Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 7 November 2022 to Friday 11 November 2022
Virtual Hearing
and
Monday 17 July 2023 to Friday 21 July 2023
Hybrid Hearing
and
Monday 29 January 2024 to Friday 2 February 2024
Virtual Hearing

Name of registrant:	Krystyna Stanis
NMC PIN:	10J0159C
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (October 2010)
Relevant Location:	Somerset
Type of case:	Misconduct
Panel members:	Penelope Titterington (Chair, lay member) Pauleen Pratt (Registrant member) (7 November 2022 to 11 November 2022 and 17 July 2023 to 21 July 2023) Jim Blair (29 January 2024 to 2 February 2024) Jane McLeod (Lay member)
Legal Assessor:	Mark Sullivan
Hearings Coordinator:	Charis Benefo (7 November 2022 to 11 November 2022) Chantel Akintunde (17 July 2023 to 21 July 2023) Zahra Khan (29 January 2024 to 2 February 2024)
Nursing and Midwifery Council:	Represented by Joe O'Leary, Case Presenter
Miss Stanis:	Present and represented by Dr Francis Graydon, Counsel instructed by the Royal College of Nursing (RCN)

Facts proved:	Charges 1a, 1b, 2a, 2b, 3, 4ai, 4aiii, 4bi, 4bii, 4biii and 4c
Facts not proved:	Charge 4aii
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to postpone the proceedings

At the outset of the hearing, Dr Graydon, on your behalf, made a request that this virtual hearing be postponed under Rule 32 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). He invited the panel to allow a postponement to enable this hearing to be re-listed for a physical hearing at a later date, in order for you to be assisted by the physical attendance of a Polish-speaking interpreter.

Dr Graydon assured the panel that this application was not a delaying tactic or strategy but had come about as a result of the Nursing and Midwifery Council's (NMC) management and approach to the hearing. He referred the panel to the chronology of correspondence between the NMC and RCN, for the period between 30 September 2022 and 4 November 2022.

Dr Graydon submitted that the issue in dispute was not about the requirement for a Polish-speaking interpreter or whether an interpreter was necessary in these proceedings. He submitted that the issue in dispute concerned how an interpreter would participate or enable you to participate effectively in these proceedings.

Dr Graydon submitted that the NMC properly started from a position of requesting a physical hearing because you required an interpreter. He said that the NMC had acknowledged from an early point that it was important for you and the interpreter to be in the same room. He submitted that there had been no opposition to this. However, the NMC's starting point had now been displaced and it had been fixated on ensuring that today's hearing started and could proceed. Dr Graydon submitted that you were not in the same room as the interpreter at this stage, and this would cause practical difficulties.

Dr Graydon referred the panel to Rule 32(4), which provided:

‘32 (4) In considering whether or not to grant a request for postponement or adjournment, the Chair or Practice Committee shall, amongst other matters, have regard to –
(a) the public interest in the expeditious disposal of the case;
(b) the potential inconvenience caused to a party or any witnesses to be called by that party; and
(c) fairness to the registrant.’

Dr Graydon submitted that the panel was not limited to these matters. He submitted that the key issue was of procedural fairness, and that one of the key questions for the panel to determine was whether your effective participation could be achieved without being in the same room as the interpreter. Dr Graydon submitted that you were at a disadvantage by not being in the same room as Counsel and the interpreter in the circumstances of this case. He submitted that procedural fairness needed to be achieved, and that the difficulty in this format required a practical solution, namely a postponement for a physical hearing which would allow you to participate effectively in the way that was originally envisaged by the NMC.

In response to questions from the panel, Dr Graydon stated that he had never attended a hearing where an interpreter had interpreted virtually, either in criminal, civil or regulatory proceedings. He explained that in his experience, when an interpreter provided assistance at court or a tribunal, they would sit close to the person requiring their assistance and speak into their left ear discreetly. He submitted that in a physical hearing, there would not be a “*stop, start*” process as had been the case in this hearing so far. Dr Graydon submitted that continuing with a virtual hearing would mean that the matter would take longer than expected, and might require the case to be re-listed in any event in order to conclude the hearing.

Mr O’Leary, on behalf of the NMC, endorsed Dr Graydon’s reference to Rule 32(4), but indicated that he opposed the application. He submitted that Rule 32(4) required the panel

to carry out a balancing exercise of the matters which had been set out alongside any other matters. Mr O'Leary submitted that there was no dispute about your right to fairness.

Mr O'Leary submitted that issue was taken with the suggestion that the present situation was as a result of the NMC's handling of the case. He submitted that the hearing could continue fairly with the Polish-speaking interpreter's virtual attendance to assist you.

Mr O'Leary asked the panel to consider how far the interpreter would be required in these proceedings, and submitted that there was a difference between every single word being translated, or interpretations being offered as and when misunderstanding arose. Mr O'Leary submitted that you are an NMC registrant and have worked in at least two care homes. He referred the panel to section 7.5 of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) which provided that a registrant must '*be able to communicate clearly and effectively in English*'. Mr O'Leary submitted that a question for the panel was whether this hearing proceeding remotely would affect your ability to participate and understand what was being said.

Mr O'Leary referred to the chronology of correspondence between the NMC and the RCN and submitted that the NMC had done everything it could to ensure that you could properly participate in the hearing. He stated that the original request for delaying was related to availability of Counsel rather than an interpreter.

Mr O'Leary submitted that just because you and the interpreter were both appearing virtually, it did not mean that the fairness of these proceedings had been impacted, because ultimately you were still having everything translated word-for-word in Polish. He submitted that at this stage, Dr Graydon's submissions on fairness amounted to a mere assertion. He submitted that the interpreter could be used for you to provide instructions to Dr Graydon, and during the cross-examination of witnesses and your own evidence. Mr O'Leary accepted that would undoubtedly make the hearing longer, but submitted that parties to the hearing would have to think more carefully about the words being used and that if there were any points of misunderstanding, these could be clarified. He highlighted

that parties could talk slowly and reminded the panel that you were being represented by experienced Counsel.

Mr O'Leary stressed the public interest of these proceedings being disposed of with expedition. He reminded the panel that the charges in this case relate to events that occurred between 2019 and 2021, and that the 2019 allegations were now clearly of some significant age. Mr O'Leary told the panel that those allegations were initially scheduled to be heard in May 2020, before the COVID-19 pandemic. Subsequently, an additional referral relating to the 2021 allegations was received and the allegations then joined together. Mr O'Leary submitted that if this hearing were postponed, it would not meet the public interest in the expeditious disposal of this case, and that alternative hearing dates were not likely to be identified any time soon.

Mr O'Leary stated that in addition, this case required the evidence of three live witnesses who had already booked time to attend the hearing. He asked the panel to consider that the witnesses' time would be wasted in the event of a postponement, and their attendance expected on another occasion. Mr O'Leary asked the panel not to give the matter of the public interest undue weight and emphasised that proceeding with the virtual hearing would not affect the fairness of proceedings.

Dr Graydon clarified the reason why the NMC's suggestion on 3 November 2022 for a local meeting room for you, the interpreter and Dr Graydon to attend in-person had not been acceptable. The panel was informed that you and Dr Graydon lived in different parts of England and had both been initially informed that this was a virtual hearing. Dr Graydon stated that he had planned his week and family circumstances on that basis. He submitted that the lateness of the NMC's suggestion, four days prior to the hearing, created logistical issues for you both and at that stage, a local meeting room would not be convenient, workable or practical. In addition, he submitted that the suggestion that the interpreter should travel to your home crossed the boundary of privacy and your right to private life.

Further, in reference to section 7.5 of the Code, Dr Graydon submitted that the Code made no reference to registrants being able to communicate effectively in any civil or criminal proceedings. He referred the panel to Article 6 of the European Convention on Human Rights, in particular the provision that everyone charged with a criminal offence should have the free assistance of an interpreter if they cannot understand the language used in court, or in this case, formal proceedings. Dr Graydon stated that his instructions were that you wished to rely on an interpreter for the entirety of the proceedings, and it was his submission that you should be entitled to that.

The panel heard and accepted the advice of the legal assessor. The legal assessor referred the panel to the observations of the Court of Appeal in the case of *Yilmaz v The Secretary of State for the Home Department* [2022] EWCA Civ 300.

The panel had regard to the chronology of correspondence between the NMC and the RCN for the period between 30 September 2022 and 4 November 2022.

The panel noted Dr Graydon's submission that an interpreter being in the same room was preferable. The panel also noted the observations of the Lord Chief Justice in the case of *Yilmaz:*

> '*The use of remote technology in legal proceedings, including hearing evidence by phone or computer link, became ubiquitous in all jurisdictions during the Covid pandemic. Many reservations about its use have been dispelled but there remains a central issue about fairness and the interests of justice that is best considered on a jurisdiction by jurisdiction basis with an eye to the different types of case and participation under consideration.*'

The panel took into account that during Mr O'Leary and Dr Graydon's submissions on the application to postpone the proceedings, you had been provided with the virtual assistance of the Polish-speaking interpreter with no issue. It recognised, however, that the cross-examination of witnesses had not yet taken place.

