Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Friday, 15 August 2025 – Tuesday, 26 August 2025

Virtual Hearing

Name of Registrant:	**Shona Margaret Hancock**
NMC PIN:	80D0117S
Part(s) of the register:	Registered Nurse – Adult RN1 – 6 June 1983
Relevant Location:	Aberdeenshire
Type of case:	Misconduct
Panel members:	Tracy Stephenson (Chair, Lay member) Idris Gbadamosi (Registrant member) Kiran Musgrave (Lay member)
Legal Assessor:	John Bassett
Hearings Coordinator:	Hamizah Sukiman
Nursing and Midwifery Council:	Represented by Vida Simpeh, Case Presenter
Mrs Hancock:	Present and represented by Jennifer McPhee, of Anderson Strathern
Facts proved by admission:	Charges 1b, 1c, 1e, 1g, 1h, 1i, 2a and 2b
Facts proved:	None
Facts not proved:	Charges 1a, 1d, 1f, 1j and 1k
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (6 months) with review**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse and registered manager of Muirhead Care Home from September 2015 to August 2018:

1) Failed to ensure and/or document that all staff at the Home:
    a) had been recruited on receipt of appropriate references
    b) had completed an induction at the Home
    c) had completed training regarding fire safety and/or dementia and/or aggression and/or stress and distress and/or moving and handling where relevant to role
    d) had been subject to supervision and or appraisal
    e) had been subject to competency assessments where relevant to role
    f) had been adhering to safe medication practice
    g) had been restraining residents appropriately, with clinical justification
    h) had been completing detailed risk assessments in respect of residents being restrained by belts
    i) had been subjected to adequate investigation and action when concerns had been raised
    j) had been planning care for residents needs in respect of manual handling and/or nutrition and/or hygiene and/or toileting and/or safety
    k) had been adhering to adequate health and hygiene practices

2) Failed to ensure that:
    a) one or more of 13 safeguarding incidents had been properly reported
    b) accident and incident records had been completed in sufficient detail

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

Background

The charges arose whilst you were employed as a Home Manager at Muirhead Care Home ('the Home'). You commenced this role in September 2015. You entered onto the Nursing and Midwifery Council ('NMC') register as a nurse in 1983.

The Home was registered to provide care to a maximum of 35 residents, and was split into two units, one of which was specifically for residents with dementia. At the relevant time, the Home was providing care for 31 residents.

On 23 and 24 July 2018, Witness 1, who was a Care Inspector, conducted an unannounced inspection of the Home with Colleague 1, a Complaints Inspector. It is alleged that the inspection uncovered underlying management issues at the Home which impacted patient safety, which were your responsibilities at the time. Witness 1 alleged that the Home lacked adequate staff recruitment, induction and training systems, and that the staff at the Home lacked training on essential elements of their role, such as manual handling. It is further alleged by Witness 1 that staff were also inadequately supervised, and that you failed to conduct appraisals. You allegedly stated that you had asked for staff training but had been denied, and that you encouraged staff to take advantage of free training but that, ultimately, it was their own responsibility whether they accessed it.

It is further alleged that you failed to address a report of a carer allegedly assaulting a resident, and failed to escalate safeguarding matters more generally. Witness 1 alleged that there were at least 13 incidents whereby the incident should have been escalated to Safeguarding, but you did not do so.

Witness 1 also alleged that you failed to ensure appropriate use of restraints, safe medication practices as well as adequate record keeping and care planning within the Home.

Due to the concerns which were identified following this visit, the Care Inspectorate, Scotland made an application to Aberdeen Sheriff Court seeking cancellation of the care service registration. The Home was subsequently closed.

You verbally tended your resignation from the Home in June 2018, and you left employment at the Home on 4 August 2018.

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

Whilst you were giving evidence under oath, Ms McPhee, on your behalf, made an application that this case be held partly in private on the basis that [PRIVATE]. The application was made pursuant to Rule 19 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ('the Rules').

Ms Simpeh, on behalf of the NMC, supported the application to the extent that [PRIVATE] should be heard in private.

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

Having heard that there may be reference to [PRIVATE], the panel determined to go into private session as and when such issues are raised in order to [PRIVATE].

Decision and reasons on application to admit Ms 1's written statement into evidence

Following the conclusion of your evidence under oath, Ms McPhee made an application, pursuant to Rule 31 of the Rules, to allow the written statement of Ms 1 into evidence. Ms 1 was not present at this hearing.

Ms McPhee informed the panel that, by chance, you met with Ms 1 the weekend prior to this hearing commencing (weekend of 9/10 August 2025), and Ms 1 expressed a willingness to submit a statement. Ms McPhee referred the panel to the

email chain between her and Ms 1, dated 19 August 2025, which detailed her attempts to secure Ms 1's attendance. Ms McPhee submitted that she followed up with Ms 1 via telephone on Wednesday, 20 August 2025, and Thursday, 21 August 2025, and she attempted to secure Ms 1's attendance, but she was unable to reach Ms 1. She submitted that, given the tight turnaround between when Ms 1 agreed to provide the statement and when the hearing commenced, she has exhausted all possibilities to engage Ms 1 and secure her attendance, but she was unable to do so as Ms 1 had work and personal commitments. Ms McPhee submitted that these are cogent and valid reasons for non-attendance, particularly considering Ms 1 is a registered nurse.

In respect of Ms 1's written statement, Ms McPhee submitted that the statement is relevant, commenting on the training, staff engagement and your leadership at the Home. She referred the panel to the decision in, and principles derived from, *R (on the application of Bonhoeffer) v General Medical Council* [2011] EWHC 1585 (Admin), namely that fairness must be considered in the round. She also referred the panel to *Nursing and Midwifery Council v Ogbonna* [2010] EWCA Civ 1216 and *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin), as well as to the principles as outlined in the decision of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). Ms McPhee submitted that the statement is not sole and decisive and can be corroborated by other documentary and oral evidence before the panel. She further submitted that there is no suggestion of bias or animosity, as Ms 1 is a professional nurse of good standing.

Ms McPhee acknowledged that Ms 1's statement – which comments on your leadership, the training and culture at the Home, based on her observations and experiences as a registered nurse – would not be subject to cross-examination. However, she drew the panel's attention to Ms 2's testimonial, which is before the panel, which also comments on aspects of the Home and is also not subject to cross-examination. She reminded the panel that there is no absolute right to cross-examination, and any unfairness caused by a lack of cross-examination can be limited by the weight that the panel chooses to assign to the evidence in its decision-making process. Ms McPhee invited the panel to admit Ms 1's statement into evidence, pursuant to Rule 31 of the Rules.

Ms Simpeh accepted that Ms 1's statement is relevant and relates to the charges you are facing.

In respect of fairness, Ms Simpeh submitted that it is crucial for Ms 1 to be cross-examined, as her written statement is contradictory with both itself and the other evidence before the panel. She further submitted that Ms 2's evidence can be partially corroborated by your oral evidence – for example, in respect of the difficulty in staff training and engagement – but Ms 1's evidence on this suggests that there were no issues with staff training or engagement. Ms Simpeh submitted that it would therefore be fair for the NMC to have the opportunity to cross-examine Ms 1, so a full account of her evidence can be established.

Ms Simpeh submitted that assigning little weight to the statement is insufficient to address the unfairness to the NMC. She submitted that there are gaps in Ms 1's evidence which would require exploration. She further submitted that the panel has no information before it on her interactions with staff at the Home, such as whether she was someone staff would raise issues with in the first place. Ms Simpeh reminded the panel that Witness 1's inspection was initially triggered by a complaint raised by a staff member at the Home, which indicated that staff were raising issues with others. Therefore, Ms Simpeh submitted that Ms 1's evidence that staff never complained was significant, as it indicates that she was not someone staff raised issues with, given her capacity as a trainer.

Ms Simpeh further submitted that, in Ms 1's evidence, she did not observe any concerning practices when she was at the Home directly contradicts Witness 1's evidence of the state of the Home at the time.

