Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday 30 August – Friday 2 September 2022

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

Name of registrant:	**Miss Deborah Karen Woods**
NMC PIN:	91I4954E
Part(s) of the register:	Registered Nurse – Mental Health Nursing (July 1994)
Relevant Location:	London Borough of Wandsworth
Type of case:	Misconduct
Panel members:	Gregory Hammond (Chair, Lay member) Susan Jones (Registrant member) Suzanna Jacoby (Lay member)
Legal Assessor:	Charles Conway
Hearings Coordinator:	Jasmin Sandhu
Facts proved:	Charges 1, 2, 3, 4a, 4b, 5a, 5b, 5c, 5d, 5e, 5f, 6, 7a, 7b, 8, 9, 10, 11, 12a, 12b, 13, 14a, 14b, 14c, 15a, 15b, 16a, 16b, 16c, 16d, and 17
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

1) On 10 November 2016 caused Service User A to be placed in seclusion when there was insufficient clinical justification for doing so. **[FOUND PROVED]**

2) On 10 November 2016 said in Service User A's presence and in reference to Service User A "He doesn't have the balls to go for anyone". **[FOUND PROVED]**

3) Caused Service User A to be kept in seclusion until 1 December 2016 when there was insufficient clinical justification for doing so. **[FOUND PROVED]**

4) Between 10 November 2016 and 1 December 2016:-

   a. failed to ensure that Service User A received sufficiently frequent medical reviews as required by the Mental Health Act 1983 Code of Practice; and/or **[FOUND PROVED]**
   b. failed to notify your line manager of any inability to meet the requirement set out at charge 4a). **[FOUND PROVED]**

5) Between 10 November 2016 and 1 December 2016 caused or permitted Service User A to be deprived of the following on one or more occasions without reasonable justification:-
   a. Visits from his family members; **[FOUND PROVED]**
   b. Visits from his Solicitor; **[FOUND PROVED]**
   c. Books and/or iPod and/or a game of chess; **[FOUND PROVED]**
   d. hot food; **[FOUND PROVED]**
   e. access to any outdoor area; **[FOUND PROVED]**
   f. the opportunity to wash without being observed and/or a shower**[FOUND PROVED]**

6) Between 10 November 2016 and 1 December 2016 overruled the professional opinions of members of the multi-disciplinary team with respect to Service User A's care and treatment. **[FOUND PROVED]**

7) On 13 May 2016:
   a. called Colleague 1 a "bloody idiot" **[FOUND PROVED]**
   b. shouted at Colleague 1 "You are just a consultant I can take you out and remove you at any time" and/or "I could terminate your employment" or words to that effect. **[FOUND PROVED]**

8) On 16 November 2016 said to colleague 1 "You don't understand, you don't work here, wait for [Colleague 2]" or words to that effect. **[FOUND PROVED]**

9) On a date in November 2016 said to Colleague 3 "I hired [Colleague 2] and I can fucking fire her too…" or words to that effect. **[FOUND PROVED]**

10) On 21 November 2016 you said to Colleague 3 "I don't give a flying fuck what you think" or words to that effect. **[FOUND PROVED]**

11) On 24 November 2016 sent Colleague 2 an email at 16.35pm. **[FOUND PROVED]**

12) On 25 November 2016 sent Colleague 2 emails at:
   a. 09.43 am; **[FOUND PROVED]**
   b. 09.58am. **[FOUND PROVED]**

13) On or around 20 November 2016 said to Colleague 4 "I hire, I fire" and "you are disposable" or words to that effect. **[FOUND PROVED]**

14) On 20 November 2016 sent Colleague 4 text messages at:
   a. 17.22pm; **[FOUND PROVED]**
   b. 18.32pm; **[FOUND PROVED]**
   c. 18.40pm. **[FOUND PROVED]**

15) On 24 November 2016 sent Colleague 4 text messages at:

a. 21.44pm; **[FOUND PROVED]**
b. 15.57pm **[FOUND PROVED]**

16) On 25 November 2016 sent Colleague 4 text messages at:
a. 06.55am; **[FOUND PROVED]**
b. 17.49pm; **[FOUND PROVED]**
c. 18.59pm; **[FOUND PROVED]**
d. 20.31pm. **[FOUND PROVED]**

17) Your conduct in respect of each of the charges at 7 to 16(d) above was unprofessional and/or of a bullying and/or threatening and/or intimidating nature. **[FOUND PROVED]**

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

Decision and reasons on service of Notice of Meeting

The panel was informed that the Notice of Meeting was sent to Miss Woods' email address by secure encrypted email on 26 July 2022. It noted that the email address used was not Miss Woods' registered email address, but an alternative email which Miss Woods has previously used to communicate with the Nursing and Midwifery Council (NMC).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, the notice of referral (NOR) decision dated 29 April 2021, and an *'on or after'* date of 30 August 2022.

In the light of all of the information available, the panel was satisfied that Miss Woods has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Background

The NMC received a referral regarding Miss Woods' fitness to practise on 12 May 2017 from the Director of Nursing and Quality at Inmind Healthcare Group (Inmind). At the time of the concerns raised in the referral, Miss Woods was working as Hospital Director at Battersea Bridge House Hospital (BBH), a low secure unit (LSU), divided into three wards.

Service User A was admitted to BBH on 5 September 2016, having been transferred from a psychiatric intensive care unit in another hospital. Service User A had a diagnosis of a psychotic illness and his risk history included a serious assault. Service User A was detained under Section 3 of the Mental Health Act 1983.

During a 1:1 session on 9 November 2016, Service User A had a session with his primary nurse. During this session, Service User A made some disparaging and threatening comments about Miss Woods and Colleague 2, a Consultant Forensic Psychiatrist and Clinical Director.

On the morning of 10 November 2016, it is said that Service User A was swearing and talking about Miss Woods, using abusive language, informing other service users to smear faeces in protest and moved a CCTV camera. At 08:00, Service User A was transferred to seclusion.

Service User A was in seclusion for 21 days. During this time, concerns were raised by staff at BBH that this was not clinically justified, and that Service User A was treated in an undignified way, including not being provided with hot food, not being able to see his family or his solicitor, and not being able to wash himself. Service User A was referred to a medium secure unit and was transferred on 1 December 2016.

In December 2016, concerns were raised with the Care Quality Commission (CQC) about Miss Woods' management of the service. A complaint was also made by the solicitors acting on behalf of Service User A.

Inmind investigated the concerns in association with an external investigator and Miss Woods was placed on leave.

