Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 4 March- Monday, 18 March 2024

Virtual Hearing

Name of Registrant:	**Leah Cradock**
NMC PIN	01I2865E
Part(s) of the register:	Registered Nurse – Sub part 1 Mental Health Nursing – 20 September 2004
Relevant Location:	Sheffield
Type of case:	Misconduct
Panel members:	Richard Weydert-Jacquard (Chair, Registrant Member) Caroline Rollitt (Lay Member) Paul Leighton (Lay Member)
Legal Assessor:	Charles Parsley
Hearings Coordinator:	Angela Nkansa-Dwamena
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter
Miss Cradock:	Not present and not represented at the hearing.
Facts proved:	Charges 4, 5, 6, 7a, 7b, 8, 9, 10, 11, 12, 14a, 14b, 17, 18, 19, 20a, 20b, 21, 22 and 23
Facts not proved:	Charges 1, 2, 3, 13, 15, 16

Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Cradock was not in attendance and that the Notice of Hearing letter had been sent to Miss Cradock's registered email address by secure email on 31 January 2024.

Further, the panel noted that the Notice of Hearing was also sent to Miss Cradock's representative at the Royal College of Nursing (RCN), who was copied into the above email.

Dr Joshi, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). Dr Joshi referred the panel to email correspondence between the Hearings Coordinator and the RCN, on behalf of Miss Cradock, dated 4 March 2024. He submitted that the RCN's confirmation of non-attendance by both Miss Cradock and her representative indicated that notice of this hearing has been received.

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Miss Cradock

The panel next considered whether it should proceed in the absence of Miss Cradock. It had regard to Rule 21 and heard the submissions of Dr Joshi who invited the panel to continue in the absence of Miss Cradock.

Dr Joshi referred the panel to the Rule 19 bundle which outlined that neither Miss Cradock, nor her representative would be attending the hearing and that they were happy for the hearing to proceed in Miss Cradock's absence:

> *'The Registrant will not be attending the hearing, nor will she be represented. No disrespect is intended by her non-attendance. The Registrant [PRIVATE] to attend and meaningfully engage with the hearing process. The Registrant has received the notice of hearing and is happy for the hearing to proceed in her absence.'*

Dr Joshi also referred the panel to email correspondence between the Hearings Coordinator and the RCN, in which the RCN confirmed that they were happy for the hearing to proceed in Miss Cradock's absence.

The panel accepted the advice of the legal assessor.

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

The panel decided to proceed in the absence of Miss Cradock. In reaching this decision, the panel considered the submissions of Dr Joshi, the representations made on Miss Cradock's behalf, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General*

Medical Council v Adeogba [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- The RCN, on behalf of Miss Cradock, has informed the NMC that they have received the Notice of Hearing and confirmed Miss Cradock is content for the hearing to proceed in her absence;
- No application for an adjournment has been made by Miss Cradock;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- There are a number of witnesses that are due to give live evidence in this case;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2022 and further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Cradock by proceeding in her absence. The evidence upon which the NMC relies has been sent to her and her representative at the RCN. She will not be able to challenge the evidence relied upon by the NMC in person and the RCN has not attended to represent her and challenge the evidence on her behalf. Nor will she be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

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

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

[PRIVATE]

Details of charge

That you, a registered nurse whilst working at the Becton Centre for Children and Young People ('the Centre');

On the night shift of 17-18 May 2022;

1) Locked Patient A in their room without any clinical justification.

2) Did not move Patient A to the Seclusion room located in the centre.

3) Did not record any observations of Patient A, after you had locked them in their room.

4) Did not document that you had locked Patient A in their room in Patient A's Care Plan.

5) Did not complete the restrictive intervention section of Patient A's notes

6) Did not complete a DATIX/Incident Form regarding the incident.

7) After locking Patient A in their room, did not;

a) Call the on-call medic;

b) Call the on-call manager.

8) Did not document that you had locked Patient A in their room in the Handover Sheet.

9) Whilst conducting handover to day shift, did not inform one or more colleagues that you had locked Patient A in their room.

On the night shift of 18-19 May 2022;

10) Whilst on the night shift/disclosing Patient A's sleep pattern during handover, did not inform one or more colleagues that you had locked Patient A in their room on the last night shift.

11) Incorrectly informed agency staff that all patients on Ruby Lodge were 2 to 1.

12) On one or more occasion locked Patient A in their room without any clinical justification.

13) Did not use any de-escalation/distraction methods on Patient A.

14) Between 04:15 – 7a.m. whilst Patient A was exhibiting distressing behaviour:

a) Restricted staff from going into Patient A's room to provide support.

b) Used words to the effect;

i) '*This is what boundaries are.'*

ii) '*No she needs to learn to self-regulate.'*

iii) *'She has always got her own way.'*

iv*) 'She needs to learn.'*

v) '*She's got away with it for too long.'*

15) Did not move Patient A to the Seclusion room located in the Centre.

16) Did not carry out/record any observations of Patient A, after you had locked them in their room.

17) Did not document that you had locked Patient A in their room in Patient A's Care Plan.

18) Did not complete the restrictive intervention section of Patient A's notes

19) Did not complete a DATIX/Incident Form regarding the incident.

20) After locking Patient A in their room, did not;

a) Call the on-call medic;

b) Call the on-call manager.

21) Did not document that you had locked Patient A in their room in the Handover Sheet.

22) Whilst conducting handover to day shift, did not inform one or more colleagues that you had locked Patient A in their room.

23) On an unknown date after Colleague Y disclosed details about an unknown patient's attachment disorder, shouted at Colleague Y using words to the effect *'no she hasn't she's just spoilt'*.

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

Background

The NMC received a referral from Sheffield Children's NHS Foundation Trust (the Trust), on 5 July 2022, raising concerns about Miss Cradock's conduct. The charges arose whilst Miss Cradock was employed as a Clinical Nurse at Becton Centre for Children and Young People (the Centre).

The Trust informed the NMC that an incident had been reported by a Healthcare Support Worker (HSW), whilst working on [PRIVATE] (the Unit), a Child and Adolescent Mental Health Service (CAMHS) inpatient unit which admits children and young people with learning disabilities and suspected mental health problems for assessment. It was alleged that on 18 May 2022, Miss Cradock had locked Patient A in their room.

It was stated that Miss Cradock chose to redirect the distressed patient back to their bedroom and followed up by locking their door. Miss Cradock was challenged by the HSW when they highlighted that this constituted restrictive practice. Miss Cradock reported that her rationale was that it was to reduce staff injuries.

Miss Cradock rang the on-call manager after her shift to inform them that staff did not have a good night with Patient A. When questioned about this, Miss Cradock raised concerns about Patient A's medication regime, but did not mention that she had locked Patient A's door.

Following the Trust's initial investigation, it came to light that a similar incident had occurred the night before (17 May 2022), with a different set of HSWs but still involving Miss Cradock.

It is further alleged that Miss Cradock did not hand over or document the unapproved practice of locking Patient A within their bedroom.

The Trust informed the NMC that when questioned about the incident, Miss Cradock lacked insight in respect of the potential harm to the patient locked in their bedroom.

Patient A [PRIVATE] and was admitted for a period of assessment. It is reported that the night shift of 17 May was the first time that Miss Cradock had met Patient A since their admission.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Dr Joshi, on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Miss Cradock.

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: Acting Lodge Manager and Investigating Manager at the time of the incidents.
- Witness 2: Support Worker on the Unit at the time of the incidents.
- Witness 3: Support Worker at the Centre at the time of the incidents.