Ms Simpeh submitted that, in light of all the above, attaching any weight to the evidence would be unfair to the NMC. She further submitted that, given the timeframes of the written statement, the NMC has not had any opportunity to seek further information to address any of the unfairness. She submitted that Ms 1's written statement is broadly drafted and consists of unsupported statements, which

would be unfair to the NMC if it was relied upon in any capacity. She invited the panel to not admit Ms 1's statement into evidence.

Ms McPhee clarified her position that Ms 1 was made aware of the charges you were facing as well as your admissions and denials to these charges.

The panel accepted the advice of the legal assessor. He referred the panel to the decisions in, and principles derived from, the cases of *Thorneycroft* as well as *Bonhoeffer*. He endorsed the submissions that, pursuant to *Bonhoeffer*, there is no absolute right to cross-examination. He further advised the panel that the weight that the panel attaches to the evidence is considered at a later stage, and that the panel is concerned with admissibility at this stage.

The panel noted that Rule 31 provides that, so far as it is '*fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, irrespective of its admissibility in civil proceedings. In reaching its decision, the panel also considered the seven principles for its consideration, pursuant to *Thorneycroft*, which adapted for the purpose of this application, are:

- Whether the statement is the sole and decisive evidence in support of the registrant's case;
- The nature and extent of the challenge to the contents of the statement;
- Whether there was any suggestion that the witness had reason to fabricate their allegation;
- The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;
- Whether there was a good reason for the non-attendance of the witness;
- Whether the registrant had taken reasonable steps to secure the witness's attendance; and
- Whether the NMC did not have prior notice that the witness statement would be read.

The panel first considered whether the evidence is relevant. The panel was satisfied that Ms 1's written statement is relevant to these proceedings and broadly relate to the charges you face. The panel noted that the statement predominantly referred to training at the Home and that you have made admissions to charge 1c. However, the panel was satisfied that the statement also comments on the Home more generally and is therefore relevant to the general matters in dispute.

The panel then moved on to consider whether it would be fair to admit the evidence. The panel noted the factors as outlined in *Thorneycroft* above.

The panel was satisfied that Ms 1's witness statement is not the sole and decisive evidence in support of your case. The panel considered that it has heard your oral evidence under oath, as well as the testimony from Ms 2 within the documentation submitted on your behalf.

The panel further considered that there has been no suggestion that Ms 1 had reason to fabricate her evidence. The panel noted that Ms 1 is a registered nurse who knew you professionally, and the panel was satisfied that there is no evidence before it suggesting that Ms 1 would fabricate her evidence or is otherwise a biased witness.

The panel noted that these allegations are serious, and the NMC is seeking a striking-off order if your fitness to practise is found impaired.

The panel also considered that Ms 1 was contacted, by chance, a few days before the hearing was set to commence, and that Ms McPhee has undertaken every reasonable step to secure Ms 1's attendance in light of the short turnaround time. The panel considered that Ms 1 remains in employment, and she was unable to attend to give evidence due to both work and personal commitments. The panel was therefore satisfied that there is good reason for her non-attendance, in light of the circumstances.

The panel considered Ms Simpeh's submissions that the NMC would not be able to cross-examine Ms 1 on her evidence. The panel accepted that the NMC is unable to

do so given Ms 1's non-attendance. However, the panel reminded itself of the legal advice, and it took into account that the right to cross-examine is not absolute, per *Bonhoeffer.* Balancing fairness to you with the fairness to the NMC, the panel was of the view that it would be fair to admit Ms 1's written statement, given its *Thorneycroft* observations above. The panel acknowledged that, in the absence of cross-examination, it would consider this when taking into account what weight to attach to the evidence in its decision-making process.

Accordingly, the panel concluded that it would be fair and relevant to accept Ms 1's written statement into evidence, pursuant to Rule 31 of the Rules.

The panel reminded itself that it would give what it deemed appropriate weight when it reaches its decision on facts, and in later stages in these proceedings.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms McPhee, who informed the panel that you make full admissions to charges 1b, 1c, 1e, 1g, 1h, 1i, 2a and 2b. Ms McPhee indicated that, whilst you make these full admissions on a factual basis, there is some contextual information which would be presented before the panel in respect of some of the charges.

The panel therefore finds charges 1b, 1c, 1e, 1g, 1h, 1i, 2a and 2b proved in their entirety, by way of your admissions. The panel noted that you are represented in these proceedings by a legal representative who has considerable experience in regulatory proceedings, and, as was demonstrated by her thorough examination of the disputed issues in this case, is aware of and able to advise you of your responsibilities as manager of the Home regarding the specific charges you face.

As such, the panel was satisfied that your admissions were properly made and unequivocal.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Simpeh and Ms McPhee.

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

- Witness 1: Registered Nurse and Care Inspector at the Care Inspectorate, Scotland

The panel also heard evidence from you under oath.

In the course of her closing submissions, Ms McPhee submitted that Witness 1 had been biased in the way she had carried out the inspection of the Home and the preparation of the Care Inspectorate Report. She reminded the panel of your evidence that Witness 1 had told you at the outset of the inspection that she had closed down homes before and would not hesitate to do so again. The panel noted that this assertion was not put to Witness 1 in cross-examination. In the circumstances, it is only right and proper that the panel records that it did not consider Witness 1 demonstrated any bias against you and the Home in giving her evidence. On the contrary, she gave her evidence in a measured and straightforward way, readily accepting that her recollection of the detail of the inspection was hindered by the passage of time and the fact that her contemporaneous notes of the inspection could not be found after being archived by the Care Inspectorate, Scotland.

Before making any findings on the facts, the panel accepted the advice of the legal assessor. He endorsed both Ms Simpeh's and Ms McPhee's submissions 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 legal assessor further advised the panel that the decision before this panel is made based on the evidence before it, and it should not speculate on evidence which might have been available to it. However, the panel is entitled to draw inferences from the evidence that it accepts into deciding whether the allegations or some of them have been proved.

The legal assessor also advised the panel that it would be proper to for the panel to consider the contents of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 ('the Regulations'), as this was referred to in both Witness 1's Care Inspection Report and in her oral evidence, and this forms the basis of the NMC's case of the duties you were responsible for, and allegedly failed to uphold, as a registered manager of the Home, pursuant to Ms Simpeh's closing submissions. The panel noted that the Regulations have not been made available before it and therefore accessed them online.

In reaching its decision on the disputed charges, the panel considered that the stem of charge 1 reads, '*Failed to ensure and/or document that all staff at the Home'*. The panel considered that some of the sub-charges – such as that in relation to safe medication practices (charge 1f) – would not relate to all staff members at the Home and would refer to clinical staff only. Accordingly, the panel was of the view that, where the charges relate to skills that were specific to certain groups of staff (such as medication), '*all'*, in these circumstances, will be interpreted as all relevant staff members.

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

Charge 1a

'That you, a registered nurse and registered manager of Muirhead Care Home from September 2015 to August 2018:

1) Failed to ensure and/or document that all staff at the Home:
   a) had been recruited on receipt of appropriate references'

This charge is found NOT proved.

The panel noted its observations in relation to '*all'* staff above, and it was satisfied that this charge related to the staff at the Home more generally, rather than any specific groups of staff.

In reaching this decision, the panel took into account that this charge alleges a failure. The panel reminded itself that, in order to find a charge of failure, it must first be satisfied that you were under a duty to do what was alleged, and subsequently, did not do so.

The panel first considered whether you were under a duty to ensure and/or document that all staff at the Home had been recruited on receipt of appropriate references.

The panel considered Witness 1's witness statement, which stated:

'… The Home Manager Shona Pearson was present at the home and supported the investigation, with the following concerns identified to her.

1. *Recruitment of staff was found to be unsafe. Evidence of no references being obtained prior to employment. [REDACTED] No evidence of induction being completed. [REDACTED].'*

The panel noted that, whilst you currently appear on the NMC Register as '*Shona Hancock*', you were registered as '*Shona Pearson*' at the relevant time. The panel was therefore satisfied that this witness statement referred to you.

