Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 8 April 2024 – Friday, 12 April 2024
Monday, 15 April 2024 – Friday, 19 April 2024
Monday, 22 April 2024 - Tuesday, 23 April 2024

Virtual Hearing

Name of Registrant:	Violet Yvonne Horsford
NMC PIN	01C2189E
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nursing – 26 April 2006
Relevant Location:	West Midlands
Type of case:	Misconduct
Panel members:	Caroline Rollitt (Chair, Lay member) Dorothy Keates (Registrant member) Margaret Jolley (Lay member)
Legal Assessor:	John Moir
Hearings Coordinator:	Stanley Udealor
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Mrs Horsford:	Not present and not represented at the hearing
Facts proved:	Charges 1a, 1b, 1c, 1d, 2a, 2b, 3f, 6a and 6b
Facts not proved:	Charges 1e, 2c, 2d, 2e, 2f, 2g, 3a, 3b, 3c, 3d, 3e, 3g, 4 and 5
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Horsford was not in attendance and that the Notice of Hearing letter had been sent to Mrs Horsford's registered email address by secure email on 8 March 2024.

Mr Radley, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Horsford's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Horsford has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Horsford

The panel next considered whether it should proceed in the absence of Mrs Horsford. It had regard to Rule 21 and heard the submissions of Mr Radley who invited the panel to continue in the absence of Mrs Horsford.

Mr Radley informed the panel that several attempts have been made by the NMC to contact Mrs Horsford but there has been no response from her. He stated that the Hearings Coordinator had sent the virtual hearing link to Mrs Horsford on 5 April 2024 and

had also attempted to contact her via emails and telephone calls on the first day of the hearing but to no avail. Mr Radley submitted that the panel could grant further time to see if Mrs Horsford could join the hearing, but this is a matter for the panel's own judgement.

Mr Radley submitted that the NMC had sent all relevant documentation with regards to these proceedings to Mrs Horsford and the panel had decided that she had been served with the Notice of Hearing in accordance with Rules 11 and 34. He highlighted that Mrs Horsford had initially engaged with the NMC and completed her Case Management Form (CMF), therefore, she was aware of the regulatory concerns against her nursing practice.

Mr Radley submitted that there is a strong public interest in the expeditious disposal of the case as the charges relate to events that occurred in 2018. He concluded that it is fair and in the public interest for the hearing to proceed in the absence of Mrs Horsford.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Horsford. In reaching this decision, the panel has considered the submissions of Mr Radley and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Although Mrs Horsford had initially engaged with the NMC and completed the CMF, she has not responded to any of the NMC emails and telephone calls in relation to joining the hearing;

- The panel had given sufficient time for Mrs Horsford to join the hearing and she has not joined the hearing;
- No application for an adjournment has been made by Mrs Horsford;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses are scheduled to give live evidence;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018 and further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Horsford in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, Mrs Horsford will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Horsford's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Horsford. The panel will draw no adverse inference from Mrs Horsford's absence in its findings of fact.

Details of charge

That you, a registered nurse, *whilst working at Jubilee Care Home,* during the night shift of 27 October 2018:

1) In relation to Resident A:

   a) Grabbed Resident A by the shoulder to move her out of a chair;

   b) Held Resident A by her waist and / or pulled her;

   c) Held Resident A by the wrist(s) and / or dragged her to a settee;

   d) Pushed and / or shoved Resident A onto a settee on one, or more, occasions;

   e) Struck and / or made contact with Resident A's face with your hand;

2) In relation to Resident A said / used words to the effect of the following:

   a) "Get out of the chair" on one or more occasion;

   b) "What the hell are you doing";

   c) "Shut ya mouth";

   d) "Who do you think you are talking to, if you think you can talk to me like that on the road you know what will happen";

   e) "If she was on the street she would knock resident out";

   f) "If you were in my house…. I would beat you";

g) *“For god sake [Resident A], stop crying. You’re not a child you’re grown up”;*

3) Acted / behaved in the following way:

   a) Said to Resident A *“don’t even think about getting on that chair”,* or words to that effect;

   b) Threatened to call the police;

   c) Mimicked the way Resident A spoke;

   d) Kicked the footrest from under the chair where Resident A was seated;

   e) Shouted at Resident B to get back in a seat and/or not to leave the seat;

   f) Said words to the effect that if Resident B gets off the chair you will go in there to take the piss;

   g) Went to Resident A’s room and shouted at her following the earlier incident referred to in charge 1.

4) Instructed Colleague 1 to leave Resident B in Resident A’s seat and / or not remove Resident B from Resident A’s seat;

5) Instructed Colleague 2 not to give Resident A their food and / or drink and / or to remove their food and / or drink

6) Did not make a record of the matters referred to in any and / or all, of the above charges in an incident report:

a) Immediately following the incident;

b) Promptly or at all

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

Background

The charges arose whilst Mrs Horsford was employed as a registered nurse by Select Healthcare Group at Jubilee Court Care Home (the Home). On 17 December 2018, Mrs Horsford was referred to the NMC by the Clinical Lead of Select Healthcare Group.

The Home is a neuro-rehabilitation centre with a capacity for twenty-five residents. It manages residents with brain injuries, physical disabilities, learning difficulties and Huntington's disease.

The referral alleged that on 27 October 2018, Mrs Horsford worked a night shift as the nurse in charge and sole nurse on duty at the Home. It was alleged that during that night shift, Resident B was sitting on a seat allegedly allocated to Resident A (a resident with Huntington's disease), which made the resident upset. Resident C allegedly asked Resident B to move to another seat which Resident B agreed and moved to. However, it was alleged that Mrs Horsford was angry with the change of seats between Residents A and B. Mrs Horsford allegedly shouted at Resident A to leave the seat and proceeded to aggressively move Resident A from the seat whilst shouting and handling Resident A in an inappropriate and threatening manner. As a result, Resident A allegedly punched Mrs Horsford and also used inappropriate language towards her. It was further alleged that Mrs Horsford did not record the incident in an incident report in accordance with the Home's policy.

The Home conducted an initial investigation which included a fact-finding meeting with Mrs Horsford on 1 November 2018 and meetings with other staff in late October/early November 2018.

The incident involving Resident A was reported to the police, however, the police case was closed without any further action taken, due to insufficient evidence. Mrs Horsford thereafter resigned from the Home on 20 November 2018.

The Home conducted a disciplinary hearing on 29 November 2018 in which it was determined that had Mrs Horsford not already resigned on 20 November 2018, she would have been dismissed for gross misconduct.

Mrs Horsford appealed the decision of the disciplinary hearing but it was upheld on 11 January 2019.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Radley under Rule 31 to admit the witness statements of Resident A, Colleagues 2 and 3 into evidence. Mr Radley submitted that the witnesses as outlined above, were unable or unwilling to attend the hearing to give evidence in these proceedings.

Mr Radley referred the panel to Rule 31(1) and submitted that it was an established fact that a panel could determine the evidence it allows before it subjects to the test of relevance and fairness. He further referred the panel to the case of *El Karout v NMC* [2019] EWHC 28 (Admin) in which the court emphasised that a panel should consider the admissibility of a hearsay statement first before the question of weight and this did not mean that a hearsay statement cannot be relied upon.

Mr Radley submitted that unlike the witnesses in the case of *El Karout,* Colleagues 2 and 3 had provided witness statements while with respect to Resident A, the NMC had applied

due diligence in obtaining the best evidence from her, given her health condition at that time. He further referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). He highlighted that this case laid out the following factors to be considered in admitting hearsay evidence:

(i) *'Whether the statements are the sole or decisive evidence in support of the charges*
(ii) *The nature and extent of the challenge to the contents of the statements*
(iii) *Whether there was any suggestion that the witnesses had reasons to fabricate their allegations*
(iv) *The seriousness of the charge, taking into account the impact which adverse findings might have on the Registrant's career*
(v) *Whether there is a good reason for the non-attendance of the witness*
(vi) *Whether the NMC have taken reasonable steps to secure attendance*
(vii) *Whether the Registrant had prior knowledge that the witness statements were to be read'*

With regards to the witness statement of Resident A, Mr Radley submitted that Resident A was the subject of the charges and therefore her witness statement was relevant in this case. He submitted that the witness statement of Resident A was not the sole and decisive evidence as there was other evidence (as outlined in the NMC Evidence Matrix) that supports her allegations.

Mr Radley highlighted that Witness 3 had stated during her oral evidence that she knew Resident A well and that although Resident A had suffered from a compulsive behaviour as part of her Huntington's disease, she had full capacity at the time of the incident. She also stated that there was no evidence of "*bad blood"* between Mrs Horsford and Resident A.