The panel noted that it had not been provided with evidence of any personal vulnerabilities or any specific and substantive information as to why proceeding virtually in this case would be inappropriate and unfair.

The panel observed that it was common for interpreter cases to be "*stop, start*" to enable translation to occur, even in physical hearings. The panel decided that although the hearing would take longer it could be managed in such a way so as to ensure fairness.

The panel was of the view that in the circumstances of this case, there would be no unfairness to you in continuing with a virtual hearing.

The panel also noted that:

- The charges in this case relate to events that occurred in 2019 and 2021;
- A five-day hearing of this case had been scheduled to commence today;
- There was a strong public interest in the expeditious disposal of this case;
- The three witnesses were due to attend to give evidence;
- Not proceeding might inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services.

In all the circumstances, and balancing all the relevant factors, the panel decided not to grant the postponement of these proceedings for a physical hearing at a later date.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr O'Leary to amend the wording of charges 1, 2, 3 and 4.

The proposed amendments were to amend typographical errors in charges 1, 2 and 3, and to set out where the allegations in charge 4 took place. It was submitted by Mr

O'Leary that the proposed amendments did not change the substance of the allegations, but would provide clarity and more accurately reflect the evidence.

"That you, a registered nurse:

1) *On 15 January 2019 at Frome Nursing Home:*

    a) *Shouted 'shut up', 'sit down', 'stay there and don't move' and 'I said be quiet' (or words to that effect) at ~~resident A~~* ***Resident D****.*
    b) *Said 'aren't you, you're a horrible woman' (or words to that effect) harshly to ~~resident A~~* ***Resident D***

2) *On 16 January 2019 at Frome Nursing Home;*

    a) *Shouted at ~~resident A~~* ***Resident D****;*
    b) *Said 'Ah! I told you to sit down' (or words to that effect) harshly to ~~patient A~~* ***Resident D****.*

3) *On 16 January 2019 at Frome Nursing Home, forcibly pulled ~~resident A~~* ***Resident D*** *into a chair.*

4) *Between 19 – 20 January 2021* ***at the Wiltshire Heights Care Home****:*

    a) *…*

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

Dr Graydon submitted that he had no issue with the proposed amendments.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

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

Details of charge [as amended]

That you, a registered nurse:

1) *On 15 January 2019 at Frome Nursing Home:*
   a) *Shouted 'shut up', 'sit down', 'stay there and don't move' and 'I said be quiet' (or words to that effect) at Resident D.*
   b) *Said 'aren't you, you're a horrible woman' (or words to that effect) harshly to Resident D*

2) *On 16 January 2019 at Frome Nursing Home;*
   a) *Shouted at Resident D;*
   b) *Said 'Ah! I told you to sit down' (or words to that effect) harshly to Resident D.*

3) *On 16 January 2019 at Frome Nursing Home, forcibly pulled Resident D into a chair.*

4) *Between 19 – 20 January 2021 at the Wiltshire Heights Care Home:*
   a) *In relation to Resident A;*
      i) *Informed them they would not be able to use the commode again until around 2am;*
      ii) *When Resident A continued to ring the bell for assistance, told them not to ring the bell again;*
      iii) *Upon Resident A continuing to ring the bell for assistance, threatened to remove their call bell if they continued to ring.*

b) In relation to Resident B;

i) Dragged the resident out of bed;

ii) Pushed the resident into a chair;

iii) Failed to acknowledge and deal compassionately with their distress and/or emotion.

c) Slapped Resident C's face.

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

Background

You first entered onto the NMC's register as an Adult Nurse on 25 October 2010.

The allegations in this case first arose whilst you were employed as a Registered Nurse at Frome Nursing Home. Frome Nursing Home caters for residents with dementia and your duties included medicine administration, working on care plans and reporting on residents.

The allegations are that during two night shifts on 15 January 2019 and 16 January 2019, you verbally abused Resident D, a service user at the home, by shouting at her and using harsh language towards her. You also allegedly physically abused Resident D on 16 January 2019 when you grabbed her and pulled her backwards into a chair as she tried to get up. These incidents were allegedly witnessed by Witness 1, an agency carer who was working at the Home on those two night shifts.

You resigned from Frome Nursing Home on 18 January 2019 with immediate effect.

The NMC received a referral from Evolve Care Group on 22 April 2019 in respect of the allegations from Frome Nursing Home.

You started working at Wiltshire Heights Care Home on 4 February 2019 as a Night Nurse. Wiltshire Heights Care Home caters for residents with dementia and your duties included management of the shift, responsibilities for the residents and the staff, medication administration, maintaining documentation and making clinical decisions when needed.

Witness 2, Team Leader at the Wiltshire Heights Care Home, raised concerns in relation to your treatment of Resident A, Resident B and Resident C on the night of 19 January 2021/20 January 2021. The NMC received a second referral from Witness 3, the Home Manager at Wiltshire Heights Care Home on 28 January 2021 in respect of these allegations. The allegations are as outlined in charge 4.

Your employment at Wiltshire Heights Care Home ended on 21 May 2021.

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

Mr O'Leary made a request that part of this hearing be held in private to the extent of references made to [PRIVATE]. The application was made pursuant to Rule 19.

Dr Graydon indicated that he did not oppose the application.

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

The panel determined to hold in private the parts of this hearing that involve reference to [PRIVATE] as and when such issues are raised in order to [PRIVATE].

Adjournment and interim order

Having heard all of the evidence relied on by the NMC and the NMC having closed its case on the facts, the hearing was adjourned on 11 November 2022 due to insufficient time to conclude within the allocated time.

At the time of adjourning, the legal assessor informed the panel that it would need to consider whether an interim order was required in this case under Rule 32(5).

The legal assessor, with the agreement of the parties, told the panel that an interim order was already in place which was due to be reviewed shortly under Article 31 of the Nursing and Midwifery Order 2001 (the Order).

The panel accepted the advice of the legal assessor.

The panel considered that there was already an existing interim order in your case which was due to be reviewed by an interim order reviewing panel. The panel therefore decided not to consider the imposition of an interim order at this stage.

The hearing was then adjourned. It will resume on 17 July 2023 by way of a physical hearing at the NMC hearing centre in Stratford.

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 O'Leary on behalf of the NMC and by Dr Graydon on your behalf.

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:

- Witness 1: Agency Carer at Frome Nursing Home;
- Witness 2: Team Leader at Wiltshire Heights Care Home; and
- Witness 3: Home Manager at Wiltshire Heights Care Home.

The panel also heard evidence from you under affirmation.

In respect of all the charges that fall under charges 1, 2 and 3

The panel noted that in relation to charges 1 to 3, the only evidence of what occurred on the relevant evenings comes from you and Witness 1. In considering the credibility and reliability of Witness 1's evidence, it took into account her own admission in evidence that her recollection was "fuzzy" in respect of some of the details, given the passage of time. However, it noted that Witness 1 said certain things stand out in her mind to this day. It therefore had regard to Witness 1's original account of events, set out in an email which she says she sent on 19 January 2019, some two/three days after the incidents occurred, her witness statement dated 4 September 2019 and her oral evidence and whether she had been consistent in her accounts. It also had regard to your account set out in written response which you said you drafted in May 2019. It also considered whether Witness 1 might have some reason to give untruthful evidence about what occurred. It noted that she was an agency nurse who only worked with you on the two shifts relevant to the charges. You indicated that at times you felt she was not carrying out her duties properly and was

knitting or using her mobile phone, but the panel could not see that could feasibly have caused her to give a deliberately untruthful account of what she saw. It was satisfied that Witness 1 was a truthful witness in the sense she was stating what she believed had occurred. It did however also consider whether she might have been mistaken.

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

Charge 1b

1) *On 15 January 2019 at Frome Nursing Home:*

   …

   b) *Said 'aren't you, you're a horrible woman' (or words to that effect) harshly to Resident D*

This charge is found proved.

As the incident in charge 1b took place before the incident set out in charge 1a on the night shift of 15 January 2019, the panel decided to consider this charge first in its deliberations on the facts.

