Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 6 January 2025 – Wednesday, 8 January 2025
Monday 4 August 2025 – Friday 8 August 2025

Virtual Hearing

Name of Registrant:	**Jayne Palfrey**
NMC PIN:	82Y0201W
Part(s) of the register:	Nurses part of the register – Sub Part 2 RN2: Adult Nurse, level 2 (November 1983)
Relevant Location:	Abergavenny
Type of case:	Misconduct
Panel members:	Judith Webb (Chair, Lay member) Helen Reddy (Registrant member) Anne Phillimore (Lay member)
Legal Assessor:	Martin Goudie KC (6 – 8 January 2025) Laura McGill (4 - 8 August 2025)
Hearings Coordinator:	Daisy Sims
Nursing and Midwifery Council:	Represented by Alex Radley (6- 8 January 2025) and Denise Amaning (4 August 2025 – 8 August 2025), Case Presenter
Mrs Palfrey:	Not present and not represented
Facts proved:	Charges 1a, 1b, 2a-d, 5a, 5b, 5c, 6, 7a, and 7b
Facts not proved:	Charges 3, 4a, 4b and 5d
Fitness to practise:	Impaired

Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Palfrey was not in attendance or represented and that the Notice of Hearing letter had been sent to Mrs Palfrey's registered email address by secure email on 3 December 2024.

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

The panel accepted the advice of the legal assessor.

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

It was noted in Mrs Palfrey's response bundle that her current surname is Ms Eacott and that is the name she was known by her employers. However, her surname remains as Mrs Palfrey on the NMC register.

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

Decision and reasons on proceeding in the absence of Mrs Palfrey

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

Mr Radley took the panel through the email communication between the NMC and Mrs Palfrey leading to this hearing, including an email from the NMC on 9 December 2024 asking Mrs Palfrey whether she will be engaging and setting a deadline for a response on 16 December 2024. There was no response from Mrs Palfrey to this email. A further email was sent on 18 December 2024 with a reminder to which Mrs Palfrey did not respond.

Mr Radley informed the panel that a meeting was held in relation to this case in September 2024 to which Mrs Palfrey was invited to attend. He told the panel that Mrs Palfrey did not attend this meeting.

Mr Radley stated that the last communication from Mrs Palfrey to the NMC was in April 2023 via email, through which she denied the local allegations made against her. Mr Radley submitted that Mrs Palfrey has not made an application to adjourn, nor has there been a request for further time to gain legal representation. He submitted that postponing the hearing would not guarantee the attendance of Mrs Palfrey at a future date.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mrs Palfrey;

- Mrs Palfrey has not engaged with the NMC in relation to this hearing and has not responded to any of the emails sent to her about this hearing;
- Mrs Palfrey has not provided the NMC with details of how she may be contacted other than her registered address;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- 2 witnesses are due to attended today to give live evidence, others are due to attend over the course of the hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Palfrey in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations other than an email, dated 19 April 2023. Mrs Palfrey will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Palfrey's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge (as amended)

That you, while a Nursing Team Leader, at Cwmcelyn Nursing Home,

1. On 28 January 2023, left the medication trolley,
    a. Unlocked.
    b. Unattended.
2. On 30 January 2023, in relation to resident A,
    a. Said you were present when he suffered a fall.
    b. Did not complete a top to toe check as required.
    c. Manually lifted him from the floor without using a hoist.
    d. Did not complete neurological observations.

3. Your actions at charge 2(a) were dishonest in that you recorded in resident A's notes that you were present when he suffered a fall when you were not, with the intention of any third party reading your notes believing them to be true.

4. Between 2 December 2022 and 31 January 2023,
    a. Did not complete "Resident of the Day" records.
    b. Did not complete resident medication records.

5. On an unknown date, in relation to resident B, did not,
    a. Complete any physical observations.
    b. Contact the out of hours GP.
    c. Complete any neurological observations.
    d. Record that he had suffered a fall.

6. On an unknown date, in relation to resident D, did not complete any observations.

That you, while a registered nurse at Glaslyn Court Nursing Home,

7. On 10 March 2023, in relation to resident C, did not,
    a. Report a safeguarding incident.
    b. Complete an incident form.

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

Background

Mrs Palfrey was referred to the NMC on 3 April 2023 by Shaw Healthcare where she was employed as a Nursing Team Leader at Cwm Celyn Nursing Home ('the Home') between 6 April 2022 and 21 February 2023. She was dismissed having failed to complete her probation.

There were a number of clinical concerns involving Mrs Palfrey between 2 December 2022 and 31 January 2023 at the Home. The exact dates are unknown as the Home moved over to a new care records system in April 2023.