The panel also had sight of Witness 1's Care Inspectorate Report, dated 26 June 2018, which stated:

'We reviewed 14 staff files and identified the following concerns:

- *There had been a failure to obtain relevant references for most of those files; there was evidence of only one reference, four had no references and two had a work reference from a staff member already employed in the service. This meant that some staff recruited to work in the home had not undergone robust assessment for their suitability to work in a care home setting where vulnerable people live. This placed people at risk of poor care.'*

The panel also heard oral evidence from Witness 1, who confirmed that she identified instances whereby staff references were done improperly, as some did not have any references whilst others had references from staff members who were already working within the Home. She also told the panel that Health and Social Care Guidance suggests that staff ought to have two references from those who are not already employees of the Home, and that you ought to have obtained two references for each member of staff, including obtaining retrospective references for employees who employed prior to you joining the Home.

The panel noted that 14 staff files identified by Witness 1 has not been made available to it.

In establishing a duty on your part, the panel considered that the Health and Social Care Guidance, as referred to by Witness 1, has not been made available before this panel. The panel took into account that Witness 1 did not specify that this was a statutory duty on the Home Manager, and her evidence suggests this was borne of guidance. In the absence of the relevant guidance before it, the panel was not satisfied that this guidance created a duty for you specifically, as the Home Manager, to obtain two references from those who were not already employed at the Home, or for you to obtain retrospective references for employees who were already at the Home when you joined.

Therefore, whilst the panel was satisfied with Witness 1's evidence in respect of the 14 staff files she identified on the inspection, it was not satisfied that you were under a duty to obtain these references as she outlined. The panel acknowledged that this

may be good practice in the running of a care home, but it determined that the NMC has not discharged its burden of proof in respect of establishing a duty, per the wording of the charge.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 1d

'That you, a registered nurse and registered manager of Muirhead Care Home from September 2015 to August 2018:

1) Failed to ensure and/or document that all staff at the Home:
d) had been subject to supervision and or appraisal'

This charge is found NOT proved.

The panel noted its observations in relation to '*all'* staff above, and it was satisfied that this charge related to the staff at the Home more generally, rather than any specific groups of staff.

In reaching this decision, the panel took into account that this charge alleges a failure. The panel reminded itself that, in order to find a charge of failure, it must first be satisfied that you were under a duty to do what was alleged, and subsequently, did not do so.

The panel first considered whether you were under a duty to ensure and/or document that all staff at the Home had been subject to supervision and/or appraisal.

The panel had sight of Witness 1's witness statement, which stated:

'2. Staff supervision and appraisal not completed for any staff.'

The panel also had sight of Witness 1's Care Inspectorate Report, dated 26 June 2018, which stated:

'The provider must put in place effective arrangements to ensure that all staff maintain appropriate skills and knowledge and to support staff continuous professional development. In order to achieve this, the provider must:

[…]

- *ensure all staff receive regular formal supervision and annual appraisals and that these are used pro-actively to support professional development and address any performance concerns.*

This is in order to comply with: The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 2011/210 Regulation 4(1)(a) and 4(1)(b) - Welfare of users, Regulation 7 (2)(c) – Fitness of managers, Regulation9(2)(b)- Fitness of employees and Regulation 15(b)(i) – Staffing.'

The panel considered each of the particularised regulations above. It noted that Regulation 4(1)(a) and 4(1)(b) states:

***'4.**—(1) A provider must—*
(a) make proper provision for the health, welfare and safety of service users;
(b) provide services in a manner which respects the privacy and dignity of service users;'

Further, Regulation 7(2)(c) states:

***'7.**—(2) The following persons are unfit to act as a manager in relation to a care service:—*
(c) a person who does not have the skills, knowledge and experience necessary for managing the care service;'

Regulation 9(2)(b) states:

*‘**9.**—(2) The following persons are unfit to be employed in the provision of a care service:—*
(b) a person who does not have the qualifications, skills and experience necessary for the work that the person is to perform;’

The panel also had sight of Regulation 15(b)(i), which states:

*‘**15.** A provider must, having regard to the size and nature of the care service, the statement of aims and objectives and the number and needs of service users—*
(b) ensure that persons employed in the provision of the care service receive—
(i) training appropriate to the work they are to perform; …’

The panel also heard oral evidence from Witness 1, where she explained that appraisals and supervision were to ensure that staff at the Home were suitably qualified to carry out their roles.

The panel considered all the information above. It determined that the Regulation clearly stipulates the responsibilities of the provider, rather than the manager. The panel noted Witness 1’s oral evidence which contradicted the Regulation, and it considered whether the responsibility as outlined in the Regulations could be delegated to a Home Manager. The panel determined that, with the Regulation outlining a statutory duty, the responsibilities outlined could not be delegated to other staff members within the Home. The panel also considered that the Care Inspectorate Report, dated 26 June 2018, also placed the responsibility of ensuring staff had been subject to supervision and/or appraisal onto the provider, rather than you as the Home Manager. Accordingly, the panel was satisfied that both the Regulation and the Care Inspectorate Report make clear that the duty for ensuring staff receive supervision and appraisals lie with the provider.

The panel also had sight of your reflection on appraisals at the Home, dated November 2024, which stated:

‘Supervisions' and appraisals , had not been carried out by the pervious manger (s) these are essential to help to priortise [sic] *people and ensure effective practice from all staff. Has I had a long, list of improvements that were required this, unfortunately was not fully address, I had however started doing apprasils* [sic] *there was an apprasils* [sic] *yearly plan on the wall. Supervisions were done to cover written concerns (as per the home policy) raised by anyone, to preserve safety, promote professionsim* [sic] *and trust.’*

The panel noted your reference to ‘*the home policy*’, and it considered the possibility of the Home’s policy outlining your duty to carry out regular staff supervision and appraisal. The panel did not have the Home’s policy before it. In the absence of this policy or any other regulations stipulating that it was your responsibility (and not the provider’s) to ensure staff had been subject to supervision and/or appraisal, the panel determined that the NMC has not discharged its burden of proof in respect of establishing a duty, per the wording of the charge.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 1f

‘That you, a registered nurse and registered manager of Muirhead Care Home from September 2015 to August 2018:

1) Failed to ensure and/or document that all staff at the Home:
f) had been adhering to safe medication practice’

This charge is found NOT proved.

The panel noted its observations in relation to ‘*all’* staff above, and it was satisfied that this charge related to clinical staff (such as nurses), as it refers to safe medication practices.

In reaching this decision, the panel took into account that this charge alleges a failure. The panel reminded itself that, in order to find a charge of failure, it must first be satisfied that you were under a duty to do what was alleged, and subsequently, did not do so.

The panel first considered whether you were under a duty to ensure and/or document that all staff at the Home had been adhering to safe medication practice.

The panel considered Witness 1's witness statement, which stated:

> *'I checked the controlled drug cupboard and this was also concerning. The record keeping was poor as there was medication for residents who were deceased still showing as being in the cupboard, but these medications were not there. The manager said she had returned the drugs, but no evidence of this was provided. The medication fridges were also left unlocked, which was clearly a risk.'*

The panel also had sight of Witness 1's Care Inspectorate Report, dated 26 June 2018, which stated:

> *'The provider must ensure that residents' health and wellbeing is maintained and improved through the provision of safe and effective arrangements for the management and administration of medicines. In order to achieve this, the provider must ensure:*
>
> - *a competent person is identified to undertake a comprehensive audit of the medication management and recording systems and to lead on regular auditing to ensure continued compliance with safe practices.*
> - *all staff have received up-to-date medication training and have receive regular formal assessments of their competence.*
>
> *This is in order to comply with: The Social Care and Social Work Improvement Scotland (Requirements for Care Services)Regulations 2011,SSI2011/210*

Regulation 3 - Principles,Regulation4(1)(a) – Welfare of users and Regulation 15(b)(i) - Staffing.'

The panel considered each of the particularised regulations, which have been outlined in full in charge 1d above.