The panel had regard to the local contemporaneous statement of Witness 1, detailing her concerns and sent to her agency on 19 January 2019, in respect of this allegation where she states:

> *'…I found Resident D in the dining room with a couple of other service users and the other carers. Resident D was sat in the chair muttering to herself. I said something to the effect of "alright?" or something else to Resident D (I can't remember) smiling at her. Krystyna Stanis, the Nurse on duty, was in there and said "oh don't pay attention to her, she's a horrible woman!" she stood infront of Resident D as she said this and then raised her voice louder and said directly to Resident D "aren't you? You're a horrible woman!" …'*

and her NMC witness statement (which she adopted as her evidence-in-chief) where she states:

> *'I went to the dining room…and saw Resident D sitting there. There were other carers and residents in the dining room as well. I walked up to Resident D to check on her and asked her something to the effect like "are you alright?" At this time, Krystyna came up to Resident D and myself and told me "oh don't pay attention to her, she's a horrible woman" … Krystyna then put her hands on her hips and bent down to be on face level with Resident D and said "Aren't you? You are a horrible woman!" Krystyna said this is a raised voice, but was not shouting.'*

With regard to the tone used when making this comment, the panel noted that Witness 1 in oral evidence said the following:

> *'THE CASE PRESENTER: Could you tell us what sort of tone Ms Stanis had when she said this?*
> *THE WITNESS: It was very forceful, very demeaning. At –[sic] to be frank, I wouldn't speak to an animal the way she spoke to her.'*

In your oral evidence, you denied this charge. In your written response produced in May 2019, you describe the busy work environment of Frome Nursing Home at the time, stating that the job was "physically exhausting" and that it was "extremely stressful" caring for residents.

The panel found Witness 1's account of this incident in the dining room, contained in her local statement, witness statement and oral evidence to be consistent and reliable. The panel find that Witness 1 directly witnessed this incident from close by and gave a detailed description, and therefore find she is not likely to have been mistaken.

The panel acknowledge the busy and stressful work environment within Frome Nursing Home as you have described in your statement produced in May 2019. However, taking

this into account and Witness 1's account of the incident in charge 1b, the panel found that, on a balance of probabilities, it is more likely than not that you said *'aren't you, you're a horrible woman'* (or words to that effect) harshly to Resident D on 15 January 2019.

Charges 1a

1) *On 15 January 2019 at Frome Nursing Home:*
   a) *Shouted 'shut up', 'sit down', 'stay there and don't move' and 'I said be quiet' (or words to that effect) at Resident D.*

This charge is found proved.

The panel had regard to the local contemporaneous statement of Witness 1 in respect of this allegation where she states:

> *'…over the next hour Stanis shouted at Resident D on multiple occasions "shut up" "sit down!" "stay there don't move" "ah I said be quiet" and similar…'*

and her NMC witness statement where she states:

> *'…over the next couple of hours until about midnight, Krystyna would shout at Resident D telling her to "shut up", "sit down", "stay there and don't move" and "I said be quiet!" Krystyna would be working in the dining room or walking around performing her duties when she shouted at Resident D.'*
>
> *'I learned that Resident D rarely sleeps in her room and that she can be loud and shouting for hours on end. She did not sleep in her room that night and everytime I took her to her room she would walk back to the dining room'*

In oral evidence, Witness 1 confirmed that she witnessed you making these comments towards Resident D every time you encountered the resident, stating that she would either

be in the dining room when she saw you both or passing through the corridors when she heard you when no one else was around. Despite the passage of time since the incident, Witness 1 was adamant under cross examination that she heard you say these specific phrases.

In your written response, you state:

> *'…. pretty much all paperwork is done on a computer which was placed in the dining room which is an wide open room/space with no doors or any kind of way to separate yourself from everyone else. With Resident D and her behaviour in the night it was impossible to concentrate on the work. Whilst Resident D was on the other side of the room and constantly walking in and out. Whereas the agency carer [Witness 1] was sat, knitting less than 2 meters away from. With my frustration and I would say under my breath "please shut up" "for god sake please be quiet" as the screaming was loud and wasn't allowing me to focus on doing my work.'*

In oral evidence, you stated that these comments were not made directly at Resident D, but rather they were muttered under your breath whilst you were either at the computer or walking around performing tasks. You also stated that such phrases, when said in your native language, are not considered offensive.

The panel accepted that Resident D was a mobile individual and known to be challenging by way of being vocal and loud within Frome Nursing Home, as per her care plan and confirmed by Witness 1. The panel acknowledged that Resident D's care plan is dated after the incident occurred, nevertheless, you confirmed in your own written response that Resident D was a mobile resident, and that she was very vocal and difficult to handle.

The panel understood that the comments made happened over a course of time during the night shift of 15 January 2019, and that this occurred after the incident detailed in charge 1b took place.

The panel accepted the fact that English is not your first language. You said that as a result you may not fully appreciate that certain words when said in English can come across as offensive. Nevertheless, given Resident D's disruptive behaviour at the time, which both you and Witness 1 have attested to, and the fact that this came after the incident set out in charge 1b, the panel did not accept that these phrases were muttered under your breath at the time, but rather they were said directly at Resident D. Given the language requirements of your job and that you had been in this job for seven years, the panel find that you were aware of the meaning of the words you used.

The panel found Witness 1's account of this incident in her local statement, witness statement and oral evidence to be consistent.

Based on the above, the panel found that, on a balance of probabilities, it is more likely than not that you shouted *'shut up', 'sit down', 'stay there and don't move'* and '*I said be quiet'* (or words to that effect) at Resident D on 15 January 2019.

Charge 2a

2) *On 16 January 2019 at Frome Nursing Home;*
    a) *Shouted at Resident D;*

This charge is found proved.

Witness 1 in oral evidence told the panel the following:

> *'THE WITNESS: That evening, Resident D seemed more agitated than the night before. She was walking around more, she wasn't being settled at all whereas the night before she did have periods where she would settle. That evening, she seemed to be a lot more restless so she was up and moving and doing her shouting a lot more so Ms Stanis was shouting in response to Resident D shouting a lot more that evening than she was the previous one. It was similar to the*

previous evening, down the corridors, when I was in the same room, but just seemed to be a lot more that evening.

…

THE CASE PRESENTER: Thank you. I think you touched on it in your last answer, but are you able to tell us what was being shouted by Ms Stanis?

THE WITNESS: It was similar to the evening before. It was, 'Shut up. Sit down. Sit down and stay there. I said "Be quiet". You horrible woman'. The majority of it was just, 'Shut up'.'

In your written response, you do not comment specifically on these words. The panel accepted your description of the stressful and busy work environment at the time.

The panel found Witness 1's account of this incident in her local statement, witness statement and oral evidence to be consistent and reliable.

Based on the above, the panel found that, on a balance of probabilities, it is more likely than not that you shouted at Resident D on 16 January 2019.

Charge 2b

2) *On 16 January 2019 at Frome Nursing Home;*

…

b) Said 'Ah! I told you to sit down' (or words to that effect) harshly to Resident D.

This charge is found proved

As the comment in charge 2b and the action in charge 3 were alleged to have happened at the same time, the panel decided to consider the evidence in relation to these two charges together in its deliberations on the facts.

The panel had regard to the local contemporaneous statement of Witness 1 in respect of this allegation where she states:

> *'…even once came up behind where Resident D had just stood up from her chair and grabbed Resident D's right shoulder from behind and pulled/shoved her telling her to sit back down…'*

and her NMC witness statement where she states:

> *'Resident D was sat in an armchair against the corner of a wall. The wall then went back towards the office and there was a bit of space to the right of her and then behind…Resident D was trying to get off the chair when Krystyna came from the office behind Resident D. Resident D was halfway up to standing, so she was slightly hunched over when Krystyna grabbed Resident D from behind and her right shoulder and pulled her back into the chair. I cannot remember exactly what Krystyna said but it was along the lines of "Ah! I told you to sit down!".'*

In oral evidence, Witness 1 was able to describe your action of pulling Resident D into the chair, specifically how you used your left hand as Resident D would have been on your left side when you came up behind the resident. Witness 1 also stated the following:

> *'THE CASE PRESENTER: Thank you. So you've described how Ms Stanis pulled Resident D back into the chair. Perhaps to help us, on a scale of 1 to 10 if 1 is very gentle and 10 is a lot of force, how much force did Ms Stanis use to pull her into the chair?*
> *THE WITNESS: I would say it would be about a 7 or 8. It's enough that me, as an able- bodied person, I would have fallen backwards had she done the same movement on me and pulled me backwards like that, I would have fallen backwards. It was quite a lot of force.'*

In your oral evidence, you denied both telling Resident D to sit back down and pulling her into a chair. In your written response and oral evidence, you stated that Resident D would sit and swing on a dining chair, so in order to prevent Resident D from hurting herself again, you said that you would stand behind her chair to support her in case she swung too far back. You stated that Resident D was a fall risk as she fell over in the hallway and broke her hip a couple of years ago.

The panel found Witness 1's account of the incident to be consistent and reliable. It found that Witness 1 directly observed this incident so is unlikely to have been mistaken. The panel accepted that there may have been occasions when Resident D swung on a dining chair, but found that the incident as described by Witness 1 did occur.

