:	Represented by Michael Collis, Case Presenter
Facts proved:	2(a), 2(b), 2(c), 2(d), 2(e), 2(f), 2(g), 2(h), 3(a), 3(b), 3(c), 3(f)(ii), 4(a), 5(b)(i), 5(b)(ii), 5(c), 5(d), 6(b), 7(a), 7(b), 7(c), 7(d), 9(a), 9(c), 9(d), 9(g), 9(h), 9(i), 10(a), 10(b), 10(c), 10(d), 11(c) and 12(b)
Facts not proved:	1(a), 1(b), 1(c), 3(d), 3(e), 3(f)(i), 4(b), 4(c)(i), 4(c)(ii), 5(b)(iii), 5(b)(iv), 5(e), 6(a), 8, 9(b), 9(e), 9(f), 11(a), 11(b) and 12(a)
No case to answer:	5(a)(i) – 5(a)(iv)
Fitness to practise:	Impaired
Sanction:	Suspension order (12 months)
Interim Order:	Interim suspension order (18 months)

Details of charge (as amended)

That you, a Registered Nurse, whilst employed by Liverpool Community Health NHS Trust ("the Trust") as Director of Operations and Executive Nurse between 7 March 2011 and 2 May 2014:

1. Failed to ensure an adequate Quality Impact Assessment ("QIA) process was followed in respect of Cost Improvement Plans ("CIPs") for:

    (a) Community District Nursing Services ("CDNS");

    (b) Intermediate Bed Based Care Services ("IBBCS");

    (c) Healthcare services at HMP Liverpool ("the Prison").

    [Charges 1(a) – 1(c) found NOT proved]

2. In relation to CDNS, failed to take adequate action in respect of:

    (a) Reports of inadequate staffing;

    (b) Reports that mandatory and non-mandatory training was not being completed by staff;

    (c) Reports of difficulties in obtaining equipment;

    (d) Reported concerns about the management of pressure care relief;

    (e) Reported concerns about medication administration;

    (f) Reported increase in complaints between March and September 2011;

(g) Colleague A's assessment that the service had a risk rating of around 20 in or around October and/or November 2011 [or 2012];

(h) Reported concerns in respect of the transfer, admission and discharge of patients between the acute setting, IBBCS and the CDNS.

[Charges 2(a) – 2(h) found proved]

3. In relation to the IBBCS, failed to take adequate action in respect of:

(a) Reported inadequate staffing;
[Found proved]

(b) Reported increase in the level of acuity of patients;
[Found proved]

(c) Reported concerns in respect of the transfer, admission and discharge of patients between the acute setting, IBBCS and the CDNS;
[Found proved]

(d) Reported inadequate investigation and/or root cause analysis and/or lessons learned procedures following reported incidents;
[Found NOT proved]

(e) Lack of reporting of incidents;
[Found NOT proved]

(f) Reported risk rating for the IBBCS of around 20 in or around:
(i) September and/or October ~~2102~~ [2012]; **[Found NOT proved]**
(ii) December 2012 **[Found proved]**

4. Attempted to minimise the concerns in respect of CDNS and/or IBBCS by:

(a) Instructing Colleague A not to share further the contents of the District Nursing Complaints and Incident Report, dated 2 November 2011;
[Found proved]

(b) Attempting to reduce and/or influence the risk rating for CDNS from around 20 to around 9 in or around October and/or November 2011 [or 2012];
[Found NOT proved]

(c) Attempting to reduce and/or influence the risk rating for the IBBCS from around 20 to a lower level in or around:

(i) September and/or October ~~2102~~ [2012]; **[Found NOT proved]**

(ii) December 2012 **[Found NOT proved]**

5. In relation to the healthcare services provided to the Prison, you:

(a) Failed to ensure the Serious Untoward Incident reports/investigations were conducted following deaths in custody in respect of one or more patients, including:

(i) Patient A; and/or

(ii) Patient B; and/or

(iii) Patient C; and or

(iv) Patient D

[No case to answer]

(b) Failed to ensure adequate escalation and/or adequate action was taken following concerns raised by the Prison and Probation Ombudsman

reports following deaths in custody in respect of one or more patients, including:

(i) Patient A; and/or **[Found proved]**

(ii) Patient B; and/or **[Found proved]**

(iii) Patient C; and or **[Found NOT proved]**

(iv) Patient D **[Found NOT proved]**

(c) Failed to ensure appropriate standards of care for patients was maintained at the Prison;

[Found proved]

(d) Failed to take adequate action in respect of concerns regarding:

(i) Inadequate care being provided to patients;

(ii) Inadequate care planning for patients;

(iii) Inadequate risk assessments for patients;

(iv) Inadequate record keeping;

(v) Poor medicines management and/or medicines administration;

(vi) Inadequate health screening/assessments and/or secondary health checks for new and/or returning patients;

(vii) Insufficient staffing levels

[Charges 5(d)(i) – 5(d)(vii) found proved]

(e) Or, alternatively to Charge 5d, took insufficient steps to ensure that you were aware of one or more of the concerns set out at (i) – (vii) above.

[Found NOT proved]

6. Failed to take adequate action in respect of an alleged sexual assault and/or hostage-taking of a member of staff, which occurred on or around 6 March 2013, in that you:

(a) Failed to ensure that a Root Cause Analysis Investigation was undertaken;

[Found NOT proved]

(b) Failed adequately to escalate the incident to your superiors and/or the Board and/or the police and/or other relevant external agencies.

[Found proved in relation to failing to escalate to the Board only]

7. Following receipt of a record of your 29 January 2014 interview with [Ms 18], amended the record to state the following:

(a) "*I do not wish representation as I am in the RCN which is the same union as [Colleague A] and I feel that I cannot be appropriately represented by the union as an executive*";

[Found proved]

(b) "*I got upset by how upset she was, and said to her "don't go, let's talk about this*"";

[Found proved]

(c) "*Because her work is her identity. We should be supporting her to come back to work when she is well enough but I don't think this grievance is anything about coming back to work. It must be untenable now for her to come back to work*";

[Found proved]

(d) "*I am sorry I have upset [Colleague A]. I value her skills and want to do anything to support her return to work. I would be happy to have facilitation or a mediated meeting if it would help*."

[Found proved]

8. Your actions as set out in Charges 7a – 7d were dishonest, in that you intended to mislead individuals reviewing the interview record as to the statements you made during the 29 January 2014 interview with [Ms 18].
[Found NOT proved]

9. Bullied and/or intimidated Colleague A, in that you:

a) In or around May 2011, stated to Colleague A words to the effect that she was no longer needed and/or that you did not want her on your team;
[Found proved]

b) On one or more occasions, left post-it notes in Colleague A's office criticising her and/or her work;
[Found NOT proved]

c) On one or more occasions, subjected Colleague A to excessive questioning and criticism during service performance meetings;
[Found proved]

d) On or around 17 November 2011, made comments to the effect that Colleague A:
    (i) Was a big disappointment;
    (ii) Had wasted 35 years of her life in the nursing profession;
    (iii) Had sent e-mails that showed she was illiterate;
    (iv) Was incapable of doing her job.
[Charges 7(d)(i) – 7(d)(iv) found proved]

e) [PRIVATE]
[Found NOT proved]

f) On an unknown date, took off a set of beads that you had been wearing and threw them at Colleague A;

[Found NOT proved]

g) On or around 13 September 2013, you raised your voice and/or shouted at Colleague A words to the effect of, "*See this is what you do. You expose me at the Board, I am always going to the Board finding out things you haven't told me about*";

[Found proved]

h) On or around 22 April 2013, when Colleague A raised a concern about another colleague attending an inquest into Patient C's death without support, stated words to the effect of, "*I know, as usual [Colleague A], you are going off on one"*;

[Found proved]

i) On or around 4 October 2013, telephoned Colleague A and caused her to leave a meeting, and then informed Colleague A that she would be coached by another colleague in respect of her report writing.

[Found proved]

10. Bullied and/or intimidated Colleague B, in that you:

(a) Following an interview you conducted with Colleague B on 30 March 2011, fed back to him that his performance was at such a low level that you had concerns about his ability to undertake his current position;

[Found proved]

(b) On one or more occasions, subjected Colleague B to excessive questioning and criticism during service performance meetings;

[Found proved]

(c) In or around March – April 2013, in relation to the Trust moving to a new headquarters, stated to Colleague B that there was no room for him at the new building and/or that you wanted him out of sight, or words to that effect;

[Found proved]

(d) On or around 27 April 2013, stated to Colleague B at a meeting about his dissertation, words to the effect that:

(i) The Board had lost trust and confidence in his work;

(ii) He had three options; to undergo a disciplinary process which would end with the Trust firing him; to complete a capability process, which again would end with the Trust firing him; or that he could resign and find another job;

[Found proved]

11. Bullied and/or intimidated Colleague C, in that you:

(a) On or around 9 July 2013, suspended Colleague C without providing an adequate explanation as to what allegations had been made against her;

[Found NOT proved]

(b) Between July – October 2013, stated to Colleague C, whilst she was suspended, words to the effect that:

(i) She had marital problems;

(ii) You had met with other staff on the wards and they had thanked you for removing Colleague C;

(iii) *"Don't worry, we don't have to prove you're guilty of anything, you just prove you're innocent of everything."*

[Found NOT proved]

(c) During a meeting in or around November 2013, when discussing a 27 October 2013 report into IBBCS, stated words to the effect that Colleague C had two options; to follow the disciplinary route, which was likely to end with her dismissal and referral to the NMC; or, alternatively, to be downgraded and transferred to another role.

[Found proved]

12. Bullied and/or intimidated Colleague D, in that you:

(a) In or around July 2013, suspended him without providing an adequate explanation as to what allegations had been made against him;

[Found NOT proved]

(b) At a meeting in November 2013, having still not identified the allegations, offered him the option of a demotion or a continuation of the disciplinary process.

[Found proved]

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

Application to amend the charges

Prior to the charges being read, Mr Collis made an application to amend charges 3(f)(i) and 4(c)(i) in order to correct a typographical error which appeared in both charges. The application was to amend '2102' to '2012' in both charges.

Ms Deignan, on your behalf, did not object to the application.

The panel was satisfied that this was an obvious typographical error and therefore allowed the application in respect of both charges.

Application for Ms 19 to give evidence via videolink

Mr Collis made an application for Ms 19 to give evidence via videolink. He informed the panel that Ms 19 was unable to attend the hearing in person due to her health and provided the panel with a letter from Ms 19's GP, dated 12 April 2019, and a summary of a consultation on 21 March 2019. The letter confirmed that Ms 19 is [PRIVATE] and unable to participate in a hearing. However, Mr Collis informed the panel that the NMC has been in contact with Ms 19 and she does feel able to participate remotely, by way of videolink.

Mr Collis summarised Ms 19's evidence and submitted that her evidence was relevant to the charges and provided a helpful overview of the management structure at the Trust.

The application was not opposed by your representative, nor by any of the other three registrants in this case.

The panel accepted the advice of the legal assessor, who referred it to Rule 31. Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He

further referred the panel to the cases of *Shodlok v GMC* [2013] EWHC 2280 (Admin) and *Polanski v Conde Nast Publications* [2005] 1 WLR 637.

The panel decided to allow the application. It was satisfied that Ms 19's evidence was relevant to the charges and there was a good reason for her being unable to attend in person, which was supported by medical evidence. The panel was also satisfied that it was fair for Ms 19 to be allowed to participate remotely. She is an important witness to these allegations and it is in the interests of justice that her evidence is heard.

Furthermore, the videolink will allow her to be seen and heard in the same way as if she were physically present in the room, and her evidence can still be tested by cross-examination.

In these circumstances, the panel was satisfied that it would be fair to allow Ms 19 to give evidence by video link.

It therefore allowed the application.

Decision and reasons on application under Rule 19

During Colleague C's evidence, Ms Deignan made an application to ask some questions in private, as they related to Colleague C's health and other personal issues. The application was made pursuant to Rule 19 of the Rules.

This application was not opposed.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having read Colleague C's witness statement, the panel was aware that there were parts of her evidence which related to her health and other sensitive personal matters. The panel was satisfied that Colleague C's right to privacy in relation to these matters outweighed the interest in a public hearing. The panel therefore determined to hold such parts of the hearing in private.

The panel later determined to hear parts of the evidence from other witnesses in private, for the same reasons.

Decision and reasons in relation to questions to be put to Ms 14

After Ms Deignan had finished cross-examining Ms 14 on your behalf, Mr Collis made submissions to the panel regarding a further question which, in his submission, ought properly to be put to Ms 14.

Mr Collis referred the panel to charge 9(e). He submitted that Colleague A had given evidence that she only disclosed her feelings at the time to you and one other person and therefore the only way that Colleague C and Ms 15 could have been aware of this was if you had told them. However, the penultimate sentence of paragraph 35 of Ms 15's statement states that she was told this by Colleague A.

Mr Collis submitted that during the course of Colleague A's cross-examination it became apparent that your defence to charge 9(e) was that no such conversation took place between you and Ms 15. Mr Collis submitted that, if you were intending to make such an assertion as part of your case, then a further question should be put to Ms 15 regarding whether you had discussed Colleague A with Ms 15.

Mr Collis further submitted that, even if the panel decided that Ms Deignan was not required to put the question, this would not necessarily prohibit the panel from asking.

Ms Deignan, on your behalf, opposed Mr Collis' submissions. She submitted that she was under a duty only to put your case to the witnesses, which she had done. She submitted that it was not her obligation to "plug gaps" in the NMC's evidence. Ms Deignan submitted that for the question to be put to Ms 15, either by her or the panel, would be unfair to you.

The panel took account of the submissions made by both parties and the legal advice given regarding the appropriateness of further questions around the issues raised in the penultimate sentence of paragraph 35 of Ms 15's witness statement.

The panel did not consider that it was incumbent on Ms Deignan to put the matter of a further conversation that you do not accept took place in any event.

The NMC has been aware of Colleague A's account of the conversation for some time and has taken no steps to ask these witnesses for further clarity. The panel considered that the NMC did not need to know your case for this matter to have been addressed in advance of this hearing with these witnesses.

The panel considered that it would be unfair for the panel to ask questions around matters that have not been raised or explored with this witness and which would not be asked for the purposes of clarification; rather, the panel would be embarking on a fishing expedition which would not be appropriate in these circumstances.

Application to adjourn the evidence of Mr 24

Mr 24 was scheduled to give evidence at this hearing on 25, 26 and 27 June 2019. On the morning of 25 June, Ms Chaker made an application, on behalf of Registrant B, to adjourn his evidence.

Ms Chaker informed the panel that a subject access request had been made to Mersey Care NHS Foundation Trust (who had taken over from Liverpool Community NHS Trust)

in advance of this hearing. At the time, Registrant B's representatives had been informed that no documents existed which matched their search criteria. However, last week the NMC received additional material obtained from Mersey Care, via a Freedom of Information request made by a third party. As a result of this material, Registrant B's representatives renewed their original subject access request and this morning were informed that in fact 1500 items of data exist which match the requested search criteria.

Ms Chaker submitted that this data may be of significant importance to Registrant B's defence and contain matters which ought to be put to Mr 24. She therefore made an application that she not be compelled to start her cross-examination of Mr 24 until she had had a chance to receive and review this data. Ms Chaker informed the panel that she had not yet received the data, as Mersey Care were required to undertake a redaction process for data protection reasons before they could disclose the information. She therefore requested that Mr 24's evidence be postponed until 09:30 the following morning (26 June) in order for further enquiries to be made.

Ms Deignan and Ms Robinson, on your behalf and that of Registrant C, respectively, supported the application to postpone until 09:30.

Ms Chestnutt, on behalf of Registrant D, opposed the application to postpone Mr 24's evidence.

Mr Collis, on behalf of the NMC, recognised that the original request was made to Mersey Care in good time and was sympathetic to Registrant B's current position. He submitted that, if the hearing was in a position to commence Mr 24's evidence at 10:00 the following morning, there was a realistic prospect of completing his evidence in the remaining allocated time and therefore postponing his evidence until 09:30 tomorrow should not cause significant delays to the hearing progress.

The panel considered the submissions made by the parties and the advice of the legal assessor. It noted that the original request had been submitted to Mersey Care in good

time and no fault could be attributed to any of the parties present for the current situation. It considered that it would be unfair to require Ms Chaker, or any of the other advocates, to commence cross-examination of Mr 24 without having had the opportunity to review this new information. It also bore in mind that Mr 24 was warned for another two days and, if the documentation could be obtained by tomorrow, then it may still be possible to conclude his evidence.

The panel therefore decided to adjourn the hearing until 09:30 the following morning (26 June 2019).

The next day Ms Chaker informed the panel that Registrant B's representatives had been in communication with Mersey Care; however the documentation had not yet been disclosed, nor did she have a time estimate for when this was likely to happen. However, she informed the panel that it had been confirmed that many of the 1500 items did relate to Mr 24 and were therefore likely to be of real significance to Registrant B's defence. Ms Chaker further submitted that, once she had received the documents, she estimated that she was likely to require a minimum of three working days to review the information and take instructions.

Ms Chaker therefore made an application to adjourn Mr 24's evidence until 8 July 2019 (when Mr 24 was next available to give evidence). Ms Chaker submitted that the intervening time could be put to good use preparing written submissions for the no case to answer application, which she intended to make once the NMC has closed its case.

Ms Robinson, on behalf of Registrant C, supported the application to adjourn Mr 24's evidence until 8 July and submitted that she also intended to make a no case to answer application and could use the time to prepare written submissions, which would minimise any delay at a later stage.

Ms Chestnutt, on behalf of Registrant D, did not oppose the application. She submitted that the time could be used to continue the process of agreeing facts with the NMC, which was already underway.

Ms Deignan, on your behalf**,** raised a number of concerns and possible prejudices which could be caused to you by the disclosure of this information and any consequent delays, but submitted that she could not start her cross-examination of Mr 24 until she knew the content of the documents.

Mr Collis, on behalf of the NMC, accepted that given the volume of material further delay was inevitable and did not oppose an adjournment of Mr 24's evidence until 8 July.

The panel accepted the advice of the legal assessor who referred it to Rule 32(4) which provides that a panel can adjourn a hearing at any stage providing it causes no injustice to any of the parties. He further advised the panel regarding the matters it should take into account when considering an application to adjourn. These include the public interest in the expeditious disposal of the case, the potential inconvenience caused to any of the parties, and fairness to the registrants.

The panel decided that it was fair to adjourn the evidence of Mr 24 until 8 July 2019. It noted that a delay at this stage was regrettable, but was through no fault of any of the registrants, nor the NMC. Registrant B knew this material existed and believed that it would be helpful to her defence, and the initial request was submitted in good time. Unfortunately she was incorrectly informed that it did not exist. Now that the information has come to light, the panel decided that it would be wholly unfair for Ms Chaker, or any of the other advocates, to compel them to cross-examine Mr 24 without first reviewing this new information. The panel was also reassured that the parties would use the adjourned period to prepare their no case to answer submissions, thereby saving time later on in the hearing. The panel recognised that an adjournment would require Mr 24 to return, and therefore cause him inconvenience. However, it was satisfied that, in

these particular circumstances, the proposed adjournment was proportionate and necessary to ensure fairness to Registrant B and the other registrants.

Application to adjourn proceedings until 18 July 2019

During the week's adjournment that was granted to secure further documents from the Trust, the panel was reconvened on 4 July 2019 to hear an application from Ms Deignan. This application was heard entirely in private**.**

[PRIVATE].

The panel rejected the application.

Application to admit a further document into evidence under Rule 31

Prior to closing the NMC's case, Mr Collis made an application to adduce an additional document into evidence. He informed the panel that, during the course of this hearing, the NMC had received a number of additional documents from a third party, obtained from the Trust via a Freedom of Information request. One of the documents, which the NMC now sought to admit into evidence, was an email sent by you on 4 May 2012 to a number of Trust staff (some of whom had been called as witnesses in this hearing).

Mr Collis informed the panel that the email related to CIPs and the vacancy control panel. He submitted it was therefore relevant to the charges in this case concerning CIPs and staff shortages. He submitted that the document supported the oral evidence given by witnesses and it did not introduce any new issues. He therefore submitted it would be fair to allow the NMC to introduce the document, particularly since it had recently been provided by a third party and was not a document that was available to the NMC previously.

Ms Deignan, on your behalf, opposed the application. She submitted that it would be unfair to admit it into evidence for a number of reasons and provided the panel with written submissions to this effect. Ms Deignan submitted that directions had been made prior to this hearing that the NMC would serve its proposed hearing bundle and case summary to each of the registrants by 14 November 2018, in order that the registrants could prepare their cases. Ms Deignan submitted that to introduce new evidence at this stage would 'radically' change the case against you and be unfair. She submitted that, if the panel allowed this email into evidence, then she may be required to recall some of the witnesses. She outlined to the panel the specific areas of questioning which would arise from this document.