The panel considered all the information above. It determined that the Regulation clearly stipulates the responsibilities of the provider, rather than the manager. The panel noted Witness 1's oral evidence which contradicted the Regulation, as she told the panel that it was your responsibility to ensure that your clinical staff were adhering to safe medication practices.

The panel therefore considered whether the responsibility as outlined in the Regulations could be delegated to a Home Manager. The panel determined that, with the Regulation outlining a statutory duty, the responsibilities outlined could not be delegated to other staff members within the Home. The panel also considered that the Care Inspectorate Report, dated 26 June 2018, also placed the responsibility of ensuring safe and effective medication practices on the provider, rather than you as the Home Manager. Accordingly, the panel was satisfied that both the Regulation and the Care Inspectorate Report make clear that the duty for ensuring staff adhered to safe medication practices lie with the provider.

In any event, the panel was of the view that the proper management of medication – including ensuring that cupboards were locked and accurate documentation was made – would be the responsibility of individual registered nurses involved in the administration of the medication as part of their nursing practice. The panel acknowledged that it may be good practice in the running of a care home for you to have had oversight over the medication practices of your clinical staff, but it determined that the NMC has not discharged its burden of proof in respect of establishing a duty, per the wording of the charge.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 1j

'That you, a registered nurse and registered manager of Muirhead Care Home from September 2015 to August 2018:

1) Failed to ensure and/or document that all staff at the Home:
   j) had been planning care for residents needs in respect of manual handling and/or nutrition and/or hygiene and/or toileting and/or safety'

This charge is found NOT proved.

The panel noted its observations in relation to '*all'* staff above, and it was satisfied that this charge related to clinical staff (such as nurses), as it refers to residents' care planning.

In reaching this decision, the panel took into account that this charge alleges a failure. The panel reminded itself that, in order to find a charge of failure, it must first be satisfied that you were under a duty to do what was alleged, and subsequently, did not do so.

The panel first considered whether you were under a duty to ensure and/or document that all staff at the Home had been planning care for residents' needs in respect of manual handling and/or nutrition and/or hygiene and/or toileting and/or safety.

The panel had sight of Witness 1's witness statement, which stated:

> *'In regard to the nutrition provided, we found that there was just not enough food in stock for the number of residents and what was offered on the menus. It was clear from the staff we spoke to that they felt there were financial problems with bills not being paid, so much so that staff were asked to bring in milk. Deliveries did not arrive, they felt this was because the bill had not been paid.*

As mentioned previously there was a lack of care planning evident in the records in respect of manual handling, this was also the case in respect of nutrition, hygiene and meeting residents' continence needs.'

The panel also had sight of Witness 1's affidavit, which stated:

'I saw a third resident [REDACTED] in a dementia unit lounge who was not being restrained at that time. However her clothing was dirty and she smelled of faeces. Her shoes were on the wrong feet and [Colleague 1] sat with her whilst I went to tell the staff she needed attention. The provider has given the court a copy of a restraint assessment for [REDACTED] which says she is unstable and could be assisted to walk but then goes on to say [REDACTED] must stay in her seat. There appears to be no follow up to the relative's consent to restraint which is dated December 2017. The information lodged in the court also says [REDACTED] can walk with the aid of two staff so this appears to be contradictory. The service is restricting [REDACTED] mobility and she will ultimately lose the use of her legs. I had to give the manager a copy of the Mental Welfare Commission guidance about restraint as she had no idea it existed.'

The affidavit also stated:

'[Colleague 1] and I also looked at nutrition when we were in the service. [REDACTED]. On 23 July [Colleague 1] and I checked the fridges and freezer and looked at the vegetable stocks. The freezer was small and half empty. We asked the chefs for the menu for that night and next day to compare the menus with the stocks. There was not enough to provide what was on the menu but the chefs were adamant the menu would not change. One resident was given two quarter sandwiches, one sausage and three grapes as a main meal. Cabbage was on the menu but there was only a half cabbage in stock. This was an inadequate portion. We looked at the food orders and the volume ordered was low for the number of people. […] The Health and Social Care Standards are clear that there must be a choice at mealtimes. […]

Because the care records were so chaotic, we could not find out information about residents' weights. We wanted to find out if people had been losing weight. We therefore asked the manager on 25 July to collate this information for us. We have never received it.'

The panel also heard oral evidence from Witness 1, who referred the panel to the Health and Social Care Standards.

The panel noted that the Health and Social Care Standards have not been made available before it, albeit it acknowledged that Ms Simpeh referred to the standards as part of her closing submissions. The panel was therefore not satisfied that it could establish a duty on you to ensure all staff had been planning care for residents, in the absence of these standards. The panel acknowledged that it may be good practice for a Home Manager to have oversight of the residents' care plans, but it was unable to establish a duty, per the wording of the charge.

Further, the panel noted that no care plans have been made available before this panel.

The panel considered that Witness 1's evidence appears to refer to three residents. The panel determined that, in the absence of their care plans, it was unable to assess whether any information in respect of their manual handling, nutrition and hygiene was adequately documented in their respective care plans in any event. The panel acknowledged that Witness 1's evidence reflected what she observed at the inspection. However, it was of the view that there is insufficient evidence from Witness 1 as to whether any of this was adequately documented in the residents' care plans. By way of example, in relation to the resident who smelled of faeces and had her shoes on the wrong feet, the panel considered that there was no information before it on how long she was in this state for, whether staff had addressed her hygiene afterwards and whether this was adequately documented in her care plan. Similarly, the panel was not satisfied that there was sufficient information before it in respect of residents' nutrition needs being documented in their care plans, albeit it acknowledged Witness 1's evidence that, at the time of her inspection, this was what she observed.

Taking all the above into account, the panel determined that the NMC has not discharged its burden of proof in respect of this charge.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Charge 1k

'That you, a registered nurse and registered manager of Muirhead Care Home from September 2015 to August 2018:

1) Failed to ensure and/or document that all staff at the Home:
k) had been adhering to adequate health and hygiene practices'

This charge is found NOT proved.

The panel noted its observations in relation to '*all'* staff above, and it was satisfied that this charge related to the staff at the Home more generally, rather than any specific groups of staff.

In reaching this decision, the panel took into account that this charge alleges a failure. The panel reminded itself that, in order to find a charge of failure, it must first be satisfied that you were under a duty to do what was alleged, and subsequently, did not do so.

The panel first considered whether you were under a duty to ensure and/or document that all staff at the Home had been adhering to adequate health and hygiene practices.

The panel noted that there is no specific guidance or regulation outlining this duty. However, the panel was of the view that day-to-day maintenance of a care home, including ensuring that staff within the Home abide by adequate health and hygiene practices, would fall within the remit of the Home Manager. The panel was therefore

satisfied that there was a duty on you to ensure and/or document that staff at the Home had been adhering to adequate practices.

The panel next considered whether you have failed to ensure and/or document that all staff at the Home had been adhering to adequate health and hygiene practices.

In reaching this decision, the panel had sight of Witness 1's witness statement, which stated:

> *'We found the home environment was cluttered and untidy, this made cleaning of shared areas and equipment challenging. There were no cleaning schedules in place. We saw staff fail to clean up accidental spillages, meaning trolleys and tables used by residents were sticky and dirty.*
>
> *Cleaning chemicals were left in shared areas, where they could easily have been consumed by residents.'*

The panel also had sight of Witness 1's affidavit, which stated:

> *'During the inspection we saw the kitchen counters and fridges were dirty. There was uncovered food and unlabelled foods stored in open containers in the fridge including jugs of milk. Staff were not wearing hairnets and had on inappropriate clothing. There were cleaning chemicals everywhere. There were unlabelled containers of chemicals in shared toilets. The sluices and domestic cupboard were open potentially giving people access to chemicals. The containers have since been collected by the service and the domestic cupboard is now being locked but on 2 August the sluices were still open. I referred these concerns to Environmental Health by telephone on 27 July and I understand HSE are going to do an unannounced inspection on 7 August.'*

The panel also heard your oral evidence, where you told the panel that you had never witnessed poor hygiene practices in the Home. The panel heard that Environmental Health had visited the Home one month prior to Witness 1, and there

were no issues reported at the time. The panel noted that this was not disputed by the NMC.