The referral also raised concerns in relation to Miss Woods' treatment of colleagues. It is alleged that on numerous occasions between 13 May and 25 November 2016, Miss Woods' behaviour and communication (both in person and over text message) to her colleagues was unprofessional and of a bullying nature.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case, from both the NMC and the Royal College of Nursing (RCN), on Miss Woods' behalf at the investigatory stage. It also had regard to the written representations made by the NMC and to the CCTV footage which was played at this meeting.

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Colleague 1: Consultant Psychiatrist at BBH (at the time of events)
- Colleague 2: Consultant Forensic Psychiatrist and Clinical Director at BBH
- Colleague 3: Social Worker at BBH (at the time of events)
- Colleague 4: Registered Counselling Psychologist at BBH
- Colleague 5: Assistant Psychologist at BBH
- Colleague 6: Hospital Director at Inmind who conducted the investigation

- Colleague 7: Group Operations Director at InMind (at the time of events)

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

The panel made the following findings:

Charge 1

1) On 10 November 2016 caused Service User A to be placed in seclusion when there was insufficient clinical justification for doing so.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 2, Colleague 3, Colleague 5, Colleague 6, and Miss Woods. Whilst the panel also had sight of the witness statements from Colleague 1, Colleague 4, and Colleague 7, it considered that these were not relevant to this particular charge.

The panel took account of the Inmind '*Seclusion and Longer-term Segregation Policy*' (the seclusion policy) at BBH at the time (reviewed in March 2016):

> *'**5.3 When Seclusion Can Be Used***
> *5.3.1 Seclusion may only be used for the containment of severe behavioural disturbance that is likely to cause harm to others…*
> *5.3.2 Seclusion should not be used as a punishment or a threat, or because of shortage of staff. It must never form part of a treatment programme…*

5.3.3 As seclusion may only be used to contain the severe behavioural disturbance that may cause harm to others, it is the responsibility to staff to assess the risk that a patient poses to others due to their challenging behaviour…'

The panel also took into account Service User A's seclusion care plan in which the reason for seclusion was set out '*Patient taken into seclusion to minimise assault on staff'.*

It took into account Colleague 2's witness statement, in which it was set out *'I had been told by two senior staff members that the risk posed by Service User A was serious and acute and I had no evidence to suggest otherwise at the early stages of seclusion…As previously mentioned, Deborah was very clear that Service User A was extremely dangerous and that she was at particular risk, and after discussing Service User A with her and with the team, we agreed that a Medium Secure Unit referral was warranted*.' The panel noted that this was hearsay evidence as Colleague 2 hadn't visited Service User A and made her own assessment at this time.

Colleague 2 further stated '…*based on the information I had at the time it occurred there was nothing to suggest it was inappropriate…However, as I obtained more objective information about the facts rather than the facts conveyed verbally by Deborah to myself and the rest of the team, then the initial decision appeared to be less appropriate'*. The panel noted that this was consistent with Colleague 2's account as recorded in the meeting minutes from the interview on 8 December 2016 '*I do not think the grounds were met. My heart sank to be fair when I heard he had been put in seclusion. I was not comfortable that there was no discussion about whether there was an alternative way of managing him at the time'*.

The panel considered that from the evidence of Colleague 2, whilst initially the decision to place Service User A into seclusion may have been justifiable, on reflection and having taken into account all of the information available at the time, this decision was not clinically justified.

The panel also had regard to evidence from Colleague 3 who set out that the decision to place the service user in seclusion would have been '*subjective and debatable'* and that

they were not present when this decision was made. The panel therefore did not place considerable weight on this evidence.

The panel considered the account from Colleague 5 to be conflicting on this matter. In their witness statement, Colleague 5 stated '*Based on what I had watched I would not have placed him in seclusion'*. However, Colleague 5 later on stated '*I will not comment on the initial reason and appropriateness to seclude Service User A because I was not there on the day and this is above my pay grade'*.

The panel also took account of the evidence from Colleague 6 who set out that they did not agree with Miss Woods' decision to place Service User A into seclusion '*In my clinical opinion, I do not agree with Deborah's assessment that Service User A was very high risk. Whilst there was risk present, this risk was qualified and understood…Service User A's behaviour was not dramatically concerning however it was clinically informative…There was insufficient justification to consider Service User A as posing a grave and immediate threat. Service User A had no history of assault within an inpatient setting…The decision to seclude Service User A therefore breached the CoP and Inmind Healthcare policy. This is because the reasons given for seclusion (documented in the records) did not meet the criteria which permits the use of seclusion, specifically it was not an "immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others" (CoP 26.103), nor was it the least restrictive option (CoP, 26.111).'*

The panel considered the account from Miss Woods, who in her reflective statement written five years after events, set out '*I believed in all good conscience that the patient in question presented a high risk of harm to a named victim who lived locally… however, it does not excuse my actions… I had a duty as a Hospital Director, as a nurse, as a human being to listen to the team, to consider and review every possible option to alleviate the level of restrictions I subjected this service user to, I did not, I took away a service users liberty, I did not realise it at the time but I let fear lead me. I would not, could not ever act in such a manner again…. I accept this regulatory concern*.'

On the basis of all the accounts before it, together with her own acceptance of this concern, the panel determined that Miss Woods' decision to place Service User A into seclusion was not in line with the seclusion policy at the time and was therefore not

clinically justified. It considered that whilst there may have been some risk presented by Service User A's behaviour at the time, this was not sufficiently high to meet the threshold as set out in the seclusion policy '*severe behavioural disturbance that is likely to cause harm to others'*. Further, the panel considered that there was not sufficient evidence to suggest that less serious measures were sought before seclusion was decided. Whilst Miss Woods stated (during the first investigative interview on 22 February 2017) that they had tried '*every form of de-escalation'*, this was not specific and there was no evidence to support this. For all the reasons outlined above, the panel finds this charge proved.

Charge 2

2) On 10 November 2016 said in Service User A's presence and in reference to Service User A "He doesn't have the balls to go for anyone".

This charge is found proved.

The panel interpreted the phrasing of the charge to mean that Miss Woods had said the alleged words in the presence of Service User A.

The panel had sight of the CCTV footage for 10 November 2016 and noted that there was a female member of staff standing in the doorway who did make a statement of this nature to Service User A. The panel also had sight of the documentary evidence before it in which it is confirmed that this female member of staff was Miss Woods. During the first investigative interview on 22 February 2017, Miss Woods stated '…*he started making comments to me, I am in the doorway, it was male staff that were in the room with him and he stared to make comments to me such as 'pick the colours of the handles to your gasket* [sic] *because you're going to be in it by Christmas, me and the boys will be coming round, I know where you live'*.