- Witness 4: Support Worker on the Unit at the time of the incidents.
- Witness 5: Colleague Y and Support Worker on the Unit at the time of the incidents.
- Witness 6: Clinical Nurse on the Unit at the time of the incidents.
- Witness 7: Staff Nurse on the Unit at the time of the incidents.

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

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

Charge 1

On the night shift of 17-18 May 2022;

1) Locked Patient A in their room without any clinical justification.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 2, 3 and 4 and the Trust's investigation meeting notes dated 20 May 2022.

The panel first considered Miss Cradock's admission to locking Patient A in her room. The panel had regard to the notes from Miss Cradock's interview with the Clinical Nurse Manager in which she admitted to locking Patient A in her room. This was supported by Witness 2's NMC witness statement in which she confirmed that Miss Cradock had locked Patient A in her room on the night shift of 17-18 May 2022. The panel determined that Miss Cradock had locked Patient A in her room on the night shift of 17-18 May.

However, the panel carefully considered the particular wording of this charge, namely *'without any clinical justification'*.

The panel noted that within her written statement, Witness 2 had described that Patient A had exhibited aggressive and challenging behaviour and Miss Cradock had been assaulted and injured by Patient A:

> *'Patient A continued to shout aggressively, constantly swearing and hitting out. At one point she punch [sic] Leah in the chest with a lot of force. Leah didn't fall to the ground or anything but the look on her face, to me, looked like it had probably hurt her. Patient A would often hit out and spit at staff as well.*
>
> *…*
>
> *Once Leah was hit in the chest we tried to come out of Patient A's bedroom.'*

Furthermore, the panel heard from Witness 2 and 3 that Patient A's behaviour presented a risk of harm to staff and that Patient A had a habit of entering the rooms of other patients and trying to get into bed with them.

The panel bore in mind that during the initial investigation interview, Miss Cradock had explained that in the past, other members of staff had sustained injuries such as *'suspected cracked ribs and bloodied faces'*, which had necessitated hospital attendances. Furthermore, she had weighed up other options such as medication

and restraint. The panel noted that at the time, Patient A had already had the maximum dose of PRN medication. The panel further noted that in her local statement, Witness 2 had stated that there were only three members of staff on shift who were appropriately trained in restraint, but five to six trained members of staff would be required to safely restrain Patient A. The panel also considered that Miss Cradock had informed management [PRIVATE] she was not up to date on her restraint training at the time of the incident.

The panel heard that seclusion was considered as a last resort and other techniques would need to be exhausted. However, the panel heard from Witness 4 who had stated that Patient A was not responding to distraction methods or verbal redirection. This was also supported by Witness 2's statement:

> *'We found that sometimes giving her space helped to de-escalate but she kept coming out in to the corridor and we had to redirect her back into the room, this involved opening the door and using hand gestures for her to go into the room. Myself, Leah and another Agency Worker… were at the door trying to redirect her when another Support Worker [Witness 4] came down. At this point we had been trying to calm her down for a while, over half an hour but she kept trying to come out and trying to hit us.'*

The panel considered the above evidence and determined that Patient A's behaviour had posed an imminent risk of harm to staff and other patients on the unit. The panel was of the view that, although seclusion was considered as a last resort, in these circumstances, Miss Cradock's action of locking Patient A in her bedroom had some clinical justification.

Accordingly, the panel found Charge 1 not proved.

Charge 2)

> 2) Did not move Patient A to the Seclusion room located in the centre.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Witness 1 and Witness 3.

During her oral evidence, Witness 1, who was the Acting Manager of the Unit at the time, stated that there was no designated seclusion room available on the Unit. This was also confirmed by Witness 3 during her live testimony in which she stated that she was not aware that there was a seclusion room on the Unit and there was not one on the unit she usually worked on (Emerald Lodge). The panel determined that there was no evidence to suggest the existence of a separate seclusion room in the Centre to which Patient A could have been moved.

In light of the above, the panel concluded that with respect to Charge 2, the NMC had not discharged its burden of proof.

Accordingly, this charge is found not proved.

Charge 3)

> 3) Did not record any observations of Patient A, after you had locked them in their room.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 2 and Witness 4, in addition to Patient A's electronic care notes dated 18 May 2022.

The panel heard from Witness 4 that after Miss Cradock had locked Patient A in her room, staff observed Patient A through the glass panel window on her door. This was consistent with her witness statement:

> *'Usually we check on Patients every hour however with Patient A we took it in*

turns to watch through the viewing panel until she went to sleep and then we would check every hour through the panel to make sure we didn't wake her up. These checks were done by all staff.'

The panel also heard from Witness 2 who had confirmed that staff had observed Patient A through the glass window during the time she had been locked in her room. Witness 2 further stated that when staff had expressed their concern about not being able to see Patient A when she went into her bathroom, Miss Cradock had unlocked the door so staff could see her. Again, this was consistent with her written statement:

'…at one point she went into her bathroom so we could no longer see her. I asked Leah if we could go in a check on her and Leah agreed so she opened the door and I saw she was sat on the toilet so we left again…'

The panel accepted the evidence of Witness 2 and Witness 4. The panel initially noted that the NMC had not put before it what specific observations were required to be documented for Patient A. Secondly, the panel noted that an entry was made by Miss Cradock in Patient A's electronic care notes at 06:08 hours on 18 May 2022. Within these notes, Miss Cradock had documented the staff's observations of Patient A throughout the shift at a time after the incident had taken place.

The panel was of the view that there must have been other notes for Patient A. However, these were not put before it. The panel concluded that Miss Cradock and members of staff under her supervision had in fact undertaken observations for Patient A during the time she was locked in her room. This had been recorded by Miss Cradock in Patient A's care notes during the shift and after the time the incident had occurred.

In light of the above, the panel concluded that with respect to Charge 3, the NMC had not discharged its burden of proof.

Accordingly, this charge is found not proved.

Charge 4)

4) Did not document that you had locked Patient A in their room in Patient A's Care Plan.

This charge is found proved.

In reaching this decision, the panel took into account Patient A's Care Notes, Care Plan, handover sheet, the Trust's investigation fact finding meeting notes and notes from the Trust's Formal Investigation Meeting with Miss Cradock on 22 September 2022.

The panel noted that Miss Cradock had admitted to not recording that she had locked Patient A in her room, in Patient A's care notes, during the fact-finding meeting with the Clinical Nurse Manager on 20 May 2022. This was reiterated by Miss Cradock during the formal investigation meeting, in which she had stated:

'I have already admitted that I didn't document it.'

The panel had regard to Patient A's records detailed above and noted that there was no record made by Miss Cradock relating to Patient A being locked in her room at any time during the shift.

The panel considered the above evidence and determined that it was more likely than not that Miss Cradock did not document in Patient A's care records that she had locked Patient A in her room during the shift.

Accordingly, the panel found Charge 4 proved.

Charge 5)

5) Did not complete the restrictive intervention section of Patient A's notes

This charge is found proved.

In reaching this decision, the panel took into account the written witness statement of Witness 1 and Miss Cradock's admissions.

The panel had noted when considering Charge 4 that Miss Cradock had admitted that she had not recorded that she had locked Patient A in her room.

The panel noted that within her written statement, Witness 1 had stated:

> *'Within the notes there is a separate section for restrictive intervention but this was not completed…'*

Although the panel heard evidence that there was specific provision within the patient notes for a 'restrictive intervention' section, the panel did not see evidence of such a section in the notes presented to it. The panel noted that at the time, Witness 1 was the Acting Manager of the Unit and had conducted the Trust investigation and reviewed all the documentation, Witness 1 stated that there was no entry in the 'restrictive intervention' section for the dates in question. The panel considered that Witness 1 was a credible and reliable witness and that there was no reason to doubt her account.