Ms Deignan also submitted that it would be unfair to admit the email into evidence because, as it had been obtained by a third party and not through the NMC's investigation, the NMC had not had to go through the process of establishing if there was any further evidence which undermined its case or assisted yours.

Ms Chaker, on behalf of Registrant B, supported the NMC's application to adduce the email into evidence. She submitted that the email was directly relevant to the culpability of Registrant B, as well as that of Registrant C and Registrant D, in relation to managing staffing shortages and supported the oral evidence that had already been given by a number of witnesses.

Ms Robinson, on behalf of Registrant C, supported the NMC's application and adopted the submissions of Ms Chaker.

Ms Chestnutt, on behalf of Registrant D, was neutral on the application.

The panel accepted the advice of the legal assessor who referred it to Rule 31. Rule 31 provides that, so far as it is *'fair and relevant',* a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered the submissions and the advice of the legal assessor. It noted that the email concerned CIPs and the vacancy control panel. The panel was therefore satisfied that the email was directly relevant to charges 1, 2(a), 3(a) and 5(d)(vii), as faced by you, and charge 1(i) as faced by Registrant B, Registrant C and Registrant D.

The panel therefore moved on to consider the issue of fairness. It was of the view that the issues raised in the email, namely CIPs and the vacancy control panel were topics which had been explored at length with Dr 20, Ms 19 and the divisional leads when they gave their oral evidence. As such, the panel did not consider that the contents of this email introduced any materially new information to the proceedings, nor did it unfairly change the case against you.

The panel had regard to the directions given at previous preliminary meetings, regarding the deadlines by which the NMC was to serve its evidence. However, it was mindful that this email had been produced, not as a result of further or ongoing enquires by the NMC, but by a third party. It also had regard to its primary role of public protection, and considered that it was important that the panel was provided with relevant information where it was available.

The panel therefore concluded that it would be fair to allow the email into evidence. While the panel was of the view that the issues raised within the email had already been sufficiently explored with the relevant witnesses in cross-examination, it would be open for Ms Deignan, on your behalf, to recall any witnesses if there were matters arising specifically from the admission of this document or, alternatively, deal with the matters in submissions or through any evidence given by you.

The panel therefore allowed the application.

Application to amend the charges

Prior to closing the NMC's case, Mr Collis made an application to amend charges 2(g) and 4(b). The proposed amendment was to add the words 'or 2012' to the end of both of these charges.

Mr Collis submitted that, in Colleague A's written witness statement she had indicated that you had attempted to reduce the risk rating for CDNS in 2011. However, in her oral evidence Colleague A stated that this may have occurred in 2012. Mr Collis submitted that the precise timing of the alleged downgrading of the risk was not material to the charge and, as a result, the proposed amendments could be made without injustice.

Ms Deignan, on your behalf, made no submissions regarding the application.

The panel accepted the advice of the legal assessor. He referred the panel to Rule 28 which provides that the panel can amend a charge at any stage before making its findings of fact, provided that it can be made without injustice.

The panel determined that such an amendment, as applied for, was in the interests of justice. Having put your case to the NMC's witnesses, the panel was satisfied that the exact date of the alleged downgrading of the risk was not material to your defence and therefore no prejudice or injustice would be caused to you by allowing the amendment. The panel therefore decided to allow the proposed amendments to charges 2(g) and 4(b).

Application of no case to answer

Ms Deignan, on your behalf, made an application that there was no case to answer under Rule 24(7) in respect of charge 5(a). Ms Deignan provided written submissions in support of her application.

Mr Collis, on behalf of the NMC, conceded that in light of the evidence so far the charge was unlikely to proceed beyond this stage.

The panel accepted the advice of the legal assessor who referred it to Rule 24(7) of the Rules and *R v Galbraith* [1981] 1 WLR 1039.

The panel took account of the submissions made and accepted the advice of the legal assessor.

In reaching its decision, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel decided that there was no case to answer in relation to charge 5(a), in its entirety, for the reason set out below.

Charge 5(a): In relation to the healthcare services provided to the Prison, you failed to ensure the Serious Untoward Incident reports/investigations were conducted following deaths in custody in respect of one or more patients, including:

(i) Patient A; and/or
(ii) Patient B; and/or
(iii) Patient C; and/or
(iv) Patient D

The panel was not provided with any Trust policies regarding Trust level investigations and Deaths in Custody ("DIC"). The panel had sight of a national policy, dated 2015, but was not provided with the earlier version of the national policy on which the local Trust policy ought to have been based. A number of witnesses gave differing recollections of what they understood the Trust policy to be. Dr 20, the Trust's Medical Director, recalled

that in his view the Trust policy regarding DICs was to defer to the statutory investigation process and allow DICs to be investigated fully by the PPO and/or the Coroner. He rejected the suggestion that any internal Trust investigation was required.

Several other witnesses gave evidence in relation to the Trust's policy but none could remember the contents of the policy with any certainty. All of them speculated based on their experience at other trusts, or what they would expect to be the case. Their evidence was wholly inconsistent.

Without any documented policy or procedure to assist it, or any consistency in witnesses' recollection of the process, the panel was presented with a number of differing recollections and assumptions as to how DICs were supposed to be investigated by the Trust, and whether or not they were treated as a SUI. Looking at this evidence as a whole, the panel was not satisfied that the evidence was reliable enough to enable it to find this charge proved.

Accordingly, it determined that there was no case to answer in relation to charges 5(a)(i) – (iv) inclusive.

Application to adjourn proceedings on 31 July 2019

The panel's no case to answer decision was handed down on 30 July 2019, leaving only three days left of the scheduled listing period for this hearing.

Mr Collis informed the panel that the NMC's preference was for these three days to be put to use by hearing evidence from you.

Ms Deignan, on your behalf, submitted that the process of you giving evidence was certain to take longer than the remaining three days available, meaning that the hearing would go part-heard in the middle of your evidence. In addition, Ms Deignan submitted that the preparation of your witness statement was not concluded because [PRIVATE]

and the panel's previous determination that the hearing was unlikely to reach this stage. She submitted that the witness statement would considerably shorten the time it would take for you to give your evidence.

The panel accepted the advice of the legal assessor who referred it to Rule 32(4) which provides that a panel can adjourn a hearing at any stage providing it causes no injustice to any of the parties. He further advised the panel regarding the matters it should take into account when considering an application to adjourn. These include the public interest in the expeditious disposal of the case, the potential inconvenience caused to any of the parties, and fairness to the registrants.

The panel decided that it would be unfair for you to start your evidence when there was no realistic prospect of completing your evidence in the remaining available time. This would result in the hearing going part-heard while you are on oath, leaving you unable to speak with your legal counsel until the hearing resumes and you conclude your evidence. The panel was mindful that it was likely to be several weeks, if not months, before this hearing would resume. It considered that it would be unfair to leave you on oath for such an extended period.

The panel also considered that the adjournment would allow you the opportunity to conclude your witness statement, which would enable you to give your evidence over a shorter period at the resumed hearing.

It therefore determined to adjourn the hearing at this stage.

The panel also had regard to Ms Deignan's submissions regarding the preparation of your written witness statement. In order to minimise the risk of any further delays at the resuming hearing, it made the following directions:

1. Helen Lockett's written witness statement to be served to the NMC case presenter by 16:00 on 4 October 2019.

2. Helen Lockett's written witness statement to be provided to the panel by 16:00 on 18 October 2019, ready for potential panel reading days in the week commencing 21 October 2019.

Resuming hearing [4 November 2019]

Application for Ms 29 to give evidence remotely

Ms Deignan made an application for Ms 29 to give evidence remotely, either by videolink or telephone, technology permitting. She informed the panel you wished to call Ms 29 as a character witness but she is unable to give evidence in person due to her health. Ms Deignan provided the panel with a letter from Ms 29's GP, dated 12 November 2019, which stated that Ms 29 [PRIVATE] but could give evidence via videolink.

Mr Collis did not object to the application.

The panel accepted the advice of the legal assessor.

The panel decided to allow the application for Ms 29 to give evidence remotely. It accepted that Ms 29 is currently unable to attend this hearing in person and was satisfied that it would be fair to you to allow Ms 29 to give evidence by other means.

Due to technical issues it was not possible to establish a videolink with Ms 29. However, it was satisfied that it would be fair for Ms 29 to give her evidence by telephone. In reaching this decision, it had regard to the fact that Ms 29 is a character witness whose credibility is not in dispute. The panel was therefore satisfied that there would be no disadvantage or prejudice caused to either you or the NMC by allowing Ms 29 to give evidence by telephone.

The panel therefore allowed the application for Ms 29 to give evidence by telephone.

Decision on application to stay proceedings on basis of abuse of process

Ms Deignan made an application to stay the proceedings as an abuse of process. She provided a skeleton argument in support of her application.

In her written submissions, Ms Deignan referred to the two categories for staying proceedings, as set out in the Supreme Court decision in *R v Maxwell* [2010] UKSC 48, namely: *'(i) Where it will be impossible to give the accused a fair trial, and (ii) where it offends the court's sense of justice and propriety to be asked to try the accused in the particular circumstances of the case. In the first category of case, if the court concludes that an accused cannot receive a fair trial, it will stay the proceedings without more. No question of the balancing of competing interests arises. In the second category of case, the court is concerned to protect the integrity of the criminal justice system. Here a stay will be granted where the court concludes that in all the circumstances a trial will "offend the court's sense of justice and propriety" (per Lord Lowry in R v Horseferry Road Magistrates' Court, Ex p Bennett [1994] 1 AC 42, 74G) or will "undermine public confidence in the criminal justice system and bring it into disrepute" (per Lord Steyn in R v Latif and Shahzad [1996] 1 WLR 104 , 112F).'*

In her written submissions, Ms Deignan identified nine areas of concern and submitted, in relation to the second category, that in order to uphold the sense of justice and integrity required in the regulatory process and to uphold confidence in this process, the proceedings should be stayed as an abuse of process. In the alternative, she invited the panel to find, in all the circumstances, that it would now be impossible for you to have a fair trial and that these proceedings should be stayed under the first category of abuse of process.

Mr Collis opposed the application and provided written submissions in response to the concerns outlined by Ms Deignan in her skeleton argument. He submitted that staying a case for an abuse of process is an exceptional course, which should only be exercised

when no other remedy is available to a registrant during the course of the hearing process. He submitted that the circumstances of this case do not come close to reaching the high threshold for a stay under either category.

In reaching its decision, the panel took account of the written submissions provided by Ms Deignan and Mr Collis. It also accepted the advice of the legal assessor who referred the panel to the cases of *CHRE v GMC and Saluga* [2006] EWHC 2784 (Admin), *Maxwell* [2010], *R v Horseferry Road Magistrates' Court, ex parte Bennett* [1994] 1 AC 42 and *R v Latif and Shahzad* [1996] 1 WLR 104.

The panel bore in mind that the bar is set high on applications to stay proceedings on the ground of abuse of process and is a remedy that ought to be employed only in exceptional circumstances.

The panel noted the concerns set out in Ms Deignan's skeleton argument but did not consider that any of these gave rise to any unfairness which would make it impossible for you to have a fair hearing. It therefore dismissed the application to stay the proceedings on the basis of the first category of abuse of process.

The panel then moved on to consider the second category of abuse of process and the nine areas of concern outlined in Ms Deignan's skeleton argument. However, the panel could identify nothing that offended its sense of justice and propriety, nor that would undermine public confidence in the regulatory system or bring it into disrepute. For example, the panel noted that a large volume of additional information has been provided to your defence team during this hearing and accepted that the "drip-feed" nature of the ongoing disclosure was unsatisfactory. However, the panel did not consider that this crossed the threshold into being unfair or improper. The NMC has disclosed information to your legal team promptly when it has come into their possession and you have been given time throughout the hearing to consider the new information. Of this disclosure, only one document has been adduced into evidence, as the panel considered it to be fair and relevant to do so, and the panel is unaware of the

content of any of the other documents. The panel also noted that it is not unusual, particularly in a case as lengthy and complex as this one, for additional evidence to be produced during a hearing as the result of witness evidence or at the request of the panel, in order to assist it in determining the charges.

As a properly constituted, professional, and experienced body, the panel is well able to analyse any evidential conflicts and to determine what weight to give to the evidence adduced. It concluded that there are no concerns that have been raised regarding an abuse of process that have not either been resolved, or could not be resolved within the hearing process. The panel could not find that the circumstances of the matters raised are so exceptional that you cannot receive a fair hearing. It could also not find anything which offended its sense of justice and propriety, such that a stay of these proceedings should be granted. As regards public confidence in the regulatory process, it noted that the allegations made against you are serious and relate to your time spent as member of the executive team of an NHS community trust. The panel considered that there is a public interest in resolving questions regarding your fitness to practise and that public confidence in the regulatory process would in fact be undermined if these proceedings were to be stayed in the absence of any exceptional circumstances.

In these circumstances the application to stay proceedings on the basis of abuse of process is refused.

Background

The allegations in this case arise from a period of time between 2011 and 2014, when you were employed as the Director of Operations and Executive Nurse for the Liverpool Community Health NHS Trust ("the Trust" / "LCH"). You were also a director of the Trust's operating board ("the Board"). You had responsibility for the clinical and operational leadership, quality of care, and risk management across the Trust. At the

relevant time, the Trust was responsible for managing the healthcare provided in a number of settings, including (but not limited to):

- Community District Nursing Services ("CDNS");
- Intermediate Bed Based Care Services ("IBBCS"); and
- HMP Liverpool ("the Prison").

LCH became a trust in 2010 following NHS changes. Many of the witnesses had previously been employed by its predecessor trust. You worked at LCH between March 2011 and April 2014. You were new to both the Trust and the area of Liverpool.

The charges in this case relate to a wide range of allegations regarding your management of the above services during your tenure as Director of Operations and Executive Nurse. These include:

- Poor governance and management of Cost Improvement Plans ("CIPs") within CDNS, IBBCS and healthcare services at the Prison;
- Failing to investigate and escalate concerns raised about nursing services in CDNS, IBBCS and the Prison;
- Poor risk management and attempting to minimise the concerns in respect of CDNS and IBBCS;
- Failing to investigate and report adverse incidents, including deaths in custody at the Prison and the hostage-taking of a Community District Nurse;
- Allegations of bullying and intimidating behaviour towards members of staff.

Decision on the findings on facts and reasons

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the written and oral submissions made by Mr Collis and Ms Deignan.

The panel 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 received the written witness statement of Ms 25, Adult Social Care Inspector at the Care Quality Commission, which had been agreed between you and the NMC. It also heard oral evidence from an additional 28 witnesses called on behalf of the NMC:

- **Colleague A:** Colleague A was employed as Head of Nursing for Quality and Safety at the Trust from 2010 until May 2015. During this time she also acted as the clinical lead for district nursing.
- **Colleague B:** Colleague B was employed as the Unplanned Care Manager at the Trust from 2006 until 2013. This included responsibility for a number of Trust services, including IBBCS.
- **Colleague C:** Colleague C was employed from November 2011 until May 2016 as Matron for Ward 35 at the Trust. Ward 35 was based at the Aintree Hospital site and was one of the four IBBCS wards within the Trust.
- **Colleague D:** Colleague D was employed as the Nurse Consultant for Older People at the Trust from 2004 until 1 July 2015. As part of this role, Colleague D spent approximately 70% of his time providing direct clinical care to patients on three of the Trust's IBBCS wards.
- **Mr 1:** Mr 1 was the Fatal Incident Investigator from the Prisons and Probations Ombudsman, who investigated the deaths of Patient A and Patient C, who both died while in custody at HMP Liverpool.
- **Ms 2:** Ms 2 was the Fatal Incident Investigator from the Prisons and Probations Ombudsman, who investigated the death of Patient B, who died while in custody at HMP Liverpool.
- **Ms 3:** Ms 3 was employed as an Advanced Nurse Practitioner at the Trust from November 2010 until November 2014. As part of her role she worked on the IBBCS ward at Kent Lodge, which was part of the Royal Liverpool Hospital.

- **Mr 4**: Mr 4 was employed as the Area Manager and Strategic Lead for District Nursing at the Trust from November 2011 until July 2015. As part of this role he had operational management for community services within South Liverpool. Prior to 2011 he also spent 12 months as the lead for IBBCS.
- **Ms 5**: Ms 5 was employed as the Ward Manager for Ward 35 from October 2011 until February 2014. She had worked on the same ward as a band 6 charge nurse for eight years prior to this. Ward 35 was one of four IBBCS wards at the Trust.
- **Ms 6:** Ms 6 was a Clinical Reviewer for the Prisons and Probations Ombudsman and assisted with the investigation into the death in custody of Patient C at HMP Liverpool. In addition to this, she was employed as Head of Healthcare at HMP Preston from February 2009 until 2013 and completed a secondment at HMP Liverpool from August to November 2014.
- **Ms 7:** Ms 7 was a Clinical Reviewer for the Prisons and Probations Ombudsman and assisted with the investigation into the death in custody of Patient D at HMP Liverpool. In addition to this, she was employed as Head of Healthcare at HMP Kirkham from November 2008 until December 2014.
- **Mr 8:** Mr 8 was Head of Healthcare Inspections for Her Majesty's Inspectorate of Prisons (HMIP). As part of an unannounced HMIP inspection between 14 and 25 October 2013, he attended HMP Liverpool with Ms 25, from the Care Quality Commission (CQC).
- **Mr 9:** Mr 9, a registered nurse, was employed as the Clinical Programme Manager at the Trust from 2011 until approximately May 2015. He became involved with HMP Liverpool between January and August 2014, following the CQC's inspection report.
- **Ms 10**: Ms 10 had been employed as the Named Nurse for Adult Safeguarding at the Trust since April 2014. In January, July and August 2014 she was involved in auditing healthcare records at the Prison.
- **Ms 11**: Ms 11 was employed as a Specialist Palliative Care Team Leader and End of Life Operational Lead at the Trust between 2010 and November 2014. As part of this role, Ms 11 provided assistance in the investigation of adverse

incidents at the Trust and conducted a root cause analysis investigation into the death of Patient C.

- **Ms 12:** Ms 12 was employed as the Interim Director of Nursing at the Trust between April and October 2014.
- **Ms 13:** Ms 13 was employed as the Business Development Manager at the Trust from November 2011 until April 2015.
- **Ms 14:** Ms 14 was employed as the Deputy Director of Operations and Nursing at the Trust from October 2013 until March 2015.
- **Ms 15:** Ms 15 was employed as the Care Manager for the IBBCS wards at the Trust between December 2011 and September 2015.
- **Ms 16:** Ms 16 was employed as the Manager for IBBCS at the Trust from July 2013 until May 2014.
- **Ms 17**: Ms 17 was employed as the Company Secretary and Head of Governance at the Trust from April 2011 until March 2015.
- **Ms 18**: Ms 18 was employed as the Interim Deputy HR Director at the Trust between May and October 2013. Following the appointment of the substantive Deputy HR Director in July 2013, Ms 18 was asked to stay on at the Trust until October to lead on a number of projects and initiatives and undertake investigations as and when necessary. Ms 18 investigated the allegations of bullying made against you by Colleague A.
- **Ms 19:** Ms 19 was employed as the Chief Executive at the Trust from November 2010 until after you left the Trust in April 2014.
- **Dr 20**: Dr 20 was employed as the Medical Director at the Trust from August 2012 until March 2016.
- **Ms 21**: Ms 21 has been employed as the Executive Director of Workforce for Mersey Care NHS Foundation Trust since 1 August 2013.
- **Mr 22:** Mr 22 was employed as the Head of Governance Consultancy Services at Capsticks LLP from June 2013. In April 2015 Mr 23 led a team from Capsticks to undertake an assurance review into the framework, management, systems and processes for quality and clinical governance within the Trust.

- **Ms 23:** Ms 23 was employed as the Deputy Director of Operations and Divisional Manager for Adult Services at the Trust from August 2011 until October 2014.
- **Mr 24:** Mr 24 was employed as a Divisional Manager at the Trust from April 2011 until October 2015. He had managerial responsibility for a number of clinical services which included healthcare within the Prison.

The panel found all of the NMC witnesses to be credible and had no doubt that they all gave their evidence honestly and to the best of their recollection. However the passage of some five to eight years between the alleged events and the giving of their evidence undoubtedly had an impact on the ability of some witnesses to recollect details of events. Specific examples of this are discussed in the panel's decision on the charges, where relevant.

The panel also heard evidence from you and from five character witnesses who had each worked with you before or after your tenure at LCH:

- **Ms 26** – Head of Health Care at HMP Bristol
- **Ms 27** – Director of Operations at North Somerset Community Partnership
- **Ms 28** – Divisional Lead at North Somerset Community Partnership
- **Ms 29** – Operational Manager & resilience Lead for North Somerset Community Partnership
- **Ms 30** – Commissioner for Bristol Community Services

In reaching its decisions on facts the panel had regard throughout to the submissions made by Ms Deignan regarding the lack of "benchmarking" and the report of Lord Carter. The panel accepted that some of the problems regarding staffing and issues in IBBCS and CDNS were not unique to LCH and similar problems were encountered in other Trusts. However, the panel was required to make factual findings on the charges faced by you and considered this report was of limited assistance at this stage.