As per its reasonings in respect of charge 1a, the panel accepted that Resident D was a mobile individual, which in turn meant that she was free to wander round the home as per her care plan**.** In light of this, there was no justification for restricting Resident D to the chair at the time. It also noted from your written response that Resident D's behaviour within Frome Nursing Home caused you to become frustrated. The panel found, given this background and the physical action that accompanied the comment in charge 2b, it was more likely than not that it was said in a harsh manner.

Based on the above, the panel found that, on a balance of probabilities, it is more likely than not that on 16 January 2019, you said '*Ah! I told you to sit down'* (or words to that effect) harshly to Resident D.

Charge 3

3) *On 16 January 2019 at Frome Nursing Home, forcibly pulled Resident D into a chair.*

This charge is found proved

For the same reasons as set out for charge 2b, the panel found that, on a balance of probabilities, it is more likely than not that on 16 January 2019, you forcibly pulled Resident D into a chair.

In respect of all the charges that fall under charge 4

The panel noted that in relation to charges that fall under charge 4, the only direct evidence of what occurred came from you and Witness 2. It considered whether Witness 2 gave a truthful account. It took into account your evidence, both oral and at the time of the local investigation meeting on 15 February 2021 that you believed she was motivated by revenge because you had declined to support her mother, who was also a carer at the home, in connection with a dispute with another carer. The panel noted that you have provided very little detail about the nature of any difficulty between you and Witness 2's mother. You said in your written response to the initial allegations which you said had been drafted around 26 January 2021 that you had been asked to provide a statement by Witness 2's mother and had declined to provide a detailed statement and wrote a brief neutral one. The panel considers it unlikely that would be sufficient to cause Witness 2 to provide a false account of what occurred. It is clear from your account that there were incidents with each of the three residents who are the subject of these charges, so they have not been fabricated by Witness 2. The only dispute relates to your actions.

The panel also noted that Witness 2 did not make the allegations immediately but rather waited until she had an appraisal a few days later which would also suggest they were not motivated by revenge for anything you may or may not have done in connection with her mother's situation. Under cross examination, Witness 2 said "*…we had a good relationship before that night. I don't know why you keep insisting that there was a conflict, or that I didn't like her. I had nothing against her."* Having considered all of the evidence and having had the benefit of hearing oral evidence from Witness 2 and yourself, the panel is satisfied that Witness 2 has not deliberately given a false account of what occurred. It will of course still need to satisfy itself that her evidence is reliable in the sense that she was not mistaken about what she saw and heard.

Charges 4ai)

4) *Between 19 – 20 January 2021 at the Wiltshire Heights Care Home:*
    a) *In relation to Resident A;*
        i) *Informed them they would not be able to use the commode again until around 2am;*

This charge is found proved.

The panel had regard to local statement of Witness 2 (provided approximately seven days after the incident) in respect of this allegation when she states:

> *'Resident A had rang for the commode shortly after our shift started, she was assisted on the commode by Krystyna. After a while Resident A rang again for the commode and was told by Krystyna that she won't be assisted on the commode until after 2am…'*

and her NMC witness statement (which she adopted as her evidence-in-chief) where she states:

> *'…shortly after the shift started, Resident A rang the bell for the commode and Ms Stanis attended to them. At this point, Ms Stanis assisted Resident A onto the commode and when they were done, Ms Stanis told Resident A they could not use the commode again until around 02:00am…'*

In oral evidence, Witness 2 told the panel that she was located at the nursing station when she overheard the comment made to Resident A. She explained that the nursing station was approximately two metres away from Resident A's room. Witness 2 said there was a fire door between Resident A's room and the nursing station. However, under cross examination, Witness 2 confirmed that the fire door automatically closes at 10:30 PM.

Witness 2 recalls the incident happening shortly after 8 PM and she was able to hear any commotion going on outside the nursing station.

In your local investigation interview minutes (held on 15 February 2021), you explained that Resident A had a set routine whereby you would assist her with the commode at 12 AM, then tell her not to ring for the commode as you will return to assist her again at 2 AM. In your written response, you state that Resident A had the tendency to ring her bell multiple times throughout the night, and that sometimes the resident is unaware that she is ringing the bell. You explained that Resident A has two call bells, one around her neck and one clipped onto her pillow, and that during the night shift of 19 to 20 January 2023, Resident A was sleeping on top of the bell around her neck, causing it to ring continuously.

The panel found Witness 2's account of the incident to be consistent and reliable. The panel was satisfied that Witness 2 was able to overhear the commotion between you and Resident A in Resident A's room, from where she was located in the nursing station.

Based on the above, the panel found that, on a balance of probabilities, it is more likely than not that between 19 to 20 January 2021, you informed Resident A that they would not be able to use the commode again until around 2 AM.

Charge 4aii

4) *Between 19 – 20 January 2021 at the Wiltshire Heights Care Home:*
   a) *In relation to Resident A;*
      …
      ii) *When Resident A continued to ring the bell for assistance, told them not to ring the bell again;*

This charge is found NOT proved.

The panel noted that Witness 2 makes no specific reference to these alleged words in her local contemporaneous statement, and that such details were only provided in her witness statement.

The panel appreciated that Witness 2's initial account of the incidents that occurred between 19 and 20 January 2019, as set out under charge 4 in its entirety, was not made for the purpose of these regulatory proceedings, and that further details may have been added when recalling the event for the purpose of her NMC witness statement. Nevertheless, due to this specific wording being omitted from Witness 2's local contemporaneous statement, the panel were not satisfied that, on a balance of probabilities, that it is more likely than not that you told Resident A not to ring the bell again when she continued to ring the bell for assistance.

Charges 4aiii)

4) *Between 19 – 20 January 2021 at the Wiltshire Heights Care Home:*
   a) *In relation to Resident A;*
      …
      iii) *Upon Resident A continuing to ring the bell for assistance, threatened to remove their call bell if they continued to ring.*

This charge is found proved.

The panel had regard to local contemporaneous statement of Witness 2 in respect of this allegation when she states:

> *'…However, Resident A rang again after a while and Krystyna went to her, I heard Krystyna telling Resident A that if she carries on ringing she will take away her bell. Resident A rang again shortly after and when I stood up to answer her bell Krystyna asked me who is ringing and when I said to her that it's Resident A she has stormed into Resident A 's room and tried to take away her bell…'*

and her NMC witness statement where she states:

> *'…Resident A kept ringing the bell and Ms Stanis stormed into Resident A's room again. I was still at the nursing station when I overheard Ms Stanis threaten to remove Resident A's bell if they kept ringing…'*

The panel also noted the following in Witness 2's oral evidence:

> *'THE CASE PRESENTER: Do you remember the words that were used regarding the threat?*
> *THE WITNESS: No.*
> *…*
> *THE CASE PRESENTER: So how can you be sure that was what was said?*
> *THE WITNESS: At the time, when it was said, I heard that it was to do with taking the bell away. I can't say the exact words that were said, but taking the bell away was mentioned in the statement.*
> *THE CASE PRESENTER: And is it ever right to threaten to take a resident's bell away?*
> *THE WITNESS: No.*
> *THE CASE PRESENTER: Why not?*
> *THE WITNESS: It's neglect, and they've got call bells for a reason, and they are in the care home for a reason. I know sometimes with Resident A, she would ring a lot, but you can't just take her bell away; that's the only way, at times, to get help when they need it.'*

In your local investigation interview and your written response, you denied threatening to take Resident A's pendant call bell away as this would be pointless because she has another bell clipped onto her pillow. You said that you recommended moving the pendant bell.

It was established that the fire door would have been closed at this time, but Witness 2 stated in oral evidence that you were shouting whilst making this comment, hence why she was able to clearly hear you at the time:

> *'THE WITNESS: I don't know what happened in the room; I only know I heard what was said.*
> *DR GRAYDON: So you don't know what happened in the room, you only heard what was said; is that your evidence?*
> *THE WITNESS: Yes.*
> *DR GRAYDON: What was said. You only heard what was said – not shouted or screamed – what was said. Is that correct, is that your evidence?*
> *THE WITNESS: It was said in quite a loud tone, as I could hear at the nurses' station what was said. To me, it sounded like shouting.*
> *DR GRAYDON: It sounded like shouting.*
> *THE WITNESS: Yes.*
> *DR GRAYDON: But this is the early morning, isn't it? That's going to disturb other residents, isn't it?*
> *THE WITNESS: Not necessarily – a lot of residents that we look after, their hearing wasn't that good – not necessarily would disturb them.'*

The panel found Witness 2's accounts in her local contemporaneous statement, witness statement and oral evidence to be consistent in that you specifically told Resident A that you would take her call bell away if she continued to ring it.

The panel heard from Witness 2 and Witness 3 in oral evidence that Resident A had the tendency to ring her call bell often, and could be forgetful about when she had last been to then toilet. The strategy included reassuring her that she had just been and asking her whether she was sure she needed to go. However, both witnesses confirmed that it would not be acceptable to remove her call bell, or to tell her that she could not go to the toilet.