In light of the above, the panel determined that Miss Cradock did not complete the 'restrictive intervention' section of Patient A's notes.

Accordingly, the panel found Charge 5 proved.

Charge 6)

> 6) Did not complete a DATIX/Incident Form regarding the incident.

This charge is found proved.

In reaching this decision, the panel again took into account the written witness statement of Witness 1 and Miss Cradock's admissions.

The panel noted that Miss Cradock had admitted to not making a record of locking Patient A in her room anywhere. Miss Cradock also stated the following in her formal investigation meeting:

'I did not complete a Datix'

Miss Cradock had also previously stated that she struggled to use computers.

The panel noted that Witness 1 had stated within her witness statement that:

'…and not [sic] DATIX/incident form completed either.'

The panel accepted the above evidence and this was confirmed by Miss Cradock's own admissions.

In light of the above, the panel determined that it was more likely than not that Miss Cradock did not complete a DATIX/incident form.

Accordingly, the panel found Charge 6 proved.

Charges 7a and 7b)

7) After locking Patient A in their room, did not;

a) Call the on-call medic;

b) Call the on-call manager.

These charges are found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1 and Witness 6 as well as Patient A's care notes.

The panel had regard to Witness 1's statement which stated:

> *'Leah also did not call the on-call medic to review Patient A and she did not call the on-call manager. These steps are necessary to ensure the wellbeing of the young person.'*

The panel heard from Witness 6 who confirmed that the Trust's Seclusion Policy outlined that the on-call medic and on-call manager would need to be informed if the seclusion of a patient was being considered or implemented. This was supported by her written statement:

> *'The Trust had a seclusion policy, it was not normal practice to lock a patient in their room. You would have to call the on-call medic and on-call manager [if out of hours]…'*

Witness 6 further explained that if Miss Cradock had called the on-call medic and manager after locking Patient A in her room, she would have expected to have received this information during handover from Miss Cradock. This was consistent with her account within her written statement. Witness 6 confirmed that she had not received this information during handover on the morning of 18 May 2022.

The panel also noted that within her entry on Patient A's care notes at 06:08 hours on 18 May 2022, Miss Cradock did not make any reference to the on-call medic or on-call manager being called.

In light of the above, the panel determined that it was more likely than not that Miss Cradock did not call the on-call medic or on-call manager after locking Patient A in her room.

Accordingly, the panel found Charges 7a and 7b proved.

Charge 8)

8) Did not document that you had locked Patient A in their room in the Handover Sheet.

This charge is found proved.

In reaching this decision, the panel had regard to Patient A's handover sheet.

The panel noted that Miss Cradock's updated entry on the handover sheet on 17 May 2022 at 21:53 hours made no reference to Patient A being locked in her room. In addition to this, there were no other entries for that shift as the next entry was on 18 May 2022 at 13:00 hours.

In light of the above, the panel determined that it was more likely than not that Miss Cradock did not document that she had locked Patient A in her room on the handover sheet.

Accordingly, the panel found Charge 8 proved.

Charge 9)

9) Whilst conducting handover to day shift, did not inform one or more colleagues that you had locked Patient A in their room.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 6.

The panel noted that with her written statement, Witness 6 stated the following:

'I worked the day shift of 18 May 2022 from 07:30 in the morning until 15:30 in the afternoon. It would have been Leah who handed over to me when I started my shift…

A typical handover involves the Nurse from the night shift handing over to the nurse and the support workers on the early shift about what happened the day before and how patients were during the night.

Leah did not handover to us that [Patient A] had been locked in her room during the night shift. I would remember if she had said this as it would have been out of the ordinary. I do not recall the specific handover that Leah did give but I would remember if she told me Patient A was locked in her room…'

Witness 6 confirmed this during her live evidence.

The panel therefore noted that Witness 6's oral and documentary evidence was consistent and determined that it was more likely than not that Miss Cradock did not inform one or more colleagues that she had locked Patient A in her room.

Accordingly, the panel found Charge 9 proved.

Charge 10)

10) Whilst on the night shift/disclosing Patient A's sleep pattern during handover, did not inform one or more colleagues that you had locked Patient A in their room on the last night shift.

This charge is found proved.

In reaching this decision, the panel took into account the oral testimony of Witness 7, in addition to the written statements of Witness 5 and 7.

The panel had regard to the following extracts from Witness 7's written statement:

> *'I confirm that I worked the day shift of 19 May 2022 taking over from Leah's night shift of the 18-19 May 2022…*
>
> *Leah conducted the handover when I arrived on shift…*
>
> *During this handover nothing was mentioned by Leah about locking [Patient A] in her room during the night shift. I think Leah did the handover all from memory, usually we would read off of the system one.'*

During her live evidence, Witness 7 confirmed that she was the nurse who took over from Miss Cradock on the morning of 19 May 2022 and that Miss Cradock did not handover any information about Patient A being locked in her room during the night shift.

This was supported by Witness 5's written statement, which stated:

> *'We started the shift with the handover and I recall staff telling us that Patient A had slept through the night…I remember being quite shocked to learn she had slept well the night before as she did not sleep well at all…*
>
> *There was nothing about a locked door mentioned during this handover just that she had slept well.'*

The panel considered the above evidence and accepted the accounts of Witness 5 and 7. It determined that it was more likely than not that Miss Cradock did not inform one or more colleagues during handover that she had locked Patient A in her room.

Accordingly, the panel found Charge 10 proved.

Charge 11)

11) Incorrectly informed agency staff that all patients on Ruby Lodge were 2 to 1.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 5.

In her witness statement, Witness 5 stated:

'I noted that Leah told agency staff that all patients were two to one meaning two staff to one patient which was incorrect, our patients were on one to one.'

This was consistent with her contemporaneous account in her local witness statement:

'Before we went onto the ward Leah stated to the agency staff that all our patients are two to one however that is incorrect.'

Witness 5 confirmed during her live testimony to the panel that Miss Cradock had incorrectly informed agency staff that patients on Ruby Lodge were two to one.

The panel considered the above evidence and accepted the account of Witness 5. It determined that it was more likely than not that Miss Cradock had incorrectly informed agency staff that patients on the Unit were two to one.

Accordingly, the panel found Charge 11 proved.

Charge 12)

12) On one or more occasion locked Patient A in their room without any clinical justification.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 5, as well as the written statement of Witness 3.

The panel heard from Witness 5 who had stated that Patient A had usually exhibited challenging behaviour and was often aggressive however, prior to being locked in her room on the night shift of 18 May 2022, this was not the case with Patient A. This was supported by Witness 5's written statement:

> *'Not once did [Patient A] raise her voice. She was prone to hitting people and being aggressive but that night not once did she show any sort of behaviour like that. The only time she became distressed and agitated was when she realised she had been locked in her room.'*

This was corroborated in the witness statement of Witness 3:

> *'Patient A was then settled and we left the room about 22:15…*
>
> *I don't think there was a need to lock Patient A in her room. She was settled and appeared to be asleep, calmed down and not showing any signs of aggression.'*

The panel considered the above evidence and accepted the accounts of Witness 3 and 5. The panel bore in mind Miss Cradock's experience on the previous shift with Patient A. However, the panel considered that there was no evidence that Patient A had exhibited challenging and aggressive behaviour prior to being locked in her room on this occasion. The panel noted that Patient A's behaviour was notably different to the behaviour that was described by Witness 2 and 4 the previous night. The panel was of the view that Miss Cradock's action of initiating seclusion by

locking Patient A in her room was not clinically justified, as it appeared that it was used as a pre-emptive measure as opposed to a proportionate response to Patient A's behaviour.