The panel also noted Ms Deignan's submissions that others within the senior management structure at LCH did not appear to be subject to any regulatory

proceedings or criticism. Again, the panel at this stage was required to make factual findings on the charges faced by you and was therefore not considering whether others at LCH had responsibility for the matters charged.

The panel considered each charge and made the following findings:

Charge 1(a)

That you, a Registered Nurse, whilst employed by Liverpool Community Health NHS Trust ("the Trust") as Director of Operations and Executive Nurse between 7 March 2011 and 2 May 2014:

1. Failed to ensure an adequate Quality Impact Assessment ("QIA) process was followed in respect of Cost Improvement Plans ("CIPs") for:
   (a) Community District Nursing Services ("CDNS");

This charge is found NOT proved.

The panel heard considerable evidence from both you and the NMC's witnesses that LCH was under pressure to make financial savings. Witnesses described that this was due to (i) a drive for LCH to achieve Foundation Trust status and (ii) wider financial pressures on NHS services generally. In order to make financial savings at LCH, services were tasked with devising CIPs, setting out how money could be saved. Before any CIP was implemented, a QIA should have been carried out. The purpose of the QIA was to assess any potential impact that the CIP may have on risks or patient care within the Trust. There were various iterations of the QIA process but, in essence, CIPs and their accompanying QIAs were scrutinised at various levels before being approved by the Board. Ultimate responsibility for signing off CIPs and QIAs lay with you and the Trust's Medical Director, Dr 20.

In her NMC witness statement, Ms 23 stated that *'Attaining Foundation status was seen as the "ultimate goal" to make the Trust great, and it was like our job to attain*

Foundation status by becoming financially viable. To an extent, care was secondary to that. As an example of this, in my experience the quality impact assessments became nothing more than a tick box exercise.' The panel also heard evidence from other NMC witnesses that the QIA process was *"haphazard"* and that CIPs were unachievable.

However, their evidence related to the overall QIA process and was not specific to CDNS. The panel was provided with one QIA document for CDNS but not the accompanying CIP, or indeed any CIPs. This QIA was not signed by anyone although the panel noted it was to be passed to the Divisional Lead for review. The panel therefore had no evidence you had ever signed off a QIA in relation to CDNS.

The panel was provided with evidence that a QIA process was in operation at the Trust. The panel was mindful that the burden of proving the charge is on the NMC. It came to the view that, in the absence of evidence of the QIA process for CDNS or signed off QIAs, the panel could not make an assessment about the adequacy of the QIA process in relation to CDNS.

The panel was therefore not satisfied that the NMC had proved, on the balance of probabilities, that you had failed to ensure that an adequate QIA process was followed in respect of CIPs for CDNS.

Accordingly, charge 1(a) is found not proved.

Charge 1(b)

1. Failed to ensure an adequate Quality Impact Assessment ("QIA) process was followed in respect of Cost Improvement Plans ("CIPs") for:
   (b) Intermediate Bed Based Care Services ("IBBCS");

This charge is found NOT proved.

In reaching this decision, the panel had regard to its earlier reasons in relation to charge 1(a). The panel was provided with one QIA document in relation to IBBCS entitled 'QIA 17'. This was not signed off by anyone. The panel was not provided with the accompanying CIP for this QIA. No evidence was produced by the NMC which explained to the panel why this QIA was inadequate in relation to IBBCS. The panel therefore had no evidence that the QIA process carried out for IBBCS was inadequate.

The panel was therefore not satisfied that the NMC had proved, on the balance of probabilities, that you had failed to ensure that an adequate QIA process was followed in respect of CIPs for IBBCS.

Accordingly, charge 1(b) is found not proved.

Charge 1(c)

1. Failed to ensure an adequate Quality Impact Assessment ("QIA) process was followed in respect of Cost Improvement Plans ("CIPs") for:
   (c) Healthcare services at HMP Liverpool ("the Prison").

This charge is found NOT proved.

In reaching this decision, the panel had regard to its earlier reasons in relation to charges 1(a) and 1(b). For this charge the panel was not provided with any QIA documents in relation to healthcare services at the Prison. It therefore had no evidence you had ever signed off a QIA in relation to the Prison.

In the absence of a completed QIA and accompanying CIP for the Prison, the panel could not make any assessment about the adequacy of the QIA process in relation to healthcare services at the Prison.

The panel was therefore not satisfied that the NMC had proved, on the balance of probabilities, that you had failed to ensure that an adequate QIA process was followed in respect of healthcare services at the Prison.

Accordingly, charge 1(c) is found not proved.

Charge 2(a), 2(b), 2(c), 2(d), 2(e), 2(f) and 2(h)

2. In relation to CDNS, failed to take adequate action in respect of:
    (i) Reports of inadequate staffing;
    (ii) Reports that mandatory and non-mandatory training was not being completed by staff;
    (iii) Reports of difficulties in obtaining equipment;
    (iv) Reported concerns about the management of pressure care relief;
    (v) Reported concerns about medication administration;
    (vi) Reported increase in complaints between March and September 2011;
    (vii) …
    (viii) Reported concerns in respect of the transfer, admission and discharge of patients between the acute setting, IBBCS and the CDNS.

These charges are found proved.

The panel noted that these charges arise from the contents of a report produced by Colleague A in October 2011. Charge 2(g) does not arise from this report and therefore is considered separately.

The panel heard evidence that, following reports of concerns within CDNS, Colleague A investigated the service and completed a report in October 2011. The panel had a copy of this report. Within it, Colleague A identifies a number of problems within CDNS. These problems included:

- inadequate staffing;
- mandatory and non-mandatory training not being completed by staff;

- difficulties in obtaining equipment;
- concerns about the management of pressure care relief;
- concerns about medicines administration;
- a reported increase in complaints between March and September 2011; and
- concerns in respect of the transfer, admission and discharge of patients between the acute setting, IBBCS and the CDNS.

Colleague A's report also included 23 recommendations to address the issues identified above.

Colleague A shared her report with you by email on 2 November 2011. The panel had a copy of this email and your reply, sent on 4 November 2011 which reads as follows:

> *'Thank you for this paper and highlighting the issues in DN services as you have assessed it. I am concerned about the issues raised. I would like to focus on solutions and service improvements, so can you arrange for me, you and [Ms 31] to meet. Can you identify an individual to lead the work please and we can discuss the specific actions when we meet.*
>
> *The findings could be very damaging to the organisation during the implementation of the ANS. Can you please not share the report any further…'*

In May 2013 Colleague A wrote another report regarding admission and discharge issues within IBBCS and CDNS. This investigation noted that a number of the concerns highlighted by Colleague A in her October 2011 report persisted. In particular, the concerns regarding inappropriate transfer/admission and discharge leading to difficulties with medicines management and pressure ulcers at IBBCS and CDNS.

In January 2014 the Trust was inspected by the Care Quality Commission ("CQC"). The CQC identified that the Trust was failing to meet a number of standards and specifically identified issues with equipment, staffing numbers and staff training within CDNS.

The panel heard evidence from a number of NMC witnesses that many of the problems within CDNS arose from a lack of funding and a drive to reduce costs further.

In your evidence, you outlined national problems in recruiting nurses but also accepted that a lack of money underpinned many of the problems faced by CDNS. The panel acknowledged your evidence and witness statement, in which you set out the action you took in respect of the concerns within the service. This included seeking assurances from the relevant Divisional Managers and others within the Trust's governance structure.

However, you were made aware of issues affecting the health and safety of patients in Colleague A's report dated October 2011 (which you asked her not to share) and did not take any action to resolve the situation at Board level until 2014. Ms 14 presented a paper dated February 2014 to the Board, which recommended that the Board invest £450,000 in CDNS and further recommended that the Board did not implement the 4% cost efficiencies that had been planned for 2014/15. This paper was presented to the Board in your absence by Ms 14, Deputy Director of Operations in March 2014.

From the evidence before it, the panel was satisfied that there were reports of the issues listed at 2(a)-2(f) and 2(h) within CDNS from as early as 2011. The panel was also satisfied that you were made aware of these concerns in 2011 and subsequently. Given the serious and persistent nature of the problems, and the fact that they had the potential to impact upon patient care and safety and the reputation of LCH, the panel was of the view that you did have a duty, in your capacity as Director of Operations and Executive Nurse, to take action to address these concerns. However, although your email to Colleague A dated 4 November 2011 states that you were '*concerned about the issues raised…[and] would like to focus on solutions and service improvements',* the

panel was not provided with any supporting evidence that any meeting to address these concerns took place with Colleague A, and indeed Colleague A stated that there was no follow up meeting.

Ms 12 gave evidence that when she joined the Trust in 2014 she could find no evidence that you had taken any action in response to the 2011 report. This was supported by the evidence of Mr 22.

The panel also noted the CQC report dated January 2014. This report highlighted the following deficiencies:

- Significant shortage of district nurses and a lack of experienced staff.
- Information CQC received from the Trust showed that across the entire district nursing service only one area had achieved 93% compliance with mandatory training with half of the team showing 70% compliance.
- People were not always protected from unsafe or unsuitable equipment. CQC were told by some managers that there had been difficulties in accessing specialist equipment with one nurses reporting *"there is a problem getting some specialist equipment, I have a very small budget and we have to go to a panel for approval"*. The CQC were told that this had been reported through the incident reporting system.

The panel had no evidence that the actions you outlined in your evidence adequately addressed the concerns within CDNS. While the panel acknowledges that the situation in relation to CDNS was escalated to the Board in February 2014, and ultimately additional funding was approved, this action was over two years after Colleague A first shared her concerns with you and only following an adverse CQC report. The panel considered that this significant delay in the action taken was inadequate. The panel took into account the evidence you provided in relation to mandatory training and breakthrough aims in relation to pressure ulcers. However the panel did not consider these actions were adequate given that the problems persisted.

The panel was therefore satisfied that in relation to CDNS you failed to take adequate action in respect of:

- reports of inadequate staffing (charge 2a);
- reports that mandatory and non-mandatory training was not being completed by staff (charge 2b);
- reports of difficulties in obtaining equipment (charge 2c);
- reported concerns about the management of pressure care relief (charge 2d);
- reported concerns about medication administration (charge 2e);
- reported increase in complaints between March and September 2011 (charge 2f); and
- reported concerns in respect of the transfer, admission and discharge of patients between the acute setting, IBBCS and the CDNS (charge 2h).

Accordingly, these charges are found proved.

Charge 2(g)

2. In relation to CDNS, failed to take adequate action in respect of:
   (g) Colleague A's assessment that the service had a risk rating of around 20 in or around October and/or November 2011 or 2012;

This charge is found proved.

In Colleague A's written NMC witness statement she states that she gave the CDNS a risk rating of 20 in *'approximately October 2011'* (20 being the highest available rating). However, when she gave oral evidence she was unsure whether she had assigned this rating in 2011 or 2012.

From the evidence provided by minutes of the Trust's Health Care Governance Sub Committee ("HCGSC") meetings, it appeared that it was more likely that Colleague A had assigned this risk rating in 2012, as it was discussed at the HCGSC meeting in November 2012. The panel heard evidence that at LCH risks would be rated on a scale

of 0 – 20. Risks of 16 or above should have been escalated to the Board. A score of 20 indicates that there is a risk to public safety and closure of the service could be considered.

From the minutes of this meeting, it appears that you were present. The panel was therefore satisfied that you would have been aware of the risk rating of 20 for CDNS.

The panel has already established that you were aware of significant problems within CDNS from November 2011, as Colleague A had shared the findings of her report with you on 2 November 2011. The problems in CDNS had persisted, such that in October/November 2012 Colleague A assigned a risk rating of 20 to the service. Given the serious and persistent nature of the problem, and the fact that it had the potential to impact upon patient care and safety and the reputation of LCH, the panel was of the view that you did have a duty, in your capacity as Director of Operations and Executive Nurse, to take action to address this risk rating and the underlying causes of it.

The panel noted the CQC report dated January 2014. This report outlined that the staffing risk was added to the Trust risk register in May 2013 with an initial and current risk rating of 'high'. This was consistent with the evidence the panel heard from Colleague A that staffing issues in relation to CDNS remained on the risk register with a high rating. Given this risk persisted on the Trust risk register for a significant period of time, the panel was satisfied that no adequate steps had been taken by you to address this matter. The panel noted the paper prepared in February 2014 and the subsequent escalation of the issues in CDNS to the Board where additional resources were secured in March 2014. The panel considered that the significant delay in escalating this risk to the Board and taking any steps to address the risk was inadequate.

For the same reasons as given in relation to charges 2(a) – 2(f) and 2(h), the panel was of the view that taking no action for a significant period of time whilst the service had a risk rating of 20 was inadequate.

Accordingly, charge 2(g) is found proved.

Charge 3(a)

3. In relation to the IBBCS, failed to take adequate action in respect of:
   (a) Reported inadequate staffing;

This charge is found proved.

The panel heard evidence from a number of NMC witnesses that the staffing levels on IBBCS wards were persistently inadequate. Ms 3 told the panel that she met with you shortly after you came into post at the Trust, and informed you of the problems within IBBCS which included staffing levels and the acuity of the patients being referred. In her NMC witness statement, Ms 3 described you as appearing *'disinterested'* in these issues.

Colleague B gave evidence that in approximately September/October 2012 Colleague C escalated the staffing shortages in IBBCS to him. Colleague B investigated further and found twenty to twenty-five vacancies, which amounted to almost an entire ward's worth of staffing. Colleague B enquired as to what was happening in respect of these vacancies and found that decisions as to whether or not to replace members of staff were pending with the VCP and no action had been taken. He found that some of these decisions had been outstanding for weeks and months. Colleague B told the panel that he escalated the situation to you, Ms 23 and the Director of Finance and made it clear that there was the need for urgent remedial action to be taken as regards the level of vacancies in IBBCS.

Colleague B also assigned IBBCS a risk level of 20 and reported it as such at the divisional level meetings in September and October 2012. The panel heard evidence that at LCH risks would be rated on a scale of 0 – 20. Risks of 16 or above should have been escalated to the Board. A score of 20 indicates that there is a risk to public safety and closure of the service could be considered.

Colleague B described that he was *'disappointed'* with your response to his escalation of the problems in IBBCS and that you claimed he was exaggerating the situation.

In January 2013 IBBCS went into business continuity and in February 2013 Colleague B was moved out of the service.

In February 2013 Colleague A produced a report regarding IBBCS. This report identified staffing levels and patient acuity as two significant causes of the pressures in IBBCS. The conclusion of the report states that *'Critically at this point there is a requirement to review the risk assessment in relation to the staffing and consider whether the controls are sufficient to mitigate the current significant risks in the system…It is clear that the staffing situation has led to intolerable practice being tolerated.'* Colleague A confirmed in her evidence that she provided a copy of this report to you.

The panel also heard evidence from Ms 23 regarding the staffing problems on IBBCS. Ms 16 also gave evidence that, when she moved to IBBCS in July 2013 (following the suspension of Colleague B, Colleague C and Ms 15), she also found significant problems regarding inadequate staffing, patient acuity, and inappropriate admission, discharge and transfer of patients.

In your evidence you accepted that inadequate staffing was an issue on IBBCS. You also outlined a number of actions you took to address this. However, taking account of all the evidence it had heard, the panel was of the view that what IBBCS really needed was significant additional resources, including staff. You failed to escalate this matter until September 2013. The panel had regard to an email sent by you to all divisional managers and senior leadership on 4 May 2012 regarding LCH's new vacancy control panel:

'Dear All

In case you were in any doubt, we have a £30m CIP to find over 5 years. £8m this year. We have not been able to identify all of the saving for this year. In order to make this happen and have rigorous monitoring of the savings, we are putting the following processes in place:

Vacancy Control Panel (VCP)

This will be for all posts in the organisation without exception.

This will include permanent posts, temporary posts, any changes in hours (increase or reduction), agency requests, bank requests and anything else.

The panel members will be me or [Dr 20], senior finance manager, senior HR manager…

…

The business case for any posts will have to be presented in person by the service lead and or clinician (as the service wishes). This will be a challenging process for some staff but is necessary. If they will need to be fully prepared with a convincing business case. We will challenge like for like posts. Every other alternative will need to be considered before attending the panel.

…

These processes will be challenging for all staff but are necessary to make the savings. We will all need to support the process and support staff through this…'

The panel heard evidence from witnesses, including Colleague C and Ms 15, about the difficulties in getting approval to recruit from the VCP.

From the evidence before it, the panel was satisfied that inadequate staffing levels on IBBCS had been raised from the time you joined LCH. The panel was also satisfied that you were made aware of these concerns soon after you joined, by Ms 3, and also throughout 2012 and 2013 by other members of staff, such as Colleague A and Colleague B. Given the serious and persistent nature of the problem, and the significant risk it posed to patient care and safety, the panel was of the view that you did have a duty, in your capacity as Director of Operations and Executive Nurse, to take action to address these concerns. Although the panel acknowledges the evidence you gave regarding the actions you took, it considered that these were inadequate. Inadequate staffing on IBBCS persisted and the situation in IBBCS continued to deteriorate. The staffing levels on IBBCS were not helped by the new-style VCP, which you set up at LCH in May 2012 and in which you played a key role. You did not escalate the situation on IBBCS to the Board until September 2013, by which point the situation on IBBCS had reached a crisis point and the service had been in business continuity for over nine months. The panel did not consider that this escalation, taken approximately two years after the concerns were first reported to you, constituted adequate action.

The panel took into account the evidence you provided in relation to the VCP and in particular that you approved a number of vacancies. The panel noted that it did not have the complete data for the whole period of the VCP and so treated this evidence with caution. The panel preferred the evidence of Ms 3, Colleague B, Colleague A, Ms 23 and Ms 16 in relation to the difficulties encountered in recruiting staff and concluded this was credible and consistent and supported a failure to address staffing shortages on IBBCS. The panel concluded that the drive to save money and the operation of the VCP, which required approval for recruitment of all staff, directly contributed to the staffing problems on IBBCS.

The panel was therefore satisfied that in relation to IBBCS you failed to take adequate action in respect of reported inadequate staffing.

Accordingly, charge 3(a) is found proved.

Charge 3(b)

3. In relation to the IBBCS, failed to take adequate action in respect of:
   (b) Reported increase in the level of acuity of patients;

This charge is found proved.

In addition to raising concerns about inadequate staffing in IBBCS, Ms 3 and Colleague B also gave evidence that they raised concerns with you regarding the acuity of patients being admitted to IBBCS. Ms 3 gave evidence that, as the result of other ward closures and bed shortages elsewhere, IBBCS wards began to receive complex patients who required a higher degree of care than the rehabilitation patients that IBBCS was intended for. As a result, the IBBCS staff did not always have the right skills or experience to properly manage these complex patients and higher levels of staffing were required on the IBBCS wards. Ms 3 gave evidence that she raised this issue with you at the same time as staff shortages.

Colleague B also gave evidence that in September/October 2012, when he became aware of the staffing shortages in IBBCS, he also discovered that the level of acuity of the patients on the wards had also increased. Colleague B gave evidence that he escalated his concerns regarding this to you at the same time as escalating his concerns regarding staffing. Colleague B gave evidence that the increased acuity of patients being admitted to IBBCS was one of the factors which led him to assigning a risk rating of 20 to IBBCS. Colleague B described that he was *'disappointed'* with your response to his escalation of the problems in IBBCS and that you claimed he was exaggerating the situation.

In January 2013 IBBCS went into business continuity. In February 2013 Colleague A produced a report regarding IBBCS. This report identified staffing levels and patient acuity as two significant causes of the pressures in IBBCS. The conclusion of the report states that *'Critically at this point there is a requirement to review the risk assessment in relation to the staffing and consider whether the controls are sufficient to mitigate the current significant risks in the system…It is clear that the staffing situation has led to intolerable practice being tolerated.'* Colleague A confirmed in her evidence that she provided a copy of this report to you.

The panel also heard evidence from Ms 23 regarding the staffing problems on IBBCS. Ms 16 also gave evidence that, when she moved to IBBCS in July 2013 (following the suspension of Colleague B, Colleague C and Ms 15), she also found significant problems regarding inadequate staffing, patient acuity, and inappropriate admission, discharge and transfer of patients.

In your evidence you accepted that you were aware of the increase in the level of acuity of patients being admitted to IBBCS, and the pressures this placed on the service and its staff. You also outlined a number of actions you took which included raising the issue in meetings with Acute Trusts and Commissioners meeting with your counterparts in the acute trusts and with Commissioners, relaunching the admission and discharge criteria, and writing a paper for the Commissioners to consider alternative models for intermediate care. However, you also accepted that, despite your efforts, the acute trusts continued to send inappropriate patients to IBBCS and your paper did not result in any changes in admissions to IBBCS.