Based on the above, the panel found that, on a balance of probabilities, it is more likely than not that between 19 to 20 January 2021, upon Resident A continuing to ring the bell for assistance, you threatened to remove their call bell if they continued to ring.

Charges 4bi

4) *Between 19 – 20 January 2021 at the Wiltshire Heights Care Home:*

…

b) In relation to Resident B;

i) Dragged the resident out of bed;

This charge is found proved.

As the action in charges 4bi and 4bii were alleged to have occurred together, the panel decided to consider the evidence for these two charges together in its deliberations on the facts.

The panel has regard to local statement of Witness 2 in respect of this allegation when she stated:

> *'Resident B 's alert mat rang. Krystyna attended to her before me as I was finishing making the bed in room 24. When I walked into room 25 I witnessed Krystyna grabbing Resident B and dragging her up from the bed then shoving her into her armchair. Resident B became very distressed, she has been crying and apologising (Resident B was incontinent of urine which angered Krystyna). I asked Krystyna if we are washing B and she replied "no", she has then proceeded to dress Resident B while Resident B kept crying. At no point has Krystyna tried to comfort Resident B…'*

and her NMC witness statement where she states:

'…Ms Stanis was the first to attend and I followed shortly. When I walked into the room, I witnessed Ms Stanis grab Resident B by both arms and dragged them out of bed and pushed them into the armchair…'

In oral evidence, Witness 2 told the panel that Resident B was not very heavy so it would not have taken much effort to transfer her from the bed to the chair. She describes the force you used to manoeuvre Resident B as *"about 8"* on a scale of 1 to 10.

In your written response, you state:

'I didn't complete personal care in the morning to wash a resident after she wet herself, instead I just moved her from her bed to a chair in her room. What actually happened is I moved her to her chair I then cleaned and changed her into fresh clothes. Since it was just 2 of us working that floor I had to do it by myself, whereas normally it would be a two-person job, but I saw no initiative from the carer to either help out or do herself which is part of her job responsibilities but then reports me that I didn't do the job. Wherein fact I did try to do the job to my best ability as I could on my own. I do apologise if it wasn't done a perfect standard but it was all I could've done on my own…'

In your oral evidence, you stated that Resident B was heavy and about the same height as you, so you would not have been able to drag her as alleged. You said you used a Zimmer frame to transfer Resident B from the bed to the chair on your own.

The panel noted that the specific detail of using a Zimmer frame to move Resident B from the bed to a chair was neither mentioned during your local investigation interview, nor in your written response. Witness 2 also makes no reference to a Zimmer frame in her accounts of this incident.

In considering both Witness 2's account and your account of the incident, the panel decided that it preferred the account provided by Witness 2 as it found it to be more

consistent. Given how clear and detailed Witness 2 account was in comparison to your own, it considered that the use of a Zimmer frame is an important detail that would have come up if it was in fact used at the time as you have suggested. Also, such detail was not put to either Witness 2 or Witness 3 in cross examination. In any event, the panel found that the late mention of a Zimmer frame did not undermine Witness 2's evidence, and is satisfied that Witness 2's account is reliable.

Based on the above, the panel found that, on a balance of probabilities, it is more likely than not that between 19 to 20 January 2021, you dragged Resident B out of bed.

Charge 4bii

4) *Between 19 – 20 January 2021 at the Wiltshire Heights Care Home:*

…

b) In relation to Resident B;

ii) Pushed the resident into a chair;

This charge is found proved.

For the reasons as set out in relation to charge 4bi, the panel found that, on a balance of probabilities, it is more likely than not that between 19 to 20 January 2021, you pushed Resident B into a chair.

Charge 4biii

4) *Between 19 – 20 January 2021 at the Wiltshire Heights Care Home:*

…

b) In relation to Resident B;

iii) Failed to acknowledge and deal compassionately with their distress and/or emotion.

This charge is found proved.

The panel noted that both you and Witness 2 agreed in your separate accounts that Resident B was distressed and emotional at the time of the incident. Specifically, Witness 2 in oral evidence states:

> *"CASE PRESENTER: Now [Witness 2], you said that Resident B was upset and distressed, what was the reason for that?*
> *THE WITNESS: She was incontinent of urine at the time, and she was quite an anxious lady as well.*
> *THE CASE PRESENTER: So is that what she need help with; the incontinent of urine, at the time?*
> *THE WITNESS: Yes.*
> *THE CASE PRESENTER: ... You said that Resident B was quite distressed, how did Ms Stanis react towards that?*
> *THE WITNESS: She just ignored it.*
> *THE CASE PRESENTER: How was Resident B showing distress?*
> *THE WITNESS: She was crying and she kept apologising as well as if she'd done something wrong.*
> *THE CASE PRESENTER: When a resident is crying and apologising, what should you do?*
> *THE WITNESS: Just speak to them, explain that they haven't done anything wrong. Just show them compassion, that whatever happened it's not their fault, and just give them time to calm down.*
> *THE CASE PRESENTER: And did Ms Stanis do this?*
> *THE WITNESS: No."*

and in your written response, you state:

> *'…Also, it was reported that the resident was crying, which is what she does mostly every night, she walks around the floor, confused and crying. Which I did write in*

reports that I would recommend her seeing a doctor to prescribe some medication for sleeping or depression but nothing happened.'

The panel noted that you provided no account of what you actually did to deal with Resident B's distress at the time, until your oral evidence. On the other hand, there is no evidence to suggest that you were specifically asked this question during your local investigation interview, rather the focus was on how you physically handled Resident B.

The panel found Witness 2's general description of the wider incident with Resident B was more detailed and consistent in comparison to your own. The panel also found that Witness 2's account of Resident B's distress and her own reaction to be compelling.

The panel found that, on a balance of probabilities, it is more likely than not that between 19 to 20 January 2021, you failed to acknowledge and deal compassionately with Resident B's distress and/or emotion.

Charge 4c

4) *Between 19 – 20 January 2021 at the Wiltshire Heights Care Home:*

   …

   c) *Slapped Resident C's face.*

This charge is found proved.

The panel had regard to the local contemporaneous statement of Witness 2 in respect of this allegation where she states:

'…at one point he has slapped Krystyna in the stomach to which she slapped him back in the face. It wasn't a hard slap, however, Resident C appeared shocked'

and her NMC witness statement where she states:

‘On this occasion, Resident C slapped Ms Stanis on her stomach, but the slap was not hard at all. There was no force behind Resident C’s movement; it was more like a tap. When Resident C slapped Ms Stanis, she immediately slapped them back on the face, which left the resident shocked…’

In your written response, you say that Resident C made some sort of contact with you. You stated that Resident C had the tendency to be aggressive toward staff and that the proper response was to ask another carer to step in. In your local investigation interview, you stated that he hit out at you while you were washing him “and everything appeared normal”. However, in your oral evidence, you confirmed that Resident C slapped you in the stomach, and that in response you put your hand on the side of his face/head to turn it towards you to tell him that it was unacceptable behaviour.

The panel accepts that Resident C was prone to physical violence as per his care plan, and as confirmed by Witness 2 in her evidence. The panel considered your account and found that turning a resident’s head to face you when they were agitated was an unusual response. The more appropriate response would have been to back off in order to defuse the situation which you accept in your written response would have been the correct action. The panel also noted that you did not mention you touching his head during your local investigation interview, which it would have expected you to do given that you were alleged to have slapped him, whereas your case now is that you did touch him but only gently to get his attention.

The panel found Witness 2’s account of this incident in her local statement, witness statement and oral evidence to be consistent and reliable.

Based on the above, the panel found that, on a balance of probabilities, it is more likely than not that you slapped Resident C’s face between 19 and 20 January 2021.

Interim order

Having reached the conclusion of the facts stage, the hearing was adjourned on 21 July 2023 due to insufficient time to conclude within the allocated time.

At the time of adjourning, the legal assessor informed the panel that it would need to consider whether an interim order was required in this case under Rule 32(5).

The panel are aware that you currently have an interim order in place on your practice, which was reviewed in May 2023 under Article 31 of the Nursing and Midwifery Order 2001 (the Order) when the order was confirmed.

The panel accepted the advice of the legal assessor.

The panel considered that there is already an existing interim order in your case, which was confirmed in May 2023. The panel therefore decided not to consider the imposition of an interim order at this stage.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely, and professionally and impairment as not being fit to practise without restriction.

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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Mr O'Leary invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr O'Leary identified the specific, relevant standards where your actions amounted to misconduct. He referred to paragraphs 1, 1.1, 1.2, 2, 2.3, 2.4, 2.6, 20, and 20.5 of the Code. He submitted that misconduct is not a matter of proof for the NMC but that it is rather a matter of judgment for the panel and referred to *Biswas* [2006] EWHC 464 (Admin) and *Roylance*.