The panel also took into account the second investigative interview dated 7 March 2017, during which Miss Woods accepted that she did state these words to Service User A. When asked *'from the CCTV footage when you and the other members of staff are in the seclusion room as you exit you say "he doesn't have the balls to go for anybody" could you give us some explanation around that sort of statement?*', Miss Woods replied '*Yes, I*

mean I should not have said that, clearly I shouldn't have said that and I put my hand up to it, he had been making a lot threats to me and he had been doing that throughout the night it was what the staff had feedback, but when the day staff arrived and there was males around he walked down quietly.'

On the basis of the above, the panel found that it was more likely than not that Miss Woods did say the words '*He doesn't have the balls to go for anyone'* in relation to Service User A. This charge is therefore found proved.

Charge 3

3) Caused Service User A to be kept in seclusion until 1 December 2016 when there was insufficient clinical justification for doing so.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 1, Colleague 2, Colleague 3, Colleague 6, and Miss Woods. The panel also had regard to the policy on '*Ending Seclusion'* as follows:

> *'**11 Ending Seclusion***
> *11.1 Seclusion should immediately end when an MDT review, a medical review or the independent MDT review determined that it is no longer warranted. Alternatively, when the professional in charge of the ward considers that seclusion is no longer warranted, it may be terminated following consultation with the patient's Responsible Clinician or the duty doctor, either in person or the telephone (MHA CoP, para 26.144).*
> *11.2 The Group requires the person-in-charge to regularly assess and decide, in consultation with the senior nurse on duty, whether it is appropriate to end seclusion.*
> *11.3 Seclusion ends when the patient is allowed free and unrestricted access to the normal ward environment or transfers or returns to conditions of Longer-Term segregation MHA CoP, para 26.145)*

11.4 Opening a door for toilet or food breaks or medical reviews does not, in itself, constitute the end of seclusion.
11.5 The Code of Practice recommends that in order to minimise the impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible. Where seclusion is used for prolonged periods, subject to suitable risk assessments, flexibility may include allowing the patient to receive visitors, facilitating brief periods of access to secure outdoor areas or allowing meals to be taken in general areas of the ward. Such flexibility should be considered during any review, and it may provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without termination the seclusion episode (MHA CoP, para 26.111).'

The panel took into consideration Colleague 1's witness statement in which it is stated '*On 16 November 2016 I telephoned Deborah and I relayed that I felt his seclusion was unwarranted and that we needed to start less restrictive options and review. Deborah responded aggressively and angrily words in effect of "You don't understand, you don't work here, wait for Jenny".*'

Further, in an email to Colleague 2 on 18 November 2016, Colleague 1 stated '*In my opinion, he should be taken out of seclusion and tested out on the wards. I spoke to Deborah who disagrees with that and wants to continue seclusion'*.

In Colleague 2's witness statement, it is stated '*The patient in seclusion is looked after by a team, and the team also manage the process of ending the seclusion and reintegrating the patient back to the ward environment. Without having the team being able to openly discuss the risks and any concerns they have and to work to a consensus view on when it is appropriate to end seclusion, then it is in practise* [sic] *not possible to end the seclusion. Deborah had made her decision very clear to the whole team and would not engage in any conversation about her decision'*.

Additionally, Colleague 3 set out '*In my experience of working at BBH and in other organisations, the usual amount of time for a service user to remain in seclusion is a day or two at most. Therefore service user A's 21 days in seclusion was highly irregular*.'

Moreover, Colleague 6 stated in their witness statement '*In other words, as soon as the need for seclusion ends, ie. There is no "immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others" (CoP 26.103), seclusion should end…The first clear recommendation that seclusion should end was given on 16 November 2016 by* [Colleague 1] … *Deborah continues by saying that she expects no changes to be made until she returns to BBH, and otherwise threatens to resign. In later emails, Deborah explicitly states that she should be involved in the decision involving Service User A's care, and threatens to place the blame for any incident on* [Colleague 2], *while making vague threats regarding people's position/employment at BBH'.*

In addition to the documentary evidence, the panel had sight of some of the CCTV footage of Service User A's seclusion period and noted that they had been kept in seclusion despite not having demonstrated threatening behaviour in any of the footage seen.

The panel also had sight of Miss Woods' account. It noted that at the first investigatory interview on 22 February 2017, Miss Woods outlined that the criteria for ending seclusion had not been met. She also went on to state that none of the members of staff had come to her to discuss ending the seclusion period. The panel noted that this is contradicted by the evidence from multiple other witnesses as well as Miss Woods' later evidence. In her statement written five years later, Miss Woods set out '*I became blinded by my own fear … I failed in my duties to ensure use of seclusion was reviewed, minimised, terminated. I failed to hear the team and ensure daily dialogue was held and actioned regarding the above… I abused my position and the power the position gave me by not working cohesively to protect and safeguard the service user… I accept this regulatory concern.'*

Having considered the evidence from the four witnesses, which are all consistent with one another, and taking into account that Miss Woods does in fact later accept this concern, the panel determined that Miss Woods did cause Service User A to be kept in seclusion (until 1 December 2016) when there was insufficient clinical justification for doing so. On this basis, the panel finds this charge proved.

Charge 4

4) Between 10 November 2016 and 1 December 2016:-

a. failed to ensure that Service User A received sufficiently frequent medical reviews as required by the Mental Health Act 1983 Code of Practice; and/or
b. failed to notify your line manager of any inability to meet the requirement set out at charge 4a).

This charge is found proved.

In considering this charge, the panel had regard to the Inmind seclusion and longer-term segregation policy section on '*Medical Reviews'* as follows:

*'**8.6 Medical Reviews***
8.6.1 Medical reviews must take place every four hours until the first (internal) MDT review has taken place, including in the evenings, night-time, on weekends and on bank holidays…
8.6.2 Medical reviews will include the following:

- *A review of the patient's physical and psychiatric health.*
- *An assessment of the adverse effects of medication.*
- *A review of the observations required (the minimum prescribed in this policy must be adhered to).*
- *A re-assessment of medication prescribed.*

An assessment of the risk posed by the patient to others.

- *An assessment of any risk to the patient from deliberate or accidental self-harm.*
- *As assessment of the need to continue seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.*

8.7 MDT Reviews 8.7.1 First (Internal) MDT Review: This should be held as soon as is practicable…
8.8 Further reviews required
8.8.1 Medical review - After the First (internal) MDT, further medical reviews will take place at least twice daily in every 24 hour period. At least one will be carried

out by the patient's Responsible Clinician, or an alternative approved clinician out of hours.

8.8.2 MDT review - must take place every 24 hours.

8.9 Independent MDT reviews

8.9.1 This should be held when a patient has been secluded for eight hours consecutively or for 12 hours intermittently in a 48 hour period. Minimum membership will include:

- *A doctor who is an approved clinician or an approved clinician who is not a doctor.*
- *A nurse.*
- *Other professionals not involved in the incident which led to seclusion, and an Independent Mental Health Advocate (IMHA) if possible.*

8.9.2 The CoP does not specify the membership of the Independent MDT Review at weekends and overnight. The Group therefore requires the review to be carried out by the on-call Approved Clinician, a nurse as well as a senior nurse all of whom were not in the incident which led to seclusion.