From the evidence before it, the panel was satisfied that the increase in the level of acuity of patients in IBBCS had been raised from the time you joined LCH. The panel was also satisfied that you were made aware of these concerns soon after you joined, by Ms 3, and also throughout 2012 and 2013 by other members of staff, such as Colleague A and Colleague B. Given the serious and persistent nature of the problem, and the significant risk it posed to patient care and safety, the panel was of the view that

you did have a duty, in your capacity as Director of Operations and Executive Nurse, to take adequate action to address these concerns. Although the panel acknowledges that you did take some action, by your own admission, this was ineffective in reducing the level of acuity of patients being admitted to IBBCS. Inadequate staffing in IBBCS and high patient acuity persisted and the situation in IBBCS continued to deteriorate. In November 2012 Colleague B assigned a risk rating of 20 to IBBCS, indicating that there was a risk to patient safety if it continued to operate. Despite this, you did not use your position as Director of Operations and Executive Nurse to refuse the admission of high acuity patients to IBBCS, nor allow the service to recruit staff in sufficient numbers and skill mix to safely manage the needs of higher acuity patients. You did not escalate the situation on IBBCS to the Board until September 2013, by which point the situation on IBBCS had reached a crisis point and the service had been in business continuity for over nine months.

Taking account of the evidence, the panel was satisfied that in relation to IBBCS you failed to take adequate action in respect of a reported increase in the level of acuity of patients.

Accordingly, charge 3(b) is found proved.

Charge 3(c)

3. In relation to the IBBCS, failed to take adequate action in respect of:
   (c) Reported concerns in respect of the transfer, admission and discharge of patients between the acute setting, IBBCS and the CDNS;

This charge is found proved.

Colleague B gave evidence that he informed you in late 2012 of his concerns regarding IBBCS. This included his concerns in respect of the transfer, admission and discharge of patients between the acute setting, IBBCS and CDNS. Colleague B gave evidence that a higher level of acuity and complexity of patients were being admitted to IBBCS

than was originally intended. Increasing pressure was being placed upon the service from acute hospitals that fed into the IBBCS to take more patients.

In May 2013 Colleague A produced a report titled “Review of Admission Discharge Issues within Intermediate Care Wards (ICU) and Community Nursing Services” as the transfer of patients between IBBCS and other settings continued to be an issue.

Ms 16 also gave evidence that, when she moved to IBBCS in July 2013 (following the suspension of Colleague B, Colleague C and Ms 15), she also found significant problems regarding inadequate staffing, patient acuity, and inappropriate admission, discharge and transfer of patients.

The panel considered, from the evidence before it, that the issue of inappropriate transfer, admission and discharge of patients between the acute setting, IBBCS and CDNS was inextricably linked with the issues of increased patient acuity on IBBCS and inadequate staffing.

You also accepted this in your evidence, and referred the panel to the various actions that you had taken to address the issue of patient acuity on IBBCS (see charge 3(b)). . From the evidence before it, the panel was satisfied that you were aware of the reported concerns in respect of the transfer, admission and discharge of patients between the acute setting, IBBCS and CDNS. Given the serious and persistent nature of the problem, and the significant risk it posed to patient care and safety, the panel was of the view that you did have a duty, in your capacity as Director of Operations and Executive Nurse, to take action to address and escalate these concerns. Although the panel acknowledges that you did take some action, by your own admission, this was ineffective in reducing the inappropriate admission and transfer of acute patients between IBBCS and other settings. High patient acuity and inadequate staffing persisted and the situation in IBBCS continued to deteriorate. In November 2012 Colleague B assigned a risk rating of 20 to IBBCS, indicating that there was a risk to patient safety if it continued to operate. Despite this, you did not use your position as

Director of Operations and Executive Nurse to refuse the admission of high acuity patients to IBBCS, nor to stop the transfer and discharge of unsuitable patients from acute settings into IBBCS. You also did not enable the service to recruit staff in sufficient numbers and skill mix to safely manage the needs of the higher acuity patients who were being admitted to IBBCS. You did not escalate the situation on IBBCS to the Board until September 2013, by which point the situation on IBBCS had reached a crisis point and the service had been in business continuity for over nine months.

Taking account of all of the evidence, the panel was satisfied that in relation to IBBCS you failed to take adequate action in relation to reported concerns in respect of the transfer, admission and discharge of patients between the acute setting, IBBCS and CDNS.

Accordingly, charge 3(c) is found proved.

Charge 3(d)

3. In relation to the IBBCS, failed to take adequate action in respect of:

(d) Reported inadequate investigation and/or root cause analysis and/or lessons learned procedures following reported incidents;

This charge is found NOT proved.

The panel noted that this charge was inextricably linked with charge 3(e) which concerns a lack of reporting of incidents.

Colleague A's "Intermediate Care Incident Report", produced in February 2013, raises the issue of under reporting of incidents and inadequate investigation following them. It comments that, according to the Intermediate Care Manager, *'far more incidents have occurred in relation to patient safety than have been reported through datix.'* Colleague A confirmed in her evidence that this report was shared with you. The panel could

identify no evidence to suggest that this issue was brought to your attention before February 2013.

Colleague A then completed a further report in May 2013 titled “Review of Admission Discharge Issues within Intermediate Care Wards (ICU) and Community Nursing Services”. This report identified an improvement in the reporting of incidents. The panel could identify no evidence to suggest that this issue persisted after May 2013.

In circumstances where, based on the available evidence, the issues appeared to have been resolved within a matter of months, the panel could establish no duty on you to take any further action in respect of these concerns.

Accordingly, charge 3(d) is found not proved.

Charge 3(e)

3. In relation to the IBBCS, failed to take adequate action in respect of:

(e) Lack of reporting of incidents;

This charge is found NOT proved.

As discussed in relation to charge 3(d), Colleague A’s “Intermediate Care Incident Report”, produced in February 2013, raises the issue of under reporting of incidents. The panel could identify no evidence to suggest that this issue was brought to your attention before February 2013.

Colleague A then completed a further report in May 2013 titled “Review of Admission Discharge Issues within Intermediate Care Wards (ICU) and Community Nursing Services”. This report identified an improvement in the reporting of incidents. The panel could identify no evidence to suggest that this issue persisted after May 2013.

In circumstances where, based on the available evidence, the issues appeared to have been resolved within a matter of months, the panel could establish no duty on you to take any further action in respect of these concerns.

Accordingly, charge 3(e) is found not proved.

Charge 3(f)(i)

3. In relation to the IBBCS, failed to take adequate action in respect of:
    (f) Reported risk rating for the IBBCS of around 20 in or around:
        (i) September and/or October 2012;

This charge is found NOT proved.

This charge relates to your alleged failure to take adequate action following the Healthcare Governance Sub-Committee meeting in either September 2012 or October 2012, at which Colleague B allegedly reported that he had rated the risk posed by IBBCS as 20.

However, during the course of the evidence it transpired that neither you, nor Colleague B, were present at the HCGSC meeting which took place in September 2012. It was also established that there was no meeting in October 2012, and the next meeting did not take place until 20 November 2012.

It is therefore not possible that Colleague B reported a risk rating of 20 in either HCGSC meetings of September or October 2012.

The NMC in its submission stated that *'it does not make any positive submissions'* in relation to this charge.

Accordingly, the charge is found not proved.

Charge 3(f)(ii)

3. In relation to the IBBCS, failed to take adequate action in respect of:

(f) Reported risk rating for the IBBCS of around 20 in or around:

(i) …

(ii) December 2012

This charge is found proved.

The panel heard evidence that Colleague B and Colleague A assigned IBBCS a risk rating of 20 in late 2012 as a result of its ongoing problems, which included inadequate staffing and high levels of patient acuity. The panel had copies of the minutes of the Healthcare Governance Sub-Committee meetings which took place in November 2012 and December 2012. You were present at both of these meetings and it was evident from the minutes that IBBCS' risk rating was discussed.

Despite the service being given a rating of 20 in late December 2012, many of its problems appeared to persist into 2013 and were the subject of further reports and escalated concerns which are discussed in relation to charges 3(a) – 3(c). The situation in IBBCS continued to deteriorate and the service went into business continuity in January 2013. In July 2013 Ms 15, Colleague C and Colleague D were suspended from their posts.

The panel has already determined that the action you took in relation to IBBCS' inadequate staffing, increased patient acuity, and inappropriate transfers, admissions and discharges, which were significant factors which had led to the risk rating of 20, were inadequate. The panel could not identify any evidence of further action taken by you until September 2013 when a turnaround team was put into IBBCS. The panel considered that this action, taken nine months after the risk was reported as 20, and several years after the issues were first escalated to you, was inadequate.

Accordingly, charge 3(f)(ii) is found proved.

Charge 4(a)

4. Attempted to minimise the concerns in respect of CDNS and/or IBBCS by:

(a) Instructing Colleague A not to share further the contents of the District Nursing Complaints and Incident Report, dated 2 November 2011;

This charge is found proved.

The panel had a copy of the report prepared by Colleague A, "District Nursing Complaints and Incident Report", dated 2 November 2011. This report highlights a number of areas of concern within CDNS and IBBCS, including:

- staffing issues;
- mandatory and non-mandatory training not being completed;
- difficulties in obtaining equipment;
- management of pressure care relief;
- medication administration;
- a reported increase in complaints between March and September 2011; and
- the transfer, admission and discharge of patients between the acute setting, IBBCS and CDNS.

Colleague A shared this report with you by email on 2 November 2011. It stated *'Helen, See attached report as requested. I have given a hard copy to [your PA] to you. Will wait for your comments.'* On 4 November 2011 you wrote:

> *'[Colleague A],*
> *Thank you for this paper and highlighting the issues in DN services as you have assessed it. I am concerned about the issues raised. I would like to focus on solutions and service improvements, so can you arrange for me, you and [Ms 31] to meet. Can you identify an individual to lead the work please and we can discuss the specific actions when we meet.*

The findings could be very damaging to the organisation during the implementation of the ANS. Can you please not share the report any further…'

In your evidence you stated that your email was *'clumsily worded*'. You gave evidence that you shared the contents of the report with the Chief Executive, Ms 19, who stated that she did not think the report needed to be reported through the HCGSC as the data in the report only referred to the district nurses in Liverpool, and not the Sefton area. You also gave evidence that Ms 19 stated that the data in the report was also already reported on a monthly basis to the Integrated Quality and Governance Committee and to the LCH Board through aggregated data reports. In your evidence you stated that you should have explained to Colleague A the reasons for not escalating the report through the governance structures.

The panel noted your explanation in your evidence that following receipt of the report you had a meeting with Ms 31 without Colleague A to discuss matters. The panel was not persuaded that this was an accurate recollection. The panel accepted Colleague A's version of events that she sent you an electronic copy attached to her email of 2 November 2011. Colleague A told the panel no further action was taken. Given the contents of the email of 4 November 2011 the panel considered that it was unlikely that there was a meeting arranged without the input of Colleague A. There was no evidence before the panel that you took any action to address the concerns arising out of this report.

However, the panel bore in mind that the contents of the report had the potential to be very damaging to the reputation of LCH and highlighted issues relating to the care and safety of patient. Further, there would be financial implications to resolve many of the issues. It also had regard to Ms 12's evidence that, when she arrived at the Trust, she could find no evidence of this report being discussed at the Quality and Risk Committee or the Board level meetings.

It was clear from your email, dated 4 November 2011, that you had instructed Colleague A not to share the contents of her report. The panel rejected your explanation for this and considered that it was more likely, given the pressures the Trust was under and the potentially damaging repercussions of the report, that your instruction to Colleague A was an attempt to minimise the concerns in respect of CDNS and/or IBBCS.

Accordingly, charge 4(a) is found proved.

Charge 4(b)

4. Attempted to minimise the concerns in respect of CDNS and/or IBBCS by:

(b) Attempting to reduce and/or influence the risk rating for CDNS from around 20 to around 9 in or around October and/or November 2011 or 2012;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague A and the minutes of the Healthcare Governance Sub-Committee (HCGSC).

Colleague A gave evidence that she had assigned a risk rating of 20 to CDNS before she went on holiday. When she returned she was informed that the risk rating had been downgraded to a nine at the HCGSC. Colleague A gave evidence that she attended the next HCGSC meeting where she was informed by you and Ms 17 that they felt Colleague A had exaggerated the risk. According to Colleague A, she argued for the rating of 20 to be reinstated, which was opposed by you. Colleague A gave evidence that she requested that it be recorded in the minutes that she did not agree with the reduced risk rating, which she said then led to the risk rating of 20 being reinstated. This was not reflected in the minutes.

In Colleague A's witness statement, she cites these events as occurring in October/November 2011. However, when she gave oral evidence she conceded that it

was more likely that they actually took place in 2012. From the evidence before the panel, it has been established that you were not present at the HCGSC meeting of October 2011 and there was not an HCGSC meeting in October 2012. This charge therefore relates to the HCGSC meeting which took place on 20 November 2012.

In your evidence to the panel you stated that you were not able to access the DATIX reporting system to amend risk ratings and did not at any time attempt to influence the reduction of the risk rating for CDNS. You accepted that in the HCGSC meetings you sought to gain more details about the risk rating and understand the mitigations against particular risks. You also stated that you sought assurances from the divisional managers that reported to you that action was being taken to mitigate the risks in the service. The panel also had the minutes of the HCGSC meeting of September 2011. You were not present. The minutes do not disclose the risk rating attributed to CDNS.

The panel had the minutes from the HCGSC meeting on 20 November 2012. The minutes record that, in relation to the risk register *'HL raised the issue that each Risk needs to display the controls and processes being implemented to manage / mitigate each risk.'* In relation specifically to the *'Adults Workforce'* entry on the risk register, the minutes state: *'Issues regarding Vacancy Control Panel and Capita regarding the recruitment of staff. There has been an increase in the number of bank / agency staff used within the Walk-In-Centre's, Bed Based Services and District Nurses. HL stated that this Risk should not be rated at 20 (5x4). CJ to feedback to Adults Services Division.'*

While the minutes of the November 2012 meeting show that you asked about the risk controls and expressed a view that the risk relating to CDNS should not be 20, there is no evidence within them that you minimised the concerns in an attempt to reduce and/or influence the risk rating inappropriately. There is no documentary evidence to support Colleague A's recollection that the CDNS risk was reduced to 9 and then increased again when she challenged this. The panel took account of the fact that significant time has passed since these events. For this reason, together with Colleague A's uncertainty

about the timeframe, the panel could not be satisfied that Colleague A's recollection of this event was reliable.

The panel bore in mind that the burden is on the NMC to prove the allegation. The panel was not satisfied that it had sufficient evidence to prove, on the balance of probabilities, that you attempted to reduce and / or influence the risk rating for CDNS from around 20 to around 9 in or around October and/or November 2011 or 2012.

Accordingly, this charge is found not proved.

Charge 4(c)(i)

4. Attempted to minimise the concerns in respect of CDNS and/or IBBCS by:
    (c) Attempting to reduce and/or influence the risk rating for the IBBCS from around 20 to a lower level in or around:
        (i) September and/or October 2012;

This charge is found NOT proved.

The panel has already discussed the issue of the September and October 2012 HCGSC meetings in relation to charge 3(f)(i).

It was established during the evidence that you were not present at the HCGSC meeting which took place in September 2012 and there was no meeting at all in October 2012. You therefore cannot have attempted to reduce or influence any risk ratings at these meetings. Further, there was no other evidence to support this charge.

The NMC in its submission stated that *'it does not make any positive submissions'* in relation to this charge.

Accordingly, the charge is found not proved.

Charge 4(c)(ii)

4. Attempted to minimise the concerns in respect of CDNS and/or IBBCS by:

   (c) Attempting to reduce and/or influence the risk rating for the IBBCS from around 20 to a lower level in or around:

      (i) …

      (ii) December 2012

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague B and the minutes of the Healthcare Governance Sub-Committee.

Colleague B gave evidence that, together with Colleague A, he assigned a risk rating of 20 to IBBCS as a result of its ongoing problems, which included inadequate staffing and high levels of patient acuity. Colleague B gave evidence that he addressed the risk rating during HCGSC meetings and that these were difficult meetings in which you challenged him regarding the rating and claimed that he was exaggerating the risk. Colleague A stated that he came under significant pressure from you and Dr 20 to downgrade his risk assessment. Colleague B gave evidence that he attended the HCGSC meeting in December 2012 and reiterated that the risk assessment should remain at 20, and again declined to downgrade it.

In your evidence to the panel you accepted that you sought to gain more details about the risk rating and controls during the HCGSC meetings but denied that you attempted to influence or reduce the risk rating.

The panel had regard to the minutes from the HCGSC meetings. At the November meeting the following is documented regarding the IBBCS risk: *'Issues regarding Vacancy Control Panel and Capita regarding the recruitment of staff. There has been an increase in the number of bank / agency staff used within the Walk-In-Centre's, Bed*

Based Services and District Nurses. HL stated that this Risk should not be rated at 20 (5x4). CJ to feedback to Adults Services Division.' Colleague B was not present at that meeting.

The next meeting took place on 12 December 2012 when you and Colleague B were both present. These minutes document that *'[Colleague B] and [Ms 23] confirmed that the actions and controls are being reviewed. Risk register to be presented at HGSC on January 17th 2013.'*

While the minutes show that in November 2012 you asked about the risk controls and expressed a view that the risk relating to IBBCS should not be 20, there is no evidence within them that you attempted to minimise concerns about IBBCS in order to reduce and/or influence the risk rating inappropriately at the meeting in December 2012. The minutes do not support Colleague B's recollection of events. The panel had in mind the significant time that had elapsed since this meeting. The panel considered Dr 20's evidence to Mr 22 that *'…escalating a risk doesn't mean you've relinquished all responsibility for it. ..I had heated discussions in the middle of various sub committee and various other meetings…but there are still some people who don't understand the principles of risk registers and how they go up and down.'*

The panel concluded that it was more likely to be a heated discussion about the risk ratings but it was not persuaded that it was an improper attempt by you to reduce or influence the risk.

The panel bore in mind that the burden is on the NMC to prove the allegation. The panel was not satisfied that it had sufficient evidence to prove, on the balance of probabilities, that you attempted to reduce and / or influence the risk rating for IBBCS from 20 to a lower level in or around December 2012.

Accordingly, this charge is found not proved.

Charges 5(a)(i)-(iv)

5. In relation to the healthcare services provided to the Prison, you:

(a) Failed to ensure the Serious Untoward Incident reports/investigations were conducted following deaths in custody in respect of one or more patients, including:

(i) Patient A; and/or

(ii) Patient B; and/or

(iii) Patient C; and/or

(iv) Patient D

No case to answer (see reasons above).

Charge 5(b)(i)

5. In relation to the healthcare services provided to the Prison, you:

(b) Failed to ensure adequate escalation and/or adequate action was taken following concerns raised by the Prison and Probation Ombudsman reports following deaths in custody in respect of one or more patients, including:

(i) Patient A; and/or

This charge is found proved.

The panel had a copy of the Prison and Probation Ombudsman ("PPO") report, dated October 2013, into the death of Patient A on 30 March 2012. This report identified a number of concerns about the management of Patient A's health and with the Prison healthcare service more generally. The report made nine recommendations, six of which were attributed to the Head of Healthcare at the Prison and which were accepted.

In your evidence you confirmed that you had sight of the PPO reports and the subsequent action plans, dated November 2013, following the death in custody of another patient (Patient C). You told the panel that you sought assurances from

Registrant B, Head of Healthcare at the Prison, and Mr 24, Divisional Lead, that the action plan was in hand.

However, although there may have been action plans in place, the panel had sight of various inspection reports and audits which pre-dated Patient A's PPO report and identified some of the same concerns that were reported in Patient A's PPO report, in particular: healthcare screening, missed appointments and record-keeping.

Healthcare screening was also identified as a concern by the CQC in October 2013. Colleague A also highlighted it as a concern in an audit carried out in May 2014. When Ms 12 joined the Trust in April 2014 she visited the Prison and also noted concerns about healthcare screening.

Her Majesty's Inspectorate of Prisons ("HMIP") visited the Prison in conjunction with the CQC in October 2013. The HMIP report identified that missed appointments continue to be an ongoing issue (having originally been identified by Patient B's PPO report in September 2012). Although the CQC inspection in March 2014 reported an improvement in relation to missed appointments, the panel heard evidence from Ms 10 that when she audited Prison healthcare records in July and August 2014 she identified concerns regarding missed appointments and record-keeping.