Mr O'Leary submitted that the panel may take guidance from your job description when you were working at Wiltshire Heights Care Home. In particular, he referred to 'Customer Care' which states that you must:

> *'Show courtesy and respect to Resident's at all times to ensure that they enjoy the highest quality of life, respect the confidentiality of Resident's and their families, friends at all times and involve families and friends in the Resident's care as appropriate…'.*

Mr O'Leary submitted that each charge that has been found proven is serious misconduct.

In relation to charges 1a and 1b, and 2a and 2b, Mr O'Leary submitted that these charges related to the shouting at / harsh words to a resident who is elderly and frail. He submitted that your actions were a serious departure of the standards expected of a nurse. He submitted that there can be no proper context for this action, and given its sustained nature, it clearly crosses the threshold for misconduct.

In relation to charges 3, 4bi and 4bii, Mr O'Leary submitted that these charges all relate to the rough behaviour and mishandling of residents which is not appropriate in any circumstance. He submitted that the panel has heard about the force that has been used and the manner in which this took place. He submitted that these matters do constitute misconduct as they show a complete disregard for the dignity of residents, their safety, and their right to be respected.

Mr O'Leary submitted that, to take Resident B as an example, Witness 3 confirmed in her evidence that it would 'never' be appropriate for Resident B to be taken by both arms and pulled from her bed by a sole individual, and that if a resident is able to take their own weight, there could be one or two people either side, however, if a patient cannot take their own weight, they would need to use equipment.

In relation to charges 4ai, 4aiii, and 4biii, Mr O'Leary submitted that these charges all amount to a complete lack of empathy and respect for the elderly who you are expected to respect and care for. Mr O'Leary submitted that you have shown yourself to be a person with limited patience and no regard for the dignity of those you are entrusted to look after.

In relation to charge 4c, Mr O'Leary submitted that this charge is plainly misconduct, as to slap a resident in the face must be misconduct as it falls far below the standards expected of a nurse.

Dr Graydon submitted that the issue of misconduct is a matter for the panel's judgement. He submitted that the panel is concerned with serious professional misconduct and that the panel would need to find each of the facts found proven to amount to serious misconduct. He submitted that not every falling short of standards will give rise to misconduct.

Dr Graydon submitted that the findings of facts that have been proven fall broadly into two categories: verbal behaviour and physical actions. Dealing with each of the allegations that have been proven in turn, he submitted that the panel will find that charges 1a and 1b constitute oral communication which can be seen as you behaving in a poor, ineffective, inappropriate, and unprofessional way. He submitted that Witness 1 provided evidence that Resident D was difficult to handle.

In respect of charge 1b, Dr Graydon submitted that the panel has acknowledged that the environment at the time of the incident was busy and stressful. He submitted that whilst the panel may conclude that this is not an excuse, the context in which words were shouted to residents have to be considered. Dr Graydon's submissions for charges 2a and 2b were the same as those in charges 1a and 1b. He submitted that your actions do not constitute to serious professional misconduct. He submitted that it is fair to say that words are less serious than physical conduct in the circumstances of this case and that this distinction must be made in the panel's consideration of misconduct.

In respect of charge 3, Dr Graydon submitted that Resident D was a challenging patient and that the panel should consider the context of the allegation that was proven. He submitted that the panel accepted that there may have been occasions where Resident D swung on a dining chair. He submitted that, by you pulling Resident D into a chair, your motivation was for the safety and reduction of risk for Resident D. He submitted that the execution of that risk reduction is what has given rise to this allegation and that the panel has found proven. He submitted that any reference to a force scale should be treated with some caution.

In respect of charge 4, excluding charge 4aii, Dr Graydon submitted that there is no evidence of harm caused to Resident A and so these charges do not constitute serious misconduct. He submitted that charge 4c concerns Resident C, and that the context of this charge is important. He reminded the panel that Resident C had slapped you in the stomach and that you responded to him. However, he submitted that your response may be described as an inappropriate strategy and that the panel may consider whether it was inappropriate and unprofessional.

Submissions on impairment

Mr O'Leary moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2)* and *Grant* [2011] EWHC 927 (Admin).

Mr O'Leary submitted that, should the panel be satisfied that some or all of the facts found proven amount to misconduct, it should then consider whether your fitness to practise is impaired.

Mr O'Leary submitted that your fitness to practise is impaired on both grounds of public protection and public interest.

Mr O'Leary referred to Dame Janet Smith's guidance in the Fifth Shipman Report and submitted that the first three limbs are engaged. He submitted that you have put patients at risk of both physical and emotional harm. He referred to the NMC's guidance on impairment and submitted that you have in the past acted, and are liable in the future, to put patients at unwarranted risk of harm.

Mr O'Leary submitted that to treat people with care and respond to their emotions is a fundamental tenet of the profession. He also reminded the panel of the provisions of the Code that he referred to in relation to misconduct.

Mr O'Leary submitted that when considering the context of the error or conduct involved in the concern, no level of context can reduce the risk presented here. He submitted that this is linked to the fundamental tenets of the profession in relation to shouting at residents, dragging residents from chairs, and slapping a resident.

In relation to public protection, Mr O'Leary submitted that there is risk to the public given that these are allegations over a period of time and at different homes. He submitted that whilst the witnesses may have said that your actions could have been out of character, the findings of fact have shown that between 2019 and 2021 a number of residents have been affected. He submitted that the panel may therefore consider that the manhandling of patients and use of harsh words were not isolated incidents, and that they have occurred in two separate homes, two years apart.

Mr O'Leary submitted that, given the similarity in allegations and the period of time over which they have been committed in those different homes, there is a risk of repetition. Additionally, he submitted that you have shown lack of insight. He submitted that the 2021 allegations took place at a time when you were aware that the 2019 matters were before the NMC. He submitted that, as noted in the determination, and as the parties have discussed, it was not in dispute that you knew the spectre of the 2019 allegations at the time when the 2021 allegations occurred. He submitted that this is particularly relevant given that the 2021 allegations are, in effect, a repetition.

Mr O'Leary referred to your documents which included testimonials and your written statements. He submitted that your testimonials are now of some age and were written prior to the findings of fact, albeit they refer to your work.

In relation to your statement, Mr O'Leary submitted that rather than reflecting on your own practice, the severity of the allegations, or the way in which the public would see the allegations, you have instead decided to discuss the failings of others. He submitted that your statement shows no insight at all. He submitted that, when looking at your description of events, the panel may also consider that under 'Evaluation', there is no evaluation of any substance, but rather a criticism of the witnesses.

Mr O'Leary submitted that you have shown no remediation. He submitted that the panel may consider your lack of remediation given that you have been aware of the findings since July 2023. He also submitted that the panel may consider that since the panel's determination on these facts were made, there has been no remediation, training or evidence of insight provided. He submitted that in the absence of any insight or proper remediation there is a risk of repetition and that this is a case where impairment still exists.

In relation to public interest, Mr O'Leary submitted that the public would be shocked and appalled if they were to learn that a nurse who has been found to have slapped, dragged, and pulled residents was able to practise freely and without restriction. In addition, he submitted that the second incident of the use of rough handling, shouting and violence in a care home occurred during COVID-19, when people placed an incredible degree of trust in nursing homes to look after their relatives. As such, he submitted that the panel may consider that impairment can also be found on the grounds of public interest.

Dr Graydon submitted that the panel is aware that the key question is whether you can practise kindly, safely, and professionally. He reminded the panel that it must consider the facts that have been found proven and have regard to the way you have acted in the past. He also reminded the panel that the purpose of Fitness to Practise proceedings is not to punish the practitioner, and that the panel must look forward and not back.

Dr Graydon submitted that the first component when dealing with impairment is the personal component. He submitted that the panel must consider whether you would be at

risk of repeating any misconduct, putting patients at unwarranted risk of harm, or whether you would breach fundamental tenets of the profession.

Dr Graydon submitted that you have been unable to practise as a nurse and therefore have been denied the opportunity to demonstrate that you have been able to perform as a satisfactory nurse. He submitted that you have continued to practise within the healthcare profession.

Dr Graydon referred to one of your supporting testimonials, namely a letter dated 16 July 2021. He submitted that, from this letter, it is clear that the job role that you have been carrying out as a care assistant demonstrates that rather than moving away from the profession, you have sought and succeeded in a caring role. He submitted that you were working in a similar dementia ward and at that point of time there were no concerns about your work. He submitted that this demonstrates your efforts to remediate any misconduct and to develop insight. He further submitted that the testimonial addresses a number of areas, including communication with residents, communicating with staff, and also manual handling techniques.

Dr Graydon also invited the panel to consider one of your testimonials via an email, dated 31 October 2022, provided when you had been a care leader for 18 months. He submitted that there is no evidence of any concerns of you regarding this role. He also submitted that you have continued in this role without any difficulties and that the panel will see your tasks set out in this letter. He submitted that you have developed sufficient insight throughout this role in order to allow you to remediate any misconduct.