In light of the above, the panel determined that Miss Cradock's action of locking Patient A in her room did not have any clinical justification on this occasion.

Accordingly, the panel found Charge 12 proved.

Charge 13)

13) Did not use any de-escalation/distraction methods on Patient A.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 3 and 5.

Witness 3 had stated during her oral evidence and in her written statement that she had read a story to Patient A in order to settle her after she had vomited on her bed. Witness 3 elaborated that both she and Miss Cradock had attended to Patient A, cleaned her bed and during this, they had been locked in the room by another member of staff outside of the room.

'Myself and Leah went into her room and the door was locked behind us, we cleaned up the room and I read Patient A a story. Patient A was then settled and we left the room about 22:15.'

Witness 5 also explained during her oral evidence that she had comforted Patient A after she had been distressed for a period of 25 minutes after being locked in.

'I went into Patient A and she was sat on the toilet crying. She then moved to her bed and all she wanted to do was be held.'

The panel noted that it did not have evidence before it to suggest that Miss Cradock herself had used de-escalation/distraction methods. However, it was of the view that as the nurse in charge, Miss Cradock would have been aware that other staff members were already employing these methods and had not stopped them from interacting with Patient A.

In light of the above, the panel concluded that de-escalation/distraction methods had been used on Patient A.

Accordingly, the panel found Charge 13 not proved.

Charge 14a)

> 14) Between 04:15 – 7a.m. whilst Patient A was exhibiting distressing behaviour:
>
> a) Restricted staff from going into Patient A's room to provide support.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 3 and 5 and the Investigation Meeting notes dated 7 June 2022.

Within her witness statement, Witness 3 had said that between the hours of 04:15 and 04:35, Patient A appeared to be distressed. Witness 3 narrated that staff had been advised against going into the room by Miss Cradock to enable Patient A to 'self-regulate'. Witness 3 then stated that she had asked Miss Cradock *'approximately two or three times'* to check on Patient A after she could no longer see Patient A through the glass panel as she had disappeared into the bathroom. At 04:35, Miss Cradock and Witness 3 briefly entered Patient A's room. During her oral evidence, Witness 3 confirmed this account and further stated that she did not see

Patient A because her view had been blocked as she was directly behind Miss Cradock. She further stated that she was not sure if Miss Cradock had seen Patient A either.

Witness 5 had also given an account in her written statement in which she stated that:

> *'At 04:15 she obviously woke up startled and tried to come out of her room to find staff but found that she couldn't because the door was locked…*
>
> *Leah then went off the ward…*
>
> *Patient A was distressed for about 25 minutes and then she took herself into her bathroom, we could not see her through the observation window and it went dead quiet…*
>
> *I said "don't you think we should check on her" and Leah's response was "can do if you want I don't know what to do".'*

This account was consistent with her oral testimony.

The panel had regard to the above evidence and noted that between 04:15 and 07:00 hours, Miss Cradock was asked on numerous occasions by staff to check on Patient A. The panel heard evidence to suggest that Miss Cradock had advised staff against entering Patient A's room whilst she was in a heightened state of distress, until she had calmed down. The panel heard that both Witness 3 and 5 did not have access to the key to the door. The panel was of the view that by leaving the ward, Patient A was left distressed and locked in her room with staff being unable to enter the room for approximately 25 minutes.

The panel noted that during a meeting with Witness 1 on 7 June 2022, Miss Cradock had said that she had *'tied a rubber glove to the key and put it on the side in the*

lounge' and had told staff where it was. However, the panel bore in mind the oral evidence of Witness 3 and 5, who both appeared to have been unaware of this and said they did not have access to the key whilst Miss Cradock was off the ward.

In light of the above, the panel concluded that Miss Cradock had restricted staff from going into Patient A's room to provide support whilst she was in distress.

Accordingly, the panel found Charge 14a proved.

Charges 14b (i-v)

> 14) Between 04:15 – 7a.m. whilst Patient A was exhibiting distressing behaviour:
>
> b) Used words to the effect;
>
> i) '*This is what boundaries are.'*
>
> ii) '*No she needs to learn to self-regulate.'*
>
> iii) *'She has always got her own way.'*
>
> iv*) 'She needs to learn.'*
>
> v) '*She's got away with it for too long.'*

These charges are found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 5.

In her local statement, Witness 5 stated that in response to Patient A's distress, Miss Cradock had addressed Witness 5 and stated:

'This is what boundaries are.'

Later, when challenged by staff in relation to checking on Patient A to help calm her, Miss Cradock responded with:

'no she needs to learn to self regulate, she has always got her own way she need to learn.'

This was supported by her NMC witness statement in which she stated:

'I was sat in the lounge and I said to Leah "should we not do something" and Leah's response was "she has to learn, this is what boundaries are, she's got away with it for too long".'

The panel was of the view that Witness 5's local statement, made closer to the event, was consistent with her NMC witness statement before the panel. It determined that it was more likely than not that Miss Cradock had used words similar to those outlined in the charge, whilst Patient A was distressed.

Accordingly, the panel found Charges 14b (i-v) proved.

Charge 15)

15) Did not move Patient A to the Seclusion room located in the Centre.

This charge is found NOT proved.

In reaching this decision, the panel took into account its findings in relation to Charge 2 and the oral evidence of Witness 1 and Witness 3.

The panel noted again that Witness 1 had stated during her oral evidence that there was no designated seclusion room available on the Unit. This was supported by Witness 3's oral evidence in which she stated that she was not aware that there was a seclusion room on the Unit and there was not one on the unit she usually worked.

In light of the above, the panel concluded that with respect to Charge 15, the NMC had not discharged its burden of proof.

Accordingly, this charge is found not proved.

Charge 16)

> 16) Did not carry out/record any observations of Patient A, after you had locked them in their room.

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 3, the written statement of Witness 5 and Patient A's electronic care notes dated 19 May 2022.

The panel noted that within her written statement, Witness 5 had reported that:

> *'…she had been locked in again and not once between 22:00-04:15 did Leah check on her so the door was locked the whole time…'*

However, this was in conflict with Witness 3's account in which she stated that both she and Miss Cradock had briefly entered Patient A's room to check on her whilst she was in the bathroom. In addition, Witness 3 told the panel that earlier in the

night, she and Miss Cradock had tended to Patient A when she had vomited, and they had been locked in the room by another member of staff.

During her oral evidence, Witness 5 did state that both she and Witness 3 would watch Patient A through the glass panel window on her door.

The panel again noted that the NMC had not put before it what specific observations were required to be documented for Patient A. However, the panel noted that an entry made by Miss Cradock in Patient A's electronic care notes at 05:44 hours made reference to staff checks:

> *'Appeared asleep in bed on checks from 1015 pm until heard awake at 415 am.'*

The panel was of the view that there must have been other notes for Patient A. However, these were not put before it. The panel was satisfied that Miss Cradock and members of staff under her supervision had, in fact, undertaken observations for Patient A during the time she was locked in her room. This had been recorded by Miss Cradock in Patient A's care noted during the shift and after the time the incident had occurred.

In light of the above, the panel concluded that with respect to Charge 16, the NMC had not discharged its burden of proof.

Accordingly, this charge is found not proved.

Charge 17)

> 17) Did not document that you had locked Patient A in their room in Patient A's Care Plan.

This charge is found proved.

In reaching this decision, the panel took into account Patient A's Care Plan compiled between 11 and 23 May 2022, Miss Cradock's admission during the Trust's fact-finding meeting and Witness 5's oral and documentary evidence.