The panel acknowledged Witness 1's evidence reflected what she saw on her inspection. The panel determined that an untidy kitchen with unlabelled foods and staff not wearing hairnets as well as chemicals being left unattended are indicative of the staff's poor hygiene practices on that day. The panel noted that there is no contextual information before it in respect of Witness 1's evidence, such as whether the kitchen staff were in the middle of mealtimes (thus making it more likely a kitchen is untidy at that particular moment in time) or whether cleaning staff were in the middle of cleaning at the time. Nonetheless, the panel accepted that this was some staff not adhering to adequate health and hygiene practices on the day.

However, whilst the panel accept Witness 1's evidence as to her inspection, the panel was of the view that it is insufficient for the panel to infer that there was a wider failure on your part to ensure that staff were adhering to adequate health and hygiene practices. The panel considered, in particular, your evidence that you had never witnessed poor practice as observed by Witness 1, as well as the undisputed evidence that Environmental Health visited the Home a month prior and found no issues, which corroborated with your evidence.

Accordingly, the panel found this charge not proved on the balance of probabilities.

Fitness to practise

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

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that

there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

Ms Simpeh invited the panel to take the view that the facts found proved amount to misconduct. She referred the panel to the decisions in, and principles derived from, the cases of *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Ms Simpeh submitted that your conduct was serious, and that, as Home Manager, you failed to ensure inductions and training were adequately undertaken and you failed to ensure that staff were subject to competency assessments. As such, staff failings were not being addressed, and they would not have all the relevant training, knowledge and skills to properly care for the residents within the Home. She further submitted that your failure as Home Manager to ensure restraints were being used appropriately and risk assessments were adequately completed placed patients at risk of harm. She reminded the panel of Witness 1's oral evidence, in which the panel heard of the risks to patient safety when inappropriate restraints, as well as a lack of proper risk assessments, were used.

Further, Ms Simpeh submitted that, by failing to deal with concerns raised to you, you placed residents at further risk of harm. She submitted that an allegation of a carer kicking a resident in the stomach was a significant and serious allegation, yet your response at the time was to allow the carer to continue working in the Home, albeit with another colleague. Ms Simpeh reminded the panel of your oral evidence, where you assumed others would carry out an investigation as you were going on annual leave, but you did not recall if you told them to do so, or if you followed up on

this matter following your return. She also drew the panel's attention to Witness 1's oral evidence, where the panel heard that this matter was so serious that it warranted a report to the police, which was not done. Ms Simpeh submitted that other members of the nursing profession would find your dealing with this incident deplorable, and the matter was sufficiently serious for a warning to be issued to you by the Crown Office and Procurator Fiscal Service, and that a prosecution could have been brought against you, albeit none was.

Ms Simpeh submitted that paragraphs 1.2, 4.1, 10, 16.1, 16.2, 16.3 and 16.4 of the Code: Professional standards of practice and behaviour for nurses and midwives 2015 ('the Code') are engaged in this case. She submitted that, whilst not all breaches of the Code amount to misconduct, your actions were so serious that they do amount to misconduct in these circumstances. She submitted that at least one resident suffered harm, having been assaulted by another staff member and that other practitioners would find your failures deplorable. She invited the panel to find that all of your actions, or inactions, in the charges admitted, amounted to misconduct.

Ms McPhee referred the panel to the decision in *General Medical Council v Meadow* [2007] QB 462 (Admin), and she invited the panel to find that your actions did not amount to misconduct. She submitted that the systematic failure on the part of the provider, the chronic underfunding and the impossible demands placed upon you are all relevant considerations for the panel. She further submitted that, in any event, you have demonstrated insight and remediation, as you have reflected and taken accountability of your role in the failures. Further, you have also continued to fully engage with the proceedings, including by attending interim order hearings in the past, submitting responses as well as giving oral evidence at this hearing.

Ms McPhee submitted that Witness 1's inspection was over two days, whilst you worked at the Home every day for three years. She submitted that you have reflected on how you did not meet the appropriate standards at the time, and that you have not sought to deflect or minimise your role in the failings. Ms McPhee then took the panel through each of the admitted charges.

In respect of charge 1b, Ms McPhee submitted that you accept the induction at the Home was sometimes inconsistent. She referred the panel to your reflective piece, which acknowledged the inadequacies. She also referred the panel to the testimonial from a staff nurse, who stated that she was never left alone when she began her role, and that you were always supportive of your staff. Ms McPhee submitted that the practice at the Home was always safe, albeit you accepted that the paperwork in relation to staff training were inadequate.

In respect of charge 1c, Ms McPhee referred the panel to your reflective piece, where you describe doing all you could despite the lack of budget given to you. She further submitted that Ms 2 noted that training was ongoing at the Home. Ms McPhee submitted that you were working in the context of systematic underfunding and non-investment in an already-declining service. If you had taken staff members away from practice in order to attend training, you would have placed patients at risk. Ms McPhee reminded the panel of your oral evidence, where you worked 55 hours a week on average, and you felt like only one day of the week could be given to the Home Manager role. She submitted that your evidence was resident-centric, and none of the residents or their relatives complained about the care received at the Home. Nonetheless, she submitted that you now recognise that you were prolonging the inevitable.

In respect of charge 1e, Ms McPhee submitted that you supervised staff whilst you were in practice, and you worked on the floor with the staff members frequently. She submitted that you gave staff informal feedback and supervisions, and that you were always available for staff to raise concerns to you. She referred the panel to Ms 2's testimonial, who confirmed that the Home had safe medicines practices. Accordingly, Ms McPhee submitted that this charge related to a failure in paperwork, and that the staff were competent in their role.

In respect of charges 1g, 1h and 1i, Ms McPhee submitted that these are documentation issues, and that you attempted to consult the providers and residents' families for funding on specialist chairs, but these were not forthcoming. She submitted that you attempted to deal with the issues with limited resources.

On the alleged assault on a resident, Ms McPhee submitted that you received a complaint of an alleged assault, and you found no injury on the resident after you inspected them. She submitted that you spoke to the relevant member of staff, and they were not left alone to care for residents for the remainder of the shift. You reported the incident to both the Deputy Manager and the owner of the Home, as you were leaving for annual leave. She submitted that, as the owner was also a registered nurse, you relied on another senior colleague to manage the incident in your absence and could have escalated matters appropriately. Nonetheless, Ms McPhee submitted that you have developed insight into this, and you recognise that you should have escalated the matter regardless of the level of injury on the resident. You acknowledge that this was an error of judgment on your part.

In respect of charges 2a and 2b, Ms McPhee reminded the panel of Witness 1's evidence, where she stated that every incident should be reported, including if a resident spilled a cup of tea on themselves. Ms McPhee submitted that this promoted an unrealistic expectation on the service to report every incident in the Home and removes autonomy from the care home to manage matters internally. She further submitted that this would be disproportionate and would trivialise serious reports. Nonetheless, you have reflected, and you now acknowledge that safeguarding is also about transparency. Ms McPhee submitted that you have completed training on the matter, and that this was a failing of judgment on your part at the time.

Ms McPhee submitted that these were not serious or deplorable failings, particularly in light of the contextual information and that the inspection lasted two days, in comparison to your experience at the Home of over three years. She invited the panel to find that the failings were not so serious to amount to misconduct.

Submissions on impairment

Ms Simpeh moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Ms Simpeh submitted that your fitness to practise is currently impaired. She referred the panel to the decision in *Clarke v General Optical Council* [2018] EWCA Civ 1463 and submitted that your intention of no longer continuing practice is of little consequence and does not mean that the panel cannot find impairment. She submitted that the case further highlighted that skills may deteriorate over time due to a lack of use in circumstances where the practitioner is no longer in practice.