Dr Graydon submitted that the panel can be assisted by Witness 3’s written statement, where she said that you would often pick up shifts when needed and drew a distinction between your relationship with nurses and non-nurses, such as care workers. He submitted that Witness 3’s understanding was that you could sometimes sound forceful, but when she spoke to you, this was not the case.

Dr Graydon submitted that you were subject to a disciplinary process and that rather than being dismissed, you were given a final written warning. He submitted that this is significant and demonstrates confidence in you at that point of time. He submitted that the public would be assured that the local disciplinary process was engaged and took its course.

With respect to the allegations brought by the NMC and its findings on facts, Dr Graydon submitted that the public would be fortified to know the regulatory process has challenged your conduct. He submitted that, if the panel reach the stage where it declares that some or all of your conduct amounts to misconduct, this in itself gives a clear message to you and the public that conduct of this nature is, firstly, not tolerated and, secondly, is not overlooked. He submitted that it is a matter of the panel's judgement whether public confidence would be undermined if a finding of impairment was not made.

Dr Graydon submitted that it is not accepted that you pose a high risk of repetition and invited the panel to consider your supporting testimonials and documentation. He submitted that he is not aware whether there are any updated testimonials from your current employer. Further, he submitted that the issue of COVID-19 is relevant as it was an extraordinary and unusual set of events at the time that the incidents occurred. He submitted that the public would understand the impact that COVID-19 had on everyone at that time, including you.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. This included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311.

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was satisfied that the above paragraphs of the Code are relevant and engaged in this context.

In relation to charges 1a and 2a, the panel found that the words used were harsh and inappropriate. However, it is the fact that they were repeated many times over a significant period of time that means that your conduct in charges 1a and 2a amounted to misconduct.

The panel found that charge 1b was a personal attack on Resident D's character which was completely unjustifiable and unkind and therefore amounted to misconduct.

In relation to charges 2b and 3, the panel determined that you failed to respect Resident D's autonomy and independence when you forcibly pulled her into a chair and used controlling language. The panel found that your behaviour was unkind. Therefore, the panel found that charges 2b and 3 amounted to misconduct.

In relation to charges 4ai and 4aiii, the panel determined that you demonstrated lack of care and respect. The panel found your misconduct to be unkind and that you lacked empathy. The panel was aware that Resident A has anxiety in relation to the use of a toilet, and so the panel found your treatment of Resident A to be unprofessional and unkind and would have caused particular anxiety for this resident. In relation to charge 4b, the panel found that you did not show humanity, that you did not act in accordance with professional standards, and that you caused Resident B emotional distress. In relation to charge 4c, the panel determined that a physical assault amounts to misconduct and that despite the fact it may have been reactive, a nurse cannot react this way to vulnerable patients. Therefore, the panel found that charge 4, excluding charge 4aii, amounted to misconduct.

In these circumstances, the panel found that your actions did fall seriously 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, your fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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. Nurses 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 finds that patients were put at risk and were caused physical and emotional harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. You demonstrated a lack of care, and your behaviour was trauma inducing to residents. The panel determined that the fact you were working during COVID-19 in 2021, which would have been extremely stressful, does not excuse your behaviour as during this period people expected higher standards of professionals as they could not see their family members. You demonstrated repeated inappropriate conduct in relation to frail and vulnerable residents, by physically and emotionally harming them. The panel was therefore satisfied that limbs a to c of *Grant* are engaged.

Regarding insight, the panel determined that you have not demonstrated an understanding of how your actions put patients at serious risk of harm, nor have you demonstrated an understanding of why what you did was wrong and how this impacted negatively on the reputation of the nursing profession. Further, you have not apologised to the affected patients, nor to this panel, for your misconduct. You have not demonstrated how you would handle the situation differently in the future.

The panel was satisfied that the misconduct in this case is capable of being addressed. However, the panel determined that it has not been addressed in your case. The panel noted that you have submitted positive references and assessments, but these are of some age and do not include any evidence of personal reflection. The panel determined that merely continuing to work in healthcare without any concerns being raised, is not sufficient to address misconduct of this nature. You have not provided any evidence of having completed additional training, for example, in relation to dealing with stress or difficult patients with dementia. The panel also had regard to your written statement where you fail to take accountability of your actions and instead shift blame to others.

The panel noted that although you had every right to defend the charges, there has been a period of several months since the findings of fact were made, and the panel would have expected you to use this time to provide some reflective pieces and demonstrate insight and also to provide evidence of remediation.

The panel is of the view that there is a real risk of repetition based on an absence of evidence to suggest that you have undertaken any insightful learning or any remediation or shown remorse. The panel determined that there are attitudinal verbal and behavioural concerns as you used physical force and harsh and unkind words to people in your care who were particularly vulnerable. The panel also took into account that these were not isolated incidents as you have repeated this behaviour in two different homes, two years apart. The misconduct in 2021 also took place when you were already under investigation by the NMC, when the panel find that you should have been particularly aware of a need to uphold professional standards.

The panel therefore determined that you continue to pose a risk of harm and your fitness to practise is currently impaired.

The panel bore in mind 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 determined that a reasonable and well-informed member of the public would be appalled to learn that a nurse that had both physically and emotionally harmed patients was permitted to practise without restriction. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case.

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

Sanction

The panel considered this case very carefully and decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

In reaching this decision, the panel 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 O'Leary informed the panel that in the Notice of Hearing, dated 5 October 2022, the NMC had advised you that it would seek the imposition of a suspension order for a period of 3 months, with a review, if your fitness to practise was found to be currently impaired. Mr O'Leary submitted that the proposal made in the Notice of Hearing, dated 5 October 2022, was made in error. Further, he informed the panel that he has spoken to Dr Graydon throughout the week and has made it clear that the sanction bid is that of a striking-off order.

Mr O'Leary referred to the SG. He reminded the panel that it had found that you caused physical and emotional harm to residents. He submitted that the SG reminds the panel that you should treat people with dignity which you did not do. He submitted that a striking-off order is appropriate when what you have done is fundamentally incompatible with being a registered professional. For imposing such a sanction, he submitted that the key considerations that the panel should take into account include the following:

- Do the regulatory concerns about the nurse raise fundamental questions about their professionalism?
- Can public confidence in nurses be maintained if the nurse is not removed from the register?
- Is striking-off the only sanction that will protect members of the public and maintain professional standards?

Mr O'Leary informed the panel that you were subject to an interim conditions of practice order in February 2021 which was replaced with an interim suspension order in December 2021. He reminded the panel that this substantive hearing started in 2022.

Mr O'Leary submitted that the following aggravating features are engaged in this case:

- Significant lack of insight and remediation

- The charges amount to a pattern of repeated conduct over a period of time, in different homes
- Physical assault to a resident
- Highly vulnerable patients put at risk of harm
- In respect to the 2021 misconduct, it was committed whilst you were aware that you were before the NMC for very similar matters

Mr O'Leary submitted that, in no doubt, Dr Graydon will be providing the panel with mitigating features.

Mr O'Leary submitted that as the findings are serious and include causing patients physical and emotional harm, a serious sanction is required. He submitted that, given the panel's findings on impairment, the imposition of no order, a caution order, a conditions of practice order, or a suspension order, is not appropriate in this case. He submitted that the slapping and demeaning of residents and the fact that the misconduct took place over a period of time may demonstrate attitudinal concerns.

Mr O'Leary submitted that the NMC make the following observations:

- This is not a single incident of misconduct
- The panel has found that there are attitudinal, verbal, and behavioural concerns
- The panel may consider that the repeated nature of the allegations may present a deep-seated attitudinal problem
- The panel has already pointed out that the misconduct in this case is capable of being addressed, however, you have not done so and instead you have shifted the blame
- The panel found that there was a real risk of repetition

Mr O'Leary referred to SAN-3E in the SG, in relation to a striking-off order. He submitted that the concerns raise fundamental questions about your professionalism and that the

panel has found that you caused harm. He submitted that this goes against the fundamentals of treating others with dignity and respect.

Mr O'Leary submitted that public confidence in nurses would be affected if you were not removed from the register. He submitted that patients and the relatives of those patients ought to be safe in the knowledge that nurses who are caring for them are doing so properly. Given the repeated nature of the misconduct, he submitted that a striking-off order would be the only appropriate sanction. He submitted that this is a concern that could result to harm to patients if not put right and that you pose a risk of repetition. Further, he submitted that the actions committed by you are fundamentally incompatible with being a registered professional.

Decision and reasons on application for part of the hearing to be held in private at this stage

Dr Graydon made a request that part of this hearing be held in private to the extent of references made to [PRIVATE]. The application was made pursuant to Rule 19.

Mr O'Leary indicated that he did not oppose the application.

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

The panel determined to hold in private the parts of this hearing that involve reference to [PRIVATE] as and when such issues are raised in order to protect your privacy.