Record-keeping also appeared to persist as a problem, despite having originally been identified in Patient B's PPO report in September 2012. The October 2013 CQC report also highlights record-keeping as a concern, as did Ms 10's audits of Prison healthcare records in January, July and August 2014. Mr 9 and Ms 6 also gave evidence that record-keeping was still an issue when they both went into the Prison in 2014.

The panel had regard to your evidence, namely that you sought assurances from Registrant B and Mr 24 that the concerns raised by the PPO reports were being addressed. While the panel accepted that primary responsibility for addressing the concerns arising from Patient A's PPO report would have fallen to the Prison's

healthcare management team, the panel also had a wealth of evidence about the steps that were taken by staff in the Prison to try to address these concerns and the problems they encountered in doing so. The panel considered that seeking assurances from Registrant B and Mr 24 that corrective actions were in place may have been adequate action to take in the first instance. However, it did not consider that getting assurances was adequate in the face of persistent repetition of the same concerns. The panel could identify no evidence that you actively monitored the implementation of these action plans, nor that you escalated the issues identified by Patient A's PPO report into the Trust's governance structure when it became apparent that problems were persisting and the action plans were not working.

The panel was therefore satisfied that you failed to ensure adequate escalation and/or adequate action was taken following concerns raised by the Prison and Probation Ombudsman reports following deaths in custody in respect of Patient A.

Accordingly, charge 5(b)(i) is found proved.

Charge 5(b)(ii)

5. In relation to the healthcare services provided to the Prison, you:
   (a) Failed to ensure adequate escalation and/or adequate action was taken following concerns raised by the Prison and Probation Ombudsman reports following deaths in custody in respect of one or more patients, including:
      (i) …
      (ii) Patient B; and/or

This charge is found proved.

The panel had a copy of the Prison and Probation Ombudsman ("PPO") report, dated September 2012, into the death of Patient B on 14 April 2012. This report identified a number of concerns about the management of Patient B's health and with the Prison

healthcare service more generally. The report made nine recommendations, five of which were attributed to the Head of Healthcare and were accepted.

In your evidence you confirmed that you had sight of the PPO reports and the associated action plan. You told the panel that you sought assurances from Registrant B, Head of Healthcare at the Prison, and Mr 24, Divisional Lead, that the action plan was in hand.

However, although there may have been an action plan in place, the panel had sight of various inspection reports and audits which appeared to identify some of the same concerns that were reported in Patient B's PPO report, in particular: care planning and record-keeping.

An internal audit of the Prison, carried out in May 2013, identified a lack of care planning for the older population and those with long term illnesses. In October 2013 HMIP and CQC carried out a joint inspection of the Prison. The reports from both organisations raised care planning as a concern. Ms 10 conducted audits of Prison healthcare records in January, July and August 2014 which again identified care-planning as a concern and Mr 9 also gave evidence that there was a lack of care-planning when he arrived at the Prison in January 2014.

Record-keeping was also identified as a concern by a number of different sources following Patient B's PPO report in September 2012. These included: an RCA report produced by Ms 11 in September 2013 following the death of Patient C, Patient A's PPO report published in October 2013, the October 2013 CQC inspection report, and Ms 10's internal audits carried out in January, July and August 2014. Ms 6 also gave evidence that record-keeping in the Prison was an issue when she arrived in August 2014.

The panel had regard to your evidence, namely that you sought assurances from Registrant B and Mr 24 that the concerns raised by the PPO reports were being

addressed. While the panel accepted that primary responsibility for addressing the concerns arising from Patient B's PPO report would have fallen to the Prison's healthcare management team, the panel also had a wealth of evidence about the steps that were taken by staff in the Prison to try to address these concerns and the problems they encountered in doing so. The panel considered that seeking assurances from Registrant B and Mr 24 that corrective actions were in place may have been adequate action to take in the first instance. However, it did not consider that getting assurances was adequate in the face of persistent repetition of the same concerns. The panel could identify no evidence that you actively monitored the implementation of these action plans, nor that you escalated the issues identified by Patient B's PPO report into the Trust's governance structure when it became apparent that problems were persisting and the action plans were not working.

The panel was therefore satisfied that you failed to ensure adequate escalation and/or adequate action was taken following concerns raised by the Prison and Probation Ombudsman reports following deaths in custody in respect of Patient B.

Accordingly, charge 5(b)(ii) is found proved.

Charge 5(b)(iii)

5. In relation to the healthcare services provided to the Prison, you:

(a) Failed to ensure adequate escalation and/or adequate action was taken following concerns raised by the Prison and Probation Ombudsman reports following deaths in custody in respect of one or more patients, including:

(i) …

(ii) …

(iii) Patient C; and or

This charge is found NOT proved.

You left the employment of the Trust in April 2014. The panel noted from the evidence that it was unclear as to whether Patient C's PPO report had been received by the Trust before you left LCH.

As the panel could not be satisfied, to the requisite standard, that Patient C's PPO report had been received by the Trust while you were still employed there, it could not establish any duty on you to ensure that adequate action or escalation was taken in response to the concerns raised in this report.

Accordingly, charge 5(b)(iii) is found not proved.

Charge 5(b)(iv)

5. In relation to the healthcare services provided to the Prison, you:

(b) Failed to ensure adequate escalation and/or adequate action was taken following concerns raised by the Prison and Probation Ombudsman reports following deaths in custody in respect of one or more patients, including:

(i) …

(ii) …

(iii) …

(iv) Patient D

This charge is found NOT proved.

The panel heard evidence that Patient D's PPO report was not received by LCH until June 2014. This was after you had left the employment of the Trust. In these circumstances, the panel could not establish any duty on you to ensure that adequate action or escalation was taken in response to the concerns raised in this report.

Accordingly, charge 5(b)(iv) is found not proved.

Charge 5(c)

5. In relation to the healthcare services provided to the Prison, you:

(c) Failed to ensure appropriate standards of care for patients was maintained at the Prison;

This charge is found proved.

The panel noted that the evidence underpinning this charge was similar to charge 5(d) and that your written response dealt with them together. The panel considered that the charge was broadly worded and that "appropriate care" encompassed all of the aspects specified in charge 5(d)(i) – 5(d)(vii). The panel's reasons for this charge should therefore be read in conjunction with its reasons for charge 5(d).

As outlined in the panel's decision on charges 5(b) and 5(d), there were numerous reports which identified significant and persistent concerns within Prison healthcare. The panel also heard oral evidence from several NMC witnesses which supported the documentary evidence.

The panel accepted that Registrant B, Registrant C and Registrant D were the senior managers within Prison healthcare and were responsible for ensuring that appropriate standards of care for patients were maintained at the Prison. However, in your witness statement you accepted that your role was to seek assurances that Prison healthcare was being managed as effectively and safely as possible, and that standards of care were being maintained. Your job description set out that you were *'accountable for the day to day running of clinical services and those support services directly supporting clinical delivery.'*

You stated that you had confidence in the ability of Registrant B, Head of Healthcare, and Mr 24, the Divisional Manager, to manage the Prison and escalate any concerns to you. You gave evidence that, when concerns were identified in the Prison, you sought assurances from Registrant B and/or Mr 24 that they were being addressed and you

received assurances that matters were being addressed, for example through action plans.

However, the panel had evidence that throughout 2012 and 2013 healthcare standards in the Prison deteriorated and, in January 2014, Mr 9 was put into the Prison to "troubleshoot" and try to ensure that appropriate standards of care were reinstated.

The panel was satisfied from the reports provided in evidence, including:

- Patient B's PPO report dated September 2012
- Patient A's PPO report dated October 2013
- CQC report dated October 2013
- Action plan dated November 2013
- Action plan dated December 2013
- Ms 13's reports
- Mr 9's report, dated March 2014
- Action plan, dated July 2013

The panel was satisfied that there was significant evidence that appropriate standards of care were not maintained at the Prison. While it accepted that you did not have day-to-day responsibility for the Prison you accepted that your role did encompass ultimate responsibility for the maintenance of standards of care within that environment. The panel considered that by accepting assurances from Registrant B and Mr 24, in the face of external reports and internal concerns that suggested that problems were not being effectively addressed, you failed to ensure that appropriate standards of care for patients were maintained at the Prison.

Accordingly, charge 5(c) is found proved.

Charge 5(d)(i) – 5(d)(vii)

5. In relation to the healthcare services provided to the Prison, you:

(d) Failed to take adequate action in respect of concerns regarding:

(i) Inadequate care being provided to patients;
(ii) Inadequate care planning for patients;
(iii) Inadequate risk assessments for patients;
(iv) Inadequate record keeping;
(v) Poor medicines management and/or medicines administration;
(vi) Inadequate health screening/assessments and/or secondary health checks for new and/or returning patients;
(vii) Insufficient staffing levels

These charges are found proved.

The panel noted that, in your witness statement, you had responded to charges 5(d)(i) – 5(d)(vii) together, as they were interlinked. The panel agreed with this approach and adopted the same in its determination.

The panel first identified the sources of the concerns listed in charges 5(d)(i) – 5(d)(vii).

The PPO report into the death of Patient B, published in September 2012, reported that *'the medical care Patient B received fell below the expected standard for general practice'.* The PPO report into the death of Patient A, published in October 2013, also reported the *'the clinical reviewer concluded that there were significant shortcomings in the care that Patient A received at Liverpool. We agree with his findings and recommend that the prison reviews Patient A's care to learn lessons.'*

More generally, the panel considered that 'inadequate care' was a broad term which encompassed all of the issues specified in charges 5(d)(ii) – 5(d)(vii) and, as such, could be supported by the evidence of each of these concerns.

The panel had evidence of concerns regarding inadequate care planning (charge 5(d)(ii)) from a number of sources, namely:

- Patient B's PPO report, September 2012
- An internal audit of the Prison carried out in May 2013
- HMIP inspection report, October 2013
- CQC report, October 2013
- The evidence of Mr 9 who worked in the Prison from January – August 2014 and his March 2014 report.
- Audits carried out by Ms 10 in January, July and August 2014

Patient B's PPO report, published in September 2012, identified care-planning as a concern and made recommendations in relation to this. Despite this, Mr 8's HMIP report from October 2013 continued to identify a lack of care plans for prisoners with long-term conditions. His report also cited staff shortages as a primary reason for the lack of outpatient care plans for prisoners with long-term conditions: *'the long-term conditions clinics did not take place owing to staff shortages; patients with chronic conditions were dispersed to other clinics. This meant that patients did not have care plans, although the care they received met national guidance'.* He confirmed in his oral evidence that he was referring in particular to the near-permanent absence of a long- term conditions nurse, whose position had been vacant for more than a year at the time of his inspection. Ms 25's CQC inspection was undertaken at the same time as Mr 8's HMIP inspection and also identified a lack of care planning for outpatient prisoners with long-term conditions. Mr 9 also raised care planning as an issue in his report in March 2014.

Ms 6 gave oral evidence about the essential role of a long-term conditions nurse in care planning for patients. She confirmed that the role is a specialist position at Band 7 level, and that it requires a minimum of 12 months training. She told the panel that it was not a role in which another nurse can 'back fill' or 'act up' unless they have completed the relevant training. This evidence was corroborated by a number of other witnesses.

The panel had evidence of concerns regarding inadequate risk assessments (charge 5(d)(iii)) from:

- The root cause analysis report into the death of Patient C, September 2013

- Ms 10's January 2014 audit.

It had also heard evidence that risk assessments formed one specific part of the overall care planning for a patient, and was therefore impacted in the same way by staff shortages.

The panel had evidence of concerns regarding inadequate record keeping (charge 5(d)(iv)) from:

- Patient B's PPO report, September 2012
- The root cause analysis report into the death of Patient C, September 2013
- Patient A's PPO report, October 2013
- CQC report, October 2013
- Audits carried out by Ms 10 in January, July and August 2014
- The evidence of Mr 9 who worked in the Prison from January – August 2014 and his March 2014 report
- The evidence of Ms 6 who worked at the Prison from August – November 2014

The panel also heard evidence from witnesses, specifically Mr 4 and Colleague A, about the impact of short staffing on record keeping. Nurses at the Prison were 'spread too thinly' and were therefore forced to prioritise more urgent aspects of care, at the expense of record keeping.

The panel had evidence of concerns regarding poor medicines management and/or medicines administration (charge 5(d)(v)) from:

- HMIP report, October 2013
- CQC report, October 2013
- A review conducted by Ms 13 between November 2013 and March 2014
- The evidence of Ms 14 who went into the Prison from June 2014
- The evidence of Ms 6 who worked at the Prison from August – November 2014

Mr 24 also confirmed in his evidence that concerns regarding medicines management and administration in the Prison had been escalated to him and were rated as a red risk on the Trust's risk register.

The panel had evidence of inadequate secondary health checks for new and/or returning patients (charge 5(d)(vi)) from:

- HMIP report, October 2013
- CQC report, October 2013
- The evidence of Ms 12 who went into the Prison in March 2014 following Ms 13's November 2013 review and the subsequent CQC inspection.

The panel also heard evidence that the number of incoming prisoners doubled from 250 to 500 in September 2012. The 72 hour screening target remained the same, but the healthcare team at the Prison was given no additional resources to cope with this increased demand, despite requests to you for additional staff and resources. As a result, by July 2013 the secondary screening completion rate had decreased from 30% to 18%.

The panel heard evidence from numerous witnesses that insufficient staffing levels (charge 5(d)(vii)) within the Prison were a persistent problem, which had a significant impact on the ability of the healthcare team to provide care to patients. The panel heard evidence of this from LCH staff, such as Colleague A, Mr 9 and Mr 24, but noted that it was also identified by external parties, such as HMIP and the CQC, as an underlying cause of other problems in the Prison.

You gave evidence that your role as Director of Operations and Executive Nurse was, in broad terms, to seek assurance that healthcare in the Prison was being managed as effectively and as safely as possible, and that standards of care were being maintained.

You stated that direct responsibility for standards of care in the Prison lay with Registrant B, Head of Healthcare at the Prison, and Mr 24, the Divisional Manger. You gave evidence that you had confidence in Registrant B's ability to manage issues within

Prison healthcare and to escalate any concerns to you. You gave evidence that, following the publication of external reports, you received assurances from Registrant B and Mr 24 that action plans were in place to deal with the concerns.

However, the panel considered that, while seeking assurances may have been adequate in the first instance, it was not adequate in the face of persistent and repeated problems. The panel heard evidence that the lack of care planning and medicines management in the Prison were both escalated as 'red risks' on the Trust's risk register by Mr 24. In these circumstances, the panel considered that you had a duty to do more than simply seek assurances, but to actively follow up on the progress of the action plans and any challenges to their success.

In your witness statement you stated that you have no recollection of Registrant B raising any particular concerns about patient care with you. You gave evidence that you visited the Prison on six occasions during your tenure at LCH. This was disputed by a number of witnesses who suggested that it was fewer. In any event, the panel considered that this did not suggest you were regularly attending at the Prison.

The panel noted from the evidence that staffing pressures appeared to underpin many of the concerns identified in, and being escalated out of, the Prison. The panel accepted the evidence it heard from you, as well as many of the NMC witnesses, about the nationwide challenges in recruiting staff to prison healthcare. However, the panel also heard a wealth of evidence about the specific difficulties in recruiting to the healthcare team in HMP Liverpool. The Trust was under pressure to save money, partly to meet national targets but also as part of its goal to achieve Foundation Trust status. CIPs were implemented across LCH services and the panel heard evidence from many witnesses regarding the impact of CIPs on staff recruitment. In relation to the Prison, Mr 24, confirmed in his oral evidence that:

i. There was a 'top down' pressure to prioritise financial savings over clinical issues. His division (which included the Prison) had a target of 20% cost savings over 12 months which he described as *"impossible".* He told the panel that, in his

experience working in the NHS for 30 years, 4% is generally accepted as the safe and effective maximum annual saving.

ii. The CIPs were first developed in 2011. The Prison proposed reducing costs by reducing the number of permanently employed GPs and relying instead on locum and agency GPs on an ad hoc basis. This was supported by a Quality Impact Assessment ("QIA") which was approved and signed off by him.

iii. The workforce at HMP Liverpool and HMP Kennet were combined in April 2012. The two managers at HMP Kennet were made redundant, leaving Registrant B, Registrant C and Registrant D as the only managers across both sites.

iv. In 2012 the Trust contracted a consultant to advise on the progression of the CIPs. He recommended the establishment of the Project Management Office ("PMO") which in turn devised the 20% CIP target for Mr 24's division.

v. One of the key methods for delivering this new target was the deletion of £10.3 million of budget lines for vacancies. This second phase of the CIPs came into effect in mid-2012.

vi. Mr 24 was performance managed for the delivery of the CIP for the division, so if one was not manageable then it was redistributed across his other services. The Prison ended up having to absorb a much higher share of the cost savings than originally planned (potentially up to 25% of the budget), due to other services within the division not being able to meet their targets.

vii. Over time, Mr 24 had to add more and more savings to the Prison's CIP as his other services struggled to meet their targets. Increasing numbers of budget lines had to be deleted, particularly in relation to vacancies.

viii. As a result of the CIP programme you established a new-style VCP in or around May 2012. All requests for additional/replacement staff had to go via the VCP and the VCP would delay and refuse recruitment requests as a technique to delay budget lines. The VCP was a key tool in delivering CIPs and the majority of requests were refused.

The panel also had evidence that you were trying to come up with 'cost neutral' solutions by reallocating staff, proposing skill mix reviews and identifying new recruitment opportunities.

The panel had a significant number of emails from the three healthcare managers – Registrant B, Registrant C and Registrant D – which evidence that they were repeatedly reporting concerns about insufficient staffing levels to Mr 24 and requesting additional support. However, Mr 24 gave evidence that he was unable to do anything about the insufficient staffing levels as he *"had no money".*

The panel also had an email chain, which included you, regarding the VCP, which originated with a VCP application from Registrant B. On being informed that her application had been put on hold by the VCP she sent an email to Mr 24, dated 26 June 2012, in which she outlines the staffing pressures in the Prison.

You denied in your evidence that the VCP was a key tool in delivery CIPs. However, the panel considered that this was inconsistent with the evidence it had heard from various Divisional managers about the difficulties in gaining approval to recruit. It accepted that staff costs were your largest liability and therefore had the potential for the greatest savings to be made.

It was also inconsistent with your email dated 4 May 2012 regarding the VCP which stated:

> *'Dear All*
>
> *In case you were in any doubt, we have a £30m CIP to find over 5 years. £8m this year. We have not been able to identify all of the saving for this year. In order to make this happen and have rigorous monitoring of the savings, we are putting the following processes in place:*

Vacancy Control Panel (VCP)

This will be for all posts in the organisation without exception.

This will include permanent posts, temporary posts, any changes in hours (increase or reduction), agency requests, bank requests and anything else.

…

The business case for any posts will have to be presented in person by the service lead and or clinician (as the service wishes). This will be a challenging process for some staff but is necessary. If they will need to be fully prepared with a convincing business case. We will challenge like for like posts. Every other alternative will need to be considered before attending the panel.

…

These processes will be challenging for all staff but are necessary to make the savings. We will all need to support the process and support staff through this…'

An example of this is Registrant B's request to the VCP for an additional member of staff in June 2012. The panel had sight of an email sent by Registrant B on 26 June 2012 following notification from the VCP that her staffing request had been placed 'on hold'. Registrant B requested an 'appeal' against the decision for the following reasons:

'I have already worked on cutting down one band 7 as part of the CIP and that will be no replacement for JK. However there is no way I can lose two. This would mean myself and Registrant D working weekends

and evenings. As you know (and I am not complaining) I work well over my hours now. I just cannot do it anymore.

Whilst I appreciate the Panel's rationale but we still have to be able to provide and deliver our services.'

The panel was satisfied, having considered the email trail, that the vacancy control panel staff forwarded that email to you together with an email from Dr 20 which stated *'this post is critical to the service's delivery'* and your response on 29 June 2012 to the other members of the VCP was as follows:

'I am going to bring my special vaccination in on Monday, to immune VCP against any hard luck stories. You also don't give a plaster or a lolly pop after your injection. CIPs don't you know. As you can see I was vaccinated at birth.'

The panel did not accept your evidence that you had approved the vacancy as this was not supported by Registrant B's request to appeal. If, as you suggested, the request was approved there would be no need for an appeal or for the VCP to consider the matter again. During your evidence you were given the opportunity on more than one occasion to explain what you meant by *'hard luck stories'* but you were unable to do so. The panel considered that the reference to 'hard luck stories' could only be a response to Registrant B's comments.

The panel noted your evidence that the request was approved subject to the removal of the 'deflator'. This was a matter outside of Registrant B's control and therefore the request had not, in effect, been approved. The panel concluded that this, in reality, placed the vacancy 'on hold'.

The panel accepted that you had no control over the savings targets imposed on LCH as part of the NHS's national programme. It also accepted that the decision to pursue

Foundation Trust status was taken before you joined LCH. However, the panel had a wealth of evidence that there was an aggressive drive within the Trust to save money, led by the Executive team and the Board, of which you were a part. There was no evidence that you had raised at Board level the impact CIPs were having on patient care and safety. Neither did you seek out evidence that an adequate standard of care was being delivered.