It is alleged that on 28 January 2023, Mrs Palfrey left the medication trolley open, unlocked and unattended on the Chestnut unit of the Home during her shift. Additionally, it is alleged on 31 January 2023, Resident A fell whilst Mrs Palfrey was on shift and that Mrs Palfrey's account of this fall is inconsistent. Resident A states that he was alone when he fell and it is alleged that Mrs Palfrey then proceeded to assist Resident A by physically lifting him to his bed instead of using a hoist which is contrary to the Home's Falls Management Policy. In addition, it is alleged that Mrs Palfrey did not complete observations or a physical assessment on Resident A in relation to this fall.

During a probation review session on 31 January 2023, concerns were raised that Mrs Palfrey was not completing residents' records including the 'Resident of the Day' form.

Additionally, it is alleged that Resident B suffered an unwitnessed fall when they fell out of bed during the night. It is alleged that Mrs Palfrey returned Resident B to bed without completing any physical assessment or taking observations and failed to complete any related records as per the Home's Falls Management Policy.

In relation to Resident D, it is alleged that Mrs Palfrey did not complete physical observations on this resident throughout her night shift, despite this task allegedly being specifically handed over to her because Resident D was very unwell. Mrs Palfrey confirmed during a probation review session on 2 December 2022, that Resident D was asleep and she checked her was breathing.

Following Mrs Palfrey's dismissal from the Home, she gained employment at Glaslyn Court Care Home on 8 March 2023. During this course of this new employment, a further concern arose in that during the night shift of 9-10 March 2023, an incident occurred with a carer and Resident C in that the carer punched Resident C in the stomach. It is alleged that Mrs Palfrey had failed to escalate the incident to senior members of staff. Mrs Palfrey did not return to Glaslyn Court following this incident.

Decision and reasons on Rule 19 application in relation to [PRIVATE]

[PRIVATE].

Decision and reasons on application to adjourn due to witness unavailability

The witnesses were warned to attend the hearing on the following dates:

- Witness 1: Monday 6 January 2025
- Witness 2: Monday 6 January 2025
- Witness 3: Tuesday 7 January 2025 and Wednesday 8 January 2025

On Monday 6 January 2025 (Day 1 of this hearing), Mr Radley requested a short adjournment as the NMC were unable to gain contact with Witness 1 who was warned to attend the hearing on Day 1.

Mr Radley also informed the panel that the NMC phoned Witness 2. This phone call was to the Home, for which Witness 2 worked, and the Home stated [PRIVATE].

Mr Radley further informed the panel that the NMC received an email from Witness 3 on Sunday 5 January 2025 in which Witness 4 stated that they will not be attending the hearing to give evidence.

The panel allowed an adjournment until the morning of Day 2 to allow Mr Radley time to investigate the issues with witness attendance.

On Day 2 of the hearing, Mr Radley informed the panel that another call was made to the Home to contact Witness 2. The Home informed the NMC that they would let Witness 2 know of the call and ask Witness 2 to call the NMC. Witness 2 has not called the NMC. [PRIVATE]. Therefore, it would not be possible for Witness 2 to attend and give evidence this week and the information had been received too late for the NMC to obtain material to consider a hearsay application.

Mr Radley stated that the NMC had been continuing to contact Witness 4 for an update to which Witness 4 responded in an email, dated 7 January 2025, stating that they are not available as they are working night shifts.

In light of these circumstances, it led to the NMC's application to adjourn due to the lack of availability of all of the witnesses scheduled to attend. Mr Radley made this application under Rule 32 of the Rules.

Mr Radley submitted that the main reason for this application is the unavailability of Witness 2 as Witness 2 is the primary witness for charges 1-6. He submitted that the NMC

were unaware that Witness 2 [PRIVATE] would not be attending the hearing.

Mr Radley updated the panel as to Witness 1 who informed the NMC that they were out of the country on holiday. Mr Radley told the panel that the NMC were aware that Witness 1 was going to be out of the country on these dates, but he is not aware what action was made by the NMC in response to this information. Additionally, he reminded the panel that Witness 3 has stated that they are working night shifts and stated he could not attend.

Mr Radley submitted that there would be no injustice caused to Mrs Palfrey by allowing the adjournment as Mrs Palfrey would be in no worse position in awaiting a future date for this hearing. Additionally, Mr Radley submitted that whilst there is a public interest in the expeditious disposal of this case, this is a relatively new case and allowing an adjournment would not jeopardise the public interest. He submitted that no inconvenience will be caused to any of the parties as none of the witnesses are able to attend the hearing this week.

Mr Radley submitted that the charges against Mrs Palfrey are serious and include a charge of dishonesty. He submitted that allowing the panel to hear all of the witness evidence together would be in the best interest of justice.