The panel acknowledged Miss Cradock's admission that she did not document that she had locked Patient A in her room.

The panel had regard to Patient A's care plan and noted that there was no record made by Miss Cradock relating to Patient A being locked in her room at any time during the shift.

Witness 5 told the panel that when she returned for her next shift on the night of 19 May 2022, she looked at Patient A's notes and noted that Miss Cradock's entry did not reflect the events of the previous night shift and there was no mention of locking Patient A in her room.

The panel accepted the above evidence and determined that it was more likely than not that Miss Cradock did not document in Patient A's care records that she had locked Patient A in her room during the shift.

Accordingly, the panel found Charge 17 proved.

Charge 18)

18) Did not complete the restrictive intervention section of Patient A's notes

This charge is found proved.

In reaching this decision, the panel took into account the written witness statement of Witness 1 and Miss Cradock's admissions.

The panel noted its findings in relation to Charge 5. It acknowledged that Miss Cradock had admitted to not recording that she had locked Patient A in her room.

The panel noted that Witness 1, as part of the local investigation, had reviewed both incidents as a whole and concluded that on both occasions, the 'restrictive intervention' section of Patient A's notes had not been completed. This was outlined in her witness statement:

> *'Within the notes there is a separate section for restrictive intervention but this was not completed…'*

The panel noted that it had not been presented with the 'restrictive intervention' section of Patient A's notes, however it decided to accept the evidence of Witness 1, as she was a credible and reliable witness who had conducted the local investigation.

In light of the above, the panel determined that it was more likely than not that Miss Cradock did not complete the 'restrictive intervention' section of Patient A's notes.

Accordingly, the panel found Charge 18 proved.

Charge 19)

> 19) Did not complete a DATIX/Incident Form regarding the incident.

This charge is found proved.

In reaching this decision, the panel again took into account the witness statement of Witness 1 and Miss Cradock's admissions.

Similar to Charge 6, the panel acknowledged that Miss Cradock had admitted to not completing a DATIX incident form.

The panel also noted that Witness 1 had detailed in her witness statement that a DATIX/incident form had not been completed by Miss Cradock.

The panel accepted the evidence of Witness 1 and determined that in light of the above evidence, it was more likely than not that Miss Cradock did not complete a DATIX/incident form.

Accordingly, the panel found Charge 19 proved.

Charges 20a and 20b)

20) After locking Patient A in their room, did not;

a) Call the on-call medic;

b) Call the on-call manager.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence of Witness 5, 6 and the oral and documentary evidence of Witness 7.

The panel had regard to Witness 6's statement which stated that as per the Trust's Seclusion Policy, a nurse would have to call the on-call medic and on-call manager, if the seclusion of a patient took place out of hours.

The panel heard from Witness 7 who confirmed that if a nurse was considering the seclusion of a patient, they would have to call the on-call medic and on-call manager and she would have expected to have been handed over this information during handover.

Witness 7 also stated the following in her witness statement:

> *'During this handover nothing was mentioned by Leah about locking Patient A in her room during the night shift. I think Leah did the handover all from memory, usually we would read off of the system one.'*

In her witness statement, Witness 5, who had been on the night shift, stated that she was not aware of any call to the on-call medic or on-call manager in relation to Patient A being locked in her room.

The panel found Charges 20a and 20b proved. It relied upon the oral testimony of Witness 7, who under panel questioning, informed the panel that information about the incident had not been handed over to her as the oncoming day shift nurse. The panel noted that once seclusion had been implemented, Miss Cradock should have consulted the on-call medic and on-call manager. The panel also acknowledged that Miss Cradock would have been expected to document her rationale and include the conversations she had had with the on-call medic and on-call manager.

Witness 1 stated in her witness statement that following the local investigation, there was no evidence to suggest that Miss Cradock had been in contact with the on-call medic or on-call manager.

In light of the above, the panel determined that it was more likely than not that Miss Cradock did not call the on-call medic or on-call manager after locking Patient A in her room.

Accordingly, the panel found Charges 20a and 20b proved.

Charge 21)

> 21) Did not document that you had locked Patient A in their room in the Handover Sheet.

This charge is found proved.

In reaching this decision, the panel took into account Patient A's handover sheet and the oral and documentary evidence of Witness 7.

The panel had sight of Witness 7's witness statement, in which she stated:

'The NMC provided me with a copy of the handover sheet for Patient A, I have read through this however there was no entry in this sheet by Leah for the shift she had done. The end of the handover says about Patient A walking down the corridor to get her pyjamas on so this would have been towards the end of the day shift not the night shift that Leah worker [sic].'

Witness 7 confirmed during her oral evidence that information about Patient A being locked in her room was not handed over to her when she came on duty.

The panel had sight of Patient A's handover sheet and noted that it stated:

'No handover dated 19/05'

During her oral evidence, Witness 7 explained to the panel that a separate function would need to be used in order to generate a handover summary. She further stated that Miss Cradock would often give her handovers from memory and Witness 7 noted that there was no reference to a locked room.

The panel accepted the evidence of Witness 7 and concluded that there was no evidence before it to suggest that Miss Cradock had documented that she had locked Patient A in her room on the handover sheet.

In light of the above, the panel determined that it was more likely than not that Miss Cradock did not document this information.

Accordingly, the panel found Charge 21 proved.

Charge 22)

22) Whilst conducting handover to day shift, did not inform one or more colleagues that you had locked Patient A in their room.

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Witness 7 and Patient A's handover sheet.

As it had when it considered Charge 21, the panel noted that Witness 7 had stated that information about Patient A being locked in her room was not handed over to her by Miss Cradock during handover. The panel also noted that on Patient A's handover sheet, there was no reference made to a locked door.

The panel accepted the evidence of Witness 7 and concluded that there was no evidence before it to suggest that Miss Cradock had informed colleagues that she had locked Patient A in her room.

In light of the above, the panel determined that it was more likely than not that Miss Cradock did not handover this information.

Accordingly, the panel found Charge 22 proved.

Charge 23)

> 23) On an unknown date after Colleague Y disclosed details about an unknown patient's attachment disorder, shouted at Colleague Y using words to the effect *'no she hasn't she's just spoilt'*.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 5 (Colleague Y).

The panel noted that in Witness 5's witness statement she had explained the following:

> *'I found with Leah on a couple of occasions she would pull the "I'm more senior" card with me. I remember one occasion when I had not long*

started we had a patient who was very difficult and would trash the ward who was very distressed and angry. One of the big bosses … came down and a couple of staff including myself and Leah were on the corridor and…asked how this patient was doing. I responded saying they had recently been diagnosed with attachment disorder and Leah shouted at me saying "no she hasn't she's just spoilt".'

Under panel questioning, Witness 5 confirmed that Miss Cradock had shouted loudly at her, whilst in close proximity, in the view of a senior manager.

The panel accepted the account of Witness 5 and concluded that there was no evidence before it to undermine her account.

In light of the above, the panel determined that it was more likely than not that Miss Cradock had shouted at Colleague Y using words to the effect *'no she hasn't she's just spoilt'*.

Accordingly, the panel found Charge 23 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Cradock's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, 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 therefore exercised its own professional judgement.

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

Submissions on misconduct

Dr Joshi submitted that the facts found proved have breached the terms of *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2018) (the Code).

Dr Joshi set out that sections 1.1 and 1.2 have been breached with respect to the treatment of Patient A and the events that took place on the night of 18 May 2022. He submitted that section 2.1 of the Code speaks about working in partnership with people to deliver care effectively and this did not happen on the night in question. Other members of staff had expressed their concern about the care that was being delivered and their concerns were not responded to.