The panel considered that, although your role within the Executive team required you to drive forward the Trust's objectives, your position as Director of Operations and Executive Nurse imposed a duty on you to ensure that patient care and safety remained a priority and did not suffer as a result of financial targets. The panel considered that your failure to respond promptly and effectively to concerns regarding staffing, which in turn were having an impact on each of the concerns set out in charges 5(d)(i) – 5(d)(vii), and to advocate these at the executive and board level was inadequate.

The panel heard evidence that pressures on recruitment did not "ease off" until after the CQC report was published in Oct 2013, where four out of seven of the CQC's standards were rated as "action needed". This was over a year after concerns were first identified and escalated to you. The panel acknowledged that, by the beginning of 2014, actions were being taken at an Executive and Board level to address problems in the Prison, but the panel considered that this action was taken too late, and that this delay was unacceptable.

Taking account of all of the evidence, the panel was satisfied that in relation to healthcare services at the Prison you failed to take adequate action in respect of concerns regarding:

(i) Inadequate care being provided to patients;
(ii) Inadequate care planning for patients;
(iii) Inadequate risk assessments for patients;
(iv) Inadequate record keeping;
(v) Poor medicines management and/or medicines

administration;

(vi) Inadequate health screening/assessments and/or secondary health checks for new and/or returning patients;

(vii) Insufficient staffing levels

Accordingly, charges 5(d)(i) – 5(d)(vii) are found proved.

Charge 5(e)

5. In relation to the healthcare services provided to the Prison, you:

(d) Or, alternatively to Charge 5d, took insufficient steps to ensure that you were aware of one or more of the concerns set out at (i) – (vii) above.

This charge is found NOT proved.

The panel noted that charge 5(e) is phrased in the alternative to charge 5(d). Having found charge 5(d) proved, the alternative charge is found not proved.

Charge 6(a)

6. Failed to take adequate action in respect of an alleged sexual assault and/or hostage-taking of a member of staff, which occurred on or around 6 March 2013, in that you:

(a) Failed to ensure that a Root Cause Analysis Investigation was undertaken;

This charge is found NOT proved.

In reaching this decision, the panel took into account your evidence and that of Mr 4. On 6 March 2013 an LCH district nurse was taken hostage in a patient's home and sexually assaulted by the patient's son. You told the panel that you became aware of this incident when the Director on call sent an email to the Chief Executive that day, copying in all of the Executives, including yourself. You also told the panel that, later that day,

you spoke with Mr 4, the Area Manager for District Nursing, who had attended the scene.

You told the panel that, in your conversation with Mr 4, you asked him whether a Root Cause Analysis ("RCA") would be completed and he confirmed that it would. The panel also had a copy of an email you sent on 6 March 2013 at 14:51 which stated *'Just to assure everyone [Mr 4] is taking the lead in supporting the nurse and doing the RCA on the incident, which I have asked to be reported to me directly.'* Mr 4 was not a recipient of this email.

In his witness statement Mr 4 stated that you asked him to call a scoping meeting and not to prepare an RCA. Mr 4 told the panel he arranged a scoping meeting for 12 March 2013. The outcome of that meeting was that an RCA investigation would be conducted by Mr 35, Health and Safety Manager, as it was a health and safety matter, not a clinical one.

The panel had sight of an investigation report conducted in 2014 by Mr 36 which identified that Mr 35 had delegated the RCA investigation to the Local Security Management Officer (LMSO). The LMSO had produced a report which Mr 36 described as *'insufficient; of very poor quality and use of inappropriate language without the full knowledge of the facts even though they were the alleged IO…Report not signed off by senior member of the team yet shared with [the nurse] and caused extreme distress…No learning or recommendations about improved safety for community nurses noted in the report…Complete failure to follow correct process or escalate if concerned process was not being followed.'* Mr 36 was not a witness in this case and did not give evidence to the panel.

The panel heard no evidence from Mr 35 (he too was not a witness in the case) and did not have sight of the report prepared by the LMSO or any of the documentation prepared during that investigation. The panel had evidence that you asked Mr 4 to

conduct a scoping meeting and that the result of that meeting was that an RCA was commissioned.

The panel had evidence that an investigation of sorts was carried out and a report prepared. The panel noted from the report of Mr 36 that his view was that the investigation and subsequent report was of poor quality and had not followed the established process.

Whilst the panel considered that it would have been desirable for you to follow up the progress of the investigation and ensure that it was adequately completed given the seriousness of the matter, it determined, having regard to the wording of the charge, that it had insufficient evidence to conclude that no RCA investigation had been undertaken.

Therefore the panel could not be satisfied on the evidence that you had failed to ensure an RCA investigation was undertaken.

Accordingly, charge 6(a) is found not proved.

Charge 6(b)

6. Failed to take adequate action in respect of an alleged sexual assault and/or hostage-taking of a member of staff, which occurred on or around 6 March 2013, in that you:

   (b) Failed adequately to escalate the incident to your superiors and/or the Board and/or the police and/or other relevant external agencies.

This charge is found proved.

The panel noted that this charge alleges a failure to escalate in respect of four different entities: your superiors, the Board, the police, and other relevant external agencies. The

panel therefore considered each of these separately when deciding if (i) you had a duty to escalate and (ii) whether you had failed in this duty.

Your superiors

The panel considered that, as Director of Operations and Executive Nurse at the Trust, your superior was the Chief Executive, Ms 19.

The panel noted that you became aware of the incident when you were notified by an email from the Director on call. This email was in fact sent to Ms 19, and you were copied in along with the other Executives. When you replied to this email, informing the Executive team that you had spoken with Mr 4 and that he would be taking the lead on the RCA, you included Ms 19 in your response.

The panel was satisfied that there was no duty on you to escalate this incident to Ms 19 as she was already aware of it, having been informed by the Director on call's email on 6 March 2013.

The Board

In your evidence you accepted that you did not escalate this incident to the Board but stated that this was because the incident was not reported as a SUI ("serious untoward incident") and therefore did not have to be reported to the Board through STEiS.

The panel was of the view that, notwithstanding that the incident was not reported as a SUI at the time, it was an extremely serious incident, which had implications not only for the reputation of the Trust but also for the mental and emotional wellbeing of the nurse concerned, as well as the health and safety of the 2000 district nurses employed by LCH. The panel considered that, in these circumstances, you did have a duty as the Executive Nurse to escalate this serious incident involving one of your nurses to the Board, even before a full investigation had taken place.

The panel was therefore satisfied that you had a duty to escalate the incident to the

Board and that you failed in this duty.

The police

The panel noted that the email informing you of the incident stated that *'The Police we [sic] called immediately …The Police have freed the DN and the Gas Man who was also held, and have arrested a man."*

Given that the police were already aware of the incident, the panel was satisfied that there was no duty on you to escalate this incident to them.

Other relevant agencies

The panel noted that the charge does not define to which 'other relevant external agencies' the NMC alleges you should have escalated this incident. The only other agency that the panel heard evidence about in relation to this charge was the Health and Safety Executive ("HSE"). The HSE only became involved at the request of the district nurse concerned. However, the panel heard evidence that, at the time, the criteria for HSE reportable RIDDOR incidents focussed on physical harm, not psychological harm. This incident therefore did not meet the HSE's reporting criteria at the time.

In light of this, the panel was satisfied that you did not have a duty to report the incident to the HSE. The panel heard no other evidence to suggest that this incident should have been reported to any other external agencies.

In these circumstances, the panel was satisfied that you did not have a duty to escalate this incident to any other external agencies.

Accordingly, the panel finds charge 6(b) proved but only in relation to failing to escalate the incident to the Board. The charge is found not proved in relation to escalation to your superiors, the police and other relevant external agencies.

Charge 7(a) – 7(d)

7. Following receipt of a record of your 29 January 2014 interview with [Ms 18], amended the record to state the following:

   (a) "*I do not wish representation as I am in the RCN which is the same union as [Colleague A] and I feel that I cannot be appropriately represented by the union as an executive*";

   (b) "*I got upset by how upset she was, and said to her "don't go, let's talk about this*"";

   (c) "*Because her work is her identity. We should be supporting her to come back to work when she is well enough but I don't think this grievance is anything about coming back to work. It must be untenable now for her to come back to work*";

   (d) "*I am sorry I have upset [Colleague A]. I value her skills and want to do anything to support her return to work. I would be happy to have facilitation or a mediated meeting if it would help*."

Charges 7(a) – 7(d) are found proved.

On 29 January 2014 you were interviewed by Ms 18, in relation to a grievance submitted by Colleague A. Following the meeting, Ms 18 sent you a typed record of the interview. Ms 18 alleges that you returned a signed copy of the interview record with a number of amendments, including those set out in charges 7(a) – 7(d).

The panel was provided with a copy of the interview record which Ms 18 had sent to you, and a copy of the version you returned. From these documents, the panel could see that the amendments set out in charges 7(a) – 7(d) had been made. You also accepted in your evidence that you made these amendments, in order to more accurately reflect what you say took place.

Accordingly, charges 7(a) – 7(d) are found proved.

Charge 8

8. Your actions as set out in Charges 7a – 7d were dishonest, in that you intended to mislead individuals reviewing the interview record as to the statements you made during the 29 January 2014 interview with Ms 18.

This charge is found NOT proved.

Ms 18 gave evidence that on 24 October 2013 Colleague A submitted a grievance regarding you. Ms 18 interviewed you regarding this on 29 January 2014. Ms 18 made handwritten notes during the interview, which she then later typed. In her evidence Ms 18 stated that while the typed notes were not necessarily verbatim, she believed they were a true reflection of the comments made during the interview.

Ms 18 sent the typed notes of the interview to you by email. You then returned them in early February 2014. Ms 18 gave evidence that when she received the record back from you she compared it with the version she sent, as she had with all of the other interviewees. Ms 18 gave evidence that you did not inform her that you had made any amendments, nor was the returned document marked with any "track changes". However, Ms 18 identified what she described as *'significant amendments'*, including the changes specified in charges 7(a) – 7(d). Ms 18 told the panel that she did not recall you making the comments which you had changed and/or added to the interview record. Ms 18 also said that, at the time, she went back and checked her hand written notes to confirm her recollection. Ms 18 gave evidence that she was concerned that the additional comments were misleading, in that they changed the nature and tone of the interview and made it sound as if you had been more conciliatory and insightful than you had actually been.

In your evidence you accepted amending the interview record sent to you by Ms 18. However you stated that you made the amendments to accurately reflect what you had said in the interview. The panel could see from the record of the interview that you had made a number of other changes which were not said to be controversial. You denied

attempting to mislead anyone or acting dishonestly. You gave evidence that you made the changes within a few days of the interview, so your recollection of what you had said was still clear. You told the panel that you did make the amendments with track changes and emailed them back to Ms 18, and that your PA prepared a hard copy which you signed but did not check, to be returned by post.

The panel noted that the allegation of dishonesty arises solely from Ms 18's assertion that you did not make the comments set out in charges 7(a) – 7(d), and that the amendments were made with an intention to mislead by creating a false impression. The panel found Ms 18 to be an honest witness who gave evidence to the best of her recollection. However, it was also mindful that she was recalling events that took place over five years earlier, and that honest witnesses can be mistaken. The panel bore in mind that, although Ms 18 gave evidence that she used her handwritten notes to check her recollection, these notes have since been destroyed and were not available to the panel. Furthermore, these handwritten notes were made by Ms 18 herself while she was also conducting the interview; there was no independent note-taker and no electronic audio recording of the interview to independently verify what was said. Ms 18 also accepted in her evidence that other alterations made by you to the interview record were accurate.

The panel was mindful that dishonesty is a very serious allegation, which requires cogent evidence to be found proved. Although the panel found Ms 18 to be an honest witness it could not, in the circumstances, place sufficient reliance on the accuracy of her recollection in order to be satisfied that you did not in fact make the comments set out in charges 7(a) – 7(d) during the interview.

Accordingly, charge 8 is found not proved.

Charge 9(a)

9. Bullied and/or intimidated Colleague A, in that you:

    a) In or around May 2011, stated to Colleague A words to the effect that she

was no longer needed and/or that you did not want her on your team;

This charge is found proved.

The panel noted that the evidence in support of this charge came from Colleague A. Colleague A gave evidence to this panel over a number of days. The panel found her to be an honest witness, who was clearly passionate about her job as a nurse and very affected by the events as she recalled them.

Colleague A gave evidence that in May 2011 she had one of her first meetings with you. Colleague A told the panel that this was an impromptu meeting and took Colleague A by surprise as you told her that she was no longer needed and that you did not want her on your team. According to Colleague A, you told her that she was not a member of the senior operations team and was not required to give any such input. Colleague A described your manner as abrupt and rude.

You cannot recall your first meeting with Colleague A but gave evidence that you could not imagine being introduced to someone and responding in the manner alleged.

The panel noted that Colleague A had a very clear recollection of this alleged incident, and it had no reason to doubt the veracity of her evidence. It was therefore satisfied, on the balance of probabilities, that in or around May 2011, you stated to Colleague A words to the effect that she was no longer needed and/or that you did not want her on your team.

Accordingly, charge 9(a) is found proved.

The panel noted that the stem of charge 9 is that you ‘bullied and/or intimidated Colleague A’. The panel decided that it would be more appropriate to determine the facts of each sub-charge first, before determining whether this amounted to bullying and/or intimidation.

Charge 9(b)

9. Bullied and/or intimidated Colleague A, in that you:

(b) On one or more occasions, left post-it notes in Colleague A's office criticising her and/or her work;

This charge is found NOT proved.

In Colleague A's NMC witness statement she states that over the years she worked with you, you would regularly leave post-it notes for her in capital letters, criticising something that she had done. In her oral evidence, when asked to give examples of what had been written on the post-it notes, Colleague A gave examples of *'See me now'* and *'Come and find me now'.* Colleague A was unable to recall any specific examples of criticisms of her or her work.

In your evidence you accepted that you often left post-it notes for colleagues if they were not at their desks, as you preferred to have face-to-face meetings. You denied ever leaving notes which criticised the work of Colleague A or anyone else.

The panel was satisfied from the evidence that you did leave post-it notes for Colleague A on one or more occasions. However, it was not satisfied that the examples it heard, namely *'See me now'* or *'Come and find me'* constituted a criticism of Colleague A nor her work.

Accordingly, the panel finds charge 9(b) not proved.

Charge 9(c)

9. Bullied and/or intimidated Colleague A, in that you:

c) On one or more occasions, subjected Colleague A to excessive questioning and criticism during service performance meetings;

This charge is found proved.

In her NMC witness statement Colleague A states that in a number of service performance meetings she and Colleague B received *'extremely harsh treatment'* from you. Colleague A stated that meetings became like *'interrogation sessions'* in which she and Colleague B would be asked *'endless questions and criticised for practices to a much greater level than anyone else'.*

This was consistent with Colleague B's evidence. In his oral evidence he described the service performance meetings as *"1 hour 45 minutes, 1 hour 50 minutes of total interrogation of myself and [Colleague A], with the last five minutes, the last remaining minutes will be with the primary care division and the children's division, which basically they have no scrutiny applied at all."*

In your witness statement you describe the purpose of service performance meetings as being constructive scrutiny, challenging of performance and to hold people to account. You told the panel that as the Adult Division was the largest division at LCH it required more time during these meetings than the other two divisions.

The panel found the evidence of Colleague A and Colleague B to be consistent and credible in relation to this charge. Although the Adults' Division may have been the largest division at LCH, the panel considered that the description used by both of them of *'interrogation'* suggested that the questioning and criticism that they came under at the service performance meetings was excessive. Moreover, both witnesses when giving their evidence were visibly distressed in recalling these matters which suggested that the service meetings had been an unduly arduous ordeal.

Accordingly, charge 9(c) is found proved.

The panel noted that the stem of charge 9 is that you 'bullied and/or intimidated Colleague A'. The panel decided that it would be more appropriate to determine the

facts of each sub-charge first, before determining whether this amounted to bullying and/or intimidation.

Charges 9(d)(i) – 9(d)(iv)

9. Bullied and/or intimidated Colleague A, in that you:

(d) On or around 17 November 2011, made comments to the effect that Colleague A:

(i) Was a big disappointment;

(ii) Had wasted 35 years of her life in the nursing profession;

(iii) Had sent e-mails that showed she was illiterate;

(iv) Was incapable of doing her job.

These charges are found proved.

Colleague A gave evidence that she met with you on 17 November 2011 in order to discuss what she perceived to be a relationship issue between the two of you. Colleague A told the panel that, during this meeting, you told her that she was a big disappointment, had wasted 35 years of her life in the nursing profession, had sent emails that showed that she was illiterate, and was incapable of doing her job.

You could not recall this meeting with Colleague A but suggested that it was highly unlikely that you would have said anything to the effect of the comments alleged in the charge. In your witness statement, you describe yourself as being *'professional and polite by nature'* and denied ever using personal or offensive language towards Colleague A, or saying anything to the effect of the words alleged in the charge. You accepted that you had sent Colleague A an email on 4 November 2011, which included a request that future reports be proof read, but stated that this was aimed at upholding standards and was not intended to question Colleague A's literacy.

The panel accepted the evidence of Colleague A. It found her oral evidence on this point to be compelling and noted that her evidence was consistent with the grievance

letter she submitted in October 2013, her interview with Mr 22 in June 2015, her written NMC witness statement in February 2017 and her oral evidence to this panel. Although Colleague A became emotional during her evidence, she was adamant that the statements at charges 9(d)(i) – 9(d)(iv) were the words which you said to her in your meeting on 17 November 2011. Colleague A also said that these comments made her feel inadequate and unworthy and caused her to become upset and cry.

Colleague A's evidence was also supported by the evidence of Ms 15 who said that she recalled a conversation with Colleague A. She saw her Colleague after she had left a meeting with you in which it was said that you had told her that she had wasted her life being a nurse and *'wasn't good at it'.* Ms 15 described Colleague A as looking *'very upset, completely demoralised and devastated.'*

The panel was therefore satisfied, on the balance of probabilities, that on or around 17 November 2011, you made comments to the effect that Colleague A:

a) was a big disappointment;
b) had wasted 35 years of her life in the nursing profession;
c) had sent emails that showed she was illiterate;
d) was incapable of doing her job.

Accordingly, charges 9(d)(i) – 9(d)(iv) are found proved.

The panel noted that the stem of charge 9 is that you 'bullied and/or intimidated Colleague A'. The panel decided that it would be more appropriate to determine the facts of each sub-charge first, before determining whether this amounted to bullying and/or intimidation.

Charge 9(e)

9. Bullied and/or intimidated Colleague A, in that you:

e) [PRIVATE]

This charge is found NOT proved.

[PRIVATE]

Accordingly, charge 9(e) is found not proved.

Charge 9(f)

9. Bullied and/or intimidated Colleague A, in that you:

   f) On an unknown date, took off a set of beads that you had been wearing and threw them at Colleague A;

This charge is found NOT proved.

In her witness statement, Colleague A alleges that during a discussion with you about IBBCS, you took off a beaded bracelet that you were wearing and threw it at Colleague A. However, this is inconsistent with Colleague A's grievance interview with Ms 18 on 20 December 2013, when she is recorded as saying that your beads *"fell off".* When questioned about this incident during her oral evidence, Colleague A's recollection was unclear.

You deny throwing a set of beads at Colleague A.

Given the inconsistencies in Colleague A's recollection of this incident, the panel was unable to place sufficient reliance on her evidence to be satisfied, on the balance of probabilities, that on an unknown date you took off a set of beads that you had been wearing and threw them at Colleague A.

Accordingly, charge 9(f) is found not proved.

Charge 9(g)

9. Bullied and/or intimidated Colleague A, in that you:

g) On or around 13 September 2013, you raised your voice and/or shouted at Colleague A words to the effect of, "*See this is what you do. You expose me at the Board, I am always going to the Board finding out things you haven't told me about*";

This charge is found proved.

In her NMC witness statement Colleague A stated that she had arranged a meeting with you on 13 September 2013 to discuss an incident which you were investigating. According to Colleague A, you arrived 10 minutes late for this meeting and then spoke over Colleague A. At a point during the meeting Colleague A stated that you became angry at her and shouted at her saying "*See this is what you always do. You expose me at the board, I am always going to the board finding out things you haven't told me about."*

In your evidence you stated that, prior to this meeting, you had attended the Executive meeting. At this meeting the incident which Colleague A was investigating was raised. You were unaware of the details. You informed the meeting that Colleague A was about to discuss it with you. According to you, the Chief Executive, Ms 19, was very critical of you for not being aware of the incident.