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

The panel carefully considered the application and noted that Witness 2 was the key witness. [PRIVATE]. It was not possible for the NMC to address the current position of Witness 2 in the time available as they needed to seek further evidence.

The panel determined that there would be no injustice to Mrs Palfrey in allowing this adjournment as she has not been in attendance at the hearing. The panel could not see any wider injustice as it was in the public interest for the NMC to be able to obtain the further material so it could present its case and witnesses were not inconvenienced as it was their lack of attendance that led to the adjournment.

The panel noted the reasons for the non-attendance of Witness 1 and Witness 4 and considered that the reasons for non-attendance are current and temporary reasons indicating that they are likely to attend a future hearing. The panel noted that there had been communication from these witnesses indicating engagement and supporting the likelihood of their attendance at a future hearing.

The panel was of the view that there would be greater injustice caused by potentially hearing one witness, even if that was possible in this sitting, than allowing the case to be adjourned for the panel to hear all of the evidence together.

The panel therefore granted the application for an adjournment.

Given the issues with witness attendance in this hearing, the panel considered that in order for a full hearing to take place in the future it is important for the NMC to make any necessary applicators regarding witnesses in a preliminary hearing before the substantive hearing takes place.

This will be sent to Mrs Palfrey in writing.

Decision and reasons on service of Notice of Hearing on resuming this hearing on 4 August 2025

The panel was informed at the start of this hearing that Mrs Palfrey was not in attendance or represented and that the Notice of Hearing letter had been sent to Mrs Palfrey's registered email address by secure email on 24 June 2025.

Ms Amaning, on behalf of the NMC, submitted that it had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mrs Palfrey on resuming this hearing on 4 August 2025

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

Ms Amaning submitted that Mrs Palfrey has voluntarily absented herself. She took the panel through email communication from the NMC to Mrs Palfrey. She had not responded to an email dated 14 July 2025 or an email dated 30 July 2025. Ms Amaning submitted that Mrs Palfrey has disengaged with proceedings.

Ms Amaning submitted that there is no reason to suppose that adjourning proceedings would secure Mrs Palfrey's attendance at a future date and she submitted that Mrs Palfrey did not attend the previous sitting of this substantive hearing. Additionally, Ms Amaning reminded the panel of the date of the charges against Mrs Palfrey. She submitted that it is in the public interest to proceed in the absence of Mrs Palfrey.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with*

the utmost care and caution' as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

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

- No application for an adjournment has been made by Mrs Palfrey;
- Mrs Palfrey has not engaged with the NMC in relation to this hearing and has not responded to any of the emails sent to her about this hearing;
- Mrs Palfrey has not provided the NMC with details of how she may be contacted other than her registered address;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Considerable time and effort to secure the 4 witnesses that are due to attend this hearing to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse affect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Palfrey in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. Mrs Palfrey will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-

examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Palfrey's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to admit hearsay evidence made to Witness 2 into evidence

The panel heard an application made by Ms Amaning under Rule 31 to allow the oral disclosure made by Resident A and night shift staff to Witness 2 into evidence. Ms Amaning made this application under Rule 31 of the Rules and referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) at paragraph 56. She specifically drew the panels attention to point 1 and 2 under *Thorneycroft:*

1. *'Whether the statements were the sole and decisive evidence in support of the charges;*
2. *The nature and extent of the challenge to the contents of the statements;'*

In relation to the first point under Thorneycroft, Ms Amaning submitted that there were verbal disclosures made by the night staff to Witness 2. She stated that this oral disclosure alleged that Resident A's fall was not witnessed. Whilst this is hearsay, Ms Amaning submitted that this is supported by Witness 2 who then went to speak to Resident A. Additionally, Ms Amaning reminded the panel that Witness 4 was present at the time and will be in attendance at this hearing. Additionally, Ms Amaning submitted that Resident A disclosed to Witness 2 that he fell. Resident A's account was that Mrs Palfrey was not present when Resident A fell, instead Mrs Palfrey was in the lounge watching TV.

Ms Amaning submitted that the verbal disclosures made by staff and Resident A to Witness 2 are not sole and decisive evidence in support of the charges 2a and 3. She reminded the panel that it will hear evidence from Witness 2 and Witness 4 who shall provide oral evidence in support of the incident. Ms Amaning referred the panel to the Discussion Record dated 31 January 2023 which contains Mrs Palfrey's response to the point that Resident A was alone at the time of the fall.

Ms Amaning submitted in relation to the nature and extent of the challenge, that Mrs Palfrey has chosen to absent herself from these proceedings and has refused to engage with the NMC. Ms Amaning referred the panel to the Discussion Record which reaffirms that Mrs Palfrey maintained that she assisted Resident A during the fall in question.