Mr Radley further highlighted that Witness 3 had directed Witness 2 to obtain a statement from Resident A and to support Resident A during her interview by the NMC appointed

Solicitors. He stated that Witness 2 confirmed that she had written the handwritten statement on behalf of Resident A. She also assisted Resident A, when she was being interviewed by the NMC appointed Solicitors, to complete the questionnaire and this subsequently led to the typed witness statement being prepared on behalf of Resident A.

Mr Radley submitted that although the witness statement of Resident A was unsigned, the chronology of the production of the witness statement as well as the live evidence of Witnesses 2 and 3, supports the assertion that the witness statement of Resident A was her true personal account. He submitted that there was no suggestion of collusion or that there was a fabrication of the witness statement. He asserted that the fact that the statement of Resident A was not signed, was merely one factor in the test to prove the authenticity of the document.

Mr Radley therefore invited the panel to admit the witness statement of Resident A into evidence.

In relation to the witness statement of Colleague 3, Mr Radley submitted that [PRIVATE]. [PRIVATE].

Mr Radley submitted that the witness statement of Colleague 3 was, in part, supportive of Mrs Horsford's defence. He submitted that the test in the case of Thorneycroft was therefore met in this regard. He invited the panel to admit the witness statement of Colleague 3 on the basis of fairness and balance.

With respect to the witness statement of Colleague 2, Mr Radley submitted that Witness 3 had confirmed during her oral evidence that Colleague 2 was no longer working at the Home and was not aware of her current employment status. He stated that the NMC had tried severally to contact Colleague 2 but to no avail. He submitted that the NMC had taken all reasonable options to secure the attendance of Colleague 2 but had not been unsuccessful in this regard.

Mr Radley submitted that the witness statement of Colleague 2 was not the sole and decisive evidence in support of the charges and there was no suggestion that Colleague 2 had fabricated her witness statement. He submitted that that the charges in this case were serious but Mrs Horsford had voluntarily absented herself. Mr Radley therefore invited the panel to admit the witness statement of Colleague 2 into evidence.

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.

The panel considered the hearsay application.

With respect to the witness statement of Resident A, the panel noted that the witness statement was not signed nor attested to, by Resident A. The panel took into account that Witness 2 stated during her oral evidence that she assisted Resident A in giving her account of the incident to the NMC appointed Solicitors which led to the production of the witness statement of Resident A. This was corroborated by Witness 3. However, both witnesses could not provide a reason as to why the witness statement of Resident A was unsigned and unattested to, by Resident A, when asked by the panel.

The panel had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence. The panel noted that the witness statement of Resident A was not the sole and decisive evidence in support of the charges except for charge 1e. It took into account that the NMC had notified Mrs Horsford in her completed CMF that the witness statement of Resident A would be tendered into evidence and she had challenged the contents of the witness statement by denying its accuracy. However, the panel was satisfied that there was no suggestion that Resident A had any reason to fabricate the allegations.

The panel considered the charges to be serious as they involved the alleged manhandling and mistreatment of a vulnerable resident and any adverse finding could have a negative impact on the nursing career of Mrs Horsford. The panel noted that there was a good reason for the non-attendance of Resident A as it considered that Resident C, Witnesses 2 and 3 had respectively confirmed during their oral evidence that Resident A had passed away.

Having considered these factors, the panel determined that it was relevant and fair to admit the witness statement of Resident A into evidence. It was of the view that although the witness statement of Resident A was unsigned and unattested, it was fair to admit the witness statement into evidence given that Resident A was the alleged victim of the regulatory concerns and it was impossible to secure her attendance at the hearing. However, the panel would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it. It would not consider the witness statement of Resident A as evidence in its finding of facts with respect to charge 1e.

In relation to the witness statement of Colleague 3, the panel took into account that [PRIVATE]. [PRIVATE].

The panel noted that the witness statement of Colleague 3 was not the sole and decisive evidence in support of the charges and was, in part, supportive of Mrs Horsford's defence. The panel took into account that the NMC had notified Mrs Horsford in her completed CMF that the witness statement of Colleague 3 would be tendered into evidence and she indicated that she accepted the contents of the witness statement. Therefore, the panel was satisfied that there was no suggestion that Colleague 3 had any reason to fabricate her witness statement. The panel also considered the charges to be serious as they involved the alleged manhandling and mistreatment of a vulnerable resident and any adverse finding could have a negative impact on the nursing career of Mrs Horsford.

In these circumstances, the panel determined that it was relevant and fair to admit the witness statement of Colleague 3 into evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

With regard to the witness statement of Colleague 2, the panel noted that the witness statement of Colleague 2 was not the sole and decisive evidence in support of the charges except for charges 2f and 5. It noted that Colleague 2 had stated in her witness statement that she was not physically present at the lounge during a substantial part of the incident and had only heard shouting from the lounge.

The panel took into account that the NMC had notified Mrs Horsford in her completed CMF that the witness statement of Colleague 2 would be tendered into evidence and she had challenged the contents of the witness statement by denying its accuracy. The panel noted that Mrs Horsford had suggested that Colleague 2 may have had reason to fabricate her evidence as she has had a previous altercation with Colleague 2. The panel considered the charges to be serious as they involved the alleged manhandling and mistreatment of a vulnerable resident and any adverse finding could have a negative impact on the nursing career of Mrs Horsford.

The panel considered the submissions of Mr Radley that several attempts have been made by the NMC to contact Colleague 2 to attend the hearing but there has been no response from her. However, the panel was not satisfied that the NMC had taken all reasonable steps to secure the attendance of Colleague 2 at the hearing. It was of the view that there were other steps that the NMC could have taken such as obtaining a Court Summons. The panel noted that there was no evidence before it that suggest any cogent reason for the non-attendance of Colleague A at the hearing.

In these circumstances, the panel determined that it was unfair to admit the witness statement of Colleague 2 into evidence as Mrs Horsford would be disadvantaged by the change in the NMC's position from reliance upon the live testimony of Colleague 2 to her written statement. It also prevented the panel from questioning Colleague 2 in relation to

her evidence. The panel concluded that it would not be possible to sufficiently mitigate the unfairness posed to Mrs Horsford by relying on the evidence of the live witnesses. Accordingly, the hearsay application is refused with respect to the witness statement of Colleague 2.

Decision and reasons on application for direction to secure the attendance of Colleague 1 at the hearing

Mr Radley made an application inviting the panel to make a direction that Colleague 1 should attend the hearing to give evidence on Wednesday, 17 April 2024 at 10:00.

Mr Radley gave a background of the application. He stated that Colleague 1 was scheduled to attend the hearing on 10 and 11 April 2024 to give evidence on behalf of the NMC. Despite numerous attempts by the NMC to contact her to join the hearing on the scheduled dates, there was no response from her. Colleague 1 later contacted the NMC to indicate that she would be available to give evidence on 12 April 2024 at 14:00. However, when contacted by the Hearings Coordinator to join the hearing on 12 April 2024 as scheduled, Colleague 1 indicated that [PRIVATE] and could not attend the hearing. She further stated that she may be available in the '*middle of the next week*'. On day 6 of the hearing, the NMC contacted Colleague 1 to confirm her availability to attend the hearing, however, [PRIVATE].

Mr Radley submitted that it is within the powers of the panel to make any direction necessary to secure the attendance of a witness and to give evidence in a hearing. He suggested that such direction could serve as a decisive and persuasive tool to encourage Colleague 1 to attend the hearing. Mr Radley submitted that it was not expedient for the NMC to apply for a Court Summons given the limited schedule for these proceedings and such application could lead to this hearing going part heard. This would not serve the public interest for the expeditious disposal of this case.

Mr Radley submitted that a direction was necessary as it may be difficult to persuade the panel to admit Colleague 1's witness statement into evidence as hearsay. This was due to the fact that Colleague 1's witness statement seems to be the sole and decisive evidence in relation to two charges in this case. He further submitted that it was important for the NMC to secure the attendance of Colleague 1 in order to utilise all available witnesses necessary to prove its case and in furtherance of its overriding duty to protect the public.

Mr Radley concluded that the NMC was ready to provide such necessary measures to support Colleague 1 to attend the hearing and give evidence on its behalf.

The panel accepted the advice of the legal assessor.

The panel took into account that despite numerous attempts by the NMC to contact Colleague 1 to join the hearing and give evidence on its behalf, Colleague 1 has not attended the hearing. The panel bore in mind that the hearing was scheduled for twelve days and it had given several date extensions to Colleague 1 to enable her to attend the hearing. However, the panel noted that it does not have the power to compel a witness to attend a hearing especially in the particular circumstances of this case [PRIVATE]. Conversely, the panel has the powers to make directions to the NMC.