You gave evidence that the discussion with Ms 19 made you late for your meeting with Colleague A. You said that you shared with Colleague A that you had just had a hard time at the Executive meeting. You said that you did this in the spirit of sharing, not blaming. According to you, Colleague A then became angry and upset and left the meeting crying so you asked Ms 23 to make sure that she was alright.

The panel took account of the evidence it had heard from a number of witnesses, including Ms 15 and Ms 23, that Colleague A would often leave meetings with you in a state of upset. It considered that it was more likely that you had become angry with Colleague A following a difficult Executive meeting and was satisfied, on the balance of

probabilities, that you did shout at Colleague A words to the effect of "*See this is what you always do. You expose me at the board, I am always going to the board finding out things you haven't told me about."*

Accordingly, charge 9(g) is found proved.

The panel noted that the stem of charge 9 is that you 'bullied and/or intimidated Colleague A'. The panel decided that it would be more appropriate to determine the facts of each sub-charge first, before determining whether this amounted to bullying and/or intimidation.

Charge 9(h)

9. Bullied and/or intimidated Colleague A, in that you:
    h) On or around 22 April 2013, when Colleague A raised a concern about another colleague attending an inquest into Patient C's death without support, stated words to the effect of, "*I know, as usual [Colleague A], you are going off on one"*;

This charge is found proved.

Colleague A gave evidence that on 22 April 2013 she met with you to discuss a number of issues, including her concerns that Registrant B would be attending Patient C's inquest with no one to support her. According to Colleague A, you responded by saying words to the effect of: *"I know, as usual [Colleague A], you are going off on one".*

You denied making these comments and gave evidence that you advised Colleague A that Registrant B was a very experienced Head of Healthcare and was experienced in attending Coroner's Court hearings.

The panel preferred the evidence of Colleague A. It found her oral evidence on this matter to be compelling and consistent with her witness statement. The panel was

therefore satisfied, on the balance of probabilities, that on or around 22 April 2013, when Colleague A raised a concern about another colleague attending an inquest into Patient C's death without support, you stated words to the effect of, "*I know, as usual [Colleague A], you are going off on one"*;

Accordingly, charge 9(h) is found proved.

The panel noted that the stem of charge 9 is that you 'bullied and/or intimidated Colleague A'. The panel decided that it would be more appropriate to determine the facts of each sub-charge first, before determining whether this amounted to bullying and/or intimidation.

Charge 9(i)

9. Bullied and/or intimidated Colleague A, in that you:
    f) On or around 4 October 2013, telephoned Colleague A and caused her to leave a meeting, and then informed Colleague A that she would be coached by another colleague in respect of her report writing.

This charge is found proved.

Colleague A gave evidence that on 4 October 2013 she was attending a meeting with other members of staff in relation to IBBCS. Her telephone rang and, because she was the on call nurse at the time, she took the call. The call was from you. According to Colleague A, you asked her to leave the room. She told you that she was in the middle of an urgent meeting but you insisted, so she left the room.

Colleague A gave evidence that you were aware that she would be on annual leave from that day and that you would like Mr 32 to coach her in report-writing. Colleague A told the panel that she was shocked that you had called her out of a meeting to discuss her development when she had not submitted a report to you since February 2013.

Colleague A gave evidence that she felt your comments were a deliberate attempt to upset and demoralise her and make her feel useless.

In your evidence you accepted that your call was not urgent but denied insisting that Colleague A take your call. You stated that your automatic greeting to colleagues is to ask whether they are with a patient, driving or in a meeting. You gave evidence that Mr 32 had offered to coach Colleague A in respect of writing Coroner's reports and you wanted to relay his offer in a timely way. The panel did not accept that this was your motivation in making this call to Colleague A.

The panel preferred the evidence of Colleague A. It was satisfied, on the balance of probabilities, that on or around 4 October 2013 you telephoned Colleague A and caused her to leave a meeting, and then informed Colleague A that she would be coached by another colleague in respect of her report writing. The panel concluded that you intended to convey to Colleague A that her report writing was inadequate and required improvement.

Accordingly, charge 9(i) is proved.

Having found charges 9(a), 9(c), 9(d), 9(g), 9(h) and 9(i) proved, the panel considered whether this amounted to bullying and / or intimidation of Colleague A, as set out in the stem of charge 9.

The panel had regard to the LCH "Bullying and Harassment" policy and, in particular, paragraph 5.2 which sets out examples of workplace bullying.

The panel was satisfied from the evidence it had heard from Colleague A that she clearly felt that she was being bullied and targeted by you during the incidents set out in charge 9. In her witness statement she describes the incident on 4 October 2013 (charge 9(i)) as *'the culmination of two years of harassment and intimidating behaviour from Ms Lockett. She had been relentless in the way in which she belittled me and*

reduced my confidence.' The situation was such that Colleague A wrote a letter of grievance to the Trust's HR Director regarding your behaviour and attitude towards her over the previous two years.

The panel also had evidence from other witnesses, including Ms 15 and Ms 23, that Colleague A would often appear very upset following her meetings with you. Ms 15 gave evidence that you would often *'belittle'* Colleague A and disagree with almost everything that she said.

The panel bore in mind that bullying can be highly subjective and it is possible that a person can perceive actions or words directed at them in a negative way that was not intended by the person doing or saying them. To this end, the panel had regard to the impressive character witnesses called on your behalf. All five of your character witnesses had worked with you either before or after your time at LCH and spoke highly of you and described you as a highly supportive manager.

The panel had regard to this character evidence, as well as the testimonials provided on your behalf. However, the panel also took into account the evidence it heard from those who directly observed you during your time at LCH, about how you conducted yourself with staff, in particular, Ms 23, Colleague B and Colleague A. The panel noted the tone of your emails could be short and your communication with others was not always good.

The panel was satisfied that your conduct towards Colleague A involved more than one occasion in which you criticised her and her professional ability and resulted in Colleague A losing her self-confidence and self-esteem. The panel considered that your actions did amount to bullying of Colleague A.

Taking account of all of the evidence, the panel was satisfied that your actions in charges 9(a), 9(c), 9(d), 9(g), 9(h) and 9(i) did amount to deliberate workplace bullying of Colleague A.

Charge 10(a)

10. Bullied and/or intimidated Colleague B, in that you:

    a) Following an interview you conducted with Colleague B on 30 March 2011, fed back to him that his performance was at such a low level that you had concerns about his ability to undertake his current position;

This charge is found proved.

In his NMC witness statement, Colleague B stated that following his interview for the position of deputy director of operations on 30 March 2011, you asked him to come to your office for feedback. You told him that he had not got the job. Colleague B told the panel that he was not surprised by this decision, as he was not expecting to get the position. However, according to Colleague B's witness statement, you *'launched into what [he] can only describe as character annihilation'.* Colleague B gave evidence that you told him that his performance in the interview had been so low that you had concerns about his ability to undertake his current position and that he needed to work really hard to try to prove himself to you. His witness statement describes the feedback as being *'so negative'* and delivered in *'such an unprofessional manner'.* Colleague B's oral evidence was consistent with his witness statement.

The panel also had a copy of Colleague B's 'bullying and harassment' grievance letter which he submitted on 14 June 2013. This letter makes reference to the *'extremely negative'* feedback that you gave him following his interview on 30 March 2011. Colleague B also mentions in his Capsticks interview with Mr 22 on 10 June 2015 that, following his interview with you in March 2011, you told him that you had no confidence in him to do his current job.

You gave evidence that you are experienced in giving feedback to unsuccessful interview candidates. You stated that you *'sensitively'* informed Colleague B that he had been unsuccessful at interview. You stated that you would have given feedback regarding areas to improve in a *'constructive and non personal way'.* You gave

evidence that you would have had no reason to comment on Colleague B's job performance in March 2011 as the interview was the first time you had met him.

The panel preferred the evidence of Colleague B. It found him to be a credible and reliable witness whose evidence on this matter had been consistent from his grievance letter in 2013 through to his oral evidence to this panel in 2019.

The panel was therefore satisfied, on the balance of probabilities, that following an interview you conducted with Colleague B on 30 March 2011, you fed back to him that his performance was at such a low level that you had concerns about his ability to undertake his current position.

Accordingly, charge 10(a) is found proved.

As with charge 9, the panel decided that it would be more appropriate to determine the facts of each sub-charge first, before determining whether this amounted to bullying and/or intimidation.

Charge 10(b)

10. Bullied and/or intimidated Colleague B, in that you:

(b) On one or more occasions, subjected Colleague B to excessive questioning and criticism during service performance meetings;

This charge is found proved.

The panel had already considered the evidence in support of this charge when considering charge 9(c). It therefore found the charge proved for the same reasons as for charge 9(c).

The panel will consider whether this amounts to bullying or intimidation once it has determined all of the facts for charge 10.

Charge 10(c)

10. Bullied and/or intimidated Colleague B, in that you:

    c) In or around March – April 2013, in relation to the Trust moving to a new headquarters, stated to Colleague B that there was no room for him at the new building and/or that you wanted him out of sight, or words to that effect;

This charge is found proved.

In his NMC witness statement Colleague B states that in approximately March / April 2013 you and he met to discuss concerns surrounding IBBCS. Colleague B gave evidence that you mentioned *'in passing'* that the Trust was in the process of moving to a new headquarters building, there was no room for Colleague B at the new building, and that you stated that you wanted him out of sight whilst pointing your finger in his face in an aggressive manner. Colleague B states that he was *'highly embarrassed'* and felt that he was being excluded from the senior team. This was consistent with your direction to exclude him from senior leadership meetings. This was also consistent with the oral evidence he gave to the panel, as well as his grievance letter, dated 14 June 2013 and his Capsticks interview with Mr 22 from 10 June 2015.

You gave evidence that the new Trust headquarters would be a hot desking environment and there would not be enough desks for everyone. Clinical managers were therefore asked to base themselves in their community services and hot desk when they came to the headquarters. You denied singling out Colleague B, or stating that you wanted him out of sight.

The panel preferred the evidence of Colleague B. It found him to be a credible and reliable witness whose evidence on this matter had been consistent from his grievance letter in 2013 through to his oral evidence to this panel in 2019.

The panel was therefore satisfied, on the balance of probabilities, that in or around March – April 2013, in relation to the Trust moving to a new headquarters, you stated to Colleague B that there was no room for him at the new building and/or that you wanted him out of sight, or words to that effect.

Accordingly, charge 10(c) is found proved.

As with charge 9, the panel decided that it would be more appropriate to determine the facts of each sub-charge first, before determining whether this amounted to bullying and/or intimidation.

Charges 10(d)(i) and 10(d)(ii)

10. Bullied and/or intimidated Colleague B, in that you:
    d) On or around 27 April 2013, stated to Colleague B at a meeting about his dissertation, words to the effect that:
        (i) The Board had lost trust and confidence in his work;
        (ii) He had three options; to undergo a disciplinary process which would end with the Trust firing him; to complete a capability process, which again would end with the Trust firing him; or that he could resign and find another job;

This charge is found proved.

In his written NMC witness statement Colleague B gave evidence that he met with you on 27 April 2013 to interview you as part of a dissertation he was writing. According to Colleague B, during this meeting you told him that Ms 33 had completed her reviews of IBBCS and it was not good news for him. You told him that the Board had lost trust and confidence in his work and he had three options:

- to undergo a disciplinary process which would end with the Trust firing him;
- to complete a capability process, which again would end with the Trust firing him;
- or that he could resign and find another job.

This was consistent with Colleague B's oral evidence, his grievance letter from June 2013 and his June 2015 Capsticks interview with Mr 22.

Colleague B gave evidence that his overall conclusion from the meeting was that you *'wanted rid'* of him and that you were extremely clear during the meeting that his focus needed to be on getting another job or else 'face the sack'. A few days later Colleague B contacted the HR Director, Ms 34, to find out more. According to Colleague B, Ms 34 said that you had gone *'off script'* during your discussion with Colleague B. Ms 34 told Colleague B that LCH wanted him to come out of IBBCS but did not want him to leave the Trust. Ultimately, Colleague B took up the role of Head of Sexual Health.

In your evidence you stated that you discussed the contents of Ms 33's report, in which Colleague B was criticised for "bullying behaviour". You denied suggesting or instigating any disciplinary process and stated that Colleague B arranged to take up the post of Sexual Health Manager without any involvement from you.

The panel preferred the evidence of Colleague B. It found him to be a credible and reliable witness whose evidence on this matter had been consistent from his grievance letter in 2013 through to his oral evidence to this panel in 2019. The panel also heard evidence from Ms 23 which supported the assertion that you had removed Colleague B from IBBCS.

The panel was therefore satisfied, on the balance of probabilities, that on or around 27 April 2013, you stated to Colleague B at a meeting about his dissertation, words to the effect that:

(i) the Board had lost trust and confidence in his work; and
(ii) he had three options; to undergo a disciplinary process which would end with the Trust firing him; to complete a capability process, which again would end with the Trust firing him; or that he could resign and find another job.

Accordingly, charges 10(d)(i) and 10(d)(ii) are found proved.

Having found charges 10(a), 10(b), 10(c) and 10(d) proved, the panel considered whether this amounted to bullying and / or intimidation of Colleague B, as set out in the stem of charge 10.

The panel had regard to the LCH "Bullying and Harassment" policy and, in particular, paragraph 5.2 which sets out examples of workplace bullying.

The panel was satisfied from the evidence it had heard from Colleague B that he clearly felt that he was being bullied and targeted by you during the incidents set out in charge 10. In his grievance letter, dated 14 June 2013, he writes that he has *'felt persecuted, belittled, criticised, humiliated and made to feel worthless by Helen over the last two years which has left me with little and no confidence…'.* The panel also heard evidence that he had time off sick which he attributes to your behaviour towards him.

As with charge 9, the panel had regard to the evidence of your good character from colleagues who had worked with you both before and after your tenure at LCH but did not find it persuasive.

The panel was satisfied that your conduct towards Colleague B undermined his professional ability to such an extent that he lost confidence and self-esteem. The panel was satisfied that you had humiliated Colleague B in the presence of Ms 23 and had, during meetings, persistently criticised him and his performance. The panel was satisfied that you had sought to exclude him and made him feel isolated.

The panel considered that your actions at charges 10(a) – 10(d) did amount to the bullying and intimidation of Colleague B.

Charge 11(a)

11. Bullied and/or intimidated Colleague C, in that you:

(a) On or around 9 July 2013, suspended Colleague C without providing an adequate explanation as to what allegations had been made against her;

This charge is found NOT proved.

Colleague C gave evidence that she was asked to attend a meeting on 9 July 2013 with Ms 23. When Colleague C arrived for the meeting, Ms 15 and Colleague D were also present. Colleague C gave evidence that, at this meeting, Ms 23 told Colleague C, Colleague D and Ms 15 that they were all being suspended from clinical leadership. Colleague C gave evidence that she was given no explanation for this other than it was an "organisational decision". This evidence was consistent with that given by Ms 15 and Colleague D.

The panel heard evidence that, following the meeting, broadly similar letters were sent to Colleague C, Colleague D and Ms 15 by Ms 23. The panel had a copies of this letter, dated 9 July 2013, which read as follows:

> *'Further to our discussion today 9th July 2013, I write to formally confirm your suspension from Clinical Practice/Leadership with immediate effect.*
>
> *The reason for this suspension relates to an allegation and a number of serious concerns which have come to light relating to patient care in the Intermediate Care Service. These allegations include but are not limited to:*
>
> - *concerns being raised by staff and supressed by the Clinical Leadership Team*
> - *whistleblowing allegations not being acted upon*
> - *failure to escalate and act following incidents*

Due to the nature of the allegations, we feel it is necessary to suspend the Clinical Leadership Team. Therefore you are suspended from Clinical Leadership Duties with immediate effect. This decision has been taken to ensure we do not compromise individuals or the investigation.

An Interim Management Team will be put in place to manage the service until the investigation has been completed.

Your suspension is a holding action pending the completion of an investigation…'

This letter was followed on 12 July 2013 by another letter which clarified that the three were only suspended from clinical work within IBBCS, and would be redeployed elsewhere in LCH.

In her oral evidence, Ms 23 confirmed that although she had been the one to suspend Colleague C, Colleague D and Ms 15 at the meeting and send the subsequent letters, she did so on your instructions.

You gave evidence that there had been persistent concerns raised about IBBCS during 2011 and 2012 and, in July 2013, urgent concerns were raised with you by Colleague A and Ms 23, following two serious falls. You called Ms 34, HR Director, into the meeting for advice and you then went to raise the concerns with the Chief Executive, Ms 19.

Ms 19 convened a meeting with you and three of the Non-Executive Directors. It was agreed that while a further review of IBBCS would be conducted, more rapid improvements were needed. You gave evidence that it was agreed that the three senior leaders in IBBCS should be redeployed elsewhere in the organisation and a 'Wraparound team' put in place in IBBCS to make the necessary improvements. You denied that you had given instructions to suspend the three employees. The panel found that they were suspended.

Taking account of the evidence, the panel was satisfied that Colleague C, Colleague D and Ms 15 were suspended by you, notwithstanding that this was communicated to them by Ms 23. However, the panel considered that the letter sent to them on 9 July 2013 did provide some explanation as to why they were being removed from IBBCS. The panel bore in mind that it is not unusual, when concerns or allegations arise, for an individual to be suspended from duty pending further investigation. The panel considered that the explanation for the suspension contained in the letter sent to Colleague C, Colleague D and Ms 15 did provide an adequate explanation for their suspension at this preliminary stage. The panel did hear other evidence to suggest that the pace of the investigation against the three senior leaders was slow, and they were provided with little or no additional information over the following months, but the panel was mindful that this charge solely related to the explanation given on or around 9 July 2013, when they were initially suspended from IBBCS, and not to the adequacy of the subsequent disciplinary investigation process.

In these circumstances, the panel was satisfied that Colleague C, Colleague D and Ms 15 were given an adequate explanation as to the allegations made against them when they were suspended on or around 9 July 2013.

Accordingly, charge 11(a) is found not proved.

Charges 11(b)(i) – 11(b)(iii)

11. Bullied and/or intimidated Colleague C, in that you:

(b) Between July – October 2013, stated to Colleague C, whilst she was suspended, words to the effect that:

(i) She had marital problems;

(ii) You had met with other staff on the wards and they had thanked you for removing Colleague C;

(iii) *"Don't worry, we don't have to prove you're guilty of anything, you just prove you're innocent of everything."*

These charges are found NOT proved.

The panel noted that the evidence in support of these charges came from Colleague C's NMC witness statement and her oral evidence. In this, she states that in September 2013 you asked her out for lunch. Colleague C agreed to this and, while you were out, you said that you were worried about her as she looked as if she was not eating or sleeping. According to Colleague C, you asked her what was happening at home and *'assumed [she] was having marital problems'.* Colleague C denied this and explained that it was the stress of her suspension from work, but you ignored her and continued to insist that she had marital problems. Colleague C's statement also says that you said *"don't worry we don't have to prove you're guilty of anything, you just have to prove you're innocent of everything".* When Colleague C queried if you had got this the wrong way round you allegedly said *"no, that's how it is in health".*

Colleague C's statement goes on say that while she was suspended she had a number of one to one meetings with you. During one of these meetings Colleague C alleges that you told her that you had met with other staff on the wards and they had thanked you for removing her, Colleague D and Ms 15 from IBBCS.

However, the panel noted that there were inconsistencies between Colleague C's NMC witness statement, and the interview she gave as part of the Capsticks investigation in June 2015. Colleague C's Capsticks interview makes no mention of marital problems, nor of you telling her that IBBCS staff had thanked you for removing her. The panel also noted that Colleague C's Capsticks interview suggests that Ms 15 had urged Colleague C to contact you, because you were *"worried sick about [Colleague C]".* When Colleague C gave oral evidence to this panel, it found her to be an honest witness who did not try to mislead the panel. However, it was evident that she found the events of July – October 2013 distressing, both at the time and to recount to the panel. As a result of this, and the passage of time, her oral evidence on charges 11(b)(i) – 11b(iii) was also somewhat inconsistent with the previous accounts she had given.

In your evidence you denied making any of the comments at charges 11(b)(i) – 11(b)(iii). You gave evidence that you made yourself available to support Colleague C and that she called you several times and you met for lunch. During your lunch meeting you claimed that you asked her general questions about her wellbeing, as you were concerned for her welfare. You asked if she was being supported by her friends and family but denied suggesting that she had marital problems. You said that neither one of you made any references at all to 'marital problems'.

You denied telling Colleague C that other staff had thanked you for removing her from IBBCS. You gave evidence that Colleague C was worried about how the IBBCS staff were coping and you attempted to reassure her by saying words to the effect of *"they have confidence in the Interim Team and the improvements they have made and morale has improved."* You gave evidence that you said this to reassure Colleague C that her staff were well and had been supported. You suggested that Colleague C perhaps misinterpreted this as meaning that the staff were glad that she had been redeployed but stated that this was not your intention.