8.9.3 If it is agreed by the Independent MDT review that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan.'

Further, the panel took into account the evidence from Colleague 2, Colleague 6, Colleague 7, and Miss Woods.

In their witness statement, Colleague 2 set out the appropriate procedure for medical reviews '*Two registered nurses need to review the service user every two hours as per the Mental Health Act Code of Practice a psychiatrist needs to review the patient every four hours until the first MDT review of seclusion occurs, and twice every 24 hours thereafter. The initial MDT review should be held as soon as practicable and should occur every 24 hours. Whether the patient still needs to be in seclusion should be formally reviewed at each occasion'*.

The panel also had sight of Service User A's clinical records and noted that the required number of medical reviews had not been carried out. This was confirmed by the evidence of Colleague 6.

In their witness statement, Colleague 6 detailed the requirements related to the medical review of patients in seclusion '*The Code requires that a patient is seen by a medical doctor every 4 hours whilst in seclusion up until the "first (internal) multi-disciplinary team" review and thereafter, "medical reviews at least twice daily (once by the responsible clinician)"* and stated *'Medical reviews as required by the CoP did not take* place'.

The panel also had regard to the second investigatory interview records, during which Miss Woods accepted that the required medical reviews were not carried out and that she did not raise this: '*CQC when they did the inspection and looked through the paper work it was evident that there hadn't been the four hourly reviews do* [sic] *on a night. Again I am not saying it is ok, I am saying they should have been done and I should have raised it*.'

Miss Woods also accepted responsibility in her later reflective statement '*I was well aware that medical reviews did not take place every 4hrs, 24hrs a day as they should … We, as an organisation failed to uphold the Mental Health Act, I as hospital director and a registered nurse failed to address this serious breach and subjected the patient group and my colleagues to unsafe and unacceptable practise* [sic]… *I accept this regulatory concern.'*

The panel took into account the witness statement of Colleague 7 who confirmed that Miss Woods did not notify them that these medical reviews did not take place '*I can confirm that Deborah did not raise any concerns to InMind or to me personally with regard to not being able to comply with the requirements of the Mental Health Act 1983 Code of Practice when dealing with service users in seclusion'*.

Taking into account the relevant consistent witness accounts, Miss Woods' own admissions, and having had sight of the Mental Health Act 1983 Code of Practice and Service User A's clinical records, the panel concluded that there was sufficient evidence to support that the required number of medical reviews were not carried out and that Miss Woods did not raise this as a problem with her manager. This charge is therefore found proved.

Charge 5a

5) Between 10 November 2016 and 1 December 2016 caused or permitted Service User A to be deprived of the following on one or more occasions without reasonable justification:-
   a. Visits from his family members;

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 6. In their witness statement, Colleague 6 set out '*The Code of Practice at 26.111 is clear that even where a patient is in seclusion, they may be able to receive visitors, in accordance with the aim of applying seclusion as flexibly as possible … Requests were made by Service User A for visits from his family and solicitor on 10 November, and on 19 November it was documented that Service User A's had not been able to visit due to him being in seclusion'.*

Furthermore, the panel had regard to Service User A's clinical notes for 19 November 2016, in which it is recorded '*Service User A's mother stated that she has not been able to see Service User A for the past month'*.

The panel also took account of Miss Woods' reflective statement in which she accepted this concern '…*I do, however, fully accept that if visits were denied or held inappropriately that my refusal to be flexible in other areas may well have unjustly influenced same. As hospital director I should have been aware at all times what was happening and ensured team discussion was held to lead to the best, risk-assessed outcome for the service user, I failed to do so. Clearly family contact is a* [sic] *vital and necessary especially under the difficult circumstances my actions had placed this service user in. This act denied the service user key support…. I accept this regulatory concern*.'

On the basis of all of the above, the panel was satisfied that this charge is proved to the extent that Miss Woods permitted Service User A to be deprived of family visits.

Charge 5b

5 Between 10 November 2016 and 1 December 2016 caused or permitted Service User A to be deprived of the following on one or more occasions without reasonable justification:-
b. Visits from his Solicitor;

This charge is found proved.

The panel took into account the evidence from Colleague 6, who stated '*The Code of Practice at 26.111 is clear that even where a patient is in seclusion, they may be able to receive visitors, in accordance with the aim of applying seclusion as flexibly as possible … Requests were made by Service User A for visits from his family and solicitor on 10 November, and on 19 November it was documented that Service User A's had not been able to visit due to him being in seclusion'.*

In addition, as recorded in the meeting minutes for the interview held with Colleague 4, it was stated by Colleague 4 '*The Service User wanted to contact his solicitor once in seclusion and but it was only scheduled in for 1st December 2016, which was cancelled as the Service User moved out of the unit to MSU on 1st December 2016*.'

The panel had sight of the CCTV footage of Service User A's time in seclusion, during which it heard them asking for their solicitor.

The panel also took account of Miss Woods' reflective statement in which she accepted this regulatory concern.

Based on the evidence from Colleague 6 and Colleague 4, together with Miss Woods' own admission and the CCTV footage, the panel concluded that Miss Woods permitted Service User A to be deprived of visits from his solicitor. This charge is therefore found proved.

Charge 5c

5 Between 10 November 2016 and 1 December 2016 caused or permitted Service User A to be deprived of the following on one or more occasions without reasonable justification:-

c. Books and/or iPod and/or a game of chess;

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 2, Colleague 3, and Miss Woods' own acceptance of this concern.

In their witness statement, Colleague 2 sets out that '*The Code (26.151) highlights that over long periods in seclusion, the environment must be no more restrictive than is necessary. This would cover providing some form of activity or entertainment for the patients as and when they wanted this. Items can be given to patients to make their time in seclusion more manageable and the risk of providing items is discussed by the nursing and MDT. Some items that are generally safe would be books. Personal music players with or without headphones are another option that it the team* [sic] *can offer the patient … I spoke to Service User A about this and he requested something to read. I checked what books were available on the ward and brought him back a book of his choice. I was later informed that Deborah had removed the book from the room stating that it could be thrown at staff. On 20 December 2016 I specifically discussed this possible risk with the staff on shift and they were all in agreement that they thought this was a risk they could accept and I gave Service User A another book. This was also later removed. There was a conversation about getting a music player for Service User A but the consensus seemed to be that this would antagonise Deborah in a way that staff were fearful of doing*'.