The panel therefore directed the NMC to secure the attendance of Colleague 1 at the hearing on Wednesday 17 April 2024 at 10:00. It also directed the NMC to provide such measures necessary to support Colleague 1 to give evidence at the hearing. If Colleague 1 is not available at the panel's directed time, the case would proceed in her absence.

Day 8 of the hearing

Colleague 1 was not present at 10:00 on Wednesday, 17 April 2024. Mr Radley therefore made an application to admit her witness statement into evidence.

Decision and reasons on application to admit Colleague 1's witness statement into evidence

The panel heard an application made by Mr Radley under Rule 31 to admit the witness statement of Colleague 1 into evidence. He submitted that despite several attempts to secure the attendance of Colleague 1 at the hearing as well as the panel's direction for the NMC to secure her attendance, Colleague 1 has not attended the hearing.

Mr Radley referred the panel to the case of *El Karout* and the factors to be considered in admitting hearsay evidence as set out in the case of *Thorneycroft.* He submitted that although the witness statement of Colleague 1 was the sole and decisive evidence with respect to charges 2g, 3c and 4, the panel should consider that other aspects of her witness statement corroborate the evidence of other witnesses in this case. He highlighted that in paragraph eleven of Colleague 1's statement, particularly line six, there were some comments that have been made by her that are prejudicial and not supported by the charges in these proceedings, and therefore, the NMC would not rely upon that evidence. He invited the panel to disregard such prejudicial statement in its consideration of the evidence in this case.

Mr Radley submitted that the NMC have taken reasonable steps to secure the attendance of Colleague 1. He referred the panel to the NMC Communication Bundle in relation to Colleague 1 and submitted that it would appear that Colleague 1 had chosen not to attend the hearing despite assurances given by the NMC to support her during the course of her evidence.

Mr Radley therefore invited the panel to admit the witness statement of Colleague 1 into evidence.

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.

The panel considered the hearsay application.

The panel had regard to the case of *Thorneycroft* which laid out the factors to be considered in admitting hearsay evidence. The panel noted that the witness statement of Colleague 1 was not the sole and decisive evidence in support of the charges except for charges 2g, 3c and 4. It noted that Colleague 1 was not physically present in the lounge during the duration of the incident but only encountered the aftermath of the incident.

The panel took into account that the NMC had notified Mrs Horsford in her completed CMF that the witness statement of Colleague 1 would be tendered into evidence and she had challenged the contents of the witness statement by denying its accuracy. The panel noted that Mrs Horsford had suggested that Colleague 1 may have had reason to fabricate her evidence as she had a previous altercation with Colleague 1, two weeks prior to the incident. The panel considered the charges to be serious as they involved the alleged manhandling and mistreatment of a vulnerable resident and any adverse finding could have a negative impact on the nursing career of Mrs Horsford.

The panel considered the submissions of Mr Radley that several unsuccessful attempts have been made by the NMC to contact Colleague 1 to attend the hearing. In this regard, the panel took account of the NMC Communication Bundle in relation to Colleague 1. The panel noted that [PRIVATE] and although, the NMC had expressed its readiness to support her during the course of her evidence, she has not attended the hearing. The panel also considered that it would not be expedient for the NMC to obtain a Court Summons to secure Colleague 1's attendance due to the limited time schedule for the case and [PRIVATE].

Therefore, the panel was satisfied that the NMC had taken all reasonable steps to secure the attendance of Colleague 1 at the hearing and there was sufficient evidence to explain Colleague 1's non-attendance at the hearing.

In these circumstances, the panel determined that it was relevant and fair to admit the witness statement of Colleague 1 into evidence. However, the panel would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it. It would not consider the witness statement of Colleague 1 as evidence in its finding of facts with respect to charges 2g, 3c and 4.

Decision and reasons on facts

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 Radley and Mrs Horsford's Final Registrant Response Bundle.

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

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:

- Resident C/Witness 1: Service user at the Home.
- Witness 2: Senior support worker at the Home at the time of the incident.
- Witness 3: Registered manager of the Home.

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

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

Charge 1a

1) In relation to Resident A:

    a) Grabbed Resident A by the shoulder to move her out of a chair;

This charge is found proved.

The panel took account of the witness statement of Resident C dated 7 October 2019, in which he stated:

> *'Following this, I recall that the Registrant kicked A (Resident A)'s foot rest, which is attached to her chair, out of the way and then grabbed A (Resident A) by her right shoulder and dragged her up out of the chair…..I recall seeing that A (Resident A) tried to sit back down, but A (Resident A) grabbed her by the shoulder again and pulled her up, causing A to be on her feet…'*

The panel considered Mrs Horsford's response to the charge, in her completed CMF, in which she denied the allegation. She stated:

> *'I deny grabbing the resident A by the shoulder to move her out the chair. She independently stood up and punched me in the chest…'*

The panel took into account that in his handwritten statement made to the Home, dated 27 October 2018, Resident C stated that Mrs Horsford had grabbed Resident A by her right shoulder to drag her from the chair. The panel noted that Resident C was present throughout the incident and his handwritten statement was a contemporaneous account of

the incident made after the incident. It further noted that Resident C confirmed this account in his oral evidence to the panel.

The panel was of the view that Resident C was clear and consistent in his oral and documentary evidence that Mrs Horsford had grabbed Resident A by the shoulder to move her out of a chair and the panel found no reason to doubt the credibility of Resident C's account. It therefore accepted his account.

Having considered the evidence before it, the panel was satisfied on the balance of probabilities, it was more likely than not, that during the night shift on 27 October 2018, Mrs Horsford had grabbed Resident A by the shoulder to move her out of a chair. Accordingly, the panel determined that charge 1a is found proved.

Charge 1b

1) In relation to Resident A:

    b) Held Resident A by her waist and / or pulled her;

This charge is found proved.

The panel took account of the witness statement of Resident A in which she stated:

> *'I refused to move because the chair was my chair, and I told the Registrant that it was my chair. Following this, the Registrant pulled me out of the chair by holding my waist and pulling me on to my feet…'*

The panel took into account the witness statement of Colleague 3 dated 23 August 2019 in which she stated:

> *'The next thing I recall was that Resident A looked as though she was going to fall over and the Registrant brought a chair towards Resident A and made Resident A*

sit in the chair. By this I mean that the Registrant placed her hands on Resident A's waist and made her sit in the chair…'

The panel noted that Mrs Horsford did not respond to this charge in her CMF and written account of the incident dated 26 December 2019.

The panel took into consideration that Witness 2 stated during her oral evidence that she assisted Resident A in giving her account of the incident to the NMC appointed Solicitors which led to the production of the witness statement of Resident A. This was corroborated by Witness 3. The panel noted that although the witness statement of Resident A was unsigned and unattested, it had earlier determined that it was fair to admit it into evidence given that Resident A was the alleged victim of the incident and it was impossible to secure her attendance at the hearing.

The panel also considered that Resident A's account of this incident was corroborated by Colleague 3 in her witness statement. Although Colleague 3's witness statement could be regarded as hearsay, [PRIVATE]. Therefore, the panel accepted the accounts of Resident A and Colleague 3 that Mrs Horsford had held Resident A by her waist and / or pulled her.

Having considered the evidence before it, the panel was satisfied on the balance of probabilities, it was more likely than not, that during the night shift on 27 October 2018, Mrs Horsford held Resident A by her waist and / or pulled her. Accordingly, the panel determined that charge 1b is found proved.

Charges 1c and 1d

1) In relation to Resident A:

    c) Held Resident A by the wrist(s) and / or dragged her to a settee;
    d) Pushed and / or shoved Resident A onto a settee on one, or more, occasions;

These charges are found proved.

The panel considered the witness statement of Resident A in which she stated:

> '*The Registrant held me by the wrists and dragged me over to the settee, and then pushed me on to the settee…'*

The panel took account of the witness statement of Resident C dated 7 October 2019, in which he stated:

> *'…The Registrant then pulled A (Resident A) to the settee in a rough/angry manner and was holding A (Resident A) by the arms….Once at the settee, the Registrant then pushed A (Resident A) down on to the settee. I recall that the Registrant shoved Resident A hard when pushing her on to the settee…'*

The panel considered Mrs Horsford's response to the allegation, in her written statement made to the Home after the incident, dated 1 November 2018, in which she denied the allegation. She stated:

> *'….I held both of resident A's wrists partly to stabilise her as well and guided her to the settee next to me where she was seated…'*

The panel took into account that Mrs Horsford confirmed her account in her completed CMF. The panel bore in mind that it had earlier determined that it was fair to admit Resident A's witness statement into evidence. It noted that both Resident A and Mrs Horsford confirmed in their respective statements that Mrs Horsford had held Resident A by her wrists. However, Mrs Horsford stated that she only guided Resident A to the settee while Resident A asserted that Mrs Horsford had dragged and pushed her on to the settee. The panel further noted that while there was no corroboration of Mrs Horsford's account of the incident, Resident C, who was also present throughout the incident, corroborated the account of Resident A that Mrs Horsford had *'pulled', 'pushed'* and

'shoved' Resident A on to the settee. Resident C was also clear and consistent in his oral and documentary evidence in his account of the incident. In this regard, the panel accepted the accounts of Residents A and C.