You also denied saying to Colleague C *"Don't worry, we don't have to prove you're guilty of anything, you just prove you're innocent of everything."*

Taking account all of the evidence, the panel found that it could not place sufficient reliance on Colleague C's evidence to be satisfied, on the balance of probabilities, that between July – October 2013 you stated to Colleague C, whilst she was suspended, words to the effect that:

(i) she had marital problems;
(ii) you had met with other staff on the wards and they had thanked you for removing Colleague C;
(iii) *"Don't worry, we don't have to prove you're guilty of anything, you just prove you're innocent of everything."*

It also considered that the context and circumstances of the meetings between you and Colleague C did not support an allegation of bullying or intimidation. The panel noted that these meetings were offered by you to support Colleague C during a difficult time. Whilst this particular meeting was at a time of great personal stress for Colleague C, and your comments may have been perceived as negative, the panel considered this was an attempt by you to reassure Colleague C rather than bullying or intimidation.

Accordingly, charges 11(b)(i) – 11(b)(iii) are found not proved.

Charge 11(c)

11. Bullied and/or intimidated Colleague C, in that you:

(c) During a meeting in or around November 2013, when discussing a 27 October 2013 report into IBBCS, stated words to the effect that Colleague C had two options; to follow the disciplinary route, which was likely to end with her dismissal and referral to the NMC; or, alternatively, to be downgraded and transferred to another role.

This charge is found proved.

In her NMC witness statement Colleague C gave evidence that on 28 October 2013 she received a copy of the report into IBBCS and a letter from you to discuss "ways forward". Shortly after she met with you, her union representative and Ms 34, HR Director to discuss the report. According to Colleague C, in this meeting you told her that the way forward was either for Colleague C to continue along the disciplinary route, which was highly likely to end with her dismissal and referral to the NMC when she would be removed from the register, or for her to be downgraded and transferred to another role. Colleague C was told that she had "time to consider" her options and the meeting was brought to a close. This was consistent with the oral evidence that Colleague C gave.

The panel also had a copy of a letter sent by you to Colleague C, dated 9 December 2013, which stated *'Following our meeting on 12th November regarding the Intermediate Care Investigation report, I can confirm our offer of a Band 7 post in the Virtual Ward as a Clinical Facilitator.'* The panel had an email chain between Colleague C's union representative and Ms 34 discussing the proposed downgrading, which included an email from Ms 34 sent on 27 November 2013 which clearly stated that *'The role has been offered as an alternative sanction/remedy to the full disciplinary process, which will be required to consider some very serious allegations.'*

In your evidence you accepted that Colleague C was offered the option of accepting a role at a lower band as an alternative to proceeding with the disciplinary process but you denied that this amounted to bullying or intimidation.

The panel was satisfied from the evidence that during a meeting in or around November 2013, when discussing a 27 October 2013 report into IBBCS, you stated words to the effect that Colleague C had two options; to follow the disciplinary route, which was likely to end with her dismissal and referral to the NMC; or, alternatively, to be downgraded and transferred to another role.

The panel rejected your explanation of the rationale for this decision. It considered that to tell someone that they would be taken through a disciplinary process unless they accepted a role at a lower job banding was, in the panel's view, undoubtedly an attempt to bully and intimidate them.

Accordingly, charge 11(c) is found proved.

Charge 12(a)

12. Bullied and/or intimidated Colleague D, in that you:
    a) In or around July 2013, suspended him without providing an adequate explanation as to what allegations had been made against him;

This charge is found NOT proved.

The panel has already discussed the evidence in relation to this charge in its decision on charge 11(a). The panel finds this charge not proved for the same reasons as given for charge 11(a).

Charge 12(b)

12. Bullied and/or intimidated Colleague D, in that you:

(b) At a meeting in November 2013, having still not identified the allegations, offered him the option of a demotion or a continuation of the disciplinary process.

This charge is found proved.

In his NMC witness statement Colleague D gives evidence that he attended a meeting in November 2013 with you, Ms 34 and his union representative. At this meeting he was told that he could accept a demotion to a Band 8b Older People's Programme Lead role or continue with the disciplinary process. He states that at this stage he had still not been told what the allegations against him were and described the situation as *'toxic and emotionally challenging'.* Ultimately, Colleague D opted to be demoted because he did not want to be disciplined and *'wanted the situation to be over* with'. Colleague D's witness statement was consistent with his oral evidence.

The panel also had a copy of a letter sent by you to Colleague D, dated 6 December 2013, in which you confirm the offer of an alternative role as the Older People's Pathway Lead, and a further letter from you to Colleague D dated 2 January 2014 in which you write that *'I feel it is important to clarify that we are not in a standard redeployment scenario and are therefore not following a standard redeployment process and the Trust offered you the post as a compromise and alternative option to the disciplinary process'.*

In your evidence you accepted that Colleague D was offered the option of accepting a role at a lower band as an alternative to proceeding with the disciplinary process but you denied that this amounted to bullying or intimidation.

The panel was satisfied from the evidence that at a meeting in November 2013, having still not identified the allegations against Colleague D, you offered him the option of a demotion or a continuation of the disciplinary process.

The panel rejected your explanation of the rationale for this decision. It considered that to tell someone that they would be taken through a disciplinary process unless they accepted a role at a lower job banding was, in the panel's view, undoubtedly an attempt to bully and intimidate them.

Accordingly, charge 12(b) is found proved.

Resuming hearing – February 2020

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined it as a registrant's suitability to remain on the register unrestricted.

At this stage the panel was provided with a bundle from you which included:

- A written reflective piece
- A "canvass of words" to describe you, created by staff when you left Bristol Community Health
- A reference from Ms 37, Youth Ambition Project Worker, dated 4 February 2020.

The panel heard oral evidence by telephone from Ms 38, Chief Executive at North Somerset Community Partnership from 2011-2016, who had previously provided a testimonial on your behalf, dated 12 April 2019. The panel also heard oral evidence from you.

Mr Collis provided the panel with written submissions. In these submissions he invited the panel to take the view that your actions amounted to a breach of *The Code: Standards of conduct, performance and ethics for nurses and midwives 2008* ("the Code"). He then directed the panel to specific paragraphs and identified where, in the NMC's view, your actions amounted to misconduct.

Mr Collis referred the panel to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

In his submissions, he invited the panel to find that your fitness to practise is currently impaired on the grounds of both public protection and public interest and 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 Deignan, on your behalf, accepted that the charges found proved amounted to misconduct, with the exception of charge 7. She referred the panel to *Bawa-Garba v GMC* [2018] EWCA Civ 1879 and encouraged the panel to have regard to the context in which the facts found proved took place. She submitted that the issues present in IBBCS, CDNS and the Prison were not unique to LCH and existed both before and after you left the Trust. Ms Deignan submitted that there was overwhelming evidence before the panel that LCH was dysfunctional and that to consider LCH in isolation would be to fail to see it in its proper context.

Ms Deignan referred the panel to the character witnesses and testimonials provided on your behalf. She submitted that each of them went not only to your working

relationships and professionalism but also to your governance and management skills. Ms Deignan submitted that since you have left LCH you have demonstrated empathy, understanding, and positive working relationships both in senior leadership positions within nursing and in your voluntary work outside of healthcare. Ms Deignan submitted that you have remedied the concerns regarding governance and bullying and therefore a finding of current impairment on public protection grounds was not required.

Ms Deignan also submitted that a finding of current impairment on public interest grounds was not required. She referred the panel to the fact that, prior to LCH, you had enjoyed an unblemished and outstanding nursing career for 29 years. This continued after you left LCH. Ms Deignan submitted that the difference between your tenure at LCH and your other roles was the dysfunctionality of Liverpool Community Health Trust and the *"increasingly undoable"* nature of your dual role as Executive Nurse and Director of Operations. Ms Deignan referred the panel to extracts from The Kings Fund: *Leadership in today's NHS* report, dated July 2018, regarding the challenges facing senior NHS leaders. She reminded the panel that you have been suspended since April 2016 and submitted that a member of the public, in full knowledge of all the facts, would be satisfied that the public interest has been served by these proceedings and that you should be allowed to continue to work without restriction.

The panel accepted the advice of the legal assessor who referred it to *Roylance*, *Yusuff v GMC* [2018] EWHC 13 (Admin), *Grant* and *Cohen v GMC* [2008] EWHC 581 (Admin).

The panel adopted a two-stage process in its consideration, as advised. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Decision on misconduct

When determining whether the facts found proved amount to misconduct the panel had regard to the terms of the 2008 NMC Code.

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

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*

1 You must treat people as individuals and respect their dignity.

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.

26 You must consult and take advice from colleagues when appropriate.

27 You must treat your colleagues fairly and without discrimination.

30 You must confirm that the outcome of any delegated task meets required standards.

31 You must make sure that everyone you are responsible for is supervised and supported.

32 You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.

33 You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards.

34 You must report your concerns in writing if problems in the environment of care are putting people at risk.

35 You must deliver care based on the best available evidence or best practice.

58 You must ensure that your professional judgement is not influenced by any commercial considerations.

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

The panel accepted the submissions made by both Mr Collis and Ms Deignan that, given that the panel had determined that the amendments made by you to the record of your interview with Ms 18 were not dishonest, charge 7 alone did not amount to misconduct.

The panel considered that the remaining charges could be grouped into two categories: management/governance failings (charges 2, 3(a)-3(c), 4a, 5(b)(i), 5(b)(ii), 5(c), 5(d) and 6(b)) and bullying (charges 9(a), 9(c), 9(d), 9(h)-9(i), 10, 11(c) and 12(b)). The

panel was satisfied that all these charges did singularly and collectively amount to misconduct. While the panel appreciated that breaches of the Code do not automatically result in a finding of misconduct, it was satisfied that, in this instance, your actions fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

The panel accepted Mr Collis' submissions that your management failings represent a prolonged failure on your part to take adequate action in respect of significant concerns in three separate areas of the Trust, namely IBBCS, CDNS and the Prison. It noted that these failings occurred over an extended period of time and agreed that the failings compromised the care provided to patients reliant on these services. The panel considered that your conduct fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

In respect of the bullying charges, the panel noted that these had occurred over a lengthy period of time and involved four different members of staff, all of whom were junior to you. The panel also bore in mind the evidence that it had heard regarding the impact of your behaviour and actions upon the mental health and well-being of the staff members concerned, some of whom had to take time away from the work place. Having noted the severe impact the bullying had on the staff members, the panel considered this was likely to have impacted on patient care. The panel was in no doubt that such behaviour fell seriously short of the standards expected of a registered nurse, particularly one in your position of leadership, and amounted to misconduct.

The panel was therefore satisfied that all of the charges found proved, with the exception of charge 7, amounted to misconduct.

Decision on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the panel considered the judgement of Mrs Justice Cox in the case of *Grant* at paragraph 74:

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

In paragraph 76 Mrs Justice Cox adopted the test set out in Dame Janet Smith's Fifth Shipman report:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> a. *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b. *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c. *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d. …'

The panel found that limbs (a), (b) and (c) of *Grant* were engaged in this case. It considered that your management failings compromised the levels of service available within CDNS, IBBCS and the Prison, which exposed patients to an unwarranted risk of harm. Your management failings and bullying conduct also, in the panel's view, brought the profession into disrepute and breached fundamental tenets of the profession.

The panel then moved on to consider whether you are liable to act in such a way in the future. The panel noted that while you accept the panel's findings you do not accept that you conducted yourself in the manner found proved. The panel was mindful of the evidence it heard from your character witnesses, all of whom worked with you either before or after your tenure at LCH. The panel accepted their evidence that they found you to be an effective, supportive and respected senior leader. To this extent, the panel was satisfied that the charges which occurred during your tenure at LCH appeared to be out of character in an otherwise long, unblemished and successful career of almost 30 years. The panel also bore in mind that the charges it had found proved were serious and constituted a course of conduct which spanned your entire tenure at LCH, which amounted to approximately three years.

The panel noted that in your reflective piece you wrote that: *'I went to work at LCH at a time of unprecedented change and uncertainty. I accepted the role of Director of Operations and Executive Nurse, taking on two Director roles instead of one, in a Trust much larger than the one I had come from. I was taking on a considerably larger role, in a much larger Trust, during a very difficult and high pressured time for everyone and I had accepted this role away from home and all my professional and personal support and networks.'*

The panel accepted that LCH was already in a difficult situation when you joined in 2011 and that these difficulties persisted after you had left. It also accepted that there were others within the Trust, including the Board and the Executive team, with responsibility

for the Trust's governance. However, when considering your evidence in relation to this aspect, the panel was of the view that you still have not recognised or fully accepted personal responsibility and accountability for your failings.

Your reflective piece and oral evidence demonstrated limited insight. While you appeared to accept some responsibility for your behaviour this was followed with criticism and blame for other parties involved, thus seeking to minimise your level of responsibility.

In your oral evidence you accepted that Colleagues A, B, C and D felt bullied but said that that was not your intention and you *'couldn't square'* the person in the charges with yourself. The panel was concerned that, although you have recognised that the scale of your role and the financial drive at LCH were *'trigger points'* for you, you do not seem to have linked this with your behaviour at the time. Although you told the panel that you would do things differently in the future, your limited insight did not support this assertion. The panel, having heard your oral evidence, was unable to accept the assertions made in your statement in relation to insight and remorse. Indeed, the panel noted that little, if any, consideration was given to the effect of your behaviour on either patients or staff members.

In relation to remediation, the panel noted that you had been suspended since 2016 and that you have not worked in a nursing environment since that time. It noted that you had started a bakery business which involved governance and business development skills. It also heard evidence that you have undertaken a voluntary role as a mentor, which involved using your coaching and health visiting skills. While the panel commended you for this work, it noted that you have not undertaken any training relevant to your previous role in the NHS.

In relation to remorse, while you stated that you were shocked and upset at what witnesses had said about your bullying behaviour, the panel did not discern that you were remorseful about the effect of your behaviour on your colleagues, or indeed the

resultant effect on patients. It seemed to the panel that you were unable or unwilling to link your misconduct and its effect with the evidence which the panel heard.

In light of your limited insight, the panel was not satisfied that, if in the future, you found yourself in a similarly “undoable job” and pressured environment, away from your network of support, that you would not revert and conduct yourself as you had done at LCH. The panel considered that you have not demonstrated a full enough understanding of your failings to reassure it that there is no risk of repetition. The panel therefore determined that a finding of current impairment on public protection grounds is required.

The panel also 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. This includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession. The panel was of the view that public confidence in the nursing profession would be wholly undermined if a finding of current impairment was not made in a case where a nurse in a senior leadership position was found to have bullied staff and had not taken adequate action in respect of persistent and serious concerns in relation to patient care and safety, which had been repeatedly brought to her attention. The panel did not consider that these proceedings, and your suspension, satisfied the public interest in the absence of developed insight, remorse and remediation and an acceptance of your misconduct.

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

Determination on sanction

The panel considered this case and decided to make a 12 month suspension order. The effect of this order is that the NMC register will show that your registration has been suspended.

In reaching this decision, the panel had regard to all the evidence that has been adduced in this case, together with the submissions of Mr Collis, on behalf of the NMC, and Ms Deignan, on your behalf.

Mr Collis provided the panel with written submissions in which he set out that, in the view of the NMC, the appropriate sanction was a striking-off order.

Ms Deignan submitted that a suspension order was the appropriate and proportionate sanction and outlined a number of mitigating and contextual factors which she invited the panel to take into account.

The panel accepted the advice of the legal assessor. It bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel considered that the aggravating factors in this case were:

- You have demonstrated limited insight into your misconduct;
- The charges proved represent a pattern of misconduct over a period of time;
- Your misconduct put patients at risk of suffering harm;
- Your misconduct caused staff members harm and distress.

The panel considered that the mitigating factors in this case were:

- The circumstances which prevailed at LCH at the time of your tenure were accepted as being very challenging;

- The evidence of your outstanding nursing career both before and after LCH;
- Since being subject to an interim suspension order you have undertaken voluntary work which has utilised some of your transferrable skills.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. Taking no further action would not protect the public from the risk of harm identified by the panel. It would also not mark the seriousness of your misconduct. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the Sanctions Guidance, which states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again'.* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. It would also not restrict your practice and would therefore not protect the public from the risk of harm identified by the panel. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. It decided that it would not be possible to formulate practical or workable conditions, given the nature of your failings. Your misconduct does not concern clinical failings, nor is it of a nature which could be addressed through retraining and conditions of practice. The panel was also of the view that placing conditions of practice on your registration would not adequately address the seriousness of this case. The panel therefore concluded that it would be neither proportionate nor in the public interest to impose a conditions of practice order.

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

- *'does the seriousness of the case require temporary removal from the register?*
- *will a period of suspension be sufficient to protect patients and the public interest?*

This sanction may be appropriate where the misconduct is not fundamentally incompatible with continuing to be a registered nurse or midwife in that the public interest can be satisfied by a less severe outcome than permanent removal from the register. This is more likely to be the case when some or all of the following factors are apparent (this list is not exhaustive):

- *a single instance of misconduct but where a lesser sanction is not sufficient*
- *no evidence of harmful deep-seated personality or attitudinal problems*
- *no evidence of repetition of behaviour since the incident*
- *the Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour*
- *…*
- *…'*

The panel determined that, although there had been a clear breach of fundamental tenets of the profession, there are mitigating circumstances. Although your misconduct spanned a period of three years and therefore cannot be characterised as *'a single instance'*, the panel bore in mind that it had to view your failings in the context of your overall career and the circumstances and nature of your role at LCH. You worked as a registered nurse for almost 30 years before LCH, including various senior leadership roles. No concerns were raised during this time and all of the evidence before the panel suggests a successful and outstanding career. You also returned to a senior leadership

role in the South West for two years after leaving LCH. No further concerns were raised about your nursing practice, management and governance skills, or professional conduct. Indeed, all of your character witnesses spoke of your professionalism in exceptional terms. For example, the Interim Chief Officer for Wiltshire CCG stated that *'I believe the profession would suffer a grave loss should Helen Lockett's name be removed from the register'.* This was a sentiment echoed by a number of very senior professionals who provided testimonials and gave evidence on your behalf.

The panel also considered that, while the bullying charges found proved are of an attitudinal nature, the testimonials and character evidence it heard suggest that this type of behaviour is out of character for you. The panel heard evidence from a number of witnesses about how you had mentored them and supported their career development. The panel was therefore satisfied that any attitudinal problem that you exhibited at LCH was not deep-seated or irredeemable.

At the impairment stage, the panel determined that you had limited insight. However, it also bore in mind that these proceedings have been ongoing since the summer of 2014, when you were referred to the NMC. The panel did not make its findings of fact until January 2020. Throughout this time, you have denied all of the charges against you. The panel noted that a number of these were found not proved. You had only two weeks to reflect on the panel's findings before giving evidence at the impairment stage. While the panel was disappointed that a nurse of your seniority and experience did not demonstrate greater insight, it bore in mind that two weeks was a short period of time for you to reflect on the panel's findings and re-evaluate your actions in the overall context of this case. [PRIVATE]. The panel saw no reason why, at this stage, if you were given further opportunity to reflect you would not be able to develop your insight further.

The panel bore in mind that the NMC's sanction bid was a striking-off order. It also reminded itself that your misconduct is serious and involves a pattern of failings over several years, as well as bullying which had a severe impact on several members of

staff. However, as outlined above, the panel was satisfied that there was a wealth of evidence that, with the exception of the three years you spent at LCH, you were a successful nurse and leader who made a positive contribution to the NHS and the personal development of many of the more junior nurses with whom you worked.

Although the panel has determined that there is a risk of repetition, it did not consider that this risk was so significant as to warrant a striking-off order. The panel determined that it was not in the public interest to permanently remove such an experienced and respected nurse from practice.

For these reasons, the panel decided that a striking-off order would be disproportionate and that the appropriate and proportionate sanction is a suspension order.

The panel therefore determined to make a suspension order for a period of 12 months. When deciding the length of the order, the panel bore in mind that you have already been subject to an interim suspension order for almost four years. However, it also had regard to the serious nature of the charges found proved and the effect of your misconduct on staff and potentially on patients. Taking this into account, it decided that 12 months was the minimum period required to protect the public and mark the seriousness of your misconduct. The panel also determined that this order would mark the importance of maintaining public confidence in the profession and would send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a review of this order is required before its expiry. Therefore at the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order. Any future panel may be assisted by:

- A written reflection
- Any evidence of how you have kept your nursing skills and knowledge up to date
- References / testimonials from any paid or unpaid employment

Determination on interim order

The panel considered the submissions made by Mr Collis that an 18 month interim suspension order should be made to cover the appeal window, on the grounds that it is necessary for the protection of the public and is otherwise in the public interest. Ms Deignan made no submissions in respect of this application.

The panel accepted the advice of the legal assessor.

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 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 interim order will be replaced by the suspension order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.