Ms Amaning submitted that there is no evidence before the panel to suggest that the verbal disclosures made to Witness 2 by Resident A were fabricated. Whilst Ms Amaning accepted that Resident A had both physical and mental health concerns which meant he had fluctuating capacity, she submitted that the report of the unwitnessed fall is also supported by support staff who were present at the time.

Ms Amaning reminded the panel that the charges are serious and include dishonesty and so there could be a great impact of adverse findings on Mrs Palfrey's career, however she submitted that this is outweighed by the NMC's overarching objective to protect the public.

In relation to the NMC's efforts to obtain a written statement from the other member of staff, Ms Amaning informed the panel that they were approached on four previous occasions by the NMC seeking a statement, however that person declined to make a statement. Additionally, she informed the panel that a decision was made by the investigation team at the NMC that it would not be necessary or proportionate to obtain a statement from Resident A given his physical and mental health concerns.

Ms Amaning submitted that Mrs Palfrey has had prior notice of these proceedings and of the evidence. She informed the panel that the unredacted version of the notes from an interview with Resident A with Witness 4 would have been provided to Mrs Palfrey.

Ms Amaning therefore submitted that the panel should permit the oral disclosures made by staff and Resident A to Witness 2 to be admitted into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is '*fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered whether Mrs Palfrey would be disadvantaged by admitting the oral disclosures made to Witness 2 into evidence. The panel considered that Mrs Palfrey would have been provided with a copy of the notes from the interview with Resident A which includes these disclosures.

The panel determined that the oral disclosures are not sole and decisive evidence for any of the charges before the panel. Additionally, the panel agreed that it would not have been appropriate to obtain a written statement from Resident A.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the oral disclosures made to Witness 2, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit verbal disclosures and the Daily Notes

The panel heard an application made by Ms Amaning under Rule 31 to allow the verbal disclosures made by Ms 5 to Witness 1 and the Daily Notes written by Ms 5 to explain the incident involving Resident C.

Ms Amaning submitted that the evidence is relevant as it goes to charge 7. Additionally, she submitted that it would be fair to admit this evidence.

Ms Amaning submitted that the Daily Notes is a document that was created by Ms 5 in the course of business and is admissible in accordance with Rule 31 as it is fair and relevant to admit these clinical notes.

In relation to the verbal disclosures made to Witness 1, Ms Amaning submitted that it is not sole and decisive of charge 7 as there is the local level statement made by Witness 1 dated 16 March 2023 which states that the clinical notes were made at the time by Ms 5. Ms Amaning submitted that these clinical notes are not the sole or decisive evidence in support of the charge 7 because the panel will hear from Witness 1 who shall provide oral evidence, and her statement also provides detail as to the injuries that she saw. Additionally, she submitted that the clinical notes provide important contextual information as to the events that took place leading to charge 7.

When considering the nature and extent of challenge, Ms Amaning reminded the panel that Mrs Palfrey has chosen to absent herself from these proceedings, she has refused to engage with the NMC and did not provide any written submissions or statements in respect of charge 7 and she has decided to forgo her opportunity to question the live witness. However, it is submitted that the calling of the NMC's witness, Witness 1, who can be questioned by the panel to alleviate some of the concerns about admitting the hearsay evidence.

Ms Amaning submitted that there is no material before the panel to suggest that Witness 1 or Ms 5 had a reason to fabricate the allegations contained within clinical notes. She further submitted that the electronic notes are dated and timed and as such it was submitted that the evidence is demonstrably reliable.

Ms Amaning submitted that the charges are serious and so there could be a greater impact of adverse findings on Mrs Palfrey's career. However, she reminded the panel that the NMC have an overarching objective to protect the public. Ms Amaning submitted that Mrs Palfrey would have had prior notice of these proceedings and of this evidence.

In relation to the non-attendance of Resident C and Ms 5, Ms Amaning submitted that neither have provided statements to the NMC. She informed the panel that Resident C could not recall the incident being someone who suffers with dementia and it appears a decision was made that it would not be proportionate to obtain a statement from Ms 5. Ms 5 was a Health Care Assistant ('HCA') who had been suspended and was not under a duty to assist the NMC.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is '*fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered whether Mrs Palfrey would be disadvantaged by admitting the oral disclosures made to Witness 1 and the Daily Notes made by Ms 5 into evidence. The panel considered that Mrs Palfrey would have been provided with a copy of the notes from the interview with Resident C which includes these disclosures.

The panel determined that the oral disclosures are not sole and decisive evidence for any of the charges before the panel. Additionally, the panel agreed that it would not have been appropriate to obtain a written statement from Resident C or Ms 5.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the oral disclosures made to Witness 1 and the Daily Notes made by