Having considered the evidence before it, the panel was satisfied on the balance of probabilities, it was more likely than not, that during the night shift on 27 October 2018, Mrs Horsford held Resident A by her wrist(s) and dragged, pushed or shoved her onto a settee on one or more occasions. Accordingly, the panel determined that charges 1c and 1d are found proved.

Charge 1e

1) In relation to Resident A:

    e) Struck and / or made contact with Resident A's face with your hand;

This charge is found NOT proved.

The panel took into account that the sole evidence adduced by the NMC in support of this charge was Resident A's account of the incident in her witness statement. The panel bore in mind that it had earlier determined that it would not consider the witness statement of Resident A as evidence in its finding of facts with respect to charge 1e.

Therefore, in the absence of any other evidence to support this charge, the panel determined that charge 1e is found not proved.

Charge 2a

2) In relation to Resident A said / used words to the effect of the following:

    a) *"Get out of the chair"* on one or more occasion;

This charge is found proved.

The panel took account of the witness statement of Resident C dated 7 October 2019, in which he stated:

> *'…Following this, the Registrant stated to A (Resident A) "get out of the chair….". From my recollection, the Registrant sounded very angry and appeared to be absolutely fuming with A (Resident A). The Registrant then shouted "get out of the chair!" in a deep and angry voice; …..'*

The panel took into account that during the interview between the NMC appointed Solicitors and Resident A (assisted by Witness 2) in January 2019, when asked whether Mrs Horsford shouted at her to get out of the chair, Resident A confirmed that Mrs Horsford shouted at her. The panel noted that this account was not included in the witness statement of Resident A.

The panel considered Mrs Horsford's response to the charge, in her completed CMF, in which she denied the allegation. She stated:

> *'I did not use any of those words relayed in section 2, I struggle with the meanings and terminology when I read them and they aren't in my vocabulary. In no certain terms was I verbally abusive or caused any distress to resident A. I'm a practicing Christian and on many occasions, I've been in the position of asking staff members to tone down their language. It is not within my nature to use that form of language, in my 4 and a half years of working with the establishment I have never been accused of such behaviour.'*

The panel took into account that in his handwritten statement made to the Home, dated 27 October 2018, Resident C stated that Mrs Horsford had said to Resident A *"Get out of the chair"*. The panel noted that Resident C was present throughout the incident and his handwritten statement was a contemporaneous account of the incident made after the

incident. It further noted that Resident C confirmed this account in his oral evidence to the panel.

The panel was of the view that Resident C was clear and consistent in his oral and documentary evidence that Mrs Horsford had said to Resident A *"Get out of the chair"*. The panel found no reason to doubt the credibility of Resident C's account. It therefore accepted his account.

Having considered the evidence before it, the panel was satisfied on the balance of probabilities, it was more likely than not, that during the night shift on 27 October 2018, Mrs Horsford had said/used words to the effect *"Get out of the chair"* on one or more occasion, in relation to Resident A. Accordingly, the panel determined that charge 2a is found proved.

Charge 2b

2) In relation to Resident A said / used words to the effect of the following:

b) *"What the hell are you doing";*

This charge is found proved.

The panel took account of the witness statement of Resident C dated 7 October 2019, in which he stated:

> *'… I recall that the Registrant shouted "what the hell are you doing (Resident A)! I told you B (Resident B) was not to move"…..'*

The panel considered Mrs Horsford's response to the charge, in her completed CMF, in which she denied the allegation. She stated:

'I did not use any of those words relayed in section 2, I struggle with the meanings and terminology when I read them and they aren't in my vocabulary. In no certain terms was I verbally abusive or caused any distress to resident A. I'm a practicing Christian and on many occasions, I've been in the position of asking staff members to tone down their language. It is not within my nature to use that form of language, in my 4 and a half years of working with the establishment I have never been accused of such behaviour.'

The panel took into account that in his handwritten statement made to the Home, dated 27 October 2018, Resident C stated that Mrs Horsford had shouted at Resident A, saying *"What the hell you doing"*. The panel noted that Resident C was present throughout the incident and his handwritten statement was a contemporaneous account of the incident made after the incident. It further noted that Resident C confirmed this account in his oral evidence to the panel.

The panel was of the view that Resident C was clear and consistent in his oral and documentary evidence that Mrs Horsford had said to Resident A *"What the hell you doing"*. The panel found no reason to doubt the credibility of Resident C's account. It therefore accepted his account.

Having considered the evidence before it, the panel was satisfied on the balance of probabilities, it was more likely than not, that during the night shift on 27 October 2018, Mrs Horsford had said/used words to the effect *"What the hell you doing"* in relation to Resident A. Accordingly, the panel determined that charge 2b is found proved.

Charge 2c

2) In relation to Resident A said / used words to the effect of the following:

   c) *"Shut ya mouth";*

This charge is found NOT proved.

The panel took account of the witness statement of Resident C dated 7 October 2019, in which he stated:

> *'… I believe that the Registrant then walked away from A (Resident A) and told A (Resident A) to "shut ya mouth". I believe that the Registrant also told (Colleague 3) to tell A to shut up. The Registrant was still speaking in a very angry tone , and in fact shouted "shut ya mouth" to A (Resident A) from across the room, as the Registrant was standing near the medication trolley near the entrance to the lounge at this time. A (Resident A) responded "no you shut yours"…'*

The panel took into account that Colleague 3 had stated in her witness statement dated 23 August 2019 that:

> *'After I separated Resident A and the Registrant, they were both shouting at each other and I recall Resident A swearing and shouting and calling the Registrant names. I don't recall the specifics of what either the Registrant or Resident A were saying, but I do not recall the Registrant using any abusive or aggressive language towards Resident A. From my recollection, the Registrant was telling Resident A that it was not right of her to be behaving in the manner which she was behaving and seemed to be trying to calm the situation down…'*

The panel considered Mrs Horsford's response to the charge, in her completed CMF, in which she denied the allegation. She stated:

> *'I did not use any of those words relayed in section 2, I struggle with the meanings and terminology when I read them and they aren't in my vocabulary. In no certain terms was I verbally abusive or caused any distress to resident A. I'm a practicing Christian and on many occasions, I've been in the position of asking staff members to tone down their language. It is not within my nature to use that form of*

language, in my 4 and a half years of working with the establishment I have never been accused of such behaviour.'

The panel considered the circumstances at the time of the alleged incident. It noted that Colleague 3 was not present in the beginning of the incident in which Mrs Horsford had removed Resident A from the chair and had shouted some words to her, which the panel had earlier found proved. Colleague 3 had only joined at the moment when Resident A had allegedly punched Mrs Horsford and Colleague 3 intervened to separate them. She then subsequently witnessed the rest of the incident.

The panel then considered that there were contradictory accounts of the same incident, given by Resident C and Colleague 3 respectively (who are both NMC witnesses). It was of the view that this may be due to the fact that at that time of the incident, Mrs Horsford had engaged in a shouting row with Resident A and it may have been unclear what was actually said or the specific words used by either party in the course of such row. The panel also noted that the allegation was neither mentioned in the witness statement of Resident A nor in the handwritten statement made on her behalf by Witness 2.

Consequently, the panel determined that there was insufficient evidence for it to be satisfied on the balance of probabilities that during the night shift on 27 October 2018, Mrs Horsford had said/used words to the effect "*Shut ya mouth"* in relation to Resident A. Accordingly, the panel determined that charge 2c is found not proved.

Charge 2d

2) In relation to Resident A said / used words to the effect of the following:

   d) *"Who do you think you are talking to, if you think you can talk to me like that on the road you know what will happen";*

This charge is found NOT proved.