In addition, Colleague 3 stated in their witness statement '*Around the second week of service user A's seclusion I asked the registrant if I could play chess with service user A. The registrant responded with words in effect of "No fucking way, you know the fucking idiots on the ward they will bring the chess board here and then he will have a weapon".*'

In her reflective statement, Miss Woods accepted this regulatory concern '*Due to the nature of seclusion being used as a setting of last resort to contain urgent risk, meaningful and recreational activities were not prioritised as they might be for patients in other settings… When I heard that some staff had decided to give books and newspaper* [sic]*, I instructed clearly that those should be removed due to the risk of him disabling the safety viewing systems again. My request was not malicious, but rather was made on the*

grounds of ensuring safety of staff in the context of the apparent oversight of others. I do however accept that I failed to work beyond this with the team to ensure some occupation or recreation for the patient... I was not flexible.'

On the basis of the direct accounts from Colleague 2 and Colleague 3, together with Miss Woods' own acceptance, the panel concluded that this charge is found proved.

Charge 5d

5 Between 10 November 2016 and 1 December 2016 caused or permitted Service User A to be deprived of the following on one or more occasions without reasonable justification:-
d. hot food;

This charge is found proved.

The panel took into account the evidence from Colleague 2 and Miss Woods' own acceptance of this concern.

In their witness statement, Colleague 2 stated '*Patients should have access to regular meals and a varied diet on seclusion and additional snacks should be offered if needed. Any risks around food items and cutlery etc are ordinarily discussed by the team and occasionally restrictions are put in place if they are necessary to manage immediate risk. There was no discussion about food and risk with respect to Service User A, but based on my clinical assessment, it would have been safe for him to have the usual ward meals on plastic plates with plastic cutlery. Deborah did not want Service User A to be given hot meals on plate and she did not want him to be given napkins when he was given sandwiches. I raised this with Deborah, and she told me that if Service User A had a napkin he would use it to block the CCTV camera in the room, so she did not allow him to have one*.'

The panel had regard to Miss Woods' reflective statement '*To give hot food on a plate with cutlery required a larger number of staff present who could intervene should the utensils be used for self-harm or should they be secreted for use as a weapon. We had trialled*

safety utensils for use in seclusion; however, these had previously been secreted, damaged and used to inflict self-harm and it was decided by the team that this was not a good solution. On these grounds sandwiches and hot finger food were provided on most days to all patients in seclusion and this would be changed where possible. The above had been the way seclusion operated at BBH since it opened and had not been regularly reviewed, I take responsibility for this, I take responsibility for the service being inflexible, I take responsibility for myself being inflexible and placing generic risk assessment before individualised patient care. To be detained in seclusion for an extended time and given the same diet daily with little variation was both unhealthy and denying the service user the basic pleasure of eating his chosen diet. I accept this regulatory concern.'

On the basis of the direct account from Colleague 2, together with Miss Woods' own acceptance, the panel concluded that this charge is found proved.

Charge 5e

5 Between 10 November 2016 and 1 December 2016 caused or permitted Service User A to be deprived of the following on one or more occasions without reasonable justification:-
e. access to any outdoor area;

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 2, Colleague 3, and Miss Woods.

Colleague 2 set out in their witness statement '*I spoke with the nurse in charge of the shift and with the other staff members on the ward, and I raised the idea of allowing Service User A out of the seclusion room for some fresh air in the garden and to allow him to have a shower... The nurse in charge asked whether I had asked Deborah about these plans; I advised that I was not going to ask her as I expected her to say no*…'

Further, in Colleague 3's witness statement it is stated '*Apprently* [sic] *on 20 November 2016* [Colleague 2] *permitted service user A for a walk around the garden and he also took a shower.*

In her reflective statement, Miss Woods indicated that she accepted this concern '*I failed to provide the service user with the basic necessity and right of having fresh air and a chance to exercise'*.

On the basis of the consistent accounts from Colleague 2 and Colleague 3, together with Miss Woods' own acceptance that she did not provide Service User A with outdoor access, the panel finds this charge proved.

Charge 5f

5 Between 10 November 2016 and 1 December 2016 caused or permitted Service User A to be deprived of the following on one or more occasions without reasonable justification:-
f. the opportunity to wash without being observed and/or a shower

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 3, Colleague 6 and Miss Woods.

Colleague 3 set out in their witness statement *'Service user A also did not have very basic provisions such as those to wash properly, change his clothes or brush his teeth. I think service user A told me that he had not brushed his teeth for a week; this surprised me and so I spoke to the staff in LSU about this and I told them that he needed a tooth brush, but the response was that the registrant will not authorise it … However I do remember that a few days afterward (unfortunately due to the passage of time I cannot offer specific dates) the registrant did yield and staff were allowed to give service user A a bucket with warm water in order for him to wash himself with*.'

Colleague 6's statement is consistent with this '*At the insistence of Deborah, Service User A was only able to wash at the sink in the seclusion en-suite under the supervision of a three-person observation team. This three-person team included staff of all genders…On 20 November 2016 … while Deborah was absent from BBH,* [Colleague 2] *and the nursing team allowed Service User A out of seclusion in order to have a shower, a change of clothes and a hot meal, allowed him some fresh air in the garden, gave him a book and then took him back to seclusion. No issues were reported with his behaviour…* [Colleague 2] *informed Deborah of this via text, and her response was very hostile, stating "He is a little shit who constantly abuses staff. I am not minded to take him out of seclusion for any reason…*'

In her reflective statement, Miss Woods accepted this concern '*The seclusion room did not have an en-suite shower, it had only a sink and toilet. The bathrooms on the ground floor (where the seclusion room was situated) had not been upgraded and had significant ligature risks. Patients in seclusion were therefore not permitted to use these bathrooms on the grounds of risk to self … It had therefore always been the case that patients in seclusion were offered a strip down wash with staff of the same gender ensuring safety and dignity. On reflection I fully understand how degrading and humiliating this must have felt to the service user, to have such limited facilities to meet personal care needs with no privacy must have been intolerable and I should have raised this fact on the hospitals risk register, I should have fought to have an adequate seclusion en-suite built. I did not… I did not listen to staff making alternative suggestions, I saw only risk and was unable to reflect and compromise though at the time I did not recognise this … I accept this regulatory concern.*'

On the basis of the direct accounts from Colleague 3 and Colleague 6, together with Miss Woods' own acceptance, the panel concluded that this charge is found proved.

Charge 6

6 Between 10 November 2016 and 1 December 2016 overruled the professional opinions of members of the multi-disciplinary team with respect to Service User A's care and treatment.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 1, Colleague 2, Colleague 2, Colleague 4, and Colleague 5.