Ms Simpeh outlined the three 'limbs' per *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council and (2) Grant* [2011] EWHC 927 (Admin), She submitted that you placed residents at an unwarranted risk of harm. She further submitted that, whilst the panel may accept the lack of funding issues relevant at the time, this did not prevent you from ensuring that staff were properly inducted or engaged in training, or competency assessments completed. She submitted that funding was not necessary to ensure that these elements of the Home's practice were adequately completed, and this was your responsibility as Home Manager.

Ms Simpeh further submitted that, irrespective of funding, you could action concerns which were raised to you, and you were aware of your obligations both as a Home Manager and as a registered nurse to escalate and report incidents raised to you. She submitted that this was a long-term and repeated misconduct, and that you knowingly placed patients at an unwarranted risk of harm.

Ms Simpeh further submitted that you have breached the fundamental tenets of the profession, as you failed to adhere to the Code.

In respect of your insight, Ms Simpeh submitted that, despite your acceptance of the charges, your insight is limited as you placed considerable blame upon others. She submitted that you blamed Witness 1 for not acquiring the correct documentation, and you sought to blame the providers for your failings. Ms Simpeh reminded the panel that [PRIVATE]. As such, she submitted that it was more incumbent on you to escalate any concerns you had, and she submitted that you have not demonstrated sufficient insight into this aspect.

Ms Simpeh further submitted that your insight on the impact of your misconduct on patient care is limited. She submitted that despite assertions that you thought of your patients, your approach was inconsistent. Patients had near misses due to manual handling as well as the patient who was assaulted by staff member and your decision that the staff member can continue working demonstrated that concerns were not adequately dealt with. Ms Simpeh further submitted that your evidence that you received no complaints further demonstrated a lack of insight, and that you sought to blame the media, which is further indicative of your insufficient insight into your conduct and its impact on the profession.

Ms Simpeh submitted that there has been insufficient evidence of your strengthened practice, as the last training you completed was in 2022, and you have not worked as a nurse since 2018, nor do you intend to do so in the future.

Ms Simpeh submitted that your fitness to practise is currently impaired on public protection grounds.

In respect of the public interest, Ms Simpeh referred the panel to the decision in *Fopma v GMC* [2018] EWHC 714 (Admin), where it was decided that:

> *'A failure to find impairment in any given case, whilst warnings as to future conduct can still be issued, is tantamount to an indication on behalf of the profession that conduct of the kind need not have regulatory consequences. If that, depending on the nature of the conduct in question, would itself be an unacceptable conclusion, then that can in any given case be a sufficient basis in itself to justify or indeed compel a conclusion of impairment.'*

Ms Simpeh submitted that, pursuant to *Fopma*, that to not find your fitness to practise impaired would be tantamount to an indication on behalf of the profession that conduct of the kind you have admitted to does not need to have regulatory consequences. She further submitted that, having regard to the nature of the conduct and the unwarranted risk of harm to residents, it would be an unacceptable conclusion if a finding of impairment was not made.

Ms Simpeh referred the panel to the NMC guidance and submitted that your conduct raised fundamental questions about your ability to uphold the values and standards due to the significant breaches of practice, your failure to properly remediate, your limited insight and lack of strengthening of practice. She invited the panel to find that your fitness to practise is also impaired on public interest grounds.

Ms McPhee submitted that, if the panel was not with her in respect of misconduct, then it should find that your fitness to practise is not impaired. She submitted that the three elements of *Cohen v General Medical Council* (2008) EWHC 581 (Admin) can be answered in the affirmative, and you have completed reflections and training, as well as provided the panel with relevant testimonials. She further submitted that you accepted that, if you were faced with a similar situation, you would escalate your concerns immediately.

In respect of the public confidence, Ms McPhee submitted that fairness forms part of the public confidence in the profession. She reminded the panel that this is against the backdrop of an otherwise unblemished 30-year nursing career and an underfunded Home. She submitted that you have provided candid and consistent insight and remediation into your failings. She further submitted that you have since retired from nursing practice and did not have to attend these proceedings, but you did so in order to provide the panel with your evidence. Ms McPhee submitted that, during cross-examination, you readily accepted what you could have done better, and you have remediated, albeit you acknowledged that you are not currently in nursing practice. She invited the panel to find that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor. He reminded the panel to consider misconduct and impairment separately, in a two-stage process. He referred the panel to the decisions in, and principles derived from, the cases of *Roylance* and *Nandi*.

Further, in respect of impairment, he advised the panel that it is irrelevant whether you have retired from nursing practice, and that the question before this panel is

whether your fitness to practise is impaired. In determining impairment, he referred the panel to the decision in *Grant,* as well as the decision in *Cohen.*

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the case of *Roylance,* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances'* as well as to the terms of the Code.

The panel considered each of the charges, as admitted, in turn.

Charge 1b

The panel considered Witness 1's evidence that she did not find evidence of induction in some of the staff files, as well as your evidence that you did conduct the inductions, albeit you did not adequately document these and the inductions were '*informal'*. The panel accepted Ms McPhee's submissions that this was an issue in relation to documentation, as opposed to whether the induction itself was completed.

The panel determined that best practice in these circumstances is to fully document formal inductions in staff files, as part of good documentation practices. However, the panel was not satisfied that this documentation issue is sufficiently serious to amount to misconduct, pursuant to *Roylance*. Accordingly, the panel determined that, whilst this was poor practice on your part, this did not amount to misconduct.

Charge 1c

The panel noted that some training was completed in the Home (such as the training delivered by Ms 2), albeit Witness 1's evidence was that the training on moving and handling was insufficient. Taking all the information into account, including the financial restraints you were under, the panel determined that training is of the utmost importance, particularly as it concerned the safety of vulnerable and elderly

residents. The panel was of the view that your responsibility included ensuring your staff were adequately trained, and you failed to do so. Accordingly, the panel was satisfied that this was sufficiently serious to amount to misconduct.

Charge 1e

The panel considered that competency assessments ensure the safety of vulnerable residents, and it determined that it was your responsibility as Home Manager to complete these assessments. The panel determined that this was not limited by any financial constraints, and that you failed to document competency assessments, despite its importance to patient safety. The panel was satisfied that this was sufficiently serious to amount to misconduct.

Charge 1g

The panel considered Witness 1's evidence that this was an inappropriate restraint on the resident. The panel noted that there appeared to be no clinical justification for this restraint, which was not documented, albeit it took into account your evidence that discussions were had with the family and other agencies in respect of restraints. The panel also considered that the resident's patient notes did not comment on the use of restraints. The panel was therefore not satisfied that there was a documented clinical justification for the use of restraints.

The panel therefore determined that the use of restraints on the resident and the failure to document the clinical justification for restraints was serious and carried a risk of harm to the resident. The panel was satisfied that this was sufficiently serious to amount to misconduct.

Charge 1h

The panel considered that there is no evidence of a risk assessment being completed in respect of residents' restraints, despite one of the residents suffering from a pressure sore. The panel determined that the failure to document the risk assessments for residents' restraints was serious, and carried a risk of harm to the

residents, as other staff members would need to be aware of the appropriate restraints for these residents. The panel was satisfied that this was sufficiently serious to amount to misconduct.

Charge 1i

The panel considered that you failed to follow through and appropriately escalate a concern raised to you in respect of a staff member allegedly assaulting a resident by kicking them in the stomach.

The panel determined that, where there are concerns, these concerns must be actioned and documented as it relates to the safety of vulnerable residents. The panel noted your evidence that it was towards the end of the shift, and you placed the staff member elsewhere under another staff member's supervision. The panel determined that this was unacceptable, that the incident occurred on your shift (albeit towards the end) and it was therefore your responsibility to have escalated immediately. The panel also considered that, as you were going on annual leave, you should have documented the incident to allow others to follow up on it in your absence.

Further, the panel determined that the resident needed to be properly assessed on whether any harm had come to them as a result of the alleged assault. The panel determined that you looking over the resident and subsequently concluding that the resident did not need further assessment was insufficient in these circumstances.