The panel took account of the witness statement of Resident C dated 7 October 2019, in which he stated:

> *'…I recall that the Registrant stated to A (Resident A) "who do you think you are talking to! if you think you can talk to me like that on the road you know what will happen". The Registrant was speaking to A (Resident A) in a very aggressive and threatening manner at this time…'*

The panel took into account that Colleague 3 had stated in her witness statement dated 23 August 2019 that:

> *'After I separated Resident A and the Registrant, they were both shouting at each other and I recall Resident A swearing and shouting and calling the Registrant names. I don't recall the specifics of what either the Registrant or Resident A were saying, but I do not recall the Registrant using any abusive or aggressive language towards Resident A. From my recollection, the Registrant was telling Resident A that it was not right of her to be behaving in the manner which she was behaving and seemed to be trying to calm the situation down…'*

The panel considered Mrs Horsford's response to the charge, in her completed CMF, in which she denied the allegation. She stated:

> *'I did not use any of those words relayed in section 2, I struggle with the meanings and terminology when I read them and they aren't in my vocabulary. In no certain terms was I verbally abusive or caused any distress to resident A. I'm a practicing Christian and on many occasions, I've been in the position of asking staff members to tone down their language. It is not within my nature to use that form of language, in my 4 and a half years of working with the establishment I have never been accused of such behaviour.'*

The panel considered the circumstances at the time of the alleged incident. It noted that Colleague 3 was not present in the beginning of the incident in which Mrs Horsford had removed Resident A from the chair and had shouted some words to her, which the panel had earlier found proved. Colleague 3 had only joined at the moment when Resident A had allegedly punched Mrs Horsford and Colleague 3 intervened to separate them. She then subsequently witnessed the rest of the incident.

The panel then considered that there were contradictory accounts of the same incident, given by Resident C and Colleague 3 respectively (who are both NMC witnesses). It was of the view that this may be due to the fact that at that time of the incident, Mrs Horsford had engaged in a shouting row with Resident A and it may have been unclear what was actually said or the specific words used by either party in the course of such row. The panel also noted that the allegation was neither mentioned in the witness statement of Resident A nor in the handwritten statement made on her behalf by Witness 2.

Consequently, the panel determined that there was insufficient evidence for it to be satisfied on the balance of probabilities that during the night shift on 27 October 2018, Mrs Horsford had said/used words to the effect "*Who do you think you are talking to, if you think you can talk to me like that on the road you know what will happen"* in relation to Resident A. Accordingly, the panel determined that charge 2d is found not proved.

Charge 2e

2) In relation to Resident A said / used words to the effect of the following:

    e) If she was on the street she would knock resident out*;*

This charge is found NOT proved.

The panel considered the witness statement of Resident A in which she stated:

'…The Registrant called me names and stated that if we were out on the street she would knock me out…'

This allegation was also mentioned in the handwritten statement made on Resident A's behalf by Witness 2.

The panel took into account that Colleague 3 had stated in her witness statement dated 23 August 2019 that:

'After I separated Resident A and the Registrant, they were both shouting at each other and I recall Resident A swearing and shouting and calling the Registrant names. I don't recall the specifics of what either the Registrant or Resident A were saying, but I do not recall the Registrant using any abusive or aggressive language towards Resident A. From my recollection, the Registrant was telling Resident A that it was not right of her to be behaving in the manner which she was behaving and seemed to be trying to calm the situation down…'

The panel considered Mrs Horsford's response to the charge, in her completed CMF, in which she denied the allegation. She stated:

'I did not use any of those words relayed in section 2, I struggle with the meanings and terminology when I read them and they aren't in my vocabulary. In no certain terms was I verbally abusive or caused any distress to resident A. I'm a practicing Christian and on many occasions, I've been in the position of asking staff members to tone down their language. It is not within my nature to use that form of language, in my 4 and a half years of working with the establishment I have never been accused of such behaviour.'

The panel noted that the only corroboration of Resident A's account of the incident was by Colleague 2. However, the panel bore in mind that it had earlier determined that it was unfair to admit the hearsay statements of Colleague 2 into evidence.

Consequently, the panel determined that there was insufficient evidence for it to be satisfied on the balance of probabilities that during the night shift on 27 October 2018, Mrs Horsford had said/used words to the effect *"If she was on the street she would knock resident out"* in relation to Resident A. Accordingly, the panel determined that charge 2e is found not proved.

Charge 2f

2) In relation to Resident A said / used words to the effect of the following:

f) *"If you were in my house…. I would beat you;*

This charge is found NOT proved.

The panel took into account that the sole evidence adduced by the NMC in support of this charge was Colleague 2's account of the incident in her witness statement. The panel bore in mind that it had earlier determined that it was unfair to admit the hearsay statements of Colleague 2 into evidence.

Therefore, in the absence of any other evidence to support this charge, the panel determined that charge 2f is found not proved.

Charge 2g

2) In relation to Resident A said / used words to the effect of the following:

g) *"For god sake [Resident A], stop crying. You're not a child you're grown up";*

This charge is found NOT proved.

The panel took into account that the sole evidence adduced by the NMC in support of this charge was Colleague 1's account of the incident in her witness statement. The panel

bore in mind that it had earlier determined that it would not consider the witness statement of Colleague 1 as evidence in its finding of facts with respect to charge 2g.

Therefore, in the absence of any other evidence to support this charge, the panel determined that charge 2g is found not proved.

Charge 3a

3) Acted / behaved in the following way:

a) Said to Resident A *"don't even think about getting on that chair", or words to that effect*";

This charge is found NOT proved.

The panel took account of the witness statement of Resident C dated 7 October 2019, in which he stated:

> *'…I believe that the Registrant was forcing B (Resident B) to sit in A (Resident A)'s chair in order to prevent A (Resident A) from sitting on the chair. However, B (Resident B) was finally able to get off the chair. I recall the Registrant saying to A (Resident A) in angry tone, "don't even think about getting on that chair".*

The panel noted that Mrs Horsford denied the allegation in her completed CMF.

The panel took into consideration that neither Colleague 3 nor Resident A (who were present at the time of the incident) mentioned such incident in their respective witness statements.

Consequently, the panel determined that there was insufficient evidence for it to be satisfied on the balance of probabilities that during the night shift on 27 October 2018, Mrs

Horsford had said to Resident A "*"don't even think about getting on that chair".* Accordingly, the panel determined that charge 3a is found not proved.

Charge 3b

3) Acted / behaved in the following way:

b) Threatened to call the police;

This charge is found NOT proved.

The panel took into account that Colleague 3 had stated in her witness statement dated 23 August 2019 that:

> *'…I also recall that the Registrant told Resident A on several occasions that she would call the police for Resident A as she had punched her, and that there were witnesses to Resident A punching the Registrant.'*

The panel had sight of Colleague 3's handwritten statement to the Home dated 30 October 2018 and the Home's Record of the fact-finding meeting with Colleague 3 on 30 October 2018 in which Colleague 3 confirmed that Mrs Horsford had stated that she would call the police.

The panel considered Mrs Horsford's response to the charge, in her completed CMF, in which she stated:

> *'I did comment that I should call the police because I had been assaulted, but it was not said with any threatening manner…'*

The panel was of the view that although there was evidence before it to demonstrate that Mrs Horsford had stated that she would call the police, there was no evidence to suggest that it was done in a threatening manner. As this was the mischief of the charge, the panel

was not satisfied that the NMC had discharged the burden of proof. Accordingly, the panel determined that charge 3b is found not proved.

Charge 3c

3) Acted / behaved in the following way:

c) Mimicked the way Resident A spoke;

This charge is found NOT proved.

The panel took into account that the sole evidence adduced by the NMC in support of this charge was Colleague 2's witness statement which the panel had determined not to admit into evidence.

Accordingly, the panel determined that charge 3c is found not proved.

Charge 3d

3) Acted / behaved in the following way:

d) Kicked the footrest from under the chair where Resident A was seated*;*

This charge is found NOT proved.

The panel took account of the witness statement of Resident C dated 7 October 2019, in which he stated:

'Following this, I recall that the Registrant kicked A's foot rest, which is attached to her chair, out of the way….'

The panel considered Mrs Horsford's response to the charge, in her completed CMF, in which she stated:

'I did remove the footrest by releasing two clips to detach from the front of the chair, but it would've been totally impossible for me to kick it from under the chair. It would've resulted in me having serious injuries because it's a very heavy object.'

The panel noted that, when questioned about the incident during his oral evidence, Resident C explained that the chair in question was a recliner chair without clips. He went on to explain how the footrest could be removed, however, he could not confirm if Mrs Horsford had kicked the footrest out of the way or whether it was possible for a person to move it away from the chair with their foot.

The panel also took into consideration that neither Colleague 3 nor Resident A (who were present at the time of the incident) mentioned such incident in their respective witness statements.

Therefore, the panel was the view that based on the evidence before it, it remained unclear what was the exact description or mechanics of the chair in question and whether the footrest could be moved by a person's foot.

Consequently, the panel determined that there was insufficient evidence for it to be satisfied on the balance of probabilities that during the night shift on 27 October 2018, Mrs Horsford kicked the footrest from under the chair where Resident A was seated. Accordingly, the panel determined that charge 3d is found not proved.