In their witness statement, Colleague 1 stated '*On 16 November 2016 I telephoned Deborah and I relayed that I felt his seclusion was unwarranted and that we needed to start less restrictive options and review. Deborah responded aggressively and angrily words in effect of "You don't understand, you don't work here, wait for Jenny". Our conversation lasted no more than five minutes.*'

In addition, Colleague 2 stated '*This was the first time in my career that I have experienced this total shut-down whereby clinical staff feel unable to have a view on a clinical situation because of the consequence them expressing their view will have from their manager. Attempts I made to start a discussion were met with silence or with a guarded comment along the lines of "You need to run this by Deborah*".'

The panel also noted Colleague 3's statement '*The registrant frequently attended MDT meetings for service users in the LSU and she would strongly voice her opinion of the service users risk of harm and how she plans for their care to continue. I witnessed the registrant veto the Psychiatrists decisions at times. Due to the registranfs* [sic] *influence over the MDT, it appeared to hinder its function.*'

Further, Colleague 4 stated '*The way that she spoke to me and her tone of voice suggested that she was warning me that my job was in jeopardy because of my disloyalty toward her in regards to Service User A's seclusion. She told me that I had "Betrayed" her*.'

The panel also took into account that Colleague 5 has detailed '*However, when I aired my opinion, Deborah's response in the MDT was words in effect of "I don't give a flying fuck about your little pieces of paper*".'

On the basis of all of the accounts as outlined above, who all attest to Miss Woods' dismissiveness of their concerns and opinions, the panel concluded that there was sufficient evidence to find this charge proved.

Charge 7

7 On 13 May 2016:
a. called Colleague 1 a "bloody idiot"
b. shouted at Colleague 1 "You are just a consultant I can take you out and remove you at any time" and/or "I could terminate your employment" or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 1, who provided a direct account of events.

In their witness statement, Colleague 1 set out '*I tried to advocate for the team saying it was not us that was arguing and then she had an argument with me and "bloody idiot". She also shouted aggressively in front of the whole class words in effect of "You are just a consultant I can take you out and remove you at any time". Another phrase she shouted was in effect of "I could terminate your employment". I feel this was extremely unprofessional.*'

In addition, in an email dated 13 May 2016, Colleague 1 stated '*Her remark was " you are a bloody idiot if you think you are more important than me in this company".*'

Whilst the panel had no evidence from Miss Woods on this charge, it considered that Colleague 1's evidence was sufficient to find this charge proved on the balance of probabilities in the context of all the other evidence about the toxic working environment the panel found Miss Woods had created.

Charge 8

8 On 16 November 2016 said to colleague 1 “You don’t understand, you don’t work here, wait for [Colleague 2]” or words to that effect.

This charge is found proved.

In considering this charge, the panel had regard to the witness statement of Colleague 1 who provided a direct account of events ‘*On 16 November 2016 I telephoned Deborah and I relayed that I felt his seclusion was unwarranted and that we needed to start less restrictive options and review. Deborah responded aggressively and angrily words in effect of “You don’t understand, you don’t work here, wait for Jenny”.*’

In the absence of any contradictory evidence, the panel concluded that Miss Woods did say these words to Colleague 1. This charge is therefore found proved.

Charge 9

9 On a date in November 2016 said to Colleague 3 “I hired [Colleague 2] and I can fucking fire her too…” or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 3.

In their witness statement, Colleague 3 stated ‘*She once said in front of me and some other staff members workds* [sic] *in effect of “I hired* [Colleague 2] *and I can fucking fire her too…*’

Colleague 3 reiterated this account of events during the interview on 21 January (year not indicated) ‘… *and I was sat there and DW was in a sort of a huff and a puff and said “I hired [Colleague 2] and I can fucking fire here too, how dare she do this, I didn’t agree to that”…*’

This was also consistent with Colleague 3’s statement to the Care Quality Commission (CQC), NMC, NHS England and Wandsworth Safeguarding Adults’ Team dated 4

December 2016, in which it is stated '*In my presence she also shouted [referring to the Consultant Psychiatrist] "I hired her, I can fucking fire her!"…*'

On the basis of the multiple consistent accounts provided by Colleague 3 and in the absence of any contradictory evidence, the panel concluded that this charge is found proved.

Charge 10

10 On 21 November 2016 you said to Colleague 3 "I don't give a flying fuck what you think" or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from Colleague 3.

The panel had regard to the meeting minutes of the interview which took place on 21 January (year not indicated) in which Colleague 3 stated '*DW was sitting in here where you are and she rose up partly out of her seat, she didn't actually hit me ,she swiped her hand through the air in a side motion and said " I don't give a flying fuck what you think" and we all just sat there and looked*.'

The panel noted that this was consistent with Colleague 3's statement to the NMC and safeguarding dated 4 December 2016 in which it is set out *'…"I don't give a flying fuck what you think!"…*'

On the basis of the consistent evidence provided by Colleague 3 and in the absence of any evidence to contradict this account, the panel finds this charge proved.

Charge 11

11 On 24 November 2016 sent Colleague 2 an email at 16.35pm.

This charge is found proved.

The panel had regard to the email from Miss Woods to Colleague 2 on 24 November 2016, with a timestamp of 16:35, as follows:

'I can not even voice how disgusted I am this meeting took place when I was on leave. It could have happened Tuesday or waited until Monday. Yet again it has been done behind my back - nobody called asking my opinion did they??
Team split has now taken on a whole new meaning as far as I am concerned.
Deborah'

This charge is therefore found proved.

Charge 12

12 On 25 November 2016 sent Colleague 2 emails at:
a. 09.43 am;
b. 09.58am.

This charge is found proved.

The panel had regard to the email from Miss Woods to Colleague 2 on 25 November 2016, with a timestamp of 09:43, as follows:

'Any meetings should include me. We are talking about potentially a massive risk which impacts operationally. I will not work with a team that excludes me, you have done this twice in one week. The meeting could have been held Monday or last Tuesday and the very least I would have expected is to be tied in yesterday via telephone.

You keep talking about these mythical staff, I have asked you repeatedly for names but you don't appear abe [sic] *to produce any? Staff come to me constantly for support how dare you say they are frightened of me? I have been a constant at BBH for them unlike yourself.*

I cannot work with you if you think the way you are acting is acceptable and not damaging to the team. You are feeding into a split on a daily basis and appear to be proud of it????

I think we need to think carefully were we go from here. I am disgusted, angry and amazed that you would do this on one of the few annual leave days I take. You have effectively ruined my time off whilst I did nothing but shield you and fight your corner last week.

At this stage there needs to be significant changes - I thought we had an agreement on Tuesday to work together, I didn't realise that only included when I was on site.