Submissions on sanction continued

Dr Graydon submitted that the NMC has set out the approach that the panel should take and referred you to the relevant guidance. He confirmed that Mr O'Leary informed him that a striking-off order was being sought.

Dr Graydon submitted that there were a number of matters that the panel should have in mind when it approaches sanction. Firstly, he submitted that the guidance offers the panel a guide as to how to approach sanction. As with determining misconduct and impairment, he submitted that the panel's decision on sanction is a matter of its judgement. He submitted that it is not a tick-box exercise and that you have been assured that the panel will approach the issue of sanction with the same diligence that it has approached misconduct and impairment. Secondly, he submitted that, in relation to proportionality, the panel is not to go beyond what is necessary in order to achieve the NMC's overarching objectives.

Dr Graydon submitted that Mr O'Leary has highlighted the aggravating features which forms part of the panel's exercise.

Dr Graydon submitted that, set against the panel's conclusion on misconduct and impairment, the purpose of sanction is not to punish. He submitted that sanctions can have a punitive effect. He reminded the panel that the NMC submitted that personal mitigation is less relevant. However, Dr Graydon submitted that personal mitigation is relevant and should be something that the panel consider in its overall approach. He submitted that the issue is how the panel balance and weigh personal mitigation against the other factors. He submitted that there are different forms of mitigation that are recognised by the NMC, but in your case, personal mitigation is important.

Dr Graydon submitted that the following mitigating features are engaged:

- You have an unblemished record

- As referred to in the testimonial from your friend and colleague, dated 15 February 2022, you are someone who has considerable experience in the nursing profession
- You have been working in the UK for a number of years
- In your description of events statement, you referred to [PRIVATE].
- [PRIVATE].

Dr Graydon submitted that Mr O'Leary has referred to deliberate acts and that it is for the panel to determine whether these acts were deliberate. He submitted that you would say that the events were out of character and that you did not act in a deliberate way.

Dr Graydon submitted that there is some reference to an apology within your description of events statement. Whilst it is accepted that it is not an explicit apology to each of the residents, he submitted that this does represent an apology which the panel is invited to consider.

Dr Graydon submitted that Mr O'Leary set out the approach that the panel should take when considering sanctions. He submitted that the starting point for the panel is the consideration of the least restrictive sanction until settling upon what it considers to be the appropriate and proportionate order in all the circumstances of the case.

Dr Graydon submitted that the panel's findings on misconduct and impairment set out a number of reasons. He highlighted that the panel is satisfied that the misconduct in this case is capable of being addressed. He submitted that, in approaching the available sanction orders, it will need to consider each of them in turn. He submitted that the panel may conclude, having considered taking no action or imposing a caution order, that both would be wholly inappropriate in light of this case.

Dr Graydon submitted that the panel highlighted its concerns regarding repetition and the key issue of harm. He submitted that the panel is invited to consider a conditions of practice order with practicable and workable conditions that would serve to protect the public, the reputation of the profession, and uphold proper standards of conduct. This

order would also allow you to return to the nursing profession albeit with a restricted practice so as to achieve those objectives.

Dr Graydon submitted that a conditions of practice order would be the appropriate order as the misconduct is capable of being addressed. He submitted that the formulation of conditions can address the specific shortcomings that the panel identified in your practice. He also submitted that this would allow you to respond positively through retraining whilst ensuring that the NMC's overarching objectives are achieved. He submitted that any conditions that the panel consider should not be tantamount to a suspension order.

In relation to a suspension order, Dr Graydon submitted that this order would be disproportionate and inappropriate in the circumstances of this case. He submitted that Mr O'Leary has highlighted to the panel that you have been subject to an interim conditions of practice order which was replaced with an interim suspension order from December 2021 until now, which is a period of two years and one month. He submitted that a suspension order has a punitive effect on you as you are unable to practise as a nurse, and, as a consequence, the impact includes reputational damage and financial impact.

[PRIVATE]. He submitted that if the panel concluded that a suspension order was appropriate, he would invite it to impose a short period of suspension which should be considered alongside the impact of the current interim suspension order.

Dr Graydon submitted that the NMC's proposal of a striking-off order should be reserved for cases where registrants have deliberately or recklessly created risk of harm to patients. He invited the panel to consider that you have maintained good practice and that these incidents were out of character. He submitted that your conduct as proven is not so serious as to be fundamentally incompatible with practising as a nurse. He submitted that the concerns can be addressed and are capable of remediation with appropriate conditions. He submitted that striking-off may be appropriate if it were the only means of protecting the public and maintaining confidence in the profession. However, he submitted

that these objectives can be achieved with a lesser sanction, such that striking-off would be disproportionate and inappropriate in all the circumstances of the case.

Dr Graydon submitted that one of the difficulties that you have had is understanding how regulatory processes work and that you have made efforts overnight to secure a letter of support from your current employer. He submitted that it is not the case that you have sat back and done nothing. He informed the panel that you do wish to return to nursing and that you have the support of your current employer.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Significant lack of insight into failings and lack of remediation
- Misconduct in different homes which occurred two years apart
- Manhandling and assault of vulnerable residents
- Deliberate unkind acts that caused vulnerable residents with dementia distress
- Repeated demeaning and derogatory conduct towards particularly vulnerable residents
- In respect to the 2021 misconduct, this was committed whilst you were aware that you were before the NMC in the past for very similar misconduct

The panel also took into account the following mitigating features:

- A stressful working environment
- No evidence of repetition of misconduct after the second episode in 2021

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor 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, its findings on impairment, and the public protection issues identified, an order that does not restrict your 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 your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the serious charges in this case, the attitudinal concerns, and repeated misconduct. There are no workable conditions that would adequately address the risk to the public. In addition, you failed to provide any evidence of relevant training, insight, or remediation which the panel found demonstrates an attitude which is inconsistent with workable conditions of practice. The panel concluded that the placing of conditions on your registration would not satisfy the public interest in the maintenance of confidence in the profession and the upholding of standards and would not adequately protect the public.

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; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour*

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate, or proportionate sanction.

The panel found that your conduct amounted to repeated unkind acts that were similar in nature and caused emotional harm to very vulnerable patients. The panel find that the nature of the misconduct is incompatible with the fundamental tenets of nursing as a caring profession. You failed to uphold patient's dignity, treat them with kindness, respect, and compassion, and to deliver the fundamentals of care. The panel find that the nature of your actions, where you were deliberately unkind to a number of very vulnerable patients in incidents that were two years apart, show a harmful and unprofessional attitude. While the panel took into account that you had been suspended for a significant period of time, it did not feel that you had demonstrated any insight, remorse, or active learning to remediate your misconduct and address your attitudinal issues. As regards the apology offered in your description of events statement, the panel considered that it amounts to little more than an attempt by you to justify your actions.

Although you said [PRIVATE], the panel find that, in the context of the allegations, this is not enough to suggest that these repeated acts are out of character for you. The panel took note that there has been no repetition of the behaviour since the second set of incidents in 2021. However, the panel find that the nature of the behaviour, the fact that

there are multiple incidents and multiple patients, that some incidents took place after you were already under NMC investigation, and the complete lack of any meaningful efforts towards remediation, leads it to the conclusion that there is a significant and real risk of repetition.

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

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

Your actions were significant departures from the standards expected of a registered nurse and demonstrate embedded professional attitudinal concerns and therefore are fundamentally incompatible with you remaining on the register. You failed to demonstrate any insight or remediation over a significant period of time. The misconduct took place in 2019 and 2021, and the panel is particularly concerned that, in the six months since it made its findings of fact, you have done nothing to develop your insight or taken steps to address your failings. In all the circumstances, the panel finds there is nothing to indicate that this is likely to change. The panel was of the view that the findings in this particular case demonstrate that the degree of your impairment is such that to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public’s view of how a registered nurse should

conduct yourself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to you in writing.

Interim order

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

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

Submissions on interim order

The panel took account of the submissions made by Mr O'Leary. He submitted that an interim suspension order for a period of 18 months is necessary given the panel's findings in order to protect the public and meet the wider public interest. He submitted that this was required to cover the 28-day appeal period and, if you do appeal the decision, the period for which it may take for that appeal to be heard. He submitted that the reputation of the profession would be significantly undermined if, despite the panel's findings, an interim suspension order was not in place, and you were allowed to practise unrestricted during the appeal period.

Dr Graydon submitted that if an interim order is considered, there is no evidence before the panel that you intend to apply for any registered nursing positions, and that the period concerned is 28 days during which you would be entitled to make an appeal. In addition, he submitted that you continue to work in a care home environment in which you are not practising as a nurse but are engaged in care activities and care roles. He submitted that, in these circumstances, it is a matter for the panel to decide whether it is necessary for public protection, in the public interest, or your own interest to impose an interim order today.

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 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 to cover the 28-day appeal period and any period in which an appeal may be heard.

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

That concludes this determination.