The panel determined that your failure in respect of this charge was deplorable, and it was sufficiently serious to amount to misconduct.

Charges 2a and 2b

Similarly to charge 1i above, the panel determined that you were under the responsibility to report incidents. The panel was of the view that it was for the authority to determine whether it sufficiently meets the threshold for a safeguarding referral, and that this decision was not yours to make. The panel determined that, as

a Home Manager, you must demonstrate that you investigated and documented incidents, even if those incidents were later determined to not meet the safeguarding threshold. The panel considered that a failure to report and escalate placed patients at risk of harm.

Accordingly, the panel determined that your failure to do so in respect of at least 13 incidents was sufficiently serious to amount to misconduct.

Taking all the above into account, panel was of the view that your actions and/or failures in respect of all admitted charges except charge 1b did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

'1 ***Treat people as individuals and uphold their dignity***
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively.

4 Act in the best interests of people at all times

6 Always practise in line with the best available evidence
To achieve this, you must:
6.2 maintain the knowledge and skills you need for safe and effective practice.

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 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.

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices.

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can.

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.

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

To achieve this, you must:

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

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

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people.

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

To achieve this, you must:

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

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 was of the view that your actions and/or failures in respect of 1c, 1e, 1g, 1h, 1i, 2a and 2b did fall seriously short of the conduct and standards expected of a nurse. The panel was satisfied that your actions amounted to misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered each of the above limbs in turn.

In relation to limb (a), on whether patients were put at unwarranted risk of harm in the past as a result of your misconduct, the panel considered that there is no evidence before it of residents suffering any actual harm as a result of your actions or inactions at the Home. However, the panel was of the view that elderly and vulnerable residents were placed at an unwarranted risk of harm, as the Home had insufficient documentation in respect of restraints, staff competencies were not adequately documented, and allegations of assault were not properly followed up on.

In relation to limbs (b) and (c), in respect of the past, the panel considered that documentation in respect of patient care, ensuring staff are assessed as competent for their roles as well as escalation and investigation following an incident are breaches of fundamental tenets of nursing practice, and your failure to do so did bring the nursing profession into disrepute.

The panel was satisfied that limb (d), concerning dishonesty, did not apply in this case.

The panel took into account that impairment is a forward-looking exercise, and it should consider whether your fitness to practise is currently impaired.

The panel next considered whether you are liable, in the future, to put patients at an unwarranted risk of harm, bring the nursing profession into disrepute and/or breach one of the fundamental tenets of the nursing profession, pursuant to *Grant*. In reaching its decision, the panel also considered the principles derived from *Cohen,* as outlined in the NMC Guidance, '*Insight and strengthened practice'* (FTP-15), namely:

- Can the concern be addressed?
- Has the concern been addressed?
- Is it highly unlikely that the conduct will be repeated?

On whether the concerns can be addressed, the panel was satisfied that many of these failings relate to identifiable areas of nursing practice, such as documentation. The panel determined that these concerns can be addressed, with sufficient training.

In relation to whether the concerns have been addressed, the panel considered your reflective statement as well as your oral evidence. The panel was of the view that you have shown some insight into your failings, and that you are able to assess what you would do in future, in a similar scenario.

However, the panel considered that there is insufficient information within your reflection on the overall impact of your failures on the residents and the wider nursing profession. The panel took into account that, whilst you have shown some remorse, you also sought to criticise others for your failings. Irrespective of the shortcomings of the providers, which the panel accepted, the panel also took account of your criticism of Witness 1 and the media. The panel determined that this demonstrated that you have not fully accepted your responsibility for your wrongdoing and failures. This was indicative of a developing, but currently insufficient, insight.

On the strengthening of your practice, the panel took into account that you have not practised since 2018, and that you are currently retired. The panel considered the training you have completed in 2022. However, it was not satisfied that you have sufficiently strengthened your practice, as this training has not been tested in a similar environment involving vulnerable residents thus far.

Taking all of the above into account, the panel was not satisfied that you have sufficiently remediated the concerns.

Based on the above, the panel then considered whether the conduct is highly unlikely to be repeated. The panel took into account that the risk of repetition increases as your insight is currently insufficient and you have not demonstrated full remorse. Accordingly, the panel was of the view that could not conclude that it is highly unlikely that the conduct will be repeated.

Based on the above, the panel determined that you are liable, in the future, to put patients at unwarranted risk of harm, to bring the nursing profession into disrepute and/or breach one of the fundamental tenets of the nursing profession, pursuant to *Grant*. Accordingly, the panel finds that your fitness to practise is currently impaired on public protection grounds.

The panel next considered whether a finding of impairment is necessary on public interest grounds. The panel bore in mind that the overarching objectives of the NMC, namely 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 well-informed member of the public would be extremely concerned and public confidence in the profession would be undermined if a finding of impairment were not made. Accordingly, the panel determined your fitness to practise is also impaired on public interest grounds.

Having regard to all of the above, the panel was satisfied that your 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 six months. The effect of this order is that the NMC register will show that your 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.

Submissions on sanction

The panel noted that in the Notice of Hearing, dated 11 July 2025, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired.

Ms Simpeh submitted that the following aggravating factors were present in this case:

- Vulnerable residents were placed at an unwarranted risk of harm;
- Limited insight;
- A pattern of misconduct, which was repeated over a period of time; and
- Misconduct was in relation to your clinical practice.

Ms Simpeh indicated that she would not address the panel on mitigating factors, as this will be outlined by Ms McPhee in her submissions.

Ms Simpeh reminded the panel that, per the NMC Sanctions Guidance, sanction needs to be considered in ascending order of seriousness. She submitted that neither imposing no order nor imposing a caution order would be suitable in this case, given the seriousness of your misconduct.

Ms Simpeh further submitted that the imposition of a conditions of practice order is not practicable or realistic, as you are no longer in nursing practice and have no intention of returning to nursing. She submitted that you are therefore not in the position to meet any conditions imposed upon your practice.

Ms Simpeh submitted that a suspension order would not be sufficient to address the concerns. She reminded the panel that this was not a single instance of misconduct, and that the panel's findings in respect of your fitness to practise were that you lacked sufficient insight and consequently posed a significant risk of repeating the behaviour. She submitted that, pursuant to the considerations as outlined in the

NMC Guidance, '*Suspension order'* (SAN-3d), a suspension order would not be appropriate in these circumstances.

Ms Simpeh submitted that the appropriate sanction is a striking-off order. She referred the panel to the NMC Guidance, '*Striking-off order*' (SAN-3e), which outlined factors for the panel's consideration.

Ms Simpeh submitted that all three factors are engaged, and that the misconduct does raise fundamental questions about your professionalism. She submitted that there were several failings which placed residents at an unwarranted risk of harm, and you sought to blame others for these failings, including Witness 1 and the media.

She further submitted that public confidence could not be maintained if you were not removed from the register. She submitted that your failings impacted several residents and staff, including the ability for staff to care for the residents (in respect of failure to ensure adequate training and competencies). She submitted that members of the public must be able to place their trust in care home staff and have the confidence that their relatives are properly cared for.

In these circumstances, Ms Simpeh submitted that a striking-off order is the only sanction which will be sufficient to protect the patients, members of the public and maintain professional standards.

Ms McPhee submitted that any sanction imposed must be fair, proportionate and the least restrictive sanction necessary.

Ms McPhee accepted the panel's findings in respect of vulnerable residents being placed at an unwarranted risk of harm, and she acknowledged that this is an aggravating factor in this case.

Ms McPhee submitted the following are mitigating factors:

- An unblemished career spanning 30 years prior to the events;

- Systematic failures on the part of the provider, leading to you working a 55-hour week when you are contracted to work 35 hours, and limiting your ability to fulfil your role as the Home Manager;
- No evidence of actual harm on residents, albeit you accept the unwarranted risk of harm placed upon the residents; and
- Remorse and apology, as well as early admissions to the charges.