Deborah'

The panel also had regard to the email from Miss Woods to Colleague 2 on 25 November 2016, with a timestamp of 09:58, as follows:

'You know what at this stage you do what you want with but record VERY clearly that I strongly oppose it. Any incidents are on your head. I also will not be fighting for sick pay for anyone who gets injured because of your, in my opinion, excessive risk actions.

The only member of my so called senior team who had the decency to call me last night and acknowledge that holding the meeting without me was wrong was [Mr 1]. *That tells me a lot about the people I work with.*

That you state in your original email about having a meeting with the MDT and nurses with no mention of including the person who runs the hospital is outrageous and better not happen in my absence.

Deborah'

This charge is therefore found proved.

Charge 13

13 On or around 20 November 2016 said to Colleague 4 “I hire, I fire” and “you are disposable” or words to that effect.

This charge is found proved.

The panel had regard to the witness statement of Colleague 4 in which it is set out ‘*She then told me that she was looking into changing some of the key positions at BBH. She said “I hire, I fire”. She also said “You are disposable”…*’

On the basis of the above, which the panel noted was a direct account from Colleague 4, and in the absence of any contradictory evidence, the panel concluded that this charge is found proved.

Charge 14

14 On 20 November 2016 sent Colleague 4 text messages at:

a. 17.22pm;

b. 18.32pm;

c. 18.40pm.

This charge is found proved.

The panel had regard to the screenshots of text messages from 20 November 2016, as exhibited by Colleague 4. It noted that text messages were sent from Miss Woods to Colleague 4 at 17:22, 18:32, and 18:40. This charge is therefore found proved.

Charge 15

15 On 24 November 2016 sent Colleague 4 text messages at:

a. 21.44pm;

b. 15.57pm

This charge is found proved.

The panel had regard to the screenshots of text messages from 24 November 2016, as exhibited by Colleague 4. It noted that text messages were sent from Miss Woods to Colleague 4 at 21:44 and 15:57. This charge is therefore found proved.

Charge 16

16 On 25 November 2016 sent Colleague 4 text messages at:
   a. 06.55am;
   b. 17.49pm;
   c. 18.59pm;
   d. 20.31pm.

This charge is found proved.

The panel had regard to the screenshots of text messages from 25 November 2016, as exhibited by Colleague 4. It noted that text messages were sent from Miss Woods to Colleague 4 at 06.55, 17.49pm, 18.59, and 20.31. This charge is therefore found proved.

Charge 17

17 Your conduct in respect of each of the charges at 7 to 16(d) above was unprofessional and/or of a bullying and/or threatening and/or intimidating nature.

This charge is found proved.

In considering this charge, the panel had regard to the definitions of unprofessional, bullying, threatening, and intimidating (as set out in the Cambridge dictionary accessed online on 31 August 2022), as follows:

- Unprofessional: *'not showing the standard of behaviour or skill that is expected of a person in a skilled job'.*

- Bullying: *'the behaviour of a person who hurts or frightens someone smaller or less powerful, often forcing that person to do something they do not want to do'.*
- Threatening: *'expressing a threat of something unpleasant or violent'.*
- Intimidating: *'making you feel frightened or nervous'.*

The panel determined that Miss Woods' conduct as found proved in the following charges amounted to *'unprofessional'*: charges 7a, 7b, 8, 9, 10, 11, 12a, 12b, 13, 14, 15a, 15b, 16a, 16c, and 16d.

The panel determined that Miss Woods' conduct as found proved in the following charges amounted to a *'bullying'* nature: charges 7b, 10, 11, 12a, 12b, 13, 15b, 16a, and 16d.

The panel determined that Miss Woods' conduct as found proved in the following charges amounted to *'threatening'*: charges 7b, 9, 10, 12a, 12b, 13, 15a, 15b, 16a, and 16d.

The panel determined that Miss Woods' conduct as found proved in the following charges amounted to an *'intimidating'* nature: charges 7a, 7b, 8, 9, 10, 11, 12a, 12b, 13,15a, 15b, 16a, and 16d.

On the basis of the findings above, the panel concluded that Miss Woods' conduct in respect of all charges from 7 to 16(d), aside from charge 16(b), was either unprofessional, of a bullying nature, threatening, and/or of an intimidating nature. This charge is therefore found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Miss Woods' fitness to practise is currently impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Representations on misconduct and impairment

In its written submissions, the NMC referred to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and identified the specific, relevant provisions where it argues Miss Woods' conduct fell significantly short of the standards of the Code. It was submitted that Miss Woods' actions were a serious departure from the standards expected of a registered nurse and do amount to misconduct.

The NMC went on to refer to Dame Janet Smith's Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of *Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant* [2011] EWHC 927 (Admin) and submit that limbs (a) to (c) of this test are engaged in this case. It was submitted that Miss Woods placed Service User A at risk of physical and emotional harm. Further, due to the serious nature of Miss Woods' misconduct towards Service User A and her colleagues, the reputation of the profession was brought into disrepute. The NMC also submitted that in failing to treat Service User A with compassion, kindness or respect, and as she acted in a bullying and intimidating manner towards her colleagues, Miss Woods breached the fundamental tenets of the profession.

The NMC submitted that as Miss Woods' conduct displayed serious attitudinal concerns towards a number of people which were manifested over a prolonged period, the misconduct is not easily remediable. It was further submitted that the concerns have not yet been remediated and therefore they are highly likely to be repeated should Miss Woods be permitted to practise as a nurse again. With regard to insight, the NMC

submitted that Miss Woods has displayed some limited insight in that she accepted a level of wrongdoing before she disengaged with the NMC process. Further, in a personal statement provided on 15 April 2020 Miss Woods accepted the regulatory concerns. The NMC also stated that whilst Miss Woods has expressed some remorse and regret, she has not provided any evidence of remediation by way of any training in the areas of concern. The NMC submitted that there is a continuing risk to the public due to Miss Woods' lack of insight and therefore a finding of impairment is required to protect the public.

The NMC also submitted that a finding of current impairment is required on public interest grounds in order to declare and uphold proper standards of conduct and behaviour and to maintain confidence in the profession and the NMC as regulator.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, of *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin), and *CHRE v Grant*.

Decision and reasons on misconduct

In coming to its decision on whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. It determined that Miss Woods' actions did amount to a breach of the Code, specifically:

Prioritise people

> *You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.*

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

2.3 encourage and empower people to share in decisions about their treatment and care

4 Act in the best interests of people at all times

To achieve this, you must:

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

5 Respect people's right to privacy and confidentiality

5.1 Respect a person's right to privacy in all aspects of their care

8 Work co-operatively

To achieve this, you must:

8.1 make sure you deliver the fundamentals of care effectively

8.2 maintain effective communication with colleagues

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

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

To achieve this, you must:

9.1 provide … constructive feedback to colleagues

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

20 Uphold the reputation of your profession at all times

To achieve this, you must, as appropriate:

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this you must

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

The panel was aware that breaches of the Code do not automatically result in a finding of misconduct. However, it considered that Miss Woods' conduct, namely her treatment of Service User A (a vulnerable adult) and her behaviour towards members of staff, fell seriously short of the conduct and standards expected of a registered nurse. The panel determined that Miss Woods' actions would be considered as '*deplorable'* by fellow practitioners, and for that matter by members of the public. The panel therefore concluded that Miss Woods' actions were sufficiently serious to amount to misconduct.

Decision and reasons on impairment

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

The panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's '*test*' which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d) ....'

The panel found that limbs a – c were engaged in this case. It determined that Service User A was put at an unwarranted risk of harm as a result of Miss Woods' actions. Miss Woods placed Service User A into seclusion for a period of 21 days without sufficient clinical justification and permitted the deprivation of several basic necessities, including hot food and access to fresh air. The panel further determined that as this vulnerable patient was put at a risk of harm, Miss Woods' actions brought the profession into disrepute. The panel also determined that Miss Woods' conduct and behaviour in relation to her treatment of both the service user and her members of staff breached fundamental tenets of the profession.

In considering whether the concerns in this case have been remediated, the panel had regard to the case of *Cohen v General Medical Council,* in which the court set out three factors which it described as being '*highly relevant'* to the determination of the question of current impairment:

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

The panel noted that the concerns in this case largely relate to Miss Woods' attitude and behaviour, which would be difficult to remediate.

In considering insight, the panel had regard to Miss Woods' reflective piece. It noted that Miss Woods does demonstrate remorse, accepts the regulatory concerns, and does take responsibility. The panel noted the following paragraphs:

> *'For my part I became caught up in fear. I did not listen to others and I did not stop to reflect.'*
>
> *'I apologise fully for my actions to the service user himself, the wider patient group who witnessed this unacceptable situation, my colleagues and team members, my employers who had their professional reputation questioned and to my profession whom I let down by acting in such a manner.'*
>
> *'As an employee I am responsible for every choice and decision that I make and as Hospital Director I am ultimately responsible for the culture of the organisation'*

Whilst the panel took into account this statement from Miss Woods, it also noted that at times, Miss Woods attempted to deflect some blame. As such, the panel concluded that although Miss Woods has developed some insight, this is incomplete and does not fully address the serious attitudinal concerns in this case.

In relation to strengthening her practice, the panel took account of the three references provided, one of which was written in the acknowledgement of these concerns. This reference dated 17 May 2017 concluded the following: '*I have no doubt about her fitness to practice* [sic] *in the future and would recommend only strong management support and good reflective supervision as I would for anyone in a similar role'.* The panel also took into consideration that Miss Woods had an otherwise unblemished nursing career of 22 years.

Notwithstanding the above, the panel bore in mind that Miss Woods has not been working as a nurse since these events took place and has now disengaged with the regulatory process. Further, it noted that these concerns are serious, relating to the poor treatment of a vulnerable service user. Miss Woods had a bullying and dictatorial attitude towards members of her staff, which was such that would put them in fear of voicing their own opinion. Furthermore, as Miss Woods herself as admitted, she also failed to consult them as a team when making decisions. It also noted that these concerns took place over a

prolonged period of time (May – November 2016). In the absence of remediation and full insight, the panel concluded that there is a risk of repetition and therefore a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

In this regard, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It considered that an informed member of the public, aware of the misconduct in this case, would be concerned if a finding of current impairment were not made. The panel therefore also finds Miss Woods' fitness to practise impaired on public interest grounds.

Sanction

The panel decided to make a striking-off order. The effect of this order is that the NMC register will show that Miss Woods has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC.

Representations on sanction

The panel had regard to the NMC's written submissions on sanction.

The NMC outlined the following aggravating factors:

1. Abuse of position of trust;
2. Psychological abuse of patient;
3. Pattern of misconduct over a period of time;

4. Lack of insight.

The NMC submitted that there were no mitigating factors present in this case.

It was submitted that the only proportionate and appropriate order in this case would be that of a striking-off order. The NMC submitted that Miss Woods' attitude and lack of professionalism both towards Service User A and her colleagues is of such grave concern that she should not be able to remain on the register. It was submitted that public confidence in the profession can only be maintained by a striking-off order.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Miss Woods' fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Abuse of a position of trust
- A pattern of misconduct over a period of time
- Conduct put the service user at risk of harm
- Poor managerial style created a toxic environment for staff members

The panel also took into account the following mitigating features:

- Some evidence of insight into failings
- Remorse for her actions
- Three positive references provided, one of which is written in the acknowledgement of these concerns

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the ongoing public protection issues identified. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Woods' practice would not be appropriate in the circumstances.

The panel next considered whether placing conditions of practice on Miss Woods' registration would be a sufficient and appropriate response. Given Miss Woods' disengagement in the regulatory process and insufficient insight, the panel was not satisfied that if it was to impose any conditions, that she would comply with them. Furthermore, the panel concluded that the placing of conditions on Miss Woods' registration would not adequately address the serious attitudinal concerns in this case and would not uphold the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel had regard to the SG which outlines the circumstances where a suspension order may be appropriate. It noted that this case concerns serious attitudinal issues and a pattern of misconduct which is wide-ranging and occurred over a period of time. Furthermore, Miss Woods has now disengaged with proceedings and her insight is incomplete.

The panel was of the view that Miss Woods' conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. It noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Woods' actions is fundamentally incompatible with her remaining on the register and, as such, determined that a suspension order would not be a sufficient, appropriate or proportionate sanction or maintain confidence in the nursing profession.

Finally, in considering a striking-off order, the panel took note of the following paragraphs of the SG:

- *‘Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?’*

The panel was of the view that these concerns do raise fundamental questions about Miss Woods’ professionalism and that public confidence in the profession would not be maintained should she remain on the NMC register. The panel considered that the misconduct in this case was extremely serious and to allow Miss Woods to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. Therefore, the panel determined that a striking-off order in this case was the only sanction that would sufficiently protect patients, the public, and maintain professional standards.

The panel considered that this order was necessary to protect the public and maintain public confidence in the profession.

This will be confirmed to Miss Woods in writing.

Interim order

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

Representations on interim order

The panel took account of the written representations made by the NMC that an interim order is required to protect patients and is also in the public interest. The NMC submitted

that an interim suspension order for a period of 18 months is necessary to cover any possible appeal period.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive striking-off order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any possible appeal period, should Miss Woods wish to make one.

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

That concludes this determination.