In relation to section 3, Dr Joshi argued that this was engaged simply because this case involved a young person (Patient A), who had had a number of vulnerabilities and difficulties. Dr Joshi submitted that Miss Cradock did not promote Patient A's wellbeing by using appropriate distraction methods prior to making the decision to lock her in her room.

With regards to section 4, Dr Joshi submitted that Miss Cradock had not acted in the best interests of Patient A, and she should have been cognisant of the policies and procedures in place at the Centre and how Patient A should have been treated.

Dr Joshi submitted that section 7 of the Code is about communicating clearly, and this was something that was lacking on Miss Cradock's part. It was incumbent upon her to make sure that the people around her and in her in her care could understand what was going on. Dr Joshi submitted that had Miss Cradock listened to her

colleagues, who had worked with Patient A before in relation to the actions to be taken, the situation could have been alleviated or entirely avoided. Dr Joshi further submitted that Miss Cradock also failed to communicate with respect to the handover, as since this was not done, there was no clear communication between Miss Cradock and her colleagues about the incident. As a result of this, it required a whistleblower to bring Miss Cradock's failings to the attention of others.

Dr Joshi submitted that section 8 is about working cooperatively. He submitted that if Ms Cradock had consulted the skills, expertise and contributions of her colleagues, and maintained effective communication, a great deal of the difficulties that arose subsequently could well have been avoided. Dr Joshi referred to sections 10.1 and 10.2 of the Code and submitted that Miss Cradock should have documented the incident soon after the event so any risks or problems that would arise could be identified and steps could be taken to deal with them.

Dr Joshi referred to section 14 which outlines that registrants should be open and candid with all service users about all aspects of their care and treatment, including when any mistakes or harm have taken place. He submitted that the witness testimony of Miss Cradock's colleagues demonstrated that had they known what had happened, they would have managed Patient A's care differently. Dr Joshi submitted that Miss Cradock should have been the one to check on Patient A through the window of Patient A's room. The Healthcare Support Workers who had worked with Miss Cradock had taken it upon themselves to do this of their own volition as opposed to being asked to at Miss Cradock's request.

Dr Joshi also referred to sections 17.3 and 20 of the Code and submitted that Patient A was vulnerable and needed extra support and protection. There were set procedures and plans in place for caring for Patient A and Miss Cradock had not adhered to this. He further submitted that Miss Cradock's offhand remarks and her behaviour in shouting at a fellow colleague in the presence of a senior manager was not in line with the standard of promoting professionalism and trust.

Dr Joshi referred the panel to NMC guidance (*FTP-2A*) and submitted that the panel should be conscious that Patient A suffered harm to the extent that she acquired a fear of being locked in and this was directly associated with the treatment she had received from Miss Cradock. Dr Joshi submitted that the panel should also consider the following factors: the duration or frequency of the conduct in question, the professional's relationship or position in relation to those involved and the vulnerabilities of anyone subject to any alleged misconduct. He submitted that although the misconduct lasted a short duration, the nature of the incident, the fact that Miss Cradock was the nurse in charge and that Patient A was particularly vulnerable, made the misconduct serious.

Dr Joshi also referred to *FTP-3* and submitted that the panel should consider the seriousness of Miss Cradock's actions. He submitted that when concerns were raised, Miss Cradock did not consider them and protecting people from harm, abuse and neglect should be at the heart of what nurses do. Miss Cradock failed to do this and had put Patient A at an unwarranted risk of harm. Dr Joshi reminded the panel that Miss Cradock had previously implied that the treatment that Patient A was receiving was essentially for her own good and did not consider what Patient A required. Dr Joshi submitted that concerns of this nature are hard to put right, and Miss Cradock's behaviour amounts to serious misconduct.

Submissions on impairment

Dr Joshi then addressed the panel on the issue of impairment. He referred the panel to NMC guidance (*reference DMA-1*) and reminded the panel that at this stage, the question is, 'can the nurse, midwife or nursing associate practise kindly, safely and professionally?'. Dr Joshi further submitted that considering impairment is a balancing act and as there are no set rules, the panel should exercise its own judgement.

Dr Joshi submitted that the panel should consider whether Miss Cradock has acted in the past and or is liable in the future to act so as to put a person receiving care at unwarranted risk of harm. He submitted that in this case, Miss Cradock's actions had

caused harm. He further submitted that Miss Cradock was also liable in the future to put patients in her care at an unwarranted risk of harm. There was very little evidence before the panel, provided by Miss Cradock or within the representations made by the RCN, to suggest the future risk of harm has been abated. Dr Joshi further highlighted that Miss Cradock has indicated that she has no intention whatsoever of returning to practice as a registered nurse.

Dr Joshi submitted that the second aspect of impairment that the panel should consider is whether Miss Cradock has in the past breached and/or is liable in the future to breach a fundamental tenet of the profession. He referred the panel to the Code and submitted that the facts found proved relate to the four themes of the Code in the following ways:

- Prioritising People- the vulnerability of Patient A
- Practising Effectively- Record keeping and communication
- Preserving Safety- The safety of Patient A and other staff members
- Promoting Professionalism and Trust- Miss Cradock's overall conduct

Dr Joshi submitted that when looking at the context of the incident, the panel should also consider firstly Miss Cradock's personal circumstances and secondly, the working environment and culture. He submitted that in relation to the working environment, the incident occurred on a shift that appeared to have been a difficult shift, but nonetheless had sufficient members of staff around. The culture outlined seemed to be centred around the utmost concern for the vulnerable individuals that were in Miss Cradock's care.

Dr Joshi submitted that with respect to any relevant training, supervision, insight or reflection from Miss Cradock, that this was sadly lacking. He submitted that due to Miss Cradock's lack of insight, the panel does not have any details of the steps she has taken to address the concerns and the evidence in relation to her current skills and fitness to practise is sparse.

Dr Joshi then addressed the topic of public interest. He submitted that public interest involves upholding proper professional standards and conduct and the overall maintenance of public confidence in the profession and what a well-informed member of the public would think of what has taken place. Dr Joshi submitted that there is not a great deal of information from Miss Cradock before the panel with respect to her current fitness to practise nonetheless, he submitted that Miss Cradock's fitness to practise is currently impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and the Code.

Decision and reasons on misconduct

The panel considered misconduct in relation to each of the charges found proved.

Charges 4, 5, 6, 17, 18 and 19

The panel concluded that Miss Cradock's conduct within these charges amounted to serious misconduct. It was of the view that the documentation of clinical events supports the building of an ongoing picture of care for a patient. When things are not documented correctly, other members of the care team are disadvantaged as they will lack relevant information which could negatively impact patient care and safety. Miss Cradock had a number of opportunities on the night shifts of 17 and 18 May 2022 to document correct information about Patient A but disregarded all those opportunities to do so.

Charges 7a, 7b, 20a and 20b

The panel considered the above charges and concluded that Miss Cradock's actions did amount to serious misconduct. The panel noted that Miss Cradock had breached the policies and procedures current in the Trust at the time, and that the Trust's

seclusion policy outlined that it was necessary for an on-call medic to be informed if a patient was to be deprived of their liberty. It was essential for patient safety and care that a patient in seclusion, a highly restrictive intervention, be medically reviewed and for management to be made aware. The panel determined that Miss Cradock's failure to do so had the potential to compromise patient safety and increase the risk of harm to Patient A.