Ms McPhee submitted that your oral evidence did not seek to deflect responsibility, but it was to provide the panel with the context surrounding the Home at the time, including the lack of support you were receiving. She submitted that you have reflected candidly, and you have continued to routinely engage with the NMC. She submitted that, by going through this hearing, you have been given further opportunity to gain insight and further reflect upon your failings.

In respect of the public protection concerns identified, Ms McPhee submitted that you have completed further training and that you have not been in breach of your interim conditions of practice order, imposed in 2018. She submitted that, taking all of this into account, a fair-minded member of the public would not expect the imposition of a striking-off order.

Ms McPhee reminded the panel that the purpose of a sanction is not to punish, but rather to maintain standards and public confidence in the profession, pursuant to *Bolton v the Law Society* [1994] WLR 512.

Ms McPhee invited the panel to impose a caution order. She submitted that the incidents arose within one Home, and you were facing pressures due to the systematic neglect of the Home on the part of the providers. She further submitted that you were stretched, and that any neglect arose as a result of you not taking a step back. She submitted that you have since gained insight on what you should have done, and how you would address the situation in future.

Ms McPhee further submitted that, if the panel imposed a caution order, the decision would be published and would remain marked against your nursing PIN. She

reminded the panel that your nursing PIN has lapsed in any event, and that you would need to complete a Return to Practice course if you wished to return to nursing practice. She submitted that this finding would be visible in any return to practice process, and that members of the public would be suitably protected by this safeguard.

Ms McPhee submitted that, if the panel was not with her, then it should impose a conditions of practice order. She submitted that this would be proportionate to address the public protection and public interest concerns identified by this panel. She submitted that the misconduct is remediable, and the imposition of conditions could target the specific areas of concern.

Ms McPhee further submitted that you are already subject to an interim conditions of practice order, and that whilst you have not been working since its imposition, you have not been in breach of the interim order. She submitted that the panel could be satisfied that you would comply with the imposition of a new conditions of practice order, and this would allow any reviewing panel to assess your insight whilst protecting the public. She gave some examples of conditions for the panel's consideration.

Ms McPhee submitted that, if seriousness must be marked more clearly, a short period of suspension may be appropriate in this case. She submitted that a lengthy suspension would serve no purpose, as you are currently retired and your practice is currently restricted by an interim conditions of practice order.

In respect of a striking-off order, Ms McPhee submitted that this would be wholly disproportionate. She submitted that this sanction is reserved for circumstances whereby the professionalism of the registrant is fundamentally incompatible with remaining on the NMC register. She submitted that this was not the case, as the panel has already identified that your misconduct is remediable, and that you are working towards gaining full insight. She submitted that you have apologised, reflected and have been complying with restrictions since 2018, and a striking-off order would be punitive in these circumstances.

In response to the panel's question on whether your retirement is a barrier to imposing a conditions of practice order, Ms McPhee submitted that a conditions of practice order would only be operative if you entered into a regulated role. However, such an order cannot be discounted from the panel's decision-making process because you are not working. Ms McPhee submitted that it is entirely a matter for you, if you choose to come out of retirement and return to nursing practice, and this has no bearing on the workability of a conditions of practice order from the panel's perspective.

Ms McPhee confirmed that you are currently working in a café which is related to your volunteering work in a charity.

The panel accepted the advice of the legal assessor. He referred the panel to the NMC guidance, '*Factors to consider before deciding on sanctions'* (SAN-1) and the accompanying guidance for each sanction available before this panel. He advised the panel to impose the least restrictive sanction necessary, and to consider each sanction in ascending order of restriction. He reminded the panel that the purpose of a sanction is not to be punitive, but that it may have this effect.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of misconduct over a period of time;
- Conduct which put vulnerable patients at risk of suffering harm; and
- Criticism of others in respect of your failures.

The panel also took into account the following mitigating features:

- Early admissions to the relevant charges;
- Remorse and developing insight, including evidence of steps taken to begin to address the concerns;
- Unblemished record spanning a 30-year nursing career, as well as positive testimonials in respect of your professionalism;
- Some failings at the Home were due to the failures of the providers (including underfunding), leading you to work long hours and undertake multiple roles which were not yours; and
- [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 in the public interest to take no further action, as the seriousness of the misconduct would not be adequately marked.

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 your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *…*
- *Potential and willingness to respond positively to retraining;*
- *…*
- *…*
- *…*
- *…*

The panel considered the above factors in turn. The panel determined that there is no evidence of any harmful deep-seated personality or attitudinal problems.

The panel was also satisfied that there are identifiable areas of your practice which are in need of assessment and retraining, and it noted that the misconduct was related to your clinical practice. However, the panel determined that the areas of concern are so wide-ranging that to impose conditions addressing every area would be tantamount to a suspension. The panel therefore was not satisfied that workable conditions can be created.

On the potential and willingness to respond positively to retraining, the panel took into account your expressed desire to not continue nursing, and that you have retired. Whilst the panel noted that your retirement is not a bar to it imposing a conditions of practice order, the panel was of the view you would be unable to respond positively to any training which you would be required to complete, as you are no longer in nursing practice and have no desire to return.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately mark the seriousness of this case and would not meet the public interest.

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

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

The panel considered the factors above in turn.

The panel noted that this was not a single instance of misconduct. However, the panel was satisfied that there is no evidence of any harmful deep-seated personality or attitudinal concerns. The panel also considered that there has been no repetition of behaviour since the incident, albeit it noted that you have not worked as a registered nurse since 2018. The panel also determined that you have started to show insight, albeit it noted the risk of repetition as identified in its decision on impairment. However, the panel determined that, given your retirement and expressed intention to not continue nursing, any risk can be sufficiently mitigated through a period of suspension.

Balancing all of these factors, the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order might cause you. However, the panel was satisfied 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 a clear message to the public and the profession about the standard of behaviour required of a registered nurse.

The panel considered Ms Simpeh's submissions, and the NMC's sanction-bid for a striking-off order. The panel considered the NMC Guidance, '*Striking-off order*' (SAN-3e), which asks panels to consider:

- *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 satisfied that, in the circumstances of this case, the misconduct does not raise fundamental questions about your professionalism. The panel determined that public confidence can be maintained if you were not removed from the register. Accordingly, the panel determined that a striking-off order is not the only sanction which will be sufficient to protect the patients, members of the public and maintain professional standards.

Taking all of the above into account, the panel concluded that it would be disproportionate to impose a striking-off order. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

The panel determined that a suspension order for a period of six 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 confirm, revoke or replace the order with another order. This panel also noted that any future reviewing panel may also allow the order to lapse with a finding of impairment, per the NMC Guidance, '*Removal from the register when there is a substantive order in place'* (REV-2h), if the relevant considerations are present.

Any future panel reviewing this case would be assisted by:

- Your continued engagement with the NMC, including your attendance at any future review hearing;

- A written statement detailing your plans in respect of your nursing practice, including any plans, as relevant, to retire from nursing.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

Ms Simpeh invited the panel to impose an 18-month interim suspension order to cover either the 28-day appeal period or any relevant appeal period (if an appeal is brought) before the substantive suspension order can take effect. She submitted that this interim order would be necessary on both public protection and public interest grounds, based on the panel's earlier decision on impairment and sanction.

Ms McPhee submitted that an interim order is not necessary in these circumstances. She reminded the panel that you could not return to your nursing practice in any event without completing a Return to Practice course given the passage of time and that your nursing PIN has since lapsed. She submitted that there is therefore no necessity for the panel to impose an interim order today on public protection grounds, as you would not be able to practise.

Ms McPhee informed the panel that the Return to Practice course can take two-years to complete.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel determined that not to impose an interim suspension order would be wholly incompatible with its earlier findings.

The panel considered the guidance on interim orders following a substantive decision (INT-4). The panel was satisfied that an interim order is necessary both to protect the public and is otherwise in the public interest. The panel had regard to the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. The panel concluded that an interim suspension order is consistent with its findings on impairment and sanction.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months, to cover any relevant appeal period and allow any appeal, if made, to conclude.

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

That concludes this determination.