Charge 3e

3) Acted / behaved in the following way:

e) Shouted at Resident B to get back in a seat and/or not to leave the seat*;*

This charge is found NOT proved.

The panel took account of the witness statement of Resident C dated 7 October 2019, in which he stated:

> *'…I recall that B (Resident B) tried to get off the chair on several occasions but the Registrant would not allow him to do so, by telling him to remain on the chair. I believe that the Registrant was forcing B (Resident B) to sit in A (Resident A)'s chair in order to prevent A (Resident A) from sitting on the chair. However, B (Resident B) was finally able to get off the chair…'*

The panel noted that Mrs Horsford denied the allegation in her completed CMF.

The panel examined the witness statement of Resident C and noted that there was no mention of the allegation that Mrs Horsford had shouted at Resident B to get back in a seat and/or not to leave the seat. However, it was only stated that Mrs Horsford told Resident B to remain on the chair.

Therefore, in the absence of any other evidence to support this charge, the panel determined that charge 3e is found not proved.

Charge 3f

3) Acted / behaved in the following way:

   f) Said words to the effect that if Resident B gets off the chair you will go in there to take the piss*;*

This charge is found proved.

The panel took account of the witness statement of Resident C dated 7 October 2019, in which he stated:

'When the Registrant was leaving, she said to me that "if B (Resident B) gets off the chair, I will go in there to take the piss"….'

The panel noted that Mrs Horsford denied the allegation in her completed CMF.

The panel took into account that in his handwritten statement made to the Home, dated 27 October 2018, Resident C stated that Mrs Horsford said to him *"if Resident B gets off the chair, I will go on there to take the piss"*. The panel noted that Resident C was present throughout the incident and his handwritten statement was a contemporaneous account of the incident made after the incident. It further noted that Resident C confirmed this account in his oral evidence to the panel.

The panel was of the view that Resident C was clear and consistent in his oral and documentary evidence that Mrs Horsford had said to him *"if Resident B gets off the chair, I will go on there to take the piss"*. Although neither Colleague 3 nor Resident A (who were present at the time of the incident) mentioned such incident in their respective witness statements, the panel was of the view that it was reasonable to infer that Resident C would remember such words used, given that they were directed towards him. The panel found no reason to doubt the credibility of Resident C's account. It therefore accepted his account.

Having considered the evidence before it, the panel was satisfied on the balance of probabilities, it was more likely than not, that during the night shift on 27 October 2018, Mrs Horsford had said words to the effect that if Resident B gets off the chair, she will go in there to take the piss. Accordingly, the panel determined that charge 3f is found proved.

Charge 3g

3) Acted / behaved in the following way:

    g) Went to Resident A's room and shouted at her following the earlier incident referred to in charge 1*;*

This charge is found NOT proved.

The panel took into account that the sole evidence in support of this charge was Colleague 2's account of the incident in her witness statement. The panel bore in mind that it had earlier determined that it was unfair to admit the hearsay statements of Colleague 2 into evidence.

Therefore, in the absence of any other evidence to support this charge, the panel determined that charge 3g is found not proved.

Charge 4

4) Instructed Colleague 1 to leave Resident B in Resident A's seat and / or not remove Resident B from Resident A's seat.

This charge is found NOT proved.

The panel took into account that the sole evidence in support of this charge was Colleague 1's account of the incident in her witness statement. The panel bore in mind that it had earlier determined that it would not consider the witness statement of Colleague 1 as evidence in its finding of facts with respect to charge 4.

Therefore, in the absence of any other evidence to support this charge, the panel determined that charge 4 is found not proved.

Charge 5

5) Instructed Colleague 2 not to give Resident A their food and / or drink and / or to remove their food and / or drink.

This charge is found NOT proved.

The panel took into account that the sole evidence in support of this charge was Colleague 2's account of the incident in her witness statement. The panel bore in mind that it had earlier determined that it was unfair to admit the hearsay statements of Colleague 2 into evidence.

Therefore, in the absence of any other evidence to support this charge, the panel determined that charge 5 is found not proved.

Charges 6a and 6b

6) Did not make a record of the matters referred to in any and / or all, of the above charges in an incident report:

   a) Immediately following the incident;

   b) Promptly or at all

These charges are found proved.

The panel took into account that Colleague 3 had stated in her witness statement dated 23 August 2019 that:

> *'…my understanding is that the Registrant failed to complete an incident form and therefore (Witness 3) asked me to complete one to record the incident…'*

The panel had regard to the Home's Accident and Incident Reporting Policy which provided that *'All accidents and/or incidents must be recorded using the official Company Accident/ Incident Form…'*

The panel noted that Mrs Horsford made admissions to the allegations in her completed CMF and in her written statement dated 26 December 2019 but provided justification for not completing an incident report.

Based on the evidence before it as well as Mrs Horsford's admissions to the charges, the panel determined that charges 6a and 6b are found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Horsford's fitness to practise is currently impaired. 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, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Horsford's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Radley referred 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. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [Nurse] practitioner in the particular circumstances.'

Mr Radley further referred the panel to the comments of Jackson J in *Calhaem v GMC* [2007] EWHC 2606 (Admin) and Collins J *in Nandi v GMC* [2004] EWHC 2317 (Admin)

'[Misconduct] connote a serious breach which indicates that the [Nurse's] fitness to practice is impaired.'

and

'The adjective 'serious' must be given its proper weight, and in other contexts there has been referenced to conduct which would be regarded as deplorable by fellow practitioners.'

Mr Radley stated that in considering the seriousness of misconduct, the panel should consider evidence of any relevant contextual factors for example, Mrs Horsford was working in a busy and challenging setting at the Home. He however submitted that Mrs Horsford's conduct was a serious departure from the standards expected of a registered nurse and such departure was sufficiently serious as to warrant a finding of misconduct in this case. He submitted that Mrs Horsford's conduct breached the following sections of the Code: Professional standards of practice and behaviour for nurses and midwives 2015' ("the Code"): 1.3, 2.1, 2.5, 3.1, 3.4, 4, 8.2, 8.3, 8.4, 8.5, 8.6, 10.2, 10.3, 14.2, 19.1, 19.3, 19.4, 20.1, 20.2, 20.3, 20.5, 20.6, 20.7 and 20.8.

Mr Radley submitted that due to Mrs Horsford's breach of the Code, it was the position of the NMC that her actions amounted to serious professional misconduct and therefore her fitness to practice is currently impaired.

Mr Radley submitted that the charges found proven were failings directly related to Mrs Horsford's clinical practice with potential to have caused harm to vulnerable residents with

Huntingdon's disease and related obsessive disorders. He submitted that Mrs Horsford's actions could be seen to demonstrate serious concerns which are more difficult to put right for example, failing to keep records covers up failings of the nurse such as charge 6. He referred the panel to the NMC Guidance on Serious concerns which are more difficult to put right (FTP-3a). Mr Radley asserted that inaccurate record keeping could impact on the treatment given by future nurses caring for the patient as this may result in opportunities for care being lost or delayed.

Mr Radley referred the panel to the NMC Guidance on Serious concerns which could result in harm if not put right. He submitted that when an act of violence or inappropriate physical restraint occurs, trust and confidence could be lost, therefore, Mrs Horsford's conduct could have had a negative impact on the trust and confidence residents had in the Home.

Mr Radley submitted that Mrs Horsford's actions were not simply breaches of a local disciplinary policy or minor concerns, rather they were matters at the heart of and fundamental to Mrs Horsford's nursing practice. He asserted that Mrs Horsford's actions amounted to serious professional misconduct because the concerns related to her position as a registered nurse with a potential impact on her nursing practice.

Mr Radley concluded that, in this case, the panel may be particularly concerned about the following concerns:

i. *"Failures in record keeping.*

ii. *The potential effects on patient care – Not being aware of/ using the seating care plan.*

iii. *Potential harm by moving residents unsafely.*

iv. *Lack of duty of candour at the time (openness for documenting the incident herself). Will this change in a busy working environment?"*

Submissions on impairment

Mr Radley referred the panel to Art 22(1)(a) of the Nursing and Midwifery Order 2001 and the *NMC Guidance on Impairment* especially the question which states:

> '*Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

Mr Radley submitted that in considering impairment, the panel should consider the test formulated By Dame Janet Smith in the *Fifth Shipman Report,* quoted in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin). He submitted that limbs a, b and c of the *Grant* test are engaged in this case.

Mr Radley stated that in considering whether Mrs Horsford's fitness to practise is currently impaired, the panel should take a holistic approach by considering all relevant factors including the context in which the charges found proved occurred. He submitted that in considering the context in this case, the panel should consider that the incident occurred at Mrs Horsford's workplace which was a busy care home, and her conduct was witnessed by other staff and residents at the Home.