Charges 8, 9, 10, 21 and 22

The panel was of the view that the charges above amounted to serious misconduct. The panel acknowledged that no one member of staff provides 24 hour care therefore, handovers are critically important to the continued care of a patient receiving 24 hour care. The panel was of the view that Miss Cradock had two opportunities to inform staff of the incident, firstly on the written handover sheet and the secondly during the morning handover, where she verbally handed over. In relation to Charge 10, Miss Cradock had another opportunity to tell staff about the incident which occurred in the previous shift but had failed to do so.

Charge 11

In relation to Charge 11, the panel was of the view that although Miss Cradock had provided incorrect information to agency staff, this was not serious enough to amount to misconduct.

Charge 12

The panel was of the view that Miss Cradock's actions in Charge 12 did amount to serious misconduct. The panel heard from witnesses that Patient A was not agitated at the time, and less restrictive interventions such as distraction had worked therefore the locking of Patient A in her bedroom was not clinically justified. The panel was of the view that Miss Cradock's action of locking Patient A in her room was not clinically justified and was unduly restrictive.

Charge 14a

In relation to Charge 14, the panel was of the view that Miss Cradock's actions did amount to serious misconduct. The panel heard from Witness 3 and 5 that they had to keep asking Miss Cradock for access to Patient A's room. The panel acknowledged that Miss Cradock had stated that she had tied a rubber glove around the key and had placed it on the side in the lounge when she left the ward. However, the panel noted that Witnesses 3 and 5 stated that this had not been communicated to them and they were unaware of this. Miss Cradock had left the ward for a considerable period of time whilst a distressed and vulnerable child had been locked in their room with staff unable to access them. The misconduct was further exacerbated by the fact that should there have been an environmental hazard, should Patient A have posed a risk to herself or should she have suffered an acute health issue, staff would have been unable to attend to her whilst Miss Cradock was not present on the ward.

Charge 14b

The panel noted that statements (i) to (iv), as quoted in the charge, when taken on their own may not amount to serious misconduct. However, collectively and in conjunction with statement (v), the panel concluded that Miss Cradock's language appeared to be punitive. The panel was of the view that the comment *'she's got away with it for too long'* was not compatible with therapeutic language that would promote Patient A's wellbeing and was at odds with the healthy sleep hygiene routine that staff were trying to encourage.

Charge 23

The panel was of the view that Miss Cradock's behaviour in this charge was inappropriate and unprofessional and there was no justification for her shouting at another member of staff in the presence of senior management. However, the panel determined that her conduct did not meet the threshold for serious 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 Miss Cradock's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Cradock's actions amounted to a breach of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

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

***1.2** make sure you deliver the fundamentals of care effectively*

…

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

…

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

8 Work cooperatively

To achieve this, you must:

***8.1** respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*

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

***8.3** keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

…

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

***8.6** share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.1 *complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
10.2 *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
10.3 *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
…
13.2 *make a timely referral to another practitioner when any action, care or treatment is required*

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 *keep to and uphold the standards and values set out in the Code'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel heard from Witness 5 and 7 that Patient A had suffered from emotional harm. Witness 5 had stated in her witness statement that on the night shift of 18 May 2022, Patient A had become distressed and very concerned about being locked in her room. Witness 7 also stated in her oral evidence that Miss Cradock's actions had a long-term effect on Patient A as for several weeks after the incident, Patient A would become distressed and would need reassurance every time a door was locked.

With regards to Charge 14a, the panel concluded that Patient A was at a high risk of increased psychological harm and distress as she had already been in a distressed state and could not be accessed or reassured by staff for at least 25 minutes. The panel noted that if there had been an emergency or an acute physical or mental health issue, such as self-harming, Miss Cradock's actions meant that Patient A could not be accessed for the period of time she had left the ward.

The panel also determined that in not documenting the incident or handing over the information to her colleagues, Miss Cradock had placed Patient A at an unwarranted risk of harm. Her actions meant that other members of staff were inhibited from having the full picture of Patient A's clinical situation which could have impacted patient safety.

The panel found that Miss Cradock's 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, Miss Cradock's fitness to practise is currently impaired.

The panel was aware that there is no statutory definition of impairment.

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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel determined that limbs a, b and c are engaged in this case.

The panel acknowledged that Patient A had been put at an unwarranted risk of harm, as a result of Miss Cradock's actions in Charge 14a. Indeed, the panel noted that emotional harm had been caused according to Witness 7. The panel found that the concerns in this case are so serious as they involve a vulnerable child who was accessing mental health care and had been put at risk of emotional harm.

The panel considered that Miss Cradock's actions had brought the reputation of the nursing profession into disrepute and that Miss Cradock was liable to repeat this conduct in the future. Further, the panel also noted that Miss Cradock's fellow practitioners, Witness 6 and 7, deemed her actions to be serious and unacceptable. The panel found that Miss Cradock's actions did fall seriously short of the conduct and standards expected of a nurse. The panel concluded that Miss Cradock's misconduct had breached the fundamental tenets of the nursing profession.

The panel considered that the misconduct in this case was capable of being remediated through significant reflection, insight, comprehensive training and supervision.

The panel noted that Miss Cradock had not provided any reflective piece or other statement expressing her remorse or addressing the concerns identified and evidencing any reflection or insight, specifically into her actions, their impact on patient safety or any steps she has taken to remediate the concerns. The panel noted that the training certificates, which were provided by Miss Cradock, did not contextualise what learning she had undertaken following on from the incidents of both night shifts.

The panel also had no evidence before it to suggest that Miss Cradock has had a sustained period of safe and effective practice or testimonials regarding her practice. Unfortunately, due to the lack of reflection, insight and remorse from Miss Cradock, the panel could only conclude that there was a likelihood of repetition of Miss Cradock's misconduct.

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

The panel determined that a finding of impairment on public interest grounds is also required as this case involved a young vulnerable patient in a facility to treat mental health, being deprived of their liberty without clinical justification. The panel was of the view that a well-informed member of the public would be deeply concerned at what had occurred. In addition, the panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case and therefore also finds Miss Cradock's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Cradock's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Miss Cradock's registration has been suspended.

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

Submissions on sanction

Dr Joshi referred the panel to NMC guidance (*reference SAN-1*) and submitted that the panel should first consider proportionality, finding a fair balance between Miss Cradock's rights and secondly the overarching objective of the NMC, public protection. He further submitted that the panel need to choose a sanction that does not go further than what is required to meet this overarching objective. Dr Joshi further submitted that the panel must ensure that its decision to restrict Miss Cradock's right to practise is justified.

Dr Joshi submitted that the charges found proved are in and of themselves serious and this is further compounded by the number of charges found proved, which aggravates the seriousness. Dr Joshi submitted that the aggravating features in this case are:

- Conduct which put a patient at risk of suffering harm.
- Considerable amount of distress experienced by Patient A
- Long and short term impact of the incidents on Patient A at the time subsequently after.
- Lack of insight from Miss Cradock into her failings
- Lack of engagement from Miss Cradock

Dr Joshi submitted that whilst this process is not about punishing a registrant, the panel must consider the risk of harm when considering an appropriate sanction. He submitted that harm did happen, and this case involves a registrant who had a number of attitudinal issues, which is borne out of the statements Miss Cradock made towards Patient A after she was challenged by other members of staff. Dr Joshi further submitted that this goes on further as in Charge 14b, the panel identified that Miss Cradock's comment *'she's got away with it for too long'* was not compatible with therapeutic language. In addition to this, Miss Cradock's behaviour in Charge 23 was inappropriate and unprofessional.

Dr Joshi also referred to Miss Cradock's attitude in relation to mitigation. He submitted that panels usually look for evidence of a registrant's insight,

understanding of the concerns and their attempts to address the concern such as apologies or any efforts made. Dr Joshi submitted that the case of Miss Cradock has been met with a lack of documentation and communication.

