Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
5 – 9, 13 – 15 December 2022
2 Stratford Place, Montfichet Road, London, E20 1EJ

16 December 2022
Virtual Hearing

14 – 18 August 2023
Hybrid Hearing

Name of registrant:	**Spilisiwe Zivurawa**
NMC PIN:	10A0413A
Part(s) of the register:	Registered Nurse – sub part 1 Mental Health Nursing (level 1) – 12 February 2010
Relevant Location:	Bradford
Type of case:	Misconduct
Panel members:	Museji Ahmed Takolia (Chair, Lay member) Mark Gibson (Registrant member) Helen Eatherton (Registrant member)
Legal Assessor:	Suzanne Palmer
Hearings Coordinator:	Jumu Ahmed (5 – 9, 13 – 16 December 2022) Chantel Akintunde (14 – 18 August 2023)
Nursing and Midwifery Council:	Represented by Silas Lee, Case Presenter
Mrs Zivurawa:	Present and represented by Wafa Shah, instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charges 20, 21(b) (in relation to Patient D)
Facts proved:	Charges 1(a), 1(b), 1(c), 2(a), 4(a), 4(c), 6(a), 6(b), 6(c), 8(b), 8(c), 8(d), 10(a), 10(b), 12, 13, 17, 19, 21(b) (in relation to Patient C)

Facts not proved:	Charges 1(d), 2(b), 3, 4(b), 5(a), 5(b), 5(c), 7, 8(a), 9(a), 9(b), 10(c), 11(a), 11(b), 11(c), 14(a), 14(b), 14(c), 15(a), 15(b), 16, 18, 21(a), 22
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (18 months)**
Interim order:	**Conditions of practice order (18 months)**

Details of charge (as amended)

That you a registered nurse;

1. *On 28 December 2020 verbally and/or physically abused Patient B by;*
   (a) Shouting at him. ***[PROVED]***
   (b) Saying words to the effect of, "you are a bastard". ***[PROVED]***
   (c) Saying words to the effect of, "Look at the mess you have made". ***[PROVED]***
   (d) Throwing a bottle of spray towards him. ***[NOT PROVED]***

2. *Failed to treat Patient B with dignity and/or respect by;*
   (a) Not changing Patient B for around 45 minutes after he had been incontinent and requested a change, on a date unknown in November 2020; ***[PROVED]***
   (b) Not changing Patient B in private on 28 December 2020. ***[NOT PROVED]***

3. *On a date unknown verbally abused Patient B by saying words to the effect of, "do you think your wife would want someone depressed like you".* ***[NOT PROVED]***

4. *On an unknown date in November 2020 failed to treat Patient B with dignity and/or respect by;*
   (a) Preventing access to the lounge. ***[PROVED]***
   (b) Failing to change his sanitary pad. ***[NOT PROVED]***
   (c) Saying to colleagues words to the effect of, "He has a toilet in his bedroom, he should know how to use the toilet". ***[PROVED]***

5. *On 26 January 2021 verbally abused Patient E by;*
   (a) Shouting at him. ***[NOT PROVED]***
   (b) Saying words to the effect of, "stop being stupid". ***[NOT PROVED]***
   (c) Saying words to the effect of, "you are a bastard". ***[NOT PROVED]***

6. *On an unknown date in November 2020 failed to treat Patient A with dignity and/or respect by;*

(a) *Holding the door closed preventing Patient A entering the lounge.* ***[PROVED]***

(b) *Blocking Patient A's entrance to the lounge using a sofa preventing the door to open.* ***[PROVED]***

(c) *Placing a bed sheet over the observation panel of the door preventing Patient A from looking through the door into the lounge.* ***[PROVED]***

7. *On 28 January or 31 January 2021 failed to treat Patient A with dignity and/or respect by instructing Colleague 2 to frighten them.* ***[NOT PROVED]***

8. *On one or more occasions on dates unknown verbally abused patients by;*

(a) *Shouting at them.* ***[NOT PROVED]***

(b) *Telling them words to the effect of, "shut up".* ***[PROVED]***

(c) *Calling them words to the effect of, "bastard".* ***[PROVED]***

(d) *Saying to them words to the effect of, "fuck you" and/or "fuck off".* ***[PROVED]***

9. *On one or more occasions on dates unknown physically abused patients when escorting them by;*

(a) *Putting pressure on their arms.* ***[NOT PROVED]***

(b) *Putting pressure on their backs.* ***[NOT PROVED]***

10. *On one or more occasions between June and October 2020;*

(a) *Slept whilst on duty.* ***[PROVED]***

(b) *Encouraged Colleague 1 to sleep whilst on duty.* ***[PROVED]***

(c) *Encouraged Colleague 1 not to trust colleagues who did not sleep outside of their break.* ***[NOT PROVED]***

11. *On 4 October 2020 bullied and/or intimidated Colleague 1 into not completing an IRIS report by;*

(a) *Shouting at her.* ***[NOT PROVED]***

(b) *Telling her words to the effect of, "that if you report what had happened, management would come down to the unit and possibly fire you".* ***[NOT PROVED]***

(c) *Saying words to the effect of, "you are acting stupid to risk losing your job".* ***[NOT PROVED]***

12. *Your actions at charge 11 above showed a lack of integrity in that you placed the interests of a colleague above those of residents in your care.* ***[PROVED]***

13. *On or after the 4 October 2020 failed to complete a safeguarding report relating to the incident that occurred between Patient A and Patient B.* ***[PROVED]***

14. *On an unknown date in January 2021 bullied and/or intimidated Colleague 1 by;*
    (a) *Shouting at her.* ***[NOT PROVED]***
    (b) *Saying words to the effect of, "you are being disrespectful".* ***[NOT PROVED]***
    (c) *Saying words to the effect of, "you can deal with him (as in Patient B) if he becomes challenging".* ***[NOT PROVED]***

15. *On a date unknown inaccurately recorded incident summaries in Patient A's care plan by;*
    (a) *Copying and pasting earlier incident summaries, and/or* ***[NOT PROVED]***
    (b) *Altering the dates.* ***[NOT PROVED]***

16. *Your actions in charge 15 were dishonest in that you deliberately sought to mislead others into believing that the incident summaries were correct when you knew that they were not.* ***[NOT PROVED]***

17. *On 19 December 2020 encouraged and/or instructed Colleague 1 to alter patients' physical observation readings so that their score could be calculated to read as 0.* ***[PROVED]***

18. *Your actions in charge 17 were dishonest in that this was an attempt to mislead others into believing that patients' physical observations were accurate knowing that they were not.* ***[NOT PROVED]***

19. *On one or more occasions on dates unknown failed to follow Patient C's care plan by using pull up sanitary pads instead of a 'Kylie'.* ***[PROVED]***

20. *On one or more occasions on dates unknown failed to follow Patient D's care plan by placing a second sanitary pad across his genitals.* ***[PROVED BY ADMISSION]***

21. *In relation to charge 19 and/or 20 failed to;*
    (a) Update Patient C's care plan and/or Patient D's care plan accordingly. ***[NOT PROVED]***
    (b) Recommend that Patient C's care plan and/or Patient D's care plan be adjusted accordingly. ***[PROVED BY ADMISSION in relation to Patient D, PROVED in relation to Patient C]***

22. *On an unknown date in January 2021 failed to follow Patient B's care plan by requesting that Colleague 1 order Patient B a pizza.* ***[NOT PROVED]***

In light of the above your fitness to practise is impaired by reason of your misconduct.

Background

You started as a care assistant before you attended university and qualified as a registered nurse in mental health in February 2010. Before this referral, you had a previously unblemished record and had not had complaints from your employers in this or any previous setting.

The NMC received a referral on 5 May 2021 from Elysium Healthcare (Elysium) regarding where you were working at the Three Valleys Hospital (the Hospital), particularly the Oakworth Ward (the Ward).

The charges arose whilst you were employed as a Charge Nurse at the Ward who cares for patients. The Ward was a nine bedded unit for male patients who have complex clinical presentations. Many have been diagnosed with physical or neurodegenerative brain

disorders, including dementia. The patients have difficult behavioural problems. Many were referred through the forensic psychiatric system and a number of them have serious index offences such as rape.

Providing consistency of care would have been challenging as there was a high turnover of staff in the unit as a result of the difficulty and challenging behaviour of the patients. There were usually three staff members at night, one registered nurse and two carers. Occasionally there would be an additional carer. There was a relatively high ratio of patients to staff. The unit relied heavily and almost daily on bank and agency staff.

The unit was geographically small, with a simple layout. There was a day room, a sensory room and a garden. The small and simple environment was intended to help control and manage patients, being able to observe them at all times, but it could feel confined or limiting at times

It is alleged that between 11 October 2020 to 9 February 2021, you:

1. Led a culture of bullying and disrespecting patients and influencing staff members to follow your example.

2. Led staff in blocking patients' access to a communal lounge area using ward furniture for sustained periods of time.

3. Instructed staff to omit or delay essential personal care interventions and routine general observations.

4. Instructed staff to falsify documentation.

Whilst working on the Ward, concerns were raised about your practice by Colleague 1, a Recovery Worker. The concerns raised are:

- That you would swear at patients, become irritated by them and use derogatory

language towards them.

- That you would physically escort patients to the room after a certain time of night to keep them out of the communal areas, even though they were requesting to stay in the communal area.

- On 4 October 2020, discouraged and pressured Colleague 1 into not submitting an incident report after Patient B threw a cup at Patient A. It is alleged that you shouted at Colleague 1, for approximately 20 minutes, and told them that they would possibly be fired if the report was submitted. You also failed to submit any safeguarding documentation for this incident.

- In November 2020, held the door to the communal lounge shut so that Patient A could not get in. You then moved the sofa in front of the door and sat on it with colleagues to further ensure that Patient A would not enter the communal lounge. Later on in this shift, whilst still sitting on the sofa used to block the lounge door, Resident B was seen roaming the corridors trying to find a member of staff asking for their pad to be changed. You failed to respond in a timely manner to Patient B.

- Around December 2020, you encouraged Colleague 1 to falsify patient observations.

- You would put Patient C in sanitary pads, even though their care plan identified that these were not to be used.

- You told Colleague 1 to order Patient B pizza which went against their choking risk assessment.

- That you would sleep on shift.

- You told Colleague 1 not to trust certain colleagues as they did not sleep outside of

their break and therefore are untrustworthy.

- You were witnessed “copying and pasting” incident summaries that you had written previously in Patient A’s care plan and changing the dates on them so they appeared to apply to more recent incidents.

- Sometime towards the end of December 2020, you aggressively threw a can of spray disinfectant towards Patient B after they had soiled themselves in the communal lounge.

- On 28 January 2021, you instructed another Colleague 2 to “frighten” Patient A so that they would return back to the sensory room and leave the communal area.

A local investigation was commenced by Elysium and you were suspended from the Hospital on 3 February 2021. You were then dismissed from Elysium on 23 March 2021 as a result of the concerns.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Shah, who informed the panel that you made admissions to charges 20 and 21(b) (in relation to Patient D).

The panel therefore finds charges 20 and 21(b) (in relation to Patient D) proved, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Lee on behalf of the NMC and by Ms Shah on your behalf. The panel accepted the advice on 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 heard live evidence from the following witnesses called on behalf of the NMC:

- Colleague 1: Recovery Worker at the Hospital.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Lee, on behalf of the NMC, to amend the wording of charge 2(a).

Mr Lee submitted that this was an incorrectly drafted charge, and that the proposed amendment was to provide clarity and more accurately reflect the evidence.

Original charge:

That you, a registered nurse:

2. *Failed to treat Patient B with dignity and/or respect by;*
   (a) Not changing Patient B in private on a date unknown in November 2020.

Amended charge:

That you, a registered nurse:

2. *Failed to treat Patient B with dignity and/or respect by;*
   (a) Not changing Patient B ~~in private~~ ***for around 45 minutes after he had been incontinent and requested a change,*** *on a date unknown in November 2020.*

The panel heard from Ms Shah who submitted that there was no objection to this application. She informed the panel that this amendment was known for a short time;

however, that it was clear that the charges do not match the evidence. She also submitted that she questioned Colleague 1 according to the proposed amendment to charge 2(a), so therefore there was no objection to this application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Ms Shah confirmed to the panel that you still dispute this (amended) charge.

Decision and reasons on facts continued

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

- Witness 3: Clinical Lead Nurse for Elysium, based at the Hospital.

Decision and reasons on application to admit Witness 4 and Witness 5's written statements as hearsay evidence

The panel heard an application made by Mr Lee under Rule 31 to admit the written statements of Witness 4 and Witness 5 as hearsay evidence. He informed the panel that the NMC seek to rely on: two investigatory meeting minutes with Witness 4, dated 11 February 2021 and 12 March 2021; the investigatory meeting minutes with Witness 5, dated 11 February 2021; and the email exchange between Witness 4 and the Hospital, dated 15 and 16 March 2021.

Mr Lee referred the panel to Rule 31(1) and the NMC's guidance on evidence (ref DMA-5). Mr Lee also referred the panel to the cases of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and *El Karout v NMC* [2019] EWHC 28 (Admin).

Witness 4:

Mr Lee informed the panel that a letter was sent by the NMC to Witness 4 on 26 August 2021 requesting for information. He said that on 28 April 2022 Witness 4 responded by stating that she did not want to give a witness statement. However, between 11 October 2022 and 4 November 2022, Witness 4 provided her evidence to the NMC via a phone call, which was then developed into a statement. That statement was sent to the witness on 4 November 2022. My Lee told the panel that since 4 November, the NMC had tried extensively to secure the witness' response to that statement and have not been successful. A witness summons was sought and issued on 23 November and was sent special delivery to Witness 4's address on 25 November 2022, summoning the witness to attend on 6 December 2022 to give evidence. Witness 4 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she had not engaged since a witness statement was drafted and did not attend the hearing.

Mr Lee submitted that there is no dispute on the relevance of Witness 4's evidence, and that the statements were not the sole and decisive evidence in support of the charges. Mr Lee submitted that in the first interview with Witness 3 and Witness 6 on 11 February 2021, Witness 4 denied that the door was blocked by the sofa and that the staff slept in the communal area. When asked whether you had referred to anyone as a bastard, Witness 4 replied "not really", before eventually stating that she had not.

Mr Lee submitted that, in the second interview on 12 March 2021, Witness 4 told the investigator that she had not been honest in her initial denials. She gave the following relevant evidence:

i. Regarding the incident on 4 October 2020, confirms that an incident occurred
ii. between two patients where one threw a cup;
iii. The use of swear words by you, albeit not to residents' faces;
iv. A strict "bedtime" policy by you;
v. The use of a sofa to block the communal area door, witnessed by her on one occasion; and that
vi. That members of staff had been sleeping on duty.

Mr Lee told the panel that Witness 4 apologised for not speaking up and stated that it was because you were intimidating.

Further, Mr Lee submitted that in an email dated 26 March 2021, Witness 4 confirmed that the contents of the minutes were accurate.

Ms Shah invited the panel to apply the test of fairness. She referred to Rule 31(1) of the Rules and submitted that the panel must decide whether or not it is fair. She said that fairness is fact specific, and fairness can be different in different cases. Ms Shah invited the panel to consider the case as a whole, the context of this evidence and the context of what you were saying and then decide whether it would be fair to allow this evidence in.

Ms Shah submitted that not only would it be unfair to admit Witness 4 and Witness 5's evidence as hearsay evidence because various things cannot be explored in cross-examination, but it would also be unfair because the panel is deprived of its ability to scrutinise Witness 4 and 5's evidence and to ask questions of the witnesses which would be pertinent in light of what you are saying has happened.

Ms Shah told the panel that there no doubt that these are very serious allegations of abuse. She submitted that in terms of context the panel have heard from Ms 3 that you have worked at the same place in Three Valleys since 2017; as a full-time agency worker and then as a substantive employee from 2020. Throughout that time, there has been no complaint made against you of abusing patients, sleeping on shift, moving sofas to block

doors, or swearing at patients. This was after you have worked with a number of agency workers that have come in over that period of time, and after working in other wards.

Ms Shah further submitted that on the other hand, there was one recovery worker made a series of complaints against you which do not quite match up with the history of your practice or your character. Ms Shah submitted that your case has always been that Colleague 1 has been fabricating her account. She submitted that it was put to her that she was colluding with other witnesses, and that she is trying to protect herself when in fact she was involved in activities that amounted to misconduct.

Ms Shah informed the panel that there is evidence that supportive accounts were being altered, which can be seen with Colleague 2, which was put to him during cross examination. She told the panel that the same line of questioning would have also been put to Witness 4 and 5. She told the panel that had this simply been a case of corroborative evidence from other care workers, then perhaps it would be fair to admit it.

In relation to Witness 4, Ms Shah told the panel that Witness 4 does not want to have anything to do with these proceedings, as she told this to the NMC twice in her emails. Witness 4 has also refused to sign her witness statement and has not provided any reason for being unable to attend. Witness 4 simply says, *"She does not want to provide a witness statement and she does not want to participate in these proceedings".* She told the panel that the NMC state that the reason for Witness 4's non-attendance is because this was a whistleblowing complaint and maybe Witness 4 was afraid to participate in it. However, she submitted that you are entitled to explore another reason for her non-attendance which could be that the reason why Witness 4 is not here is because she does not want to stand by what she said in her second interview is because it is false. Ms Shah told the panel that the panel has two interview notes from Witness 4 which the NMC seeks to rely on. In the first interview note, Witness 4 more or less says she has never seen you do anything of the sort and therefore does not support the allegation.

Ms Shah submitted that Witness 4 was then invited to a second interview a month later. In the second interview on 12 March 2021, Ms Shah submitted that the meeting was opened in an interesting way as in the second line of the interview, it says:

> *'[Witness 3] advised that in our last meeting [Witness 4] may remember we discussed some allegations made against Spili Zivurawa and that a follow up investigation is now taking place to find out what other staff members' involvement in those allegations is."*

Ms Shah told the panel that Witness 3 said, *"Another investigation does not in fact take place".* She submitted that Colleague 2 will be telling the panel that he gave his honest account and then started being pressurised to give a different account. Ms Shah submitted that this was important and needs to be explored with Witness 4. She submitted that the panel may well wish to explore these questions as it has a duty to forensically examine these allegations. She further submitted that the reason for her non-attendance is simply her unwillingness which in and of itself raises concerns about the reliability of what she says.

Ms Shah further submitted that the reason provided by the NMC on Witness 4's non-attendance was not good enough because these are very serious and critical witnesses for very serious allegations. She said that there is no doubt that if these allegations are found proved the panel would be considering striking off. She said that you have been a nurse for a very long time without any concerns being reported against her and in those circumstances, a short delay may well be justified in obtaining a key witness, but that this has not been the NMC's approach.

Ms Shah submitted that in allowing Witness 4's statement as hearsay evidence, it would be grossly unfair because neither you nor the panel would be able to cross-examine her, and the panel would not be in a position to properly scrutinise the changing of the accounts. Therefore, it should not be admitted.

<u>Witness 5:</u>

Mr Lee submitted that the NMC was not able to successfully contact Witness 5 as an email was sent to the Witness 5's email address, which bounced back. He informed the panel that no reason for non-attendance has been provided but that the NMC has not been able to locate or contact her.

Mr Lee submitted that there is no dispute on the relevance of Witness 5's evidence, and that the statements were not the sole and decisive evidence in support of the charges. He submitted that the photograph in front of the panel was of Witness 5. Mr Lee also submitted that Witness 5's evidence confirms that a large sofa was pushed up in front of the door, to stop Patient A entering the communal lounge which occurred between 1am and 5am and that you gave the instruction for this to take place. Witness 5 also confirms in her evidence that a sheet was placed over the window to block the view; and to stop Patient B from entering. Mr Lee also submitted that Witness 5 also confirms that you stated *"he has a toilet in his room, leave him to it",* and that it was 30-45 minutes between him being incontinent and care being delivered.

Mr Lee submitted that Witness 5 also gives evidence that observations were not all conducted and you completed observation sheets and told the recovery workers to follow your lead. She confirms that some personal care was attended to by removing the sofa temporarily to enter the corridor, and that you had used of the word "bastards" towards patients. Mr Lee also informed the panel that Witness 5 confirmed that you only behaved in an abusive or inappropriate way in front of certain members of staff and that Patient E was forcefully pushed out of the communal area to the bed by you. Mr Lee also submitted that Witness 5's evidence also confirms that staff, including you, slept in the communal lounge during shift time. Witness 4, in the interview, stated that she knew what was going on was wrong but that she did not feel confident in speaking up.

Mr Lee submitted that for both Witness 4 and Witness 5, the evidence was not the sole or decisive evidence in respect of any of the charges. He submitted that each charge was substantiated by the live evidence of Colleague 1, to which the panel had the benefit of testing. He also submitted that the hearsay evidence was corroborative in nature as it supported Colleague 1's evidence, in that: you were abusing in the ways alleged and

that you were intimidating and so, the recovery workers were afraid to speak out. Mr Lee further submitted that none of the charges rely solely on the proposed hearsay evidence, which meant that no findings would be decided on the basis of hearsay alone, so therefore it would be fair to admit these.

Mr Lee submitted that there was no reason for Witness 4 and Witness 5 to fabricate their evidence. He informed the panel that you suggest that these were fabricated, however he submitted that Witness 4 and 5 risked being dismissed for gross misconduct in making these disclosures and that it was for the panel's professional judgement to make this decision.

Mr Lee further submitted that these are very serious allegations of misconduct. The potential impact could be very severe, should adverse findings of fact be made by the panel. This underlines the need for caution in considering this application. The authorities emphasise that hearsay applications are not to be treated in a routine manner. Practically speaking, that means fully grasping the evidential context into which the hearsay would be admitted and the impact on the case as a whole.

Ms Shah submitted that Witness 5 has not given a reason as to why she does not want to give evidence. She told the panel that an email was sent from the NMC to Witness 5 which had bounced back. She that the NMC have wide powers to trace witnesses by liaising with other regulators, particularly where Witness 5 is a healthcare worker. She submitted that the NMC have not sought to trace this witness or seek a different address. She, therefore submitted that the NMC has done the bare minimum, particularly as they have not even sought to try and contact another regulator to see if this Witness is regulated and to seek up to date details for her.

Ms Shah told the panel that Witness 5 is also a critical witness as she provides evidence relating to extremely serious allegations. Ms Shah submitted that Witness 5 clearly has a motive to fabricate an account as she was investigated for falsifying records and to pin the blame on someone else. She said that this should be explored with Witness 5 and in

allowing her statement as hearsay evidence would deprive you of pursuing valid lines of cross examination.

In light of this, Ms Shah invited the panel to deem this evidence as inadmissible and to let the NMC then take the view as to how they want to proceed in terms of trying to secure the attendance of these witnesses.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that 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.

In determining whether it is fair to admit the Witness 4 and Witness 5's hearsay evidence the panel carefully considered the principles set out in Thorneycroft.

Witness 4

The panel first considered the evidence subject to this application in respect of Witness 4 to be relevant.

The panel noted the Witness 4 has not provided a signature on her written statement to the NMC. Further, Witness 4 refused to take part in the proceedings entirely. It noted that Witness 4, at first, denied it all because she said that she was afraid and wanted to protect herself from incriminating herself if she was to agree. However, after you were suspended, she was able to talk. She said that she did not want to get in trouble and wanted to keep her job, particularly as she was supporting her family.

The panel noted that the admission of hearsay evidence when the principal witness is absent should not be regarded as a routine matter. It noted that Thorneycroft under-scores that the fitness to practise rules require the panel to consider the issue of fairness before admitting the evidence.

The panel also noted that the absence of a primary witness can be reflected in the weight to be attached to their evidence. This is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.

The panel next considered whether there is a good and cogent reason for the non-attendance of Witness 4. The panel noted that in Thorneycroft this principle is described as an *"important factor"*. The panel also noted that the absence of a good reason does not automatically result in the exclusion of the evidence.

In this regard, the panel noted that the NMC has not obtained a signature from Witness 4. The panel noted paragraph 56 of Thorneycroft and the need for a prosecutor to take "reasonable steps" in securing a witness's attendance. It was of the view that the NMC had taken reasonable steps to secure the attendance of Witness 4, to no avail, including obtaining a witness summons.

In light of the above, the panel decided that, whilst the NMC has made some efforts to secure Witness 4's attendance, there is no good reason for the witness having failed to provide a signed witness statement or to attend. insufficient good and cogent reason for not obtaining a signed statement and therefore her attendance.

The panel next considered whether the evidence is the sole and decisive evidence. It was of the view that it is not the sole and decisive evidence. The panel decided that the evidence was not of itself demonstrably reliable. There was evidence that Witness 4 could have some grounds for collusion or fabrication. Further, she also refused to sign her witness statement. There were some reasons for doubting her evidence, and it was fair and in the interests of justice for her evidence to be tested.

The panel took into account the seriousness of charges. It was of the view that the charges are extremely serious and if found proved, may well have a significantly adverse effect upon your nursing registration and career.

The panel having considered each of the various principles in Thorneycroft decided overall to rule that the evidence in relation the Witness 4 is inadmissible. Having balanced the various Thorneycroft factors, the panel placed significant weight on its finding that, in the circumstances of this case, the NMC has not established a sufficiently good and cogent reason for not obtaining a signature from Witness 4 and her attendance at this hearing.

In this regard and on overall balance of the Thorneycroft factors, the panel decided that it would be unfair to you to admit Witness 4's statement as hearsay evidence. In these circumstances the panel refused the application.

Witness 5

The panel first considered the evidence subject to this application in respect of Witness 5 to be relevant to the charges.

The panel next considered whether there is a good and cogent reason for the non-attendance of Witness 5. The panel was of the view that the NMC had not taken reasonable steps to secure the attendance of Witness 5. Only one email was sent to this witness which had bounced back. No other steps were taken and the NMC should have done more.

In light of the above, the panel decided that, whilst the NMC has made some efforts to secure Witness 4's attendance, there is insufficient good and cogent reason for Witness 5's non-attendance.

It also determined that Witness 5's evidence was not the sole and decisive evidence.

The panel had no evidence before it to which would demonstrate that Witness 5 would have a reason to fabricate her evidence. However, there was an allegation from you that she had reason to do so, and it would be appropriate for her evidence to be tested. As the charges are extremely serious, the panel was of the view that you should be afforded the opportunity to challenge this evidence.

In light of this, the panel decided that it would be unfair to you to admit Witness 5's statement as hearsay evidence. In these circumstances the panel refused the application.

Decision and reasons on facts continued

The panel also heard live evidence from the following witness called on behalf of you:

- Colleague 2: Senior Support Worker at the Hospital.

The panel also heard evidence from you under oath.

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

During the course of your evidence, you referred to matters relating to the health and personal circumstances of you and members of your family. Ms Shah made an application that this case be held in partly private on the basis that proper exploration of your case involves your health and third party interests. The application was made pursuant to Rule 19 of the Rules.

Mr Lee did not oppose the application.

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

Having heard that there will be reference to the health and personal circumstances of you and others, the panel determined to hold the hearing partly in private as and when such issues are raised.

Decision and reasons on application to admit Ms 7's interview notes into evidence

The panel heard an application made by Ms Shah under Rule 31 to allow the interview notes of Ms 7 into evidence.

Ms Shah told the panel Ms 7 is somebody who's referred to by Colleague 1 as being present when the incident took place in relation to changing Patient B in the communal lounge. When it's alleged by Colleague 1 that there were derogatory comments made to Patient B by you and that a spray of soap was thrown on Patient B by you. She submitted that Ms 7 would have heard these derogatory comments that were made by you and would see the soap being thrown. She therefore submitted the contents of those investigation notes are relevant to that aspect of the allegations.

Ms Shah told the panel that the NMC are a regulatory body and that it is incumbent upon them and is their duty to investigate matters fully before bringing them to a panel, that includes investigating exculpatory evidence. She submitted that it is clear from Ms 7's interview in which she says, *"Yes, there was a change in the communal area"*, it was in order to ensure that the patient wasn't left covered in faeces for a period of time. She submitted that *"It was a best interest decision, and I didn't see anything else happen"*, is exculpatory evidence. Ms Shah told the panel that you did not get Ms 7's notes via the NMC but rather that they were provided to you during the disclosure and barring service investigations. She informed the panel that Witness 3, who was called by the NMC, had sight of these notes and that Witness 3 had confirmed that this note is a note of a meeting that took place during her investigation.

Ms Shah submitted that you are not in a position to try and obtain and secure the evidence of Ms 7 by seeking co-operation from Three Valleys by obtaining addresses and phone numbers.

Ms Shah also submitted that it would be unfair to not to allow exculpatory evidence even though it takes the form of hearsay in the absence of Ms 7. She submitted that this was simply down to the fact that the NMC did not seek to obtain the full notes of all the

interviews and to try and contact Ms 7. She told the panel that the status of these notes is different from the others because of this disparity of position between you and the NMC.

Ms Shah informed the panel that some attempt was made by the NMC to contact Ms 7. However, she said that she was not sure where that led to and why the NMC stopped pursuing her.

When considering fairness, Ms Shah submitted that the panel ought to look at the issue of fairness in the round. One of the contextual matters, she invited the panel to consider is that you simply cannot obtain the attendance of this witness. She submitted that clearly this is evidence that's relevant and that assists you and it would be unfair if the panel were to simply disregard it or deem it inadmissible and therefore disregard it.

Mr Lee opposed the application. He informed the panel that there was an effort made by the NMC to contact Ms 7. The NMC had sent to an email address that the NMC obtained for her. That email asked the witness to provide a witness statement but a response was never received. So therefore, there was no response or communication directly made with Ms 7 but, just an attempt via email to get her to provide a statement.

Mr Lee submitted that if all of the interview notes were before the panel, he would not be opposing this application. However, that there were three considerations as to why this is being opposed: the first is the issue of fairness, the second is an issue of reliability, and the third is the context in which that evidence would be admitted, if it were to be admitted.

Regarding fairness, Mr Lee submitted that it would not be fair to admit evidence that is essentially of the same nature as Witness 3 and 4’s evidence, in which the panel refused to admit as the panel would only be admitting only that evidence that favours one side and not the other.

With regards to reliability, Mr Lee submitted that he would not have the opportunity to cross-examine Ms 7. The NMC case is that Ms 7’s interview evidence is fabricated and therefore contains lies. He informed the panel that there are three people that say that Ms

7 was involved in the sofa incident and she denies this in her interview. She denies a number of other suggestions but in the absence of her live evidence, there will be no opportunity to test that. He submitted that there is a clear motive in an investigatory meeting for Ms 7 to have denied involvement in what would amount to abuse of patients that she was supposed to be looking after. He submitted that he would not be able to test any of Ms 7's evidence, and therefore it would not be fair to have that evidence in as hearsay unchallenged.

In relation to context, Mr Lee submitted that in admitting Ms 7's interview notes as evidence in on its own, it is not properly situated in the full context of those other interview minutes. In which allegations are made by other members of staff that she had been fully involved in some of the abuse that has been alleged against you.

Me Lee submitted that the fair approach is to either to include all of those interview minutes to have the full context, or to have none of them on the basis that they cannot properly be tested. Halfway in between would not be fair.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that 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.

In determining whether it is fair to admit the Ms 7's interview notes as hearsay evidence, the panel carefully considered the principles set out in the Thorneycroft case.

The panel first whether the NMC would be disadvantaged in allowing Ms 7's interview notes into evidence. As Witness 3 and Witness 4's evidence was not admitted, panel determined that the NMC would be at a disadvantage.

The panel next considered whether it would be relevant and fair to admit Ms 7's interview note as hearsay evidence. The panel was of the view that the interview notes were

relevant as it directly speaks to the charges. It also was of the view that the interview notes were not the sole and decisive evidence.

In these circumstances, the panel came to the view that it would not be fair and relevant to admit Ms 7's interview notes into evidence. The panel determined that you could have sought to find ways to contact Ms 7 for her to attend and to give live evidence, including asking the NMC to provide information. It is not solely on the NMC to find this witness. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Ms 7 and the opportunity of questioning and probing that testimony.

In these circumstances the panel refused the application.

Decision and reasons on facts continued

The panel noted that this was a case in which much turned on a factual dispute between you and Colleague 1 about what happened. It was mindful that it should be careful to consider the evidence from each of you in relation to each charge. However some general themes about credibility could be identified from the panel's discussions and are set out here. The panel was also required to consider these points because you alleged that Colleague 1 was part of a conspiracy against you.

The panel noted that there were no complaints raised by the Hospital or from your previous employer. It also took into account your good character. It further noted references you had provided which said that you took a professional approach to care and were diligent and calm.

On the other hand, during your evidence, the panel considered that you seemed to seek to put some distance between you and the care assistants, in particular Colleague 1, although both you and Colleague 1 said that you had previously had a good working relationship.

The panel appreciated that there were patients who were extremely challenging at the Hospital. It considered it likely that there would be situations when frustration would have arisen in response to challenging behaviours from patients, possibly even with angry words, which may not have been directly towards the patients but towards colleagues.

The panel considered that you had been evasive in some aspects of your evidence, even to the extent of saying that you did not recognise the lounge from photographs taken of it. The panel considered this implausible, and found that it raised questions about the reliability or credibility of some of your evidence. It further noted that you had a tendency at times to cite what best practice would have been, rather than provide direct answers to questions about what actually happened. On many occasions when challenged about what you had said at disciplinary meetings your response was to deny the content of the minutes rather than to engage with the question.

In contrast, the panel considered that Colleague 1 had given a consistent account, which was also consistent, other than in minor points of detail, with the account she gave during the Trust's investigation. In the course of her evidence she incriminated herself in some quite unpleasant work practices. The panel could see no reason for her to do so unless she wanted to come clean about what actually happened. She had been open and transparent about her involvement. The panel noted that she had raised very specific allegations, some of which were of a nature or type which would be difficult to fabricate, and had provided a high level of detail. She had not been able to recall specific information such as dates or times in relation to some charges, but this did not significantly undermine her evidence.

The panel noted that Ms Shah had invited the panel to take the conspiracy into account. The panel noted Ms Shah's submission that Colleague 1's evidence was tainted by ill will or collusion.

You told the panel that you did not have a problem with Colleague 1, but that you were shocked and traumatised by her conspiracy towards you, and therefore you complained about her.

Having regard to the evidence as a whole, including the general themes identified above, the panel concluded that there was insufficient evidence to support any suggestion of a conspiracy against you.

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

Charges 1(a), 1(b) and 1(c)

1. On 28 December 2020 verbally and/or physically abused Patient B by;

(a) Shouting at him.

(b) Saying words to the effect of, "you are a bastard".

(c) Saying words to the effect of, "Look at the mess you have made".

(d) Throwing a bottle of spray towards him.

These charges are found proved, with the exception of 1(d) which is found not proved.

In reaching this decision, the panel took into account Colleague 1's witness statement, Colleague 1's statement dated 3 February 2021 and Witness 3's investigation meeting notes dated 9 February 2021. The panel also took onto account your evidence.

In Colleague 1's witness statement, the panel noted:

> *'12. Just before New Year in December 2020, I was on shift with the Registrant and another Recovery Worker called [Ms 7]. It was after 00.00, and a patient, Patient B, had opened his bowels on a chair in the communal lounge. The three of us discussed how we would deal with the situation, and decided that our first step should be to put on PPE. I went to [Patient B]'s bedroom and set up all the PPE and cleaning equipment we would need. I also got clean clothes and a fresh sanitary pad ready for [Patient B]. I returned to the lounge and the Registrant asked me where the PPE was. I told her it was ready in [Patient B]'s bedroom and she said*

that we were going to change and clean [Patient B] in the lounge, so that he would not leave a trail of faeces in the corridor. I was surprised by this instruction because it is not regular practice to give personal care to residents in the lounge. Although there was no one else there, it was not a completely private space so to change him where anyone could come in would not be respecting [Patient B]'s privacy and dignity.

13. The Registrant starting[sic] doing the patient's personal care while he was sitting in the soiled chair. She was speaking to him in an angry and aggressive tone of voice and was being derogatory, she was asking him why he had not used his bathroom and said, "Look at the mess you have made." I am fairly sure that she called him a bastard. [Patient B] responded by shouting back at her and the situation escalated into a shouting match. I cannot now recall exactly what was said. There is a spray can of soap that we use when we are attending to the patients' hygiene and the Registrant threw the can at [Patient B], It did not hit him, it just fell on the floor.'

The panel also took into account Colleague 1's statement dated 3 February 2021:

'On 28th of December […]. [Patient B] was in the lounge, sat on a chair. He had opened his bowels on the chair and the team got ready to attend to his personal care in the lounge. became agitated. Nurse SZ started shouting at him. She told the patient "you are a bastard!". She then threw the bottle of spray can towards the patient. The patient was not touched by it.'

The panel noted that this concern had never arisen before, and nothing of a similar nature had been reported or complained about of you. The panel also noted that there was no other corroborative evidence before it, other than the minutes of the meeting of the investigation.

The panel also took into account Witness 3's investigation meeting notes with Colleague 1 dated 9 February 2021:

'[Witness 3] referred to [Colleague 1's] statement and asked about an incident where became agitated and shouted at him, called him "a bastard" and threw the bottle of spray in his direction. [Witness 3] asked if [Colleague 1] felt that SZ had thrown the spray intentionally. [Colleague 1] advised that hard to say at the time and that [Colleague 1] wanted to believe that SZ hadn't done so intentionally, but couldn't understand why SZ would do it. [Colleague 1] said that the spray didn't hit but was thrown towards his arm. [Colleague 1] asked if [Colleague 1] was sure that the spray was throw, not dropped. [Colleague 1] definitely thrown due to where she and SZ were standing. MG asked if there were any other witnesses to that incident. [Colleague 1] stated that [Ms 7] was a witness.'

You denied these charges to the panel and said nothing like this had happened. You said that you never had feelings of frustration. The panel took into account the background of the Hospital. It took into account the unit you had worked in, the type of patients you were dealing with who were violent, had dementia and were volatile and unpredictable. The panel noted that this was a single incident and that no other incidents of a similar nature had been alleged against you. However the panel was of the view that it was plausible that in the context of the unit and the patients you were working with, the stresses might be sufficient to test someone's patience and to become frustrated and to express that frustration.

However, the panel was of the view that Colleague 1's evidence was consistent throughout her oral and written evidence, which was written close to the time of the incident. It accepted Colleague 1's evidence.

The panel determined, that on the balance of probabilities, it is more likely than not that you verbally and/or physically abused Patient B by shouting at him, saying words to the effect of, "you are a bastard" and "Look at the mess you have made". The panel, therefore, finds charges 1(a), 1(b) and 1(c) proved in its entirety.

In relation to charge 1(d), the panel considered that you were in very close proximity to Patient B. It considered that it was implausible that, if you had thrown the spray bottle towards Patient B, it would not have hit him. The panel therefore considered that, although you may have thrown the bottle in a moment of frustration, it could not be satisfied on the balance of probabilities that you threw it towards Patient B. It therefore found charge 1(d) not proved.

Charge 2(a)

2. Failed to treat Patient B with dignity and/or respect by;

(a) Not changing Patient B for around 45 minutes after he had been incontinent and requested a change, on a date unknown in November 2020

This charge is found proved.

The panel noted that this allegation appears to be about the same alleged incident as charge 4(b). Both charges relate to Patient B being excluded from the communal lounge for a period of time. There is therefore duplication of this charge.

In reaching this decision, the panel took into account Colleague 1's witness statement and Witness 3's investigation meeting notes dated 9 February 2021.

In Colleague 1's witness statement, the panel also noted:

'14. On a night shift in November 2020, it was after 00.00 and the Registrant and I were trying to get the patients to bed. There was one particular patient, Patient A, who tended to have unsettled nights and would wander into the corridor or into the lounge several times during the night. Usually a colleague or I would walk back to his bedroom with him. On this shift, he came out into the corridor and I closed the door that connected the corridor to the lounge. I did this to encourage him to return to his bedroom. I was joined by the Registrant and another recovery worker called [Witness 5], and together we held the door closed to prevent [Patient] A from

getting through. The Registrant then suggested that ye use the two seater sofa in the communal lounge to obstruct the door. We moved the sofa in front of the door, and we stuck a bed lining sheet to the clear panel in the top of the door so that the patients would not be able to see us on the other side. We then sat down on the sofa.

15. It was wrong to obstruct the door because the communal lounge should have been accessible for all the patients at any time, and it was dangerous because there may have been a fire. There is a camera in the corridor that is linked up to a screen. We placed this screen on a table so that we could see what was going on in the corridor while the sofa was obstructing the door. However, if an incident had taken place in the corridor and one of the patients had needed help, we would not have been able to get to them promptly so patient safety was compromised by our actions.

16. At around 04.30 or 05.00 another patient, [Patient B], came out of his bedroom and into the corridor. We could hear him moving around and he was calling for the Registrant who was still sitting on the sofa completing some paperwork. [Patient B] *kept asking why the door was closed. Via the camera we could see him pulling down his trousers and his sanitary pad and looking down at the pad, seeing that he had been incontinent of urine. He kept saying, "I need to get changed". He was walking repeatedly between the door and his bedroom and he told us that there was faces on his bed. Seeing his incontinence is a regular trigger of distress for [Patient B]. I could tell that he became increasingly anxious and when he looked at his pad and saw the incontinence he became even more distressed. I knew that he was probably going to open his bowels on the bed or chair in his room and this was discussed among the three of us. The Registrant said that we would sort it out later and stated, "He has a toilet in his bedroom, he should know how to use the toilet"*

[…]

17. The door stayed closed until 05.30 because 06.00 is the time when we would usually start personal care for the two patients on the unit who are bedbound, and the Registrant decided we would look after [Patient B] first. Because [Patient B] had said that he had opened his bowels on his bed, the Registrant said we needed to be prepared with PPE so we got changed in the communal lounge and put on aprons, visors, gloves, and tied bin bags into our feet to protect out shoes. We then moved the sofa back to its usual position and went to attend to [Patient B] I recall that the Registrant conducted the personal care and [Witness 5] and I cleaned the room.'

The panel also took into account of Witness 3's investigation meeting notes dated 9 February 2021:

'16. At around 04.30 or 05.00 another patient, [Patient B], came out of his bedroom and into the corridor. We could hear him moving around and he was calling for the Registrant who was still sitting on the sofa completing some paperwork. [Patient B] *kept asking why the door was closed. Via the camera we could see him pulling down his trousers and his sanitary pad and looking down at the pad, seeing that he had been incontinent of urine. He kept saying, "I need to get changed". He was walking repeatedly between the door and his bedroom and he told us that there was faces on his bed. Seeing his incontinence is a regular trigger of distress for [Patient B], I could tell that he became increasingly anxious and when he looked at his pad and saw the incontinence he became even more distressed. I knew that he was probably going to open his bowels on the bed or chair in his room and this was discussed among the three of us. The Registrant said that we would sort it out later and stated, "He has a toilet in his bedroom, he should know how to use the toilet".*

17. [Witness 3] asked when SZ asked staff to put plastic bags on your feet and double with aprons, at what point in time did it come to light that had been incontinent [Colleague 1] said that she was not sure. [Witness 3] asked [Colleague 1] if she felt that the response to the personal care need had been prompt or delayed. [Colleague 1] said that it was delayed. [Witness 3] summarised that staff

knew that a patient had a need and it wasn't dealt with immediately. [Colleague 1] said yes. [Witness 3] said that the photograph is useful and supports the investigation. [Witness 3] asked [Colleague 1] what made her take the photo. [Colleague 1] said that it was just the bin bags around her feet were funny, but [Colleague 1] did think afterwards that it might be used.'

The panel was of the view that Colleague 1 gave clear and consistent evidence in relation to this incident. Colleague 1 produced a photograph which clearly shows a sofa in front of where the door would be. The panel found your evidence on this issue unsatisfactory. Initially you said that you were unable to see the photograph clearly on your telephone. When the photograph was displayed on a large screen, you said that you were unable to identify the location. The panel found this implausible. It accepted Colleague 1's evidence that the sofa was in that location on this occasion.

The panel noted that observation charts were signed by you at 3am and 4am, indicating that you were present on the night of 20-21 November 2020. If you were present, the panel considered that, regardless of who initially put the sofa there or decided to do so, you must have been aware that it was there, and that it was providing a physical obstacle to care being provided to Patient B after he had been incontinent and requested a change.

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that you did not change Patient B for around 45 minutes after he had been incontinent and requested a change, and thereby failed to treat him with dignity and respect. The panel, therefore, finds charge 2(a) proved.

Charge 2(b)

2. Failed to treat Patient B with dignity and/or respect by;

(b) Not changing Patient B in private on 28 December 2020.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague 1's witness statement. The panel also took into account your oral evidence.

In Colleague 1's witness statement, it stated:

> *'12. Just before New Year in December 2020, I was on shift with the Registrant and another Recovery Worker called [Ms 7]. It was after 00.00, and a patient [Patient B], had opened his bowels on a chair in the communal lounge. The three of us discussed how we would deal with the situation, and decided that our first step should be to put on PPE'. I went to [Patient B]'s bedroom and set up all the PPE and cleaning equipment we would need. I also got clean clothes and a fresh sanitary pad ready for [Patient B]. I returned to the lounge and the Registrant asked me where the PPE was. I told her it was ready in [Patient B]'s bedroom and she said that we were going to change and clean [Patient B] in the lounge, so that he would not leave a trial of faeces in the corridor. I was surprised by this instruction because ii is not regular practice to give personal care to residents in the lounge. Although there was no one else there, it was not a completely private space so to change him where anyone could come in would not be respecting [Patient B]'s privacy and dignity.'*

You explained to the panel why it would be in Patient B's best interest to change him on the spot rather than trying to take him back to his room. You said that he was an agitated and aggressive patient and it would be easier and likely to involve less potential confrontation or physical aggression to change him there and then. The panel was of the view that you appeared to know Patient B really well, what aggravates him, and what he is sensitised to. The panel was also of the view that, during your evidence, you had demonstrated self-awareness by accepting that you had not put a notice up to give others a warning. However, whilst this was less than ideal, the panel was persuaded that this was better than trying to move him elsewhere. The panel considered that you had provided a reasonable explanation for the considered decision you took in a difficult context.

In light of this, the panel did not find charge 2(b) proved.

Charge 3

3. *On a date unknown verbally abused Patient B by saying words to the effect of, "do you think your wife would want someone depressed like you".*

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague 1's witness statement and Witness 3's investigation notes with Colleague 1 dated 9 February 2021.

In Witness 3's investigation notes with Colleague 1 dated 9 February 2021:

> *'[Colleague 1] said yes, that SZ is often shouting and swearing at patients and trying to frighten them. [Colleague 1] added that for example, when delivering personal care, SZ told "do you think your wife would want someone depressed like you?" when he was becoming agitated. [Colleague 1] asked if that would be considered bullying.*
>
> *[Witness 3] agreed that would be regarded as bullying, especially when a patient has a cognitive impairment that means they are unable to regulate their behaviour.'*

The panel could not identify the dates of when this incident had supposedly taken place. No detail or specifics of this incident had been provided. There was no evidence about it in Colleague 1's witness statement. The only reference to it was in the unsigned minutes referred to above. The panel noted that you denied the incident. It accepted your evidence that you knew and understood your patients well, and that you would be aware that such a remark would cause distress.

The panel had no other evidence to prove that this incident had taken place.

In light of this, the panel was of the view that in the absence of any other evidence, the NMC had not proven its case on the balance of probabilities. It, therefore, found this charge not proved.

Charge 4(a)

4. On an unknown date in November 2020 failed to treat Patient B with dignity and/or respect by;
(a) Preventing access to the lounge.

This charge is found proved.

For the same reasons as charge 2(a), the panel finds this charge proved.

Charge 4(b)

4. On an unknown date in November 2020 failed to treat Patient B with dignity and/or respect by;
…
(b) Failing to change his sanitary pad.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague 1's documentary and oral evidence. This included the statement dated 3 February 2021 and Witness 3's investigation meeting notes with Colleague 1 dated 9 February 2021. The panel also took into account your oral evidence.

In Colleague 1's witness statement:

'16. At around 04.30 or 05.00 another patient, Patient B, came out of his bedroom and into the corridor. We could hear him moving around and he was calling for the

Registrant who was still sitting on the sofa completing some paperwork, [Patient B], *kept asking why the door was closed. Via the camera we could see him pulling down his trousers and his sanitary pad and looking down at the pad, seeing that he had been incontinent of urine. He kept saying, "I need to get changed". He was walking repeatedly between the door and his bedroom and he told us that there was faeces on his bed. Seeing his incontinence is a regular trigger of distress [Patient B]. I could tell that he became increasingly anxious and when he looked at his pad and saw the incontinence he became even more distressed. I knew that he was probably going to open his bowels on the bed or chair in his room and this was discussed among the three of us. The Registrant said that we would sort it out later and stated, "He has a toilet in his bedroom, he should know how to use the toilet".'*

In Colleague 1's statement dated 3 February 2021, she wrote:

'16. *[Patient B] was in the lounge, sat on a chair. He had opened his bowels on the chair and the team got ready to attend to his personal care in the lounge. [Patient B] became agitated.*

18. [Patient B] was certainly waiting for more than half an hour to be tended to, it may have been around 45 minutes. I included this incident when I reported my concerns about the unit because I knew it was not good care. A patient should be cleaned up as soon as a member of staff is aware that personal care is needed.'

In Witness 3's investigation meeting notes dated 9 February 2021:

'[Patient B] had been incontinent in the chair in the lounge and [Colleague 1], SZ and [Ms 7] were working […]

[Colleague 1] advised that [Patient B] was in the lounge and had been incontinent. We [the staff team] were in the office and discussed what we were going to do. [Colleague 1] said that she would paper all the equipment and laid all the equipment out in [Patient B]'s bedroom and prepared the relevant PPE. [Colleague

1] then went into the lounge and told the staff team that the room was ready. SZ and [Ms 7] tried to help [Patient B] up. SZ asked [Colleague 1] where is the soap and wipes. [Colleague 1] asked SZ if we are going to do it in [Patient B's] bedroom. SZ said no, otherwise it will leave a trail of faeces in the lounge and hallway.

[Witness 3] asked [Colleague 1] to clarify that personal care for incontinence was carried out in the lounge.
[Colleague 1] confirmed that it was.
[Witness 3] asked, in the interest of dignity, if there were any other patients in the lounge who witnessed this.
[Colleague 1] said no, the lounge was otherwise empty.

[…]

SZ didn't want to know that staff were there so nobody said anything. Kept saying "I can't open the door" and becoming distressed was going back and forth to his room. [Colleague 1] added that at some point, said that he had opened his bowels in his room. [Colleague 1] said that we [staff] didn't go straight away and was not sure how long before we went but SZ wanted us to go and assist him before 6am. [Colleague 1] stated that at around 5:30, she got ready to assist with his personal care. [Ms 7] put on bin bags around her feet, [Colleague 1] thought it was funny, so took a photo of her.'

In your oral evidence, you told the panel that you had changed Patient B's sanitary pad as the patient needed his care to be undertaken. The panel noted that you knew Patient B's behaviour, that you saw that he was agitated by other care workers and that these staff waited for you to undertake the change of his pad and he responded better to you.

The panel noted that Colleague 1 was present when the care for this patient was being undertaken. The panel noted that in Witness 3's investigatory meeting notes dated 9 February 2021, Colleague 1 said that they did not go straight away to clean Patient B, but

that Patient B '*was certainly waiting for more than half an hour to be tended to, it may have been around 45 minutes.'*

In light of this, the panel determined that, albeit late, you did change Patient B's his sanitary pad. It, therefore, did not find this charge proved.

Charge 4(c)

> *4. On an unknown date in November 2020 failed to treat Patient B with dignity and/or respect by;*
>
> *…*
>
> *(c) Saying to colleagues words to the effect of, "He has a toilet in his bedroom, he should know how to use the toilet".*

This charge is found proved.

In reaching this decision, the panel took into account Colleague 1's documentary and oral evidence. This included the statement dated 3 February 2021 and Witness 3's investigation meeting notes with Colleague 1 dated 9 February 2021. The panel also took into account your oral evidence.

The panel noted from Witness 3's investigation meeting notes with Colleague 1 dated 9 February 2021:

> *'[Witness 5] said that [Patient B] went back into his room for about 5 minutes, but he was in and out and up and down the corridor. SZ told [Witness 5] and [Colleague 1] "he has a toilet in his room, leave him to it."*
>
> *[Witness 3] asked if [Witness 5] is aware that is unable to use the toilet independently*
>
> *[Witness 5] confirmed that she is aware.*

[…] asked how long [Witness 5] would say it was between him coming and personal cares being delivered.

[Witness 5] said it was about half an hour/45 minutes.'

You denied this in your oral evidence. You told the panel that Patient B does not respond well to other staff as it upsets him. Which is why you went to him as he responds well to you. You also told the panel that Patient B had dementia and therefore could not use the toilet.

The panel noted that your version of events completely contradicts Colleague 1's.

The panel accepted Colleague 1's version of events. It was of the view that you had made these remarks, although not directly towards the patient. It was also of the view that you had made these remarks knowing that it would cause this patient distress, but it was not made with the intention to directly harm the patient.

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that you had said the words to the effect of, *"He has a toilet in his bedroom, he should know how to use the toilet*" to colleagues and therefore failed to treat Patient B with dignity and/or respect by. The panel, therefore, finds charge 4(c) proved.

Charges 5(a), 5(b) and 5(c)

5. On 26 January 2021 verbally abused Patient E by;

(a) Shouting at him.

(b) Saying words to the effect of, "stop being stupid".

(c) Saying words to the effect of, "you are a bastard".

These charges are found NOT proved.

In reaching this decision, the panel took into account Colleague 1's documentary and oral evidence and Colleague 1's statement dated 3 February 2021. The panel also took onto account your evidence.

The panel noted during Colleague 1's oral evidence, Colleague 1 was not able to attach these comments to specific incidents, but stated that it happened in general situations. This was inconsistent with what she told the Trust in her written statement dated 3 February 2021:

> *'- On the 26th of January, [Patient E] was feeling agitated during several hours. During several hours, Nurse SZ was shouting at him to stop shouting, to stop "being stupid". At one point, she told him "you are a bastard!".'*

When asked by the panel to Colleague 1 about why her account had changed, Colleague 1 did not provide an explanation for that inconsistency.

In light of this, the panel was of the view that in the absence of any other evidence, the NMC had not proven its case on the balance of probabilities. It, therefore, found these charges not proved.

Charges 6(a), 6(b) and 6(c)

6. On an unknown date in November 2020 failed to treat Patient A with dignity and/or respect by;

(a) Holding the door closed preventing Patient A entering the lounge.

(b) Blocking Patient A's entrance to the lounge using a sofa preventing the door to open.

(c) Placing a bed sheet over the observation panel of the door preventing Patient A from looking through the door into the lounge.

These charges are found proved.

In reaching this decision, the panel took into account Colleague 1's documentary and oral evidence and Colleague 1's statement dated 3 February 2021. The panel also took into account the notes taken during investigation meeting with you dated 12 February 2021 and your documentary and oral evidence.

The panel noted from Colleague 1's witness statement:

> *'14. On a night shift in November 2020, it was after 00.00 and the Registrant and I were trying to get the patients to bed. There was one particular patient, Patient A, who tended to have unsettled nights and would wander into the corridor or into the lounge several times during the night. Usually a colleague or I would walk back to his bedroom with him. On this shift, he came out into the corridor and I closed the door that connected the corridor to the lounge. I did this to encourage him to return to his bedroom. I was joined by the Registrant and another worker called [Witness 5] and together we held the door closed to prevent from getting through. The Registrant then suggested that we use the two seater sofa in the communal lounge to obstruct the door. We moved the sofa in front of the door, and we stuck a bed lining sheet to the clear panel in the top of the door so that the patients would not be able to see us on the other side. We then sat down on the sofa.*
>
> *15. It was wrong to obstruct the door because the communal lounge should have been accessible for all the patients at any time, and it was dangerous because there may have been a fire. There is a camera in the corridor that is linked up to a screen. We placed this screen on a table so that we could see what was going on in the corridor while the sofa was obstructing the door. However, if an incident had taken place in the corridor and one of the patients had needed help, we would not have been able to get to them promptly so patient safety was compromised by our actions.*
>
> *17. The door stayed closed until 05.30 because 06.00 is the time when we would usually start personal care for the two patients on the unit who are bedbound, the Registrant decided we would look after [Patient B] first. Because Patient B had said*

that he had opened his bowels on his bed, the Registrant said we needed to be prepared with PPE so we got changed in the communal lounge and put on aprons, visors, gloves, and tied bin bags into our feet to protect out shoes […]'

The panel noted from Witness 3's investigation meeting notes with Colleague 1 dated 9 February 2021:

'[Colleague 1] said that on 20th November, staff on shift were SZ, [Witness 5] and [Colleague 1]. [Colleague 1] said that around midnight, Patient A, went to bed. [Colleague 1] noted that he comes back and forth to the lounge a lot and at that time, he was agitated. came back to the lounge, [Colleague 1] closed the door over but left a head space so that she could see [Patient A]. [Patient A] started hitting and kicking the door. SZ and [Colleague 1] held the door so it couldn't be opened. SZ put the sofa in front of the lounge door and put a sheet over the window.

[Witness 3] asked which sofa was used.

[Colleague 1] said that it was the one facing the TV.

[Witness 3] said that she could see from the photo that it had been pushed longways against the door, besides the office. [Witness 3] asked if the sheet used to cover the window.

[Colleague 1] said yes. [Colleague 1] added that [Patient A] went back to his room. SZ said "we'll settle here" and was in front of the door for several hours. [Colleague 1] stated that at around 4am, possibly 4:30, [Patient B] got up from his room and wanted to go to the lounge but the door was blocked. [Colleague 1] said that [Patient B] was trying to open it. SZ didn't want [Patient B] to know that staff were there so nobody said anything. [Patient B] was going back and forth to his room. [Colleague 1] added that at some point, [Patient B] said that he had opened his bowels in his room. [Colleague 1] said that we [staff] didn't go straight away and was not sure how long before we went but SZ wanted us to go and assist him

before 6am. [Colleague 1] stated that at around 5:30, she got ready to assist with his personal care. [Witness 5] put on bin bags around her feet, [Colleague 1] thought it was funny, so took a photo of her.

[…]

[Witness 3] asked [Colleague 1] if she could say approximately what time the sofa was placed in front of the door.

[Colleague 1] advised that it was around 12:30 or 1:00am

[…]

[Witness 3] asked if the sofa was moved and then put back.

[Colleague 1] advised that none of the patients needed personal care.

[Witness 3] asked, in order to do that, if the sofa was moved and put back.

[Colleague 1] said that should couldn't specifically remember as it had happened a few times and had become part of the routine.

[Witness 3] asked if this had been done at any other times.

[Colleague 1] said yes, SZ has told other staff to do this.

[Witness 3] asked if [Colleague 1] could confirm any other staff who were told to do this.

[Colleague 1] confirmed [Witness 4] and [Witness 5].'

The panel had sight of observation sheets dated 18 to 20 November 2020. It noted that you were working between these hours of when these incidents took place.

The panel also took into account the notes taken during investigation meeting with you dated 12 February 2021:

> *'[Witness 3] moved on to discuss an allegation that the large 3 seater sofa is used to block the doorway to the communal lounge.*
>
> *SZ said that she didn't know about that but noted that staff sometimes move the sofa's to clean.*
>
> *[Witness 3] asked if SZ was aware if the sofa has been used to block the door, not just moved for cleaning but being pushed about 3 metres across the room and using it as a barricade to stop the lounge door being opened.*
>
> *SZ said no, she is not aware of that.*
>
> *[Witness 3] asked if this had ever happened on your shifts.*
>
> *SZ said no.*
>
> *[Witness 3] asked if SZ was aware of a sheet from the laundry being used to cover the window panel on the lounge door.*
>
> *SZ said no, she doesn't know about that, not on her shift.*
>
> *[Witness 3] advised that it is alleged that this happened on a particular shift and was attempting to coming into the lounge but he was denied access. [Witness 3] stated that the allegation is that the doorway was blocked at around 12:30/1am and as a result, hourly observations did not take place and SZ instructed staff to falsify the documentation.*

[Witness 3] advised that it has been stated that the sofa was not moved until around 4:30/5am and the lounge door was blocked and no hourly observation took place.

SZ said that she doesn't know about that.

[Witness 3] advised that it is alleged that between 2:30 and 4:30, Patient B, came to the lounge and wasn't able to open the door due to the sofa being used as a barricade and Patient B stated "I'm wet through, I've shit myself" as he frequently does when he is in need of assistance repeatedly left the lounge door and came back and it is alleged that SZ prevented 2 staff from assisting with personal care despite being aware he had soiled. It is stated the SZ said Patient B was attention seeking and had a toilet in his room. When staff eventually gave assistance, it is alleged that SZ instructed staff to place plastic aprons over the front and back and use bin bags to cover their shoes due to faeces. [Witness 3] asked if SZ could recall this.

SZ said no, she doesn't remember all that and she never told anyone to do that. SZ said that staff can use what PPE they want and know what they're supposed to put on.

[Witness 3] asked if SZ had ever witnessed staff putting plastic bags over their shoes.

SZ said no.

[Witness 3] asked if SZ could think of any occasions where the sofa would have blocked the lounge door. SZ said no. [Witness 3] asked SZ if she was aware of any staff who had carried this out or discussed that practice. SZ said no [Witness 3] summarised that SZ didn't think this was common practice and discussed between the staff. SZ said that she doesn't know anything about that. [Witness 3] said that it

has been alleged that SZ has demonstrated a threatening and intimidating manner towards staff who have been uncomfortable about some of these practices, such as bad language and using the sofa to block the door and those staff felt as though their jobs could be on the line, but felt unable to raise concerns out of fear that they wouldn't be believed. [Witness 3] stated that those staff have described you as having favourite people to work with and working on a trust basis. [Witness 3] clarified that it is alleged that SZ would behave like this with some staff who SZ trusts not to whistleblow but not with others who SZ would be more cautious of because SZ doesn't trust them. [Witness 3] asked SZ if she had anything to say regarding that allegation. SZ said that it was not true, these are lies. SZ asked why staff haven't addressed this with her during those shifts. SZ asked that if it is an issue, why staff haven't spoken up. SZ wondered why staff didn't complain previously.'

The panel also took into account your witness statement:

*'**Instructing staff to place a sofa across a fire exit door to prevent patients from accessing the communal lounge area***

11. This allegation is untrue. I did not have anything to do with the sofa being used to block access to the lounge. The only time I remember the sofa being moved is when recovery support workers were cleaning the lounge floor but it would be moved back after. Blocking patients from entering places is unfair as this would have meant that their freedom would have been compromised therefore I would not engage in or encourage such behaviour. I did not witness anybody blocking the door preventing service users from accessing the lounge and garden. It was a fire door to be left open always. Additionally, other Hospital staff members were accessing the staff office using the same door if they wished to come to the Ward.'

During your oral evidence, and when the panel asked you about the photograph that Colleague 1 took, you said that you did not know where that photograph was taken. In

relation to charge 2(a) above, the panel found this denial implausible, undermining the credibility of your evidence in relation to this charge.

The panel accepted that there was no other evidence on these charges. However, it preferred the evidence of Colleague 1, rather than yours. It was of the view that Colleague 1's evidence was consistent and had placed her in a whistleblowing position. It did not have any evidence to prove why Colleague 1 would lie about this, particularly as it puts her job in a vulnerable position. Therefore, the panel determined that as you were on this particular shift, you would have known that a sofa was blocking access by patients to the lounge. It would be your responsibility to supervise the actions of your staff. If the sofa had been moved without your knowledge or participation, you would have been able to tell staff to remove it.

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that these incidents had taken place. The panel, therefore, finds charge 6 proved in its entirety.

Charge 7

7. On 28 January or 31 January 2021 failed to treat Patient A with dignity and/or respect by instructing Colleague 2 to frighten them

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague 1 and Colleague 2's documentary and oral evidence and your evidence.

The panel took into account Colleague 1's witness statement:

'11. There was an incident that took place on 28 January 2021. I believe that prior to this exchange a patient called, Patient A, had been challenging, although I cannot recall the details, and had gone to spend some time in the sensory room.

The patient walked out of the sensory room into the communal lounge and asked [Colleague 2] for something. The Registrant told [Colleague 2] to "frighten him" and indicated that she wanted the patient to return to the sensory room. She spoke in an irritated tone of voice and appeared to have lost her patience. [Colleague 2] lifted his finger and pointed at the patient and said "Go back" in a direct and firm tone while walking towards him. The patient returned to the sensory room.'

You denied this charge.

Colleague 2, in his oral evidence, told the panel that he did not do this, corroborating your denial. There was no other evidence before the panel.

There was conflicting evidence, and in the absence of any other evidence to prove this charge, the panel determined that charge 7 is not proved.

Charge 8(a)

8. On one or more occasions on dates unknown verbally abused patients by;
(a) Shouting at them.

This charge is found NOT proved.

In reaching this decision, the panel took into account Colleague 1 documentary and oral evidence and your evidence.

The panel noted that you said you never get frustrated. However, the panel determined that this was very unlikely as even the most professional of nurses can be frustrated by the aggression and abuse presented by the patients within this unit. Therefore, there would be a high degree of tolerance required. The panel noted that you were sensitive to these patients needs, and were able to recall patients and the effect particular approaches would have on them. The panel was of the view that you may have spoken loudly so therefore this could be construed as shouting inadvertently. Furthermore, you told the

panel that you often found yourself having to repeat what you say, which could mean that you spoke louder. Further, the panel was of the view that raising the voice and shouting is subjective and will be taken differently by different people.

The panel had no other evidence before it which demonstrated that you were shouting at patients. The panel therefore found this charge not proved.

Charges 8(b), 8(c) and 8(d)

8. On one or more occasions on dates unknown verbally abused patients by;
(b) Telling them words to the effect of, "shut up".
(c) Calling them words to the effect of, "bastard".
(d) Saying to them words to the effect of, "fuck you" and/or "fuck off".

These charges are found proved.

In reaching this decision, the panel took into account Colleague 1 and Colleague 2's documentary and oral evidence and your evidence.

The panel noted from Colleague 1's witness statement:

> *'8. I will say that there were shifts where the Registrant had great communication with the patients, she would listen to them, and laugh with them. However, there were shifts where her attitude with the patients concerned me. Given that all the patients on the Unit struggled with psychological illnesses, it was not uncommon for them to exhibit challenging behaviours. For example, if there was a patient demanding attention repeatedly, the Registrant seemed to become irritated and would swear at the patient and tell them to "shut up" or would call them a "bastard". I would say this happened on most shifts. I have also heard the Registrant saying, "fuck you" or fuck off" to the patients. This was an occasional as opposed to regular occurrence, and I would estimate that this happened on four or five shifts through but the time I worked on the Unit.*

9. I have been asked whether the Registrant's attitude affected how other members of staff conducted themselves with the patients. I cannot recall any other members of staff swearing at patients. However, in the ward office after the patients had gone to sleep the Registrant would continue to refer to patients using insulting language such as, "he's a bastard" and I heard another Recovery worker [Colleague 2] repeat this language when he agreed with her. […].*'*

The panel had regard to your witness statement:

'8. I never spoke to patients in a bossy manner but if a patient was displaying challenging behaviour that was affecting other patients, I would encourage them to stop or to go somewhere that other patients were not. I never verbally abused, swore at or about patients or raised middle fingers at them. On the contrary, many times where patients displayed challenging behaviour such as swearing or making gestures, I dealt with the situation by telling the patients that this was not okay. I have never on any occasion called a patient a "bastard" or "stupid". I did not tell a patient "fuck you" or to "fuck off". I would not ever swear at a patient and do not swear. English is not my first language and swearing is not in my culture.'

The panel noted that there was a direct conflict between you and Colleague 1 in relation to these allegations. You denied ever using that language. Colleague 1 was adamant that you did so. The panel noted that the allegations amounted to a handful of occasions and there was an absence of specifics about the incidents. The panel took into account the positive references it had seen about your professionalism, and also your good character and the absence of previous complaints about similar behaviour.

However, the panel considered, as set out in relation to charge 8(a), that it was plausible that there may have been times when you became frustrated and used language of this type about patients in the office and, on occasion, directly to them. Colleague 1 had been specific in her recollection of the words used. On balance, the panel accepted her account and found that these incidents occurred as alleged.

Charges 9(a) and 9(b)

9. On one or more occasions on dates unknown physically abused patients when escorting them by;

(a) Putting pressure on their arms.

(b) Putting pressure on their backs.

These charges are found NOT proved.

In reaching this decision, the panel took into account Colleague 1's documentary and oral evidence and your evidence.

The panel noted from Colleague 1's witness statement:

> *'10. It was my impression that the Registrant had a strict rule about the patients needing to be in bed before 00.00. When she felt that it was time for the patients to go to bed, staff would escort them to their rooms. On a regular basis, some patients insisted on staying in the lounge after 00.00. When this happened, the Registrant would escort them to their rooms physically, by putting pressure on their arms and back in order to steer them. She also did this when the patients got back up and tried to return to the communal lounge after they had gone to bed. I witnessed [Colleague 2] doing the same thing. I did not see [Colleague 2] doing this on every shift, it was only on the shifts when the patients insisted on staying in the communal areas later than midnight.'*

The panel noted from your statement:

> *'13. I did not have strict rules about patients going to bed. As a night nurse it was my duty to promote healthy sleeping making sure those service users who were asleep in lounge were escorted to bed for them to have a comfortable good night rest. There was no specific time designated for going to bed. I did not on any*

occasion put pressure on any patient's arms whilst escorting service users to bed at all, they were more than capable of walking to bed on their own. If there were any issues with mobility or falls we escorted them to bed using wheelchairs.'

The panel had no evidence to suggest that excessive physical force was used. There was no evidence of any injury to patients, such as incident reports or notes of bruising. There was no other evidence to demonstrate any methods you had adopted to help your patients were outside of your training. The panel also noted that you were sensitive to patient needs and knew of them. These were patients who often had a heightened sensitivity to physical contact and had shown themselves to be capable of aggression and violent behaviour. It seemed inherently implausible that you would risk escalating those behaviours by using inappropriate force towards them.

The panel accepted that there may have been some physical contact to encourage patients to go to bed. Whatever the level of contact was, the panel considered that, taking the NMC's evidence at its highest, there was insufficient evidence to find that it amounted to putting pressure on the patients to such an extent as to amount to the physical abuse alleged in the stem of the charge.

Therefore, the panel finds this charge not proved.

Charge 10(a)

10. On one or more occasions between June and October 2020;
(a) Slept whilst on duty.

This charge is found proved.

In reaching this decision, the panel took into account Colleague 1's documentary and oral evidence and Colleague 2's investigation meeting dated 9 February 2021.

Colleague 1 in her witness statement stated:

‘32. When I first started working on the Unit, and throughout June and July 2020, there were fewer patients in residence and the shifts were not as busy. During this time, the Registrant would regularly suggest that I go and sleep on the sofa in the communal lounge and I would see her doing the same. Although we were allowed to sleep during our allocated break time of one hour and forty minutes each shift, this would happen outside of those times very frequently. From around October 2020 I stopped sleeping outside of my breaks, firstly because I had become more accustomed to working night shifts and secondly because there were several new members of staff on the Unit and the Registrant said that we could not yet trust them so sleeping outside of our breaks was risky. I can recall more than one occasion in January 2021, where the Registrant and I would take two bean bag chairs into the ward office and we would sleep on them, but this would only be during my break time. The potential harm of sleeping outside of our breaks was that we would not be aware if a patient needed us. I have been asked whether there was ever an occasion when all three members of staff working a night shift would be asleep at the same time. This is possible, because it was not necessarily something that we talked about needing to avoid. If this happened, it would have been during the summer in 2019, before new staff came into the Unit and while we had just six patients in residence. Also, after this date, some staff thought it was too risky to sleep in the lounge because some of our new patients were sexually disinhibited. I have also been asked whether routine personal care for patients was ever affected by members of staff sleeping outside of their allocated breaks. We had a four-hour schedule for routine care, so this would not have been affected and we did not miss any routine personal care for the bedbound patients.’

The panel noted from Colleague 2’s investigation meeting dated 9 February 2021:

‘[Colleague 2] also noted that [Colleague 1] has referred to SZ sleeping on shift and asked if this was for long periods.

[Colleague 1] said that it was hard to say how long and SZ lies down a lot in the lounge even when patients are present. [Colleague 1] said that there are two patients who very often come to the lounge during the night, and SZ didn't want to be bothered, so SZ started to put beanbags in the office to sleep on.'

You told the panel that you did not have a break at all as you had to be available in the ward at all times. Therefore, you deny that you slept whilst on duty. Furthermore, the panel was of the view that Colleague 2 was vague about break times within the ward. It noted that there was no written policy regarding breaks. However, Colleague 2 told the panel that you did have breaks and that you were entitled to breaks on every shift.

The panel was of the view that there was a lack of clarity regarding staff sleeping during their break times. However, it noted that you were the only nurse on duty and so therefore would need to be present in the ward at all times, whether or not you were on your break. This was different from the position for carers, who were permitted to go off site during their breaks. The panel considered it plausible that you may have slept for periods of time during your shift.

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that as you could not leave the ward at any time, you slept whilst on duty between June and October 2020. The panel, therefore, finds this charge proved in its entirety.

Charge 10(b)

10. On one or more occasions between June and October 2020;
(b) Encouraged Colleague 1 to sleep whilst on duty.

This charge is found proved.

In reaching this decision, the panel took into account Colleague 1's witness statement and oral evidence and Colleague 2's investigation meeting dated 9 February 2021. It also took into account your evidence.

In Colleague 1's witness statement, the panel noted:

> *'33. It was my perception that the Registrant considered a colleagues' willingness to sleep outside of their break times as a kind of loyalty test. She once said to me, "You can't trust anyone who does not sleep outside of their break". I think she felt that if they refused to engage in this practice themselves, they would inform management about what was happening. [Ms 7] and [Witness 5] did not sleep whilst on duty, and I recall the Registrant telling me to "be careful" of them*.'

In Colleague 2's investigation meeting dated 9 February 2021:

> *'[Colleague 1] said that it was hard to say how long and SZ lies down a lot in the lounge even when patients are present. [Colleague 1] said that there are two patients who very often come to the lounge during the night, and SZ didn't want to be bothered, so SZ started to put beanbags in the office to sleep on.*
>
> *[Colleague 2] asked if those are the sensory room bean bags. [Colleague 1] said yes and added the SZ had done so for other staff to sleep.*
>
> *[Colleague 2] asked if this was in nurse's office or ward managers office.*
>
> *[Colleague 1] said that this was in the nurse's office, next to the lounge.*
>
> *[Colleague 2] asked if patients up and walking around the lounge whilst staff are sleeping.*
>
> *[Colleague 1] said yes*
>
> *[Colleague 2] asked if staff or the nurse in charge is sleeping, who would have the handheld monitor on them.'*

You deny this charge.

Whilst there is one reference to this allegation in Colleague 1's witness statement about a conversation on sleep, there was no other evidence of a corroborative nature. However, it appears from the evidence that there was a culture on the Unit whereby staff were permitted to sleep during their breaks, and possibly also outside those breaks as Colleague 1 asserts. The panel found Colleague 1's evidence credible and accepted it. It therefore found this charge proved.

Charge 10(c)

10. On one or more occasions between June and October 2020;

(c) Encouraged Colleague 1 not to trust colleagues who did not sleep outside of their break

This charge is found NOT proved.

The panel had regard to the evidence set out at charge 10(b). It noted that even taken at its highest, the NMC's evidence was that you made an observation to Colleague 1. Not even Colleague 1 asserts that this was being done in order to encourage her to think the same thing: she describes her understanding of the conversation as being you explaining what you "felt". The panel found that there was insufficient evidence to find this charge proved on the balance of probabilities.

Charges 11(a), 11(b) and11(c)

11. On 4 October 2020 bullied and/or intimidated Colleague 1 into not completing an IRIS report by;

(a) Shouting at her.

(b) Telling her words to the effect of, "that if you report what had happened, management would come down to the unit and possibly fire you".

(c) Saying words to the effect of, "you are acting stupid to risk losing your job".

These charges are found NOT proved.

In reaching this decision, the panel took into account of Colleague 1's and Colleague 2's witness statement and oral evidence and Colleague 2's investigation meeting dated 9 February 2021. It also took into account your evidence.

In Colleague 1's witness statement, the panel noted:

'19. I think this incident occurred on 4 October 2020. Two patients, Patient A and Patient B were in the lounge, I believe that one was sitting down and the other was standing. It was a rule on the Unit that one member of staff always needed to be in the communal lounge because we had repeated incidents of patients hitting each other. However, I was in the Ward office with another recovery worker called [Witness 4]. I heard shouting and I saw through the window of the Ward office that one patient threw a cup at the other, I believe it was [Patient B] who threw it at Patient A. The cup did make contact with Patient A, I believe it hit either his body or his nose. [Witness 4] and I separated the two men and then we later informed the Registrant about the incident.'

20. We both said that we should have been in the lounge at the time, I immediately told her that I would take the blame for the incident and would write up the IRIS form. I am not sure what IRIS stands for, but it is the online report that we complete when there is an incident. The Registrant asked me what I meant and why I wanted to write a report. I said that we needed to record what had happened between [Patient A] and [Patient B] and then the Registrant started shouting at me. She said that [Witness 4] and I should have been in the lounge not the office and, if I reported what had happened, management would come down to the unit and possibly fire me. She shouted at me for approximately twenty minutes. I kept trying to interject, not to interrupt but to explain myself, but the Registrant did not allow me

to speak and kept repeating that I was acting stupid to risk losing my job and that she had seen similar outcomes in another hospital.

21. In the end I did not complete the IRIS form because I felt under a lot of pressure from the Registrant not to do so and she made me feel very worried that I would lose my job. I did know that completing the report was a Safeguarding issue because the cup had actually made physical contact with a patient. I was also aware that reporting was important because it enabled the Unit to keep track of any patterns of behaviour.'

In Colleague 2's investigation meeting dated 9 February 2021:

'[Colleague 1] advised that SZ will present [her work methods] to staff in a way that what she is doing benefits the patients and if anybody disagrees with SZ, she would becoming intimidating. [Colleague 1] advised that SZ had done that at least twice with her, shouting and becoming threatening.

[Colleague 2] asked if SZ had shouted at [Colleague 1] when [Colleague 1] has challenged her.

[Colleague 1] said yes. [Colleague 1] advised that she challenged SZ about the event on 4th October— [Colleague 1] explained the incident to SZ and said that she would write an IRIS report. SZ disagreed and told [Colleague 1] "you don't know what you're doing" and that management would see the IRIS and report and fire [Colleague 1]. [Colleague 1] added that every time [Colleague 1] tried to say anything else, SZ shouted "the problem with you is that you don't listen to me".'

The panel noted from Colleague 2's witness statement:

'14. In addition to encouraging this member of staff to not comply with their obligation to complete a statutory notification and alert, it was alleged that the Registrant had threatened this individual and made them feel that if they were seen

to be creating a nuisance by completing the statutory notification, that they would probably lose their job.'

However, Colleague 2 did not observe this, nor have any direct evidence of this incident or provide evidence of her speaking to other witnesses about this alleged incident. Colleague 2 told the panel that you have an unblemished record.

You deny this charge.

In your witness statement, you wrote:

'Failing to complete safeguarding reports in relation to an incident between two patients

17. During handover in October 2020, we all heard a bang and left. I ran to the lounge where the incident happened. We went to find out what was happening and check if everyone was safe on the Ward. Two recovery workers, [Witness 4] and [Colleague 1] were present. […]. [Mr 8] completed the relevant paperwork and IRIS regarding the incident. He was unable to complete everything as he was very busy so [Mr 8] emailed me details he completed for the safeguarding alert and the reference number for me to use completing Care Quality Commission ("CQC") notification when I was on a night shift. I completed this and emailed him back informing him I had completed the CQC notification and he thanked me.'

The panel took into account your witness statement:

'18. I did not encourage [Colleague 1] not to submit the incident report. I did not comment about the incident to [Colleague 1] or shout at her. As explained above [Mr 8] completed the incident report himself and safeguarding alert. He emailed me the incident information and safeguarding reference number so I could submit the CQC notification later that night.'

There was no other evidence before the panel or any other witnesses who heard you say this to Colleague 1. The panel concluded that it was likely that there was a conversation about whether or not a report should be submitted, and that you were seeking to persuade Colleague 1 not to do so. However the panel considered it inherently implausible that there would have been sustained shouting for 20 minutes as alleged by Colleague 1. It further noted your evidence that you have a loud voice. A loud or raised voice is capable of being misconstrued by others. The panel found that there was insufficient evidence for it to be able to find that you shouted at Colleague 1.

In relation to charges 11(b) and 11(c), the panel accepted on the balance of probabilities Colleague 1's evidence that the words described were used by you during the conversation. It accepted that a degree of coercion was likely used towards Colleague 1 to seek to persuade her not to complete a report. However, the panel considered that there was insufficient evidence for it to be able to find that this amounted to intimidation and bullying of Colleague 1 as alleged in the stem of the charge. It noted that at the time you would not have been aware that your relationship with Colleague 1 was deteriorating. If anything, your words appear to have been seeking to protect Colleague 1 from potential adverse consequences for her of reporting matters. Whilst this may have demonstrated a lack of integrity (which is addressed in charge 12), it did not in the panel's view demonstrate bullying or intimidation.

In light of this, the panel was not satisfied that you bullied and/or intimidated Colleague 1 into not completing an IRIS report ~~by~~. It therefore found this charge not proved.

Charge 12

12. *Your actions at charge 11 above showed a lack of integrity in that you placed the interests of a colleague above those of residents in your care.*

This charge is found proved.

For the reasons set out above in relation to charge 11, whilst the panel finds that charge not proved, it accepts that you used the words alleged in charges 11(b) and 11(c) with the intention of seeking to persuade a colleague not to submit an IRIS report. The panel therefore found that you were seeking to prevent Colleague 1 from reporting an incident which ought to have been reported, placing Colleague 1's interests above those of the residents in your care. The panel considered that this amounts to a lack of integrity. It therefore finds this charge proved.

Charge 13

> *13. On or after the 4 October 2020 failed to complete a safeguarding report relating to the incident that occurred between Patient A and Patient B.*

This charge is found proved.

In reaching this decision, the panel took into account Colleague 1's documentary and oral evidence and Colleague 2's investigation meeting notes with you dated 12 February 2021. The panel also took into account Elysium Healthcare's Safeguarding Adults policy and your evidence.

The panel noted from Colleague 1's witness statement:

> *'19. I think this incident occurred on 4 October 2020. Two patients, Patient A and Patient B were in the lounge, I believe that one was sitting down and the other was standing. It was a rule on the Unit that one member of staff always needed to be in the communal lounge because we had repeated incidents of patients hitting each other. However, I was in the Ward office with another recovery worker called [Witness 4]. I heard shouting and I saw through the window of the Ward office that one patient threw a cup at the other, I believe it was [Patient B] who threw it at [Patient A]. The cup did make contact with [Patient A], I believe it hit either his body or his nose. [Witness 4] and I separated the two men and then we later informed the Registrant about the incident.*

[…]

22. I have been asked whether the Registrant also discouraged me from completing any Safeguarding alerts. It is not my role to submit Safeguarding documentation. It would have been my job to complete the internal IRIS documentation, and the Registrant's job to carry out any necessary statutory reporting. On this occasion, I know that she did not submit any Safeguarding alert. The following shift that we worked together, the Registrant said to [Colleague 2] and me that it would have taken hours.'

In Witness 3's investigation meeting notes with you dated 12 February 2021, it stated:

'[Witness 3] moved on and noted that it is alleged that later on that evening, SZ explained to a staff member that safeguarding documentation is very long and this staff member felt like you didn't want to have to go through the lengthy process of safeguarding.

SZ said no, if it [safeguarding] needs to be done, she always does it.

[Witness 3] asked if SZ could remember if anything recorded from 4th October was recorded as an incident on IRIS or a care note entry made.

SZ she could not remember off the top of her head.

[Witness 3] asked SZ if she could recall a staff member offering to do an incident report.

SZ said no, she doesn't recall that.

[Witness 3] asked SZ if she was aware of an incident like that, would SZ, as a designated safeguarding officer, recognise that would require an incident report on IRIS and safeguarding.

SZ said of course.

[Witness 3] asked if SZ, on that incident, recognised that as a safeguarding incident and do the necessary documentation.'

The panel also took into account your witness statement:

'17. During handover in October 2020, we all heard a bang and left. I ran to the lounge where the incident happened. We went to find out what was happening and check if everyone was safe on the Ward. Two recovery workers, [Witness 4] and [Colleague 1] were present. [Mr 8] spoke to both recovery workers who witnessed the incident and it was reported that Patient A threw a cup at Patient B's head. We went back to our manager's office and I finished the handover and went home. [Mr 8] completed the relevant paperwork and IRIS regarding the incident. He was unable to complete everything as he was very busy so [Mr 8] emailed me details he completed for the safeguarding alert and the reference number for me to use completing Care Quality Commission ("CQC") notification when I was on a night shift. I completed this and emailed him back informing him I had completed the CQC notification and he thanked me.

'18. […] [Mr 8] completed the incident report himself and safeguarding alert. He emailed me the incident information and safeguarding reference number so I could submit the CQC notification later that night.'

The panel had sight of Elysium Healthcare's Safeguarding Adults policy, which stated:

‘8.8 Safeguarding Lead / Named safeguarding designated person – each Elysium Healthcare facility will nominate a safeguarding Lead / designated safeguarding person and deputy who will be responsible for:

[…]

Acting as first point of contact for the service with regard to issues related to safeguarding

[…]

12. ELYSIUM HEALTHCARE CONCERN LINE

12.1. Safeguarding is everyone's responsibility, as such Elysium Healthcare expects staff to raise any safeguarding concerns as set out within their local protocol. However, should staff feel that their concerns have not been acted upon, they should contact one of the following:

Group Chief Executive
Registered Manager
Operations Director
Director of Human Resources
Director of Policy and Regulation
Group Head of Safeguarding
Speak Up Guardian
Elysium Healthcare Concern Line – […]’

The panel noted that there was a significant discrepancy between your investigation meeting notes with Witness 3 dated 12 February 2021 and your witness statement. The panel did not have before it the safeguarding report relating to the incident that occurred between Patient A and Patient B. It, therefore, preferred the evidence of Colleague 1 that

a safeguarding report was not completed at all. It was it was of the view that her evidence was consistent throughout her witness statement and oral evidence.

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that ~~as~~ you failed to complete a safeguarding report relating to the incident that occurred between Patient A and Patient B. The panel, therefore, finds this charge proved.

Charges 14(a), 14(b) and 14(c)

14. On an unknown date in January 2021 bullied and/or intimidated Colleague 1 by;

(a) Shouting at her.

(b) Saying words to the effect of, "you are being disrespectful".

(c) Saying words to the effect of, "you can deal with him (as in Patient B) if he becomes challenging".

These charges are found NOT proved.

In reaching this decision, the panel took into account Colleague 1's documentary and oral evidence. The panel also took into account Colleague 2's investigation meeting dated 9 February 2021.

The panel noted from Colleague 1's witness statement:

> *'S31. On this particular evening, I had taken all the patients' orders and I was in the ward office ready to telephone the takeaway shop. The Registrant came in and asked me if I had asked [Patient B] what he wanted.'*

There was a lack of evidence from the investigation meeting on this matter. This meant that the panel had to rely on the accounts provided by you and Colleague 1. In the case of you, there was a degree of consistency in your account and a strong denial of the allegations made by Colleague 1.

The panel noted from Colleague 2's investigation meeting dated 9 February 2021:

> *'[Colleague 1] advised that SZ will present [her work methods] to staff in a way that what she is doing benefits the patients and if anybody disagrees with SZ, she would becoming[sic] intimidating. [Colleague 1] advised that SZ had done that at least twice with her, shouting and becoming threatening.'*

In your evidence, you told the panel that the patient just needed a soft diet and that you spoke with this patient's wife about this.

The panel noted that it was not in dispute that ultimately Patient B did not have a pizza. The panel noted that it was clear from your evidence, which it accepted, that you were aware that Patient B had required the Heimlich manoeuvre on two previous occasions. You were aware of his needs and of the risks associated with him having food which was not "mashable", as set out in his care plan. You were able to recall a meeting with Patient B's wife in January 2021 in which his need for a "mashable" diet was discussed. You also described how Patient B was likely to be "triggered" by seeing other patients' food. The panel also accepted your evidence that food capable of being mashed was available from the kitchen on this particular food occasion, as an alternative to buying food from outside.

In those circumstances the panel considered that it was inherently improbable that you would have told Colleague 1 to order pizza for Patient B. You were consistent and clear in your evidence that you would never give Patient B pizza. The panel did not accept Colleague 1's evidence that to order pizza for Patient B would give you an "easy life". Although other patients' food could be a trigger for him, the risks of choking were significant and an incident requiring emergency procedures would not be "an easy life". The panel preferred your evidence in relation to this charge to that of Colleague 1, and accepted your account. It found charges 14(a), (b) and (c) not proved on the balance of probabilities.

Charges 15(a) and 15(b)

15. On a date unknown inaccurately recorded incident summaries in Patient A's care plan by;

(a) Copying and pasting earlier incident summaries.

(b) Altering the dates.

These charges are found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Colleague 1 and your evidence.

'23. I did have further concerns about the Registrant's work ethic. The Nurses on the Unit were responsible for writing care plans and every patient had a particular Staff Nurse who was linked to them as a 'primary nurse'. The Registrant was the primary nurse for a number of patients including [Patient A]. I recall one occasion when the Registrant had been asked by the Ward Manager to write a summary to be [Patient A]'s care plan of all the incidents that he had been involved in. The Registrant asked me to start typing this summary on Microsoft Word. Patient A had been involved in a high number of incidents so I was working on this summary for several hours. When the Registrant came to check on my progress I told her that I would not be finished by the end of that shift. The Registrant took over and I witnessed her copy and pasting incident summaries that she had written previously for this patient, and changing the dates so they appeared to apply to the more recent incidents that she needed to summarise. The Registrant did not hide the fact that she was doing this from me, she said "Look, I'm not stupid, I'll just copy paste from the other incidents and change the dates". The potential harm of her taking this shortcut was that the incident overview in Patient A's 's care plan would not contain an accurate summary of his progress or how his behaviours were improving or deteriorating. Having an accurate picture was very important for Patient A's care because his medication had been changed and the Unit needed to understand whether this change had been effective in making Patient A more

psychologically stable. I did not inform anyone about the Registrant's copy and pasting.'

The panel noted from your witness statement:

'*19. There were many incidents occurring on the Ward on both day and night shifts. Due to Ward demands and staffing shortages, at times the relevant paperwork was unable to be completed immediately. I do not accept that I dishonestly made inaccurate entries by copying and pasting summaries from previous incidents with the intention to mislead. On an occasion I did copy and paste as I was putting incident reports of Patient A in chronological order for [Mr 8] ready for an MDT review. I did not ever use shortcuts for patients care plans or incident reports.*

The panel noted that Colleague 1's evidence in relation to this charge did not appear to be significantly in dispute. However it appeared that she may have misunderstood what you were doing and for what purpose. The panel was mindful that Colleague 1 would not have been familiar with care records or incident reporting in the way that a registered nurse would.

The panel noted that cutting and pasting is not necessarily problematic, provided that any records or incident report accurately represents what is being described. Falsification of records is however a serious allegation. The panel noted that there was no cogent evidence of any report or incident compiled by you containing inaccurate or misleading information. There was no evidence of what you cut and pasted, or that it was inappropriate or inaccurate in the circumstances to do so. There was no evidence that dates had been altered in a material way or that the incident summaries were inaccurately recorded, particularly given that this was a document being created for the multi-disciplinary team as a summary of recent incidents.

The panel concluded that the NMC had provided insufficient evidence in support of charge 15(a) or charge 15(b). It therefore finds these charges not proved.

Charge 16

16. *Your actions in charge 15 were dishonest in that you deliberately sought to mislead others into believing that the incident summaries were correct when you knew that they were not.*

This charge is found NOT proved.

As the panel found charge 15 not proved, charge 16 automatically falls away and is not proved.

Charge 17

17. *On 19 December 2020 encouraged and/or instructed Colleague 1 to alter patients' physical observation readings so that their score could be calculated to read as 0.*

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Colleague 1 and your evidence. It also had regard to Witness 3's investigation meeting notes with Colleague 1 dated 9 February 2021.

In Colleague 1's witness statement, she stated:

'25. On a shift on 19 December 2020, I went to inform the Registrant that some of the patients had "scored", meaning that they had registered an observations result of more than 0. The Registrant told me that I should have changed the patients' physical observation readings so that their score could be calculated as 0. The explanation that she gave for this instruction was that every person has a different baseline physical health so the scores were not truly representative of their current state. By telling me to ensure that the patients scored 0, the Registrant was asking

me to falsify documentation because the individual who carries out the clinical observations must sign their name to the results that they have recorded.'

The panel noted from Colleague 1's statement of fact dated 3 February 2021:

'During one shift in December, after I had finished doing the physical observations on patients, I shared the NEWs Scores with NIC SZ. Some of the patients had a NEWS score of 1 or 2. Nurse SZ told me to lie on the physical observations sheet to make a score of 0. NIC SZ explained that all patients have different health, blood circulations, thus depending on the patient, NEWs scores could mean nothing.'

The panel also noted from Witness 3's investigation meeting notes with Colleague 1 dated 9 February 2021:

'[Witness 3] noted that [Colleague 1] had said in her written statement that on one shift in December but not a specified date, [Colleague 1] had done some physical observations on patients, some patients had scored 1 and 2 on the NEWS chart and [Colleague 1] handed over to the nurse, SZ, who told [Colleague 1] to lie to make the score 0. [Witness 3] asked if SZ had specifically told [Colleague 1] to lie or what her words were at the time.'

The panel noted from Colleague 1's evidence during cross examination that when talking about this, the only question that arose about paragraph 25 of her witness statement was in relation to whether she was instructed on 19 December.

The panel also noted from your oral evidence during cross examination that when asked about the observation results, you said you did not encourage Colleague 1 to produce lower scores as you never spoke to Colleague 1 about observations at all because she knew what she was doing.

The panel did not accept this evidence from you. It considered it implausible that you never spoke to Colleague 1 about observation scores, particularly as you had a good

working relationship and had shared multiple shifts together. The panel preferred Colleague 1's evidence in relation to this charge.

In light of this, the panel determined, that on the balance of probabilities, it is more likely than not that you encouraged and instructed Colleague 1 on 19 December 2020 to alter patients' physical observation readings so that their score could be calculated to read as 0. The panel, therefore, finds this charge proved.

Charge 18

> 18. *Your actions in charge 17 were dishonest in that this was an attempt to mislead others into believing that patients' physical observations were accurate knowing that they were not.*

This charge is found NOT proved.

In reaching this decision, the panel took into account of the documentary and oral evidence of Colleague 1 and your evidence. It also had regard to Witness 3's investigation meeting notes with Colleague 1 dated 9 February 2021.

In Colleague 1's witness statement, she stated:

> *'25. On a shift on 19 December 2020, I went to inform the Registrant that some of the patients had "scored", meaning that they had registered an observations result of more than 0. The Registrant told me that I should have changed the patients' physical observation readings so that their score could be calculated as 0. The explanation that she gave for this instruction was that every person has a different baseline physical health so the scores were not truly representative of their current state. By telling me to ensure that the patients1 scored 0, the Registrant was asking me to falsify documentation because the individual who carries out the clinical observations must sign their name to the results that they have recorded.*

26. I realised that this was not the right thing to do, I am confident that I never actually did change any patients' scores. I did learn that depending on the patient, a score of 1 may be within their normal baseline range, for example if they were a smoker. I can recall that the following shift that I worked with the Registrant and she asked me again to ensure that the recorded score was 0, I explained to her that even if 1 was a patients average, I could still record it as such and the other Charge Nurses I had worked with were satisfied that the observations did not need to be repeated within four hours for a particular patient because a score of 1 was their average. The Registrant was receptive to this explanation.'

In Witness 3's investigation meeting notes with Colleague 1 dated 9 February 2021, the panel noted:

'[Witness 3] noted that [Colleague 1] has advised that SZ said that different health conditions meant that the NEWS score could mean nothing. [Witness 3] asked for [Colleague 1]'s thoughts around that.

[Colleague 1] advised that SZ kept trying to convince [Colleague 1] that all the nurses do this, she kept continuing with telling [Colleague 1] how they're health issues are different and the NEWS score could mean nothing.

[Witness 3] asked if SZ gave any rationale or justification.

[Colleague 1] said that SZ told her she was taught by other nurses to do this and all the patients have different health issues, for example depending on the time and the persons appetite, so blood pressure could be low or high, so the NEWS score might not be correct.

[Witness 3] asked how [Colleague 1] recorded the NEWS score.

[Colleague 1] said that a lot of the NEWS scores were to do with resps, so she would continue to do the observations again and again to try and get a score of 0.

[Colleague 1] said that on that day, she was concerned about resps and SZ could see that [Colleague 1] was concerned, so SZ said "I will do them myself". A few hours later after he had gone to bed, SZ told [Colleague 1] that the score was a 0. [Colleague 1] said that she would keep trying with observations to get a zero rather than report a high score to SZ.'

The panel had regard to the legal advice it had received in relation to the test for dishonesty. It first considered what was in your mind at the time you gave the instruction to Colleague 1, considering what inferences it could draw from the evidence before it.

The panel considered that it was clear from Colleague 1's evidence that what you said to her was that the patients' health issues could mean that the NEWS scores did not reflect their health. That appears to have been the reason why you gave her the instruction you did.

The panel further noted that it was clear from Colleague 1's evidence that, when she corrected you, you were receptive to her explanation. You then understood the position and changed your stance.

The panel considered that the inference which could be drawn from this was that your instruction to Colleague 1 arose from a degree of incompetence or poor clinical judgment on your part. At the time you gave the instruction, you genuinely believed that the explanation you were giving was accurate, and once you had been corrected by Colleague 1, you changed your stance about whether the scores should be altered.

In the circumstances, the panel was of the view that your actions in charge 17 were ~~this was~~ not done with a motivation or a desire to mislead or to be dishonest. It, therefore, finds this charge not proved.

Charge 19

19. On one or more occasions on dates unknown failed to follow Patient C's care plan by using pull up sanitary pads instead of a 'Kylie'.

This charge is found proved.

In reaching this decision, the panel took into account of the documentary and oral evidence of Colleague 1 and your evidence.

In Colleague 1's witness statement, she stated:

> *'27. One of the bedbound patients was called Patient C. According to his written care plan he was not meant to wear sanitary pads ("pull ups") because he had a tendency to put them in his mouth. Instead, in order to keep his bed hygienic, we were meant to use a "kylie" which was a thick piece of sheet made from cotton and plastic which was laid across the bed at abdomen level. At night the Registrant would instruct us to put pull ups on [Patient C] anyway. It is my view that this was the right decision because I could see [Patient C] was not putting the pads in his mouth. It was also better for his dignity because when pads were not used. [Patient C] had access to the soiled material and would touch his faeces and put it on his face and ears and mouth. Nevertheless, the use of pull ups was technically contrary to his care plan.'*

The panel had regard to your witness statement:

> *'23. Patient C had a high risk of choking by ripping up his sanitary pads and eating them therefore he wore a 'Kylie'. I did not on any occasion tell [Colleague 1] or any other Support Worker to put pull ups or pads on Patient C. On the contrary his care plan was always followed.'*

The panel noted that you were the primary nurse for Patient C and therefore had primary responsibility for managing the patient's care plan. It further noted that Colleague 1 was not critical of the clinical decision you took to use pull-up pads instead of a Kylie. She

believed that this was better for the patient even though it was contrary to the care plan in place at the time.

The panel accepted Colleague 1's evidence that you used pull-up pads instead of a Kylie. It considered that it was plausible and logical that, as Patient C's primary nurse, you would have taken the legitimate clinical decision that this was preferable to what was in the care plan. What should then have happened, however, was that you should have recommended an update to Patient C's care plan. That is the subject of charge 21(b).

The panel, therefore, finds this charge proved.

Charge 20

> *20. On one or more occasions on dates unknown failed to follow Patient D's care plan by placing a second sanitary pad across his genitals.*

This charge is found proved by way of your admission.

Charge 21(a)

> *21. In relation to charge 19 and/or 20 failed to;*
>
> *(a) Update Patient C's care plan and/or Patient D's care plan accordingly*.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary and oral evidence of Colleague 1 and your evidence.

The panel noted that there was insufficient evidence before it which demonstrated that you should have updated the care plans yourself. The panel took into account Colleague 1's witness statement. However, it noted that Colleague 1 was not a registered nurse and was

not responsible for the management of care plans. Witness 3 does not talk about this at all in her evidence.

The evidence available to the panel suggested that any proposed update to the care plan would be recommended and discussed with a doctor. Only after that would the care plan be updated. There was no evidence that those steps had happened in respect of the care plans for Patient C and/or Patient D. There was therefore no evidence to establish that you were under a duty to update those plans. Therefore, the panel did not find this charge proved.

Charge 21(b)

21. In relation to charge 19 and/or 20 failed to;

…

(b) Recommend that Patient C's care plan and/or Patient D's care plan be adjusted accordingly.

This charge is found proved by admission in relation to Patient D and is found proved in relation to Patient C.

For reasons set out in relation to Charge 19, the panel found that you were under a duty to recommend an adjustment to Patient C's care plan and failed to make that recommendation in respect of the use of pull-up sanitary pads instead of a Kylie.

Charge 22

22. On an unknown date in January 2021 failed to follow Patient B's care plan by requesting that Colleague 1 order Patient B a pizza.

This charge is found NOT proved.

In reaching this decision, the panel took into account of the documentary and oral evidence of Colleague 1 and your evidence. It had regard to its findings in relation to this incident, set out in relation to charge 14 above.

As the panel found that you did not make the request to Colleague 1 to order pizza for Patient B, it follows logically that it finds that you did not fail to follow Patient B's care plan in this regard. It therefore finds this charge not proved.

Decision and reasons on application for panel to reconsider its determination on the facts

Following the panel handing down its findings on the facts, Mr Lee made an application for the panel to reconsider its decision in relation to charges 11 and 12.

From his understanding, Mr Lee noted that the panel had found charge 11 not proved because the stem of this charge (alleging bullying and/or intimidation) was not made out. However, he submitted that the panel had found some of the acts alleged in the particulars of charge 11 (namely 11(b) and 11(c)) proved. He further noted that the panel had gone on to find charge 12 proved. Mr Lee submitted that charge 12 is based on charge 11, in that it says "*Your actions at charge 11 above showed a lack of integrity…"*.

Mr Lee submitted that the panel's decision in finding charge 11 not proved, but charge 12 proved, raises a potential procedural irregularity. He further submitted that it could cause confusion for someone reading only the charges, in that charge 11 was found not proved, but charge 12, which was based on it, was found proved.

Mr Lee submitted that it appeared that the panel had effectively found an amended version of charge 11 proved, in that it had effectively found charge 11(b) and (c) proved as though the stem read:

> '*On 4 October 2020 ~~bullied and/or intimidated~~* ***sought to persuade*** *Colleague 1 into not completing an IRIS report…'*

However, Mr Lee observed that neither he or Ms Shah had the opportunity to make representations prior to such an amendment being made, or to make submissions in relation to the amended charge once the amendment had been made.

Mr Lee therefore proposed that the panel give consideration to one of the following courses of action, indicating that he preferred the first course:

- that the panel re-open the facts stage, making a decision as to whether to amend the charge of its own volition, having first heard from the parties in relation to the proposed amendment, and then give Ms Shah on your behalf the opportunity to make submissions as to whether the amended charge amounts to lack of integrity; or
- that the panel find that, because charge 12 only refers to “your actions” at charge 11, there is no need to amend charge 11, and the decision can stand.

Ms Shah submitted that the current wording of charge 12, which the panel found proved, relies on charge 11 which is found not proved. Given the concerns with this as outlined by Mr Lee in his submissions, she submitted that it is only right that this be raised with the panel before moving onto the next stage of these proceedings.

Ms Shah submitted that the options available to the panel in order to address the raised concerns, which she invited the panel to consider, are as follows:

- that the panel acknowledge on record the concerns raised in respect of its decision and reasons for charges 11 and 12, but make no change to the wording of charge 11 and/or its decision and reasons on the facts;
- that the panel find charge 12 not proved (on the basis that charge 11 was not proved), on the basis that parties were not given the opportunity to make appropriate submissions on this and that the facts stage has now concluded. Ms Shah acknowledged that this course of action may not reflect the panel’s decision in relation to the disputed facts in charge 11; or

- that the panel reopens the facts stage in order to consider an amendment to the wording of charge 11 as proposed by the NMC, and then invite submissions in respect of the amended charges, seek legal advice, and then retire to redeliberate on this charge. Ms Shah submitted that this would effectively correct the “missed step”.

Ms Shah reminded the panel that it should not only consider the public interest in determining whether to amend charge 11 and proceed with the hearing as suggested, but fairness to you, particularly as it would accurately reflect the decreased level of seriousness of this charge.

The panel accepted the advice of the legal assessor.

The panel carefully considered the submissions from both Mr Lee and Ms Shah in respect of this application.

The panel considered the fact that it has already handed down its determination on the facts of this case which brought the facts stage to a conclusion, during which it took full account of the submissions made by both Mr Lee and Ms Shah in respect of the factual allegations contained in charges 11 and 12.

The panel referred itself to the reasons provided for its decision in finding charge 11 in its entirety not proved, and charge 12 proved in respect of charge 11. The panel did not find that the alleged actions in charge 11 amounted to bullying or intimidating behaviour. However, it did find on the balance of probability that the actions alleged in charges 11(b) and 11(c) had occurred as alleged. It was those actions which in the determination of the panel, whilst falling short of intimidation or bullying, nevertheless represented an attempt to persuade a colleague not to report a matter which ought to be reported. This in turn was putting the colleague’s interests above those of the patient and thereby demonstrated a lack of integrity.

The panel accepted that a rewording of charge 11 might have given greater clarity. However it considered that the reasoning set out in its determination made its findings, and the basis of those findings, sufficiently clear and did not require further amendment. It therefore determined that it was not required to re-open the facts stage, amend charge 11, invite further submissions, deliberate further in relation to charge 12, or change its determination. It did not consider that any prejudice or injustice would be caused to you.

The panel therefore decided to refuse this application.

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 your fitness to practise is currently impaired by reason of that misconduct. There is no statutory definition of fitness to practise. However, 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, it was required to determine whether the facts found proved amount to misconduct. Second, and only if the facts found proved amount to misconduct, the panel was required to decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

The panel heard evidence from you under oath. In addition, you provided a reflective piece and a bundle of documents consisting of testimonials and training certificates.

Mr Lee invited the panel to take the view that the facts found proved amount to misconduct.

Mr Lee referred the panel to the NMC guidance in relation to misconduct, specifically: '*Serious concerns which are more difficult to put right' (ref FTP-3a); 'Serious concerns which could result in harm to patients if not put right' (ref FTP-3b);* and *'Serious concerns based on public confidence or professional standards' (ref FTP-3c)*.

Mr Lee then referred the panel to *'The Code: Professional standards of practice and behaviour for nurses and midwives 2015'* (the Code). He submitted that your proved conduct in this case breached the following main principles of the Code: to prioritise people; practise effectively; preserve safety; and promote professionalism and trust. Giving the panel's findings on the facts, particularly where the panel found that your conduct lacked integrity, Mr Lee submitted that your behaviour in this case clearly breached fundamental aspects of the Code as outlined.

Mr Lee then moved onto the matter of impairment and referred the panel to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council [2008]* EWHC 581 (Admin).

Focusing first on the case of *Grant* [2011], Mr Lee took the panel through the four limbs of the test set out in its judgment which the panel should take into consideration when determining whether a registrant's fitness to practise is impaired. He submitted that it is the NMC's position that the proved conduct in your case satisfies the first three limbs of the test.

Mr Lee then drew the panel's attention to the judgment in the case of *Cohen* [2008] which sets out what the panel should take into consideration when determining whether the misconduct is remediable. He submitted that it is the NMC's position that the misconduct in your case is not easily remediable.

Mr Lee submitted that, taking into account the oral and documentary evidence the panel has heard and received from you, the NMC considers that you have demonstrated limited insight into your behaviour and that the concerns around your practice have not been fully addressed.

With regard to insight, Mr Lee submitted that, whilst it is clear that you are knowledgeable in your area of practice, capable of being an impressive nurse, and were able to discuss in detail best practice within the profession, nevertheless your evidence at both stages of the hearing had focused on best practice rather than what happened at the time. He submitted that you had not demonstrated sufficient insight into your actions and your own emotions and reactions to the pressures of your working environment at the time, and how this had contributed to your failures. He submitted that in the absence of an understanding of where you went wrong, the reason behind this and how you would avoid this in the future, your insight into the proven conduct is limited, and therefore there is a high likelihood of the conduct being repeated in the future.

Mr Lee submitted that some of the issues identified around your practice also give rise to attitudinal concerns, noting that the proved conduct only occurred on shifts with certain staff members. He acknowledged the circumstances you have described within the Hospital at the time of the incidents, one being that the Hospital was understaffed which put pressure on registered nurses. However, Mr Lee submitted that this does not explain why the proved conduct only occurred on shifts with certain staff, and not on other shifts.

In light of his submissions, Mr Lee submitted that it is the NMC's position that your fitness to practise is currently impaired, and invited the panel to take this view.

Ms Shah accepted on your behalf that the conduct found proven by the panel amounts to misconduct, although she acknowledged that it is a matter for the panel to determine whether this is the case. However, with regard to charge 17, she noted that the panel in its findings determined that the conduct was not dishonest, but rather down to your poor clinical judgment at the time. Therefore, Ms Shah submitted that the panel may wish to

take the view that charge 17 does not amount to misconduct or a serious falling short of the standards expected of a registered nurse.

Ms Shah then moved onto the matter of impairment. She acknowledged that the panel's findings on the facts would give rise to wider public interest considerations, and in turn a finding of impairment. However, she submitted that various factors in this case show that it is unlikely that the proved conduct will be repeated in the future.

Ms Shah submitted that in light of the evidence available about your professional career, there is no real risk of the proved conduct being repeated. She submitted that you had been practising as a nurse for over a decade prior to these events, and that you practised for 8 months after these events, during which time there have been no NMC referrals or regulatory concerns raised in relation to your practice (with the exception of this current matter). She requested that the panel take this into consideration when determining the likeliness of repetition in your case.

Ms Shah referred the panel to the eight positive testimonials you have provided from past colleagues, some of whom are registered nurses, pointing out that they covered the period from 2010 to 2020 and the period when you were practising after these events. She took the panel through each testimonial, highlighting the areas where they comment on your good character and your capabilities as a good nurse. Ms Shah submitted that these testimonials present you as an exemplary nurse who provides high quality of care to patients, is an advocate to patients, and treats patients kindly. She therefore submitted that this shows that it was out of character for you to engage in the conduct found proved in this case.

Ms Shah submitted that it is particularly relevant for the panel to also take into consideration the context behind the proved conduct, in determining whether the conduct is remediable and to what extent you need to demonstrate this. She submitted that the Hospital at the time was not an easy place to work in, given the high turnover of staff resulting in understaffing, which the panel have acknowledged in its findings on the facts. Ms Shah submitted that this was particularly challenging for you as you were the only

registered nurse on shift dealing with several vulnerable patients, and therefore unable to leave the Ward during your breaks. She submitted that these factors had a part to play in why the conduct of an otherwise exemplary nurse such as yourself fell so far short of the expected standards.

In addition to this, Ms Shah pointed out that the incidents occurred during the height of the COVID pandemic, which put healthcare professionals under a lot of pressure, particularly those working with elderly vulnerable patients who were at high risk of catching COVID. She referred to your oral evidence where you talked about your experience working during the pandemic and the stress this put you under, particularly with other members of staff off sick. Ms Shah submitted that you did not use this as an excuse for your proved conduct, but that it was again relevant in explaining how the events occurred and why you acted out of character. She referred to your evidence that you had not wanted to let patients down and had therefore continued to work, and submitted that this underlined the fact that you are normally a committed and dedicated nurse.

Ms Shah submitted that you have demonstrated that commitment by the approach you have taken to these proceedings, showing a high level of engagement and a willingness to learn a salutary lesson from your past mistakes and to improve your practice.

With regard to insight, Ms Shah submitted that your denial of the allegations should not be considered as evidence of a lack of insight, nor should it be held against you. She referred the panel to your oral evidence and reflective piece. Ms Shah submitted that you have clearly acknowledged the seriousness of the conduct found proved, that such behaviour is unacceptable, and have accepted that your behaviour put patients at risk. She submitted that you also understand the impact your proved conduct had on patients and their relationship with other nursing professionals. Ms Shah submitted that this demonstrates a significant level of insight. She reminded the panel that you have acknowledged your actions to have been “disgusting”, that it amounted to abuse of patients, and that you said you are ashamed of the matters which have been found proved against you.

With regard to the steps you have taken to address the concerns identified around your practice, Ms Shah referred the panel to the training certificates you have provided, which include training in the areas of: promoting patient safety; understanding bullying in healthcare organisations (albeit that the allegation of bullying was found not proved); effective communication; record keeping and more. She submitted that this demonstrates your clear understanding of the need for and importance of keeping your nursing practice up to date in order to return to safe practice.

In light of her submissions, Ms Shah submitted that your fitness to practise is not currently impaired, and invited the panel to take this view. She further submitted that the wider public interest considerations have been satisfied to some extent in this case by the airing and exploration of your misconduct during the course of this hearing.

The panel accepted the advice of the legal assessor which included reference to a number of relevant authorities, including: *Roylance, Nandi v General Medical Council* [2004] EWHC 2317 (Admin); *R (Remedy UK Ltd) v GMC* [2010 EWHC 1245 (Admin); *R (Calhaem) v GMC* [2007] EWHC 2606 (Admin); *Johnson & Maggs v NMC (No. 2)* [2013] EWHC 2140 (Admin); *Cohen v GMC* [2008] EWHC 581 (Admin); *CHRE v NMC & Grant* [2011] EWHC 927 (Admin); *Ahmedsowida v GMC* [2021] EWHC 3466 (Admin); *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin); and *Sawati v GMC* [2022] EWHC 283 (Admin).

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code and considered each of the proven charges separately. It found that your actions amounted to breaches of the Code. Specifically, it considered that

the following provisions of the Code were engaged by the actions which have been found proved in this case:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

***1.1** treat people with kindness, respect and compassion*

…

***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:

…

***2.6** recognise when people are anxious or in distress and respond compassionately and politely*

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

…

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

***10.3** complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 *take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

17.2 *share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information*

…

20 Uphold the reputation of your profession at all times

To achieve this, you must:

…

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

…

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It considered in detail whether each of the proven charges fell seriously short of the standards expected of a registered nurse and whether it amounted to serious misconduct as follows:

Charges 1(a), 1(b) and 1(c)

The panel found that you failed to treat a patient under your care with dignity and respect by subjecting them to verbal abuse by means of shouting negative and derogatory comments. This was not simply a case of general frustration being expressed to colleagues in private, but was directed at the vulnerable patient who required care from you. It determined that this behaviour breached sections 1.1 and 1.5 of the Code and fell significantly short of the standards expected of a registered nurse. The panel therefore found that your proven behaviour in relation to charge 1 was a sufficiently serious departure from required standards to amount to misconduct.

Charges 2(a), 4(a) and 4(c)

The panel considered the proven aspects of charge 2 and charge 4 together, because they related to different aspects of the same incident, involving the same patient. The panel found that you failed to treat a patient under your care with dignity and respect by knowingly leaving him in an incontinent state for around 45 minutes after he requested a change, by preventing him from accessing the lounge area within the Hospital, and by making a derogatory comment about him to a colleague. No reasonable explanation had been provided for this behaviour (for example, there was no evidence to suggest that you had been called away to attend to other urgent duties). The panel considered that this showed a poor level of care in respect of this patient, particularly with regards to charge 2(a). The panel determined that this behaviour breached sections 1.1, 1.4 and 1.5 of the Code and fell significantly short of the standards expected of a registered nurse. The panel therefore found that your proven behaviour in relation to charges 2(a) and 4(a) and 4(c) was a sufficiently serious departure from required standards to amount to misconduct.

Charges 6(a), 6(b) and 6(c)

The panel noted that the patient in the incident outlined in charge 6 was permitted to move around all areas of the Hospital at will. Your actions (whether by instructing the obstruction of access to the lounge or by knowingly allowing it to continue) had the effect of restricting the movement and the rights of this patient which caused him emotional distress. No reasonable explanation had been provided for this and the panel noted that you have acknowledged the seriousness of your actions. It determined that this behaviour breached sections 1.5 and 2.6 of the Code and fell significantly short of the standards expected of a registered nurse. The panel therefore found that your proven behaviour in relation to charge 6 was a sufficiently serious departure from required standards to amount to misconduct.

Charges 8(b), 8(c) and 8(d)

The panel found that you failed to treat a patient under your care with dignity and respect by subjecting them to verbal abuse by means of using rude and profane language. The panel noted in your oral evidence that you specifically talked about the importance of maintaining a “therapeutic relationship” with patients. Your actions in relation to this charge would, as you acknowledge, undermined that therapeutic relationship. The panel

determined that this behaviour breached sections 1.1 and 1.5 of the Code and fell significantly short of the standards expected of a registered nurse. The panel therefore found that your proven behaviour in relation to charges 8(b), 8(c) and 8(d) was a sufficiently serious departure from required standards to amount to misconduct.

Charges 10(a) and 10(b)

The panel understood from the evidence that in the context of this Hospital, it was not unusual, and indeed appears to have been part of the culture, for staff on 12 hour shifts to take naps during their breaks. The panel noted that this is clearly behaviour which has the potential to raise safety issues if it is not properly managed to ensure that patients are not left unattended. However there was no evidence in this case that any patient was put at risk or that the situation was not properly managed. The panel noted that you were the only registered nurse on shift and were unable to leave the Ward during your breaks. There was no staff room in which breaks could be taken, and there was a culture on the Ward in which sleeping was tolerated or accepted practice. The panel considered that your proven actions in relation to charge 10 were not good practice and were not appropriate. However, in the circumstances and context of this particular setting, the panel determined that, whilst this behaviour was a departure from the standards expected of a registered nurse, it was not a sufficiently serious departure to amount to misconduct.

Charge 12

The panel found that, within the healthcare profession, putting the interests of colleagues above the interests and needs of vulnerable patients under your care directly and significantly goes against the professional standards expected of nurses and demonstrates a lack of integrity. The panel found at the previous stage in relation to charge 11 that although the alleged actions did not amount to bullying and were therefore not proved, you had (in relation to 11(b) and 11(c)) carried out the actions alleged in order to seek to persuade a junior colleague not to report an incident which ought to have been reported. Given your position as the nurse in charge, such behaviour would have influenced staff under you to put their own interests above those of patients. The panel determined that this behaviour breached sections 20.2 and 20.5 of the Code and fell significantly short of the standards expected of a registered nurse. The panel therefore

found that your proven behaviour in relation to charge 12 (referring to the actions described in charges 11(b) and (c)) was a sufficiently serious departure from required standards to amount to misconduct.

Charge 13

The panel considered it to be important that any incidents involving patients (particularly vulnerable patients) be documented appropriately and in a timely manner, in order to reduce the potential risk of further harm to patients. As the nurse in charge and the only registered nurse on duty, it was your responsibility under local policy to ensure that such documentation is completed, which you did not do. The panel determined that this behaviour breached sections 17.1 and 17.2 of the Code and fell significantly short of the standards expected of a registered nurse. The panel therefore found that your proven behaviour in relation to charge 13 was a sufficiently serious departure from required standards to amount to misconduct.

Charge 17

The panel noted that it had accepted at the fact-finding stage that you genuinely believed you were doing the right thing at the time by instructing a colleague to alter the patient's observation readings, as you believed that their state of health at the time may have impacted on their score. The panel considered that this represented poor practice, poor clinical judgment and poor grasp of clinical policy. However, it noted that once the correct position had been pointed out to you, you had accepted that you were wrong and altered your position. The panel determined that whilst this behaviour was a departure from the standards expected of a registered nurse, particularly section 10.3 of the Code, it was not a sufficiently serious departure in all the circumstances to amount to misconduct.

Charge 19

The panel noted its findings at the facts stage. It had found that you used your clinical judgment at the time by using a pull up sanitary pad on the patient because you thought that this would be a better way to meet his needs, despite his care plan indicating that a Kylie should be used. The NMC's evidence was that your decision was the correct one. The panel accepted that you were exercising your clinical judgment in the patient's best

interest at the time. Although in general terms it would not be good practice to depart from the care plan without the care plan having been updated, the panel considered that in the particular circumstances, this did not represent a departure from required standards and did not amount to misconduct.

Charge 20

The panel was mindful that it had, again, found that you used your clinical judgment at the time by deciding to place a second sanitary pad across the patient's genitals, even though this was a departure from what was in the care plan. As with charge 19, the panel accepted that you were exercising your clinical judgment in the patient's best interest at the time. As with charge 19, it determined that in the particular circumstances, this did not represent a departure from required standards and did not amount to misconduct.

Charge 21(b)

The panel had regard to its finding that you failed to recommend an update to the patients' care plans in relation to the matters referred to in charges 19 and 20. It considered that this failure represented poor practice, because by recommending a change to the care plan (to be considered by the multi-disciplinary team), you would have enabled information to be shared with other staff in the interests of the patients. However, the panel noted that charge 21 involved a single and narrow example of poor practice in relation to care plans. The panel determined that whilst this omission was a departure from the standards expected of a registered nurse, particularly section 10.2 of the Code, it was not a sufficiently serious departure in all the circumstances to amount to misconduct.

Decision and reasons on impairment

The panel noted that it had found misconduct in relation to your proven actions in respect of charges 1(a), 1(b), 1(c), 2(a), 4(a), 4(c) 6(a), 6(b), 6(c) 8(b), 8(c), 8(d), 12 and 13. It next went on to decide whether, as a result of that 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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

d) *...'*

The panel found that limbs a), b) and c) of the test outlined above were engaged in this case by your actions and omissions. It considered that patients were put at risk of harm, and in some instances were caused emotional harm, as a result of your misconduct. It further considered that your misconduct breached the fundamental tenets of the nursing profession, in particular in relation to treating patients with dignity and respect, and also brought the reputation of the profession into disrepute.

The panel therefore went on to consider whether you were liable, or likely, to act in such a way in future. In doing so, it had particular regard to your professional history, your levels of insight and the training you have undertaken.

In evaluating your level of insight into your misconduct, the panel took account of your oral evidence at both stages of the hearing and your reflective piece dated 14 August 2023. The panel acknowledged your evident desire to return to your nursing practice, and noted that you have expressed significant levels of remorse about your actions and have clearly learned a salutary lesson from these proceedings. The panel noted that you had, throughout your evidence, been able to go into detail about best practice with regard to patient care, and had demonstrated insight into what you should have done. You had also been able to identify pressures in the workplace environment and more generally which may have impacted on your behaviour at the time, including high staff turnover, understaffing, being the only registered nurse on shift, and the impact of the COVID pandemic. The panel noted, however, that although your frustration may have impacted your behaviour in some specific incidents, there were others (notably the incident regarding the sofa) which could not be explained by this and which may suggest an element of attitudinal concern.

Overall, however, the panel considered that you had shown more limited reflection and insight in relation to your specific actions and behaviours at the time. It noted that you had struggled to articulate how you felt at the time, or how this affected your behaviour, why you acted as you did, and how you could identify and take steps to prevent any factors which might risk a recurrence. You had reflected on what you should have done, but not so extensively on what you did, and why, and the seriousness of your actions. You had also only demonstrated limited understanding of the impact your misconduct had on the patients and colleagues involved, and on public perception of the nursing profession. The panel therefore considered that while you have demonstrated some insight, your insight is still developing and is not yet fully formed.

Although the misconduct in this case is serious involving your treatment of extremely vulnerable patients for whose care you were responsible, your breach of your duty of candour and the coercion of junior staff, the panel was satisfied in the circumstances of this case that the misconduct is capable of being addressed. In considering the steps you have taken to strengthen your practice to address the concerns identified, the panel took into account the positive testimonials from your previous colleagues, the patient feedback reviews from Cheswold Park Hospital, and the training certificates you have provided.

The panel considered that the testimonials and patient feedback you had provided were compelling and reassuring. They were consistent in attesting to your generally good character and work ethic throughout your nursing career prior to and subsequent to these events. They attest to the fact that you are usually kind, sensitive and considerate to patients and colleagues and are well-regarded for your clinical skills and professionalism. The panel accepted that this evidence suggested that your actions were out of character with the rest of your professional career.

The panel also noted that, despite not having practised for some time, you have done all you could to ensure that you undertook relevant training in relation to the areas of concern identified in this case. It was also satisfied that you were able to demonstrate the learning you gained from these training courses during your oral evidence. However, as you are currently not working in a nursing capacity, you have not yet had the opportunity to put

your learning into practice within a healthcare setting caring for patients, in order to demonstrate that you are capable of returning to safe practice.

Taking all of the above into account, the panel is of the view that although you are unlikely to repeat your past actions, there remains a residual risk of repetition at this time if you were to return to unsupervised practice. This is mainly due to the under-developed nature of your insight and the fact that you have yet to have the opportunity to demonstrate the lessons you have learned through safe clinical practice in a nursing capacity. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment was not made in this case given the nature of the misconduct in this case. It therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Mr Lee invited the panel to impose a striking-off order. He submitted that this is a serious case involving the neglect and verbal abuse of vulnerable patients. He accepted that there were challenging circumstances on the Ward, but submitted that this provides minimal mitigation given that the incidents were not one-off, but occurred over the period of several months. Mr Lee further submitted that the neglect and verbal abuse of patients in this matter can neither be considered as impulsive 'heat of the moment' failings, nor a mere lapse of judgment.

Mr Lee submitted that the aggravating factors in the case are as follows: the vulnerability of the patients involved; the wide-ranging nature of the concerns; and your lack of integrity. He submitted that Ms Shah would address the panel with regard to mitigating factors, but noted these may include the fact that there has been no repetition of the concerned behaviour, and the positive testimonials provided which attest to your character and professionalism.

Mr Lee submitted that given the circumstances of this case and in light of the panel's findings, the NMC are seeking the imposition of a striking off order on both public protection and public interest grounds. He submitted that the panel might consider a suspension order to be an insufficient sanction, although he reminded the panel that sanction is a matter for the panel's judgment. He submitted that the panel in its findings on impairment found your insight to be limited (although developing) and identified potential attitudinal concerns. Mr Lee submitted that the NMC considers the misconduct in this case as incompatible with ongoing registration, and that anything less than a striking off order would diminish public confidence in the nursing profession.

Mr Lee submitted that the panel may wish to take into account the positive testimonials provided which indicate that the misconduct in this case was out of character, your developing insight, as well as your long lasting commitment to the profession. However, he concluded that it remains the NMC's position that given the seriousness of the panel's findings, a striking off order is the only appropriate and proportionate response that will sufficiently protect the public, satisfy the public interest and maintain public confidence in the profession.

Ms Shah invited the panel to impose a 'stringent' conditions of practice order. She referred the panel to the NMC guidance on sanctions. She reminded the panel that the purpose of a sanction is not to punish a registrant, but to protect the public and to satisfy the public interest. Ms Shah submitted that the guidance makes it clear that a panel should start off by considering the least serious sanction available, and then work its way up the options when determining whether any given sanction will satisfy the public interest and protect the public. She submitted that this approach ensures that the minimal necessary restriction on a registrant's practice is imposed to satisfy the overarching objective of the NMC.

Focusing on the public interest, Ms Shah submitted that the panel should take into account what response a reasonable, informed member of the public would expect in the circumstances of this case. She then moved on to address a number of factors which she considered that informed members of the public would regard the panel as entitled to take into account.

Ms Shah submitted that you are an exemplary nurse with an excellent history of service working as a registered nurse for 13 years, before which you worked as a Healthcare Assistant (HCA) for eight years. Ms Shah submitted that this is the first time regulatory concerns have been raised concerning your practice, referring to the panel's findings on impairment where it accepted that the misconduct was out of character for you in light of the evidence it has received.

Ms Shah referred to the panel's findings on impairment which indicated that you have shown a significant level of remorse and stated that it is unlikely that you will repeat your actions. She submitted that although the panel found there to be a residual risk of repetition, this arose solely from your need to develop further insight and demonstrate that you are now capable of practising safely.

Ms Shah submitted that the panel should impose the most proportionate and necessary response to reflect the factors above and satisfy the public interest. She reminded the panel that the public interest not only calls for a response to the poor behaviour identified, but also allowing a committed and dedicated nurse to return to safe practice. She submitted that removal from the register would not be the only sanction which would address the concerns in this case.

Ms Shah identified the following mitigating factors in your case: you have no previous regulatory findings against you during either your nursing career of over a decade or during your previous career as a HCA; the misconduct/concerns in this case have not been repeated during the eight months you practised since the incidents; positive testimonials (including from your line manager and other registered nurses), as well as positive feedback from patients in your care. Ms Shah pointed out that these attest to your 'excellent level of practice', referring to your good character, professionalism and work ethic, describing you as an asset to the team and referred to your kindness to patients, dedication and passion.

Ms Shah further submitted that the mitigating factors in your case also include: that the misconduct was out-of-character for you (based on the testimonials from individuals who have known you for an extended period of time); the misconduct only took place over a number of months, making it an isolated period; and the misconduct was limited to one employment setting in which there were pressures from the workplace environment at the time.

Moreover, Ms Shah further submitted that the workplace pressures included a high staff turnover, understaffing, you being the only nurse on duty and the impact of the COVID-19

pandemic. In respect of the potential attitudinal concerns identified by the panel, Ms Shah noted that there had been significant periods of practice, prior to and subsequent to this incident, without similar concerns arising, and submitted that it was an isolated incident with mitigating circumstances.

Ms Shah also submitted that, although the misconduct was wide-ranging, it was not a case where you had repeatedly committed the same misconduct. She submitted that you have appeared before your regulator and demonstrated remorse, and that you had learned a salutary lesson and are unlikely to repeat your actions.

Ms Shah submitted that the panel at the impairment stage found the misconduct in this case to be capable of being remedied. She submitted that your significant levels of remorse made it less likely to be repeated, and reminded the panel that it had found that, even when you were not working as a nurse, you had taken significant steps to remedy your failings by undertaking extensive training despite being suspended from practice. She submitted that you have engaged fully with these proceedings and demonstrated your commitment to the profession.

In all the circumstances, Ms Shah, submitted that the panel could find that a striking-off order was not the only appropriate or necessary sanction. She submitted that a lesser sanction would not undermine the seriousness of the case. She also submitted that there was the possibility of a return to safe practice in this case, even if this was not necessarily immediate, but once you had further developed your insight, demonstrated that you had learned your lessons and were capable of addressing your misconduct. Therefore, she submitted that the panel should consider sanctions other than a striking off order, which is usually the last resort if the misconduct is deemed incapable of being remedied.

Ms Shah submitted that an aspect of the public interest has already been met in this case by these regulatory proceedings, and that the public interest would be served by your return to safe practice. She submitted that the imposition of a conditions of practice order would be the most appropriate and proportionate sanction. She submitted that such an

order would also serve to address any residual risk of repetition by subjecting you and your practice to stringent supervision.

Ms Shah proposed that the following conditions would ensure that your practice is sufficiently monitored, and that the risks identified are suitably managed: that you be indirectly supervised by another registered nurse (meaning that you will never be the only nurse on shift); that you should not be the nurse in charge of any shift; that your practice be restricted to a single substantive employer; that you create a professional development plan (PDP) focussing on the areas of integrity, duty of candour, responding to challenging behaviour and other training needs deemed necessary by the panel; that you maintain a reflective diary; and that you produce a reflective piece prior to the next hearing and make this available to any reviewing panel, along with your reflective diary. Ms Shah submitted that these conditions would guard against any residual risk and would ensure that you practice in a familiar environment, where a manager is aware of the concerns and risks can be managed. She submitted that you have demonstrated already that you are willing and able to identify your training needs and undertake the necessary steps.

Ms Shah submitted that if the panel are not satisfied that a conditions of practice order at this time is appropriate, then it may wish to consider a suspension order. However, when considering the length of such an order, she requested that the panel take into account your level of remorse and the low risk of repetition of the misconduct. She submitted that the panel might determine in the circumstances that a shorter period of suspension is suitable before giving you the opportunity to put your learning into practice by way of a conditions of practice order. Ms Shah further submitted that it would then be beneficial for the panel to put forward recommendations to guide you on what you should do during the suspension period.

In light of her submissions, Ms Shah submitted that it is clear that a striking off order is not the only or the most appropriate sanction available in this case as the misconduct, including the lack of integrity, is capable of being remedied. She therefore invited the panel to consider a less restrictive sanction to satisfy the public interest and protect the public.

Decision and reasons on sanction

Having found your 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:

- The incidents involved extremely vulnerable patients.
- The concerns are wide-ranging and occurred over a period of several months.
- The findings included a finding of a lack of integrity involving junior colleagues.
- The findings involved an abuse of your power.
- At least one of the findings involved an attitudinal aspect.
- There was an aspect of poor and/or inappropriate communication with colleagues and patients.

The panel also took into account the following mitigating features:

- The misconduct was contained within a single workplace setting and was confined to a period of a few months.
- No similar concerns were raised in your lengthy career prior to this episode or in the eight months of nursing practice subsequent to the incident.
- There were very positive testimonials in relation to your previous and subsequent nursing career attesting to your good character, professionalism and high standards of practice, including your kindness to patients, compassion and dedication.
- The incidents could therefore be regarded as out of character within an otherwise excellent and well-regarded nursing career.
- The incidents took place within a contributory context of significant pressures in the

workplace environment at the time, including the demanding clinical environment, staffing pressures, high levels of agency staff, you being the only registered nurse on shift, and the effects of the COVID-19 pandemic on the Ward and on you personally.

- You have demonstrated significant remorse and have undertaken training relevant to the areas of concern to strengthen your practice.
- You have demonstrated some insight although this requires further development.
- You have demonstrated yourself willing to take further steps to strengthen your practice.

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 residual risks identified at the previous stage. To impose no order would be insufficient to protect the public or to satisfy the wider public interest considerations in this case.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the ongoing public protection issues identified, an order that does not restrict your practice would not be appropriate. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that the imposition of a caution order would neither be sufficient to protect the public nor to satisfy the wider public interest considerations in this case.

The panel next considered whether a conditions of practice order on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel found that the misconduct in your case was remediable, and noted that you have already taken steps to address some of the concerns identified and strengthen your practice to date. The panel determined that it would be possible to formulate appropriate and workable conditions which would address the failings highlighted in this case while protecting the public.

You have demonstrated during these proceedings a willingness to engage with the NMC and to take further steps to strengthen your practice, and a strong desire to return to safe practice. The panel had regard to your years of commitment and dedication to the profession, and to the period of clinical practice without incident which occurred after these incidents occurred. It also had regard to the extremely positive references about your high standards of professionalism and clinical practice prior to and subsequent to these events. It bore in mind the significant remorse you have demonstrated, together with your understanding of how you should have acted and your developing insight into your actions.

In all the circumstances, the panel considered that it would be in the public interest to enable an experienced, competent, committed and well-regarded nurse with developing insight into her failings the opportunity to address the concerns identified in the context of suitable supervision and monitoring. This is in order to enable a return to safe practice. The panel was therefore confident that you will comply with any appropriate conditions imposed on your practice, and determined that such an order would not only serve the public interest, but also sufficiently protect the public.

The panel was satisfied, given the low risk of repetition, that a conditions of practice order would be effective to protect the public while you take the further steps required of you to develop your insight and remedy your past failings. It also considered that in the circumstances of this case, such an order would be sufficient to satisfy the wider public interest considerations in this case, marking the seriousness of your actions, ensuring that professional standards are upheld, and upholding public confidence in the profession.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be disproportionate and unduly punitive in the circumstances of your case. This is because the risks identified are capable of being sufficiently managed by conditions on your practice, and you have indicated that you are willing to work on strengthening your practice whilst working under conditions. The panel was mindful that the incidents in this case were very serious. However, they were entirely out of character with your normal practice. The panel noted that a considerable period has elapsed since these events. During that period you have taken the opportunity to demonstrate a sustained period of eight months of practice without further incident, and have taken further steps to strengthen your practice even when you were no longer able to work. You have demonstrated your commitment to strengthening your practice and ensuring that further regulatory concerns do not recur. The panel has found that you are unlikely to repeat your actions and you have shown your determination to returning to the safe and dedicated practice which you have demonstrated at all other times in your professional career.

On this basis, the panel determined that a period of suspension at this time would serve no purpose. It further considered that your actions were not incompatible with remaining on the register, and that striking you off the register would be wholly disproportionate.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order would be sufficient to mark the seriousness of your actions, address the

ongoing risks identified, uphold professional standards, maintain public confidence in the profession, and send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. *You must restrict your practice to one substantive employer. This must not be an agency.*

2. *You must neither be the nurse in charge of a shift, or the sole nurse on duty during a shift at any time.*

3. *You must ensure that you are indirectly supervised. Your supervision must consist of working at all times on the same shift as, but not always directly observed by, another registered nurse.*

4. *You must work with your line manager, mentor or supervisor to create a personal development plan (PDP). Your PDP must address the following areas:*
    - *Integrity;*
    - *Duty of candour;*
    - *Responding to challenging behaviour; and*
    - *Effective communication with patients and colleagues.*

    You must provide a copy of this PDP to your NMC case officer prior to any review hearing. This report must show your progress towards achieving the aims set out in your PDP.

5. *You must meet with your line manager, mentor or supervisor on a monthly basis to discuss your performance and conduct, as well as your progress with your PDP, in particular in relation to the following areas:*
    - *Integrity;*
    - *Duty of candour;*
    - *Responding to challenging behaviour; and*
    - *Effective communication.*

6. *You must provide a report from your line manager, mentor or supervisor commenting on your conduct and performance generally, and with specific reference to the following areas:*
    - *Integrity;*
    - *Duty of candour;*
    - *Responding to challenging behaviour; and*
    - *Effective communication.*

    You must provide a copy of this report to your NMC case officer prior to any review hearing.

7. *You must maintain a reflective log in relation to your clinical practice, providing your ongoing reflections on any incidents which arise which relate to the issues identified in this case and to the areas identified in your PDP. You must also produce a reflective statement, setting out your further reflections on, and insight into, the events giving rise to these proceedings.*

    You must provide a copy of both the reflective log and the reflective statement to your NMC case officer prior to any review hearing.

8. *You must keep the NMC informed about anywhere you are working by:*

a) *Telling your NMC case officer within seven days of accepting or leaving any employment.*
b) *Giving your NMC case officer your employer's contact details.*

9. *You must keep the NMC informed about anywhere you are studying by:*
   a) *Telling your NMC case officer within seven days of accepting any course of study.*
   b) *Giving your NMC case officer the name and contact details of the organisation offering that course of study.*

10. *You must immediately give a copy of these conditions to:*
    a) *Any organisation or person you work for.*
    b) *Any employers you apply to for work (at the time of application).*
    c) *Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.*

11. *You must tell your NMC case officer, within seven days of your becoming aware of:*
    a) *Any clinical incident you are involved in.*
    b) *Any investigation started against you.*
    c) *Any disciplinary proceedings taken against you.*

12. *You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:*
    a) *Any current or future employer.*
    b) *Any educational establishment.*

c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 18 months. The panel considers that this will allow sufficient time for you to secure employment and then demonstrate a sustained period of safe and effective practice while you are carefully monitored and supervised. It will also allow you a sufficient period to achieve the further development required in your levels of insight. The panel considered, given the seriousness of your actions, that a shorter period would be insufficient to satisfy the public interest considerations in this case.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted, whether or not you have succeeded in securing work in a nursing capacity by the time of a review, by:

- References or testimonials from paid and/or unpaid employment, whether in a nursing role or in any other role in a healthcare setting or elsewhere, attesting to your character and nursing practice; and
- A reflective piece demonstrating your insight into these incidents.

This decision will be confirmed to you in writing.

Interim order

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

Submissions on interim order

Mr Lee submitted that following the panel's decision to impose a substantive order, this decision procedurally will not take effect until after the 28-day appeal period. He submitted that it is the NMC's position that an interim order is necessary to cover this appeal period and to protect the public during this time.

Mr Lee submitted that the NMC is seeking the imposition of an interim conditions of practice order, on the same terms as the substantive conditions of practice order, on the grounds of public protection and in the public interest.

Ms Shah submitted that she had no objections to the imposition of the interim conditions of practice order as proposed by the NMC.

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 nature 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 interim suspension order would not be appropriate in this case, due to the reasons already identified in the panel's determination for imposing a substantive order. The panel therefore decided to impose an interim conditions of practice order, on the same terms as the substantive conditions of practice order, for a period of 18 months, on the grounds of public protection and public interest. The panel determined that this would ensure that the public is suitably protected during the appeal period.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.