Mr Radley highlighted that Mrs Horsford had breached relevant sections of the Code which amounted to breaches of fundamental tenets of the nursing profession. He asserted that in consequence, a finding of impairment is required in this case in order to mark the unacceptability of the behaviour, emphasise the importance of the fundamental tenets breached, and to reaffirm proper standards or behaviour. He referred the panel to the case of *Yeong v GMC* [2009] EWHC 1923 (Admin) per Hamer, paragraph 36.07).

Mr Radley further highlighted that the impairment stage is a forward-looking exercise and therefore the question for the panel is whether Mrs Horsford's fitness to practise is currently impaired. He referred the panel to the various training certificates and testimonials in Mrs Horsford's Final Registrant Response Bundle. He however submitted

that those documents have not been tested or challenged in evidence given that Mrs Horsford did not attend the hearing. Therefore, it was highly likely that the charges found proved could be repeated.

Mr Radley submitted that the consequences of Mrs Horsford's conduct had an impact on patient care and posed a risk of harm to the public. He asserted that the public expect members of the nursing profession to maintain high standards of professionalism and behaviour and therefore Mrs Horsford's conduct was unacceptable and has no place in the nursing profession. Mr Radley therefore submitted that it is the position of the NMC that Mrs Horsford's fitness to practise is currently impaired on the grounds of public protection and public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

The panel was of the view that Mrs Horsford's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Horsford's actions amounted to a breach of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.1*** *treat people with kindness, respect and compassion*
> ***1.3*** *avoid making assumptions and recognise diversity and individual choice*
> ***1.5*** *respect and uphold people's human rights*
>
> ***2 Listen to people and respond to their preferences and concerns***

To achieve this, you must:

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

***2.2** recognise and respect the contribution that people can make to their own health and wellbeing*

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

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

***3.4** act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*

4 Act in the best interests of people at all times

To achieve this, you must:

***4.1** balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*

8 Work cooperatively

To achieve this, you must:

***8.2** maintain effective communication with colleagues*

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*

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 *act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*

14.2 *explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*

14.3 *document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

19.2 *take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures…*

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 *keep to and uphold the standards and values set out in the Code*
20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
20.3 *be aware at all times of how your behaviour can affect and influence the behaviour of other people*
20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*
20.6 *stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers*
20.7 *make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way*
20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel took into consideration the surrounding circumstances and the context of the incident. It considered that Mrs Horsford felt that it was unfair for Resident A to ask Resident B to leave the chair in question for her although he was already seated on it and therefore Mrs Horsford proceeded to remove Resident A from the chair. However, the panel was of the view that as the nurse in charge on that shift, Mrs Horsford ought to have been aware that Resident A had a fixation on the chair due to her Huntingdon's disease as it was included in Resident A's seating care plan at the time of the incident. Therefore, the panel found Mrs Horsford's conduct to be inappropriate and wholly unacceptable. It noted that there was no evidence to suggest that Resident A had any mobility problems and therefore it was unnecessary for Mrs Horsford to have handled Resident A while transferring her out of the chair. Even if it was necessary to assist Resident A to move out of the chair, the panel was of the view that Mrs Horsford employed improper methods that failed to respect and uphold the dignity of Resident A.

The panel noted that Mrs Horsford's conduct posed a risk of harm and caused actual harm to Resident A in terms of emotional and psychological distress. The panel therefore found Mrs Horsford's actions to be extremely serious and unprofessional, and that they would be seen as deplorable by other members of the profession and members of the public. Accordingly, the panel determined that Mrs Horsford's actions in charges 1a, 1b, 1c and 1d amounted to misconduct.

With respect to charges 2a and 2b, the panel considered the words *"Get out of the chair"* and *"What the hell are you doing*" said by Mrs Horsford to Resident A at the time of the incident. It noted that Mrs Horsford said those words out of frustration to Resident A in order to make her to leave the chair in question. However, the panel had found that it was wrong for Mrs Horsford to move Resident A out of the chair, as Resident A had a fixation on it due to her Huntingdon disease. Although, Mrs Horsford had used those words in an unprofessional manner, the panel determined that the words used by Mrs Horsford did not meet the threshold of seriousness as to amount to misconduct.

With regard to charge 3f, the panel noted that, when questioned during his oral evidence about the meaning of the words in this charge, Resident C could not explain what the words meant. In the absence of any evidence to explain the meaning of the words in this charge or what they conveyed, the panel was therefore unclear as to the meaning of the words in this charge. Consequently, the panel determined that this charge did not meet the threshold of seriousness as to amount to misconduct.

The panel then considered charges 6a and 6b. It noted that Colleague 3 had asked Mrs Horsford if an incident form needed to be completed but Mrs Horsford had dismissed it as unnecessary and only recorded the incident in the Daily Records/Care Notes for Resident A and the handover notes. Although Mrs Horsford had provided several justifications for not completing the incident form, the panel was of the view that Mrs Horsford, as an experienced nurse at the Home and the nurse in charge on that shift, was expected to be aware of the Home's Accident and Incident Reporting Policy which provided that *'All*

accidents and/or incidents must be recorded using the official Company Accident/ Incident Form…' The panel considered accurate record-keeping as one of the fundamental tenets of the nursing profession and that completing an incident form after an accident/incident had occurred, was one of the fundamental obligations expected from a registered nurse especially in care homes for safeguarding purposes. Accordingly, the panel determined that Mrs Horsford's actions in charges 6a and 6b to be sufficiently serious and amounted to misconduct.

Consequently, having considered all the charges individually and as a whole, the panel determined that Mrs Horsford's actions at charges 1a, 1b, 1c, 1d, 6a and 6b did fall significantly short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Registered nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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 *Grant* test are engaged in this case. It was of the view that at the time of the incident, Mrs Horsford's misconduct placed Resident A at unwarranted risk of harm and caused actual harm to Resident A in terms of emotional and psychological distress. The panel determined that Mrs Horsford's misconduct constituted a serious breach of the fundamental tenets of the nursing profession as she failed to treat Resident A kindly, with respect and dignity. Consequently, Mrs Horsford failed to uphold

the standards and values of the nursing profession and therefore brought the reputation of the nursing profession into disrepute.

The panel had regard to the NMC Guidance on Impairment especially the question which states:

> '*Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

The panel is aware that this is a forward-looking exercise and, accordingly, it went on to consider whether Mrs Horsford's misconduct is remediable and whether she had strengthened her nursing practice.

The panel had regard to the case of *Cohen v GMC [*2008] EWHC 581 (Admin)*,* where the court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

The panel first considered whether the misconduct is capable of remediation. It was of the view that although the concerns were attitudinal in nature, the misconduct in this case was capable of remediation through retraining in managing vulnerable persons with brain diseases and demonstration of sufficient insight into the misconduct.

The panel then went on to consider the efforts Mrs Horsford had made to remediate her misconduct. Regarding insight, the panel was of the view that Mrs Horsford has failed to demonstrate insight into her conduct. It noted that it has not seen any reflections from Mrs Horsford on the impact of her conduct on Residents A, B and C, her colleagues and the nursing profession. The panel was concerned that Mrs Horsford did not demonstrate sufficient understanding of the seriousness of her conduct but sought to provide

justifications for her actions and did not provide detailed steps she would take if similar scenarios should occur in future or to prevent such situation in future.

In considering whether Mrs Horsford had strengthened her nursing practice, the panel took account of the various training courses that Mrs Horsford had completed and the several testimonials made on her behalf. However, the panel noted that all but one of the training certificates had expired and the various testimonials were made between the period of 2019 and 2020. Therefore, in the absence of up-to-date training certificates in the relevant areas of concern and updated testimonials, the panel was not satisfied that Mrs Horsford had demonstrated sufficient steps to strengthen her nursing practice.

The panel was also of the view that the nature of Mrs Horsford's misconduct was such that it could discourage members of the public from seeking or accessing appropriate care when required for themselves or their vulnerable relations. Family members might well be reluctant to place relations living with brain disease in the care of healthcare providers if they felt that their dignity might be compromised in this way.

In light of this, this panel determined that there is a real risk of repetition of Mrs Horsford's misconduct and therefore concluded 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.

The panel had regard to the serious nature of Mrs Horsford's misconduct and the public protection issues it had identified and determined that public confidence in the profession, particularly as the misconduct involved a failure to respect and uphold the dignity of a resident, would be undermined if a finding of impairment were not made in this case. For

these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that Mrs Horsford's 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 suspension order for a period of six months. The effect of this order is that the NMC register will show that Mrs Horsford's registration has been suspended.

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 Radley reminded the panel that in considering sanction, it should aim to strike a fair balance between Ms Horsford's right to practise as a registered nurse and the overarching objective of public protection. He referred the panel to the case of *Huang v Secretary of State for the Home Department* [2007] UKHL 11. Mr Radley submitted that it was the position of the NMC that the panel could justifiably restrict Mrs Horsford's right to practise as a registered nurse, given the panel's earlier findings on misconduct and impairment.

Mr Radley highlighted that, in general terms, the panel should first consider whether the sanction with the least impact on the nurse would be sufficient to achieve public protection, if not, the panel should then consider escalation until it arrives at the most appropriate sanction necessary to protect the public and otherwise in the public interest.

Mr Radley submitted that the panel should impose a restriction on Mrs Horsford's nursing practice given the aggravating factors in this case. He submitted that registered nurses occupy a position of privilege and trust in the society but in this case, Mrs Horsford had abused her position of trust as a registered nurse. He submitted that Mrs Horsford had failed to demonstrate insight into her failings and she had breached fundamental tenets of the nursing profession, thereby bringing the reputation of the profession into disrepute.

Mr Radley noted that the panel had found that limbs a, b and c of the *Grant* test are engaged in this case and that Resident A was placed in unwarranted risk of harm in both psychological and physical terms in these circumstances. He submitted that Mrs Horsford failed to demonstrate an understanding of the seriousness of her misconduct, instead, she provided justifications for her behaviour. Mr Radley highlighted that the panel had noted that Mrs Horsford did not provide up to date relevant training certificates and that her fitness to practise is currently impaired on both grounds of public protection and public interest.

Mr Radley submitted that in terms of mitigating factors, the panel should consider that there were no previous regulatory or disciplinary findings against Mrs Horsford, there were no direct and lasting patient harm caused and the relevant experience and age of Mrs Horsford.

Mr Radley submitted that, given the panel's findings of serious misconduct and impairment as well as the severity of the charges found proved, it was the NMC's position that the appropriate sanction in this case is a striking-off order. He submitted that the panel should take into account that Mrs Horsford failed to demonstrate any insight into her misconduct and no evidence that she had learnt from the incident, which heightens the risk of repetition. He highlighted that Mrs Horsford made those comments in the charges found proved in front of other staff and residents at the Home and her behaviour created a hostile environment at the Home in which residents were left distressed at Mrs Horsford's conduct.

Mr Radley concluded that a striking-off order is the only sufficient sanction to protect the public, maintain public confidence and professional standards in the nursing profession.

Decision and reasons on sanction

Having found Mrs Horsford's 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 identified the following aggravating features:

- Mrs Horsford abused her position of trust.
- No evidence of reflection, insight or remorse.
- Mrs Horsford's conduct placed Resident A at risk of harm and caused actual harm.
- Mrs Horsford's fundamental misunderstanding of the importance of recording incidents on the incident form and incident reporting.
- No up-to-date information about Mrs Horsford's current nursing practice as well as updated training certificates or testimonials.

The panel also identified the following mitigating features:

- There are no concerns about Mrs Horsford's clinical practice.
- This was an isolated incident in Mrs Horsford's twelve years of experience as a registered nurse at the time of the incident.
- Various positive references were made on her behalf between the period of 2019 and 2020.

- Mrs Horsford stated that she was assaulted by Resident A at the time of the incident.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. It had found that there remains a risk of repetition and that Mrs Horsford's fitness to practise is currently impaired on both public protection and public interest grounds. The panel therefore determined that it would neither protect the public nor be in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, Mrs Horsford's lack of insight, the absence of updated testimonials and training certificates and the public protection issues identified, an order that does not restrict Mrs Horsford's nursing practice would not be appropriate in the circumstances. 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 Mrs Horsford's misconduct was not at the lower end of the spectrum and that a caution order would not be proportionate nor appropriate in view of the issues identified. The panel decided that a caution order would neither protect the public nor be in the public interest.

The panel next considered whether placing conditions of practice on Mrs Horsford's 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:

> *'Conditions may be appropriate when some or all of the following factors are apparent:*
>
> - *No evidence of harmful deep-seated personality or attitudinal problems;*

- *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.'*

Although the concerns were attitudinal in nature, the panel was of the view that there was no evidence of deep-seated attitudinal concerns and that this was an isolated incident over an otherwise unblemished career. The panel acknowledges that it might have been possible to address the concerns identified through retraining in managing vulnerable persons with brain diseases and de-escalation techniques in healthcare. However, it was of the view that given the lack of meaningful engagement by Mrs Horsford with the proceedings, the absence of information about her present circumstances, her lack of insight into the severity and impact of her misconduct on Residents A, B and C, her colleagues and the nursing profession, and the absence of up-to-date training certificates in the areas of concern and updated testimonials, there are no practical or workable conditions that could be formulated.

Accordingly, a conditions of practice order would not address the risk of repetition and this poses a risk of harm to patients' safety and the public. The panel had no evidence before it to suggest that Mrs Horsford would comply with any conditions of practice. Consequently, the panel determined that any conditions of practice order would not be workable or appropriate in this case and would not protect the public nor be in the public interest.

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

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

The panel found that Mrs Horsford's misconduct amounted to a breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. It noted that Mrs Horsford failed to demonstrate insight into the severity and impact of her misconduct on Residents A, B and C, her colleagues and the nursing profession. The panel further noted that Mrs Horsford failed to fully engage with these proceedings and there was a lack of information about her current nursing practice or current circumstances.

Notwithstanding this, the panel took into account that this was a single instance of misconduct, there was no evidence of harmful deep-seated personality or attitudinal problems and no evidence of repetition of behaviour since the incident. The panel also recognised that Mrs Horsford had taken some steps to strengthen her nursing practice through completing various training courses in the areas of concern albeit now outdated and there were several positive references made on her behalf between the period of 2019 and 2020. Consequently, the panel was satisfied that the misconduct in this case was not fundamentally incompatible with remaining on the register.

The panel carefully considered the submissions of Mr Radley in relation to the imposition of a striking-off order in this case. It also considered following paragraphs of the SG with respect to imposing a striking-off order:

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

However, in taking account of all the evidence before it, including that this was a single instance of misconduct, the limited steps Mrs Horsford had taken to strengthen her nursing practice and the positive testimonials on her behalf, the panel concluded that a striking-off order would be disproportionate. Although Mrs Horsford's misconduct raises questions about her professionalism, it was, in the panel's view, not to the extent that required her removal from the register. Also, in the absence of information about Mrs Horsford's nursing practice or present circumstances, the panel was not satisfied that a striking-off order was the only sanction sufficient to protect the public and to address the public interest considerations in this case. Whilst the panel acknowledges that a suspension order may have a punitive effect, it would be unduly punitive in this case to impose a striking-off order. It was of the view that a striking-off order could deprive the public of a registered nurse who has the potential to return to nursing practice in the future. Therefore, a striking-off order would not serve the public interest considerations in this case.

Balancing all of these factors, the panel concluded that a suspension order would be the appropriate and proportionate sanction to protect the public and address the public interest in this case. It was satisfied that a suspension order for a period of six months would provide Mrs Horsford with an opportunity to demonstrate evidence of sufficient insight into her misconduct and that her fitness to practise is no longer impaired. The

panel determined that this order is necessary to protect the public, mark the seriousness of the misconduct, maintain public confidence in the profession, and send to the public and the profession, a clear message about the standard of behaviour required of a registered nurse.

The panel noted the hardship such an order will inevitably cause Mrs Horsford, however, this is outweighed by the public interest in this case.

The panel decided that a review of this order should be held before the end of the period of the suspension order.

Before the end of the period of suspension, another panel will review the order. At the review hearing, the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case may be assisted by:

- A reflective statement from Mrs Horsford using an accepted model of reflection, demonstrating sufficient insight on the incident at the Home, the severity of her misconduct and its impact on Resident A, B and C, her colleagues and the nursing profession.
- Any updated references or testimonials within the past twelve months attesting to Mrs Horsford's capability to perform her duties, in whatever role, professionally in any paid or unpaid work subsequent to this hearing.
- Up-to-date relevant training courses undertaken in the areas of concern including in managing challenging behaviours.
- Mrs Horsford's full engagement and attendance at any future review hearing.

This will be confirmed to Mrs Horsford in writing.

Interim order

As the suspension 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 Mrs Horsford's own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Radley. He highlighted that at this stage, the panel should undertake a risk assessment of this case in order to determine whether an interim order is necessary. Mr Radley submitted that given that the concerns are serious and the panel's findings, an interim suspension order for a period of 18 months is necessary in order to protect the public and otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective.

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

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and otherwise in

the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Mrs Horsford is sent the decision of this hearing in writing.

That concludes this determination.