Dr Joshi submitted that a panel would also expect examples of how a registrant has followed the principles of good practice, but sadly in this case, this is also lacking. However, Dr Joshi submitted that what the panel does have is personal mitigation, namely [PRIVATE].

Dr Joshi submitted that it is the NMC's position that the most appropriate sanction in this case is that of a striking-off order. He submitted that first and foremost, the panel should consider what occurred on the nights in question. Secondly, the fact that Patient A was a vulnerable young patient and due to this, she was at a significant risk of harm. Thirdly, Patient A was caused significant distress, which amounts to actual harm. Dr Joshi further submitted that Miss Cradock's clinical and decision-making failures are directly linked to her practice as a nurse and her failure to demonstrate a meaningful level of insight, remorse and remediation into her failings indicate a deep-seated attitudinal problem.

Dr Joshi submitted that no further action and a caution order are not suitable in this case considering the misconduct is serious. He submitted that a conditions of practice order would not be an appropriate sanction too. Dr Joshi submitted that Miss Cradock has been a registrant for over 20 years, and she is an experienced nurse, who was fully aware of what took place and what her actions were, against the background of working on an inpatient mental health ward for children. He further submitted that there was a segregation and seclusion policy in place, which made it extremely clear what the expected procedure was. Miss Cradock chose to not follow this procedure and there were clinical failings such as record keeping, communication and handover issues. Therefore, a conditions of practice order would not address the public protection and public interest considerations in this case.

With respect to a suspension order, Dr Joshi submitted that the panel may consider the concerns in this case are sufficiently serious enough to warrant Miss Cradock's temporary removal from the register. However, he submitted that Miss Cradock's

misconduct occurred over two consecutive night shifts, and following on from that, there appeared to be a harmful attitudinal problem, demonstrated through her lack of insight. Dr Joshi also submitted that there is a risk of repetition therefore, due to the panel's findings of misconduct and impairment, a suspension order is not appropriate.

Dr Joshi submitted that Miss Cradock's actions over the two separate shifts, in dealing with her colleagues and Patient A and her disregard for the concerns raised by her colleagues, may amount to the abuse and neglect of a young patient, which raises fundamental concerns about her professionalism and trustworthiness. Dr Joshi further submitted that Miss Cradock's level of insight seems to show that she does not accept that what took place was outside her scope of practice, and the issues raise a significant risk of repetition. Miss Cradock restricted staff members from providing a distressed patient with support and made inappropriate comments during this time. Dr Joshi submitted that Miss Cradock's actions should be considered as being fundamentally incompatible with remaining on the register.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Conduct which put a patient at risk of suffering harm.
- Actual emotional harm caused to a patient who was a vulnerable child.
- Limited reflection, remorse and insight into failings.
- Persistent lack of communication (documentary and verbal) with other members of staff which increased the risk of harm.

The panel also took into account the following mitigating features:

- Personal mitigation- [PRIVATE]
- Miss Cradock was not provided with managerial supervision for a lengthy period of time.
- Miss Cradock was assaulted by Patient A on the night shift of 17 May 2022.
- [PRIVATE]

The panel bore in mind that Miss Cradock had no previous fitness to practise concerns in her 20 years as a registered nurse, in addition to no previous concerns raised by the Trust in the nine years she was employed at the Centre. [PRIVATE]

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 would it satisfy the public interest in this case as it involved a vulnerable young adult and a number of fundamental tenets had been breached.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Cradock's 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 Miss Cradock's 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 Miss Cradock's registration would be a sufficient and appropriate response. The panel noted that Miss Cradock's misconduct was capable of remediation. However, the panel noted that Miss Cradock was no longer working as a nurse and there was no evidence

before it to suggest that any workable conditions could be put into place. In light of Miss Cradock's lack of engagement and evidence of willingness to work, the panel was satisfied that there was little prospect that a conditions of practice order would be effective. The panel also acknowledged that the SG states the conditions should be relevant, proportionate, workable and measurable. The panel was of the view that conditions would not be workable as [PRIVATE]. Furthermore, the panel concluded that the placing of conditions on Miss Cradock's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG (*reference SAN-3*) states that suspension order may be appropriate where some of the following factors are apparent:

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

The panel was of the view that the concerns did not arise from a single instance of misconduct, however, they did not occur over a long period of time. The panel distinguished that Miss Cradock failed to document, handover and communicate clearly with her colleagues on both nights but used an unduly restrictive practice on the night of 18 May 2022 only.

The panel was of the view that there was some evidence of Miss Cradock's attitude, which may be described as problematic on the nights in question, however, there was no evidence of a deep-seated attitudinal problem. The panel noted that there was no evidence of remorse, reflection or insight from Miss Cradock immediately after the incidents and during the local investigation. However, since then there is some limited evidence of insight into her actions and their impact upon Patient A and the wider nursing profession:

'*I realise that my documentation and handover being inadequate could have a negative impact on the patient because staff do not know what has happened to the patient. I learned that restrictive practice, whether restraint, seclusion or other, is distressing for the patient, other patients, all the staff and relatives/ carers.*'

The panel had regard to the SG (*reference SAN-2*) which states:

'When considering sanctions in cases involving the abuse or neglect of children or vulnerable adults, panels will, as always, start by considering the least severe sanction first and move upwards until they find the appropriate outcome. However, as these behaviours can have a particularly severe impact on public confidence, a professional's ability to uphold the standards and values set out in the Code, and the safety of those who use services, any nurse, midwife or nursing associate who is found to have behaved in this way will be at risk of being removed from the register.'

The misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. Furthermore, the panel was mindful of the above guidance surrounding misconduct involving a vulnerable child. However, the panel considered it imperative to balance the guidance with the context of this registrant's circumstances.

Having provisionally identified a suspension order as the appropriate sanction, the panel was mindful that it should consider the next most restrictive sanction and it gave very careful consideration to whether a striking off order was required in this case. The panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that this was not a single instance of misconduct. As such, the panel considered that this raised questions about Miss Cradock's professionalism. Accordingly, the panel considered whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate in this case. The panel considered that a striking off order was not the only sanction that could protect the public or maintain professional standards. The panel was of the view that a member of the public, fully informed of all the facts and Miss Cradock's personal circumstances, would consider a suspension order sufficient to maintain public confidence in the profession. Accordingly, the panel considered that a suspension order would be the least restrictive sanction which would satisfy both public protection and public interest.

The panel noted the hardship such an order will inevitably cause Miss Cradock. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

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

Any future panel reviewing this case would be assisted by:

- Active engagement with the NMC and attendance at any future review hearings.
- A significant reflection on:
  a) The impact of her actions on the patient, her colleagues and the wider nursing profession.
  b) Learning undertaken to demonstrate up to date knowledge around restrictive practices, documentation and communication within a mental healthcare setting.
- [PRIVATE]
- Up to date work (paid or unpaid) testimonials attesting to her character and conduct from a current employer/organisation.
- A clear indication as to her intention regarding her nursing career.

This will be confirmed to Miss Cradock in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel 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 Miss Cradock's own interests until the suspension 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 Dr Joshi. He invited the panel to impose an interim order for a period of 18 months on the grounds of public protection and otherwise in the public interest. He submitted that as the suspension order will not take effect until after the 28-day period, an interim order is necessary to cover this intervening period to protect the public and meet the public interest in light of the panel's findings.

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 determined that in view of its findings on impairment, only an interim suspension order would be consistent with the panel's determination.

The panel has therefore imposed an interim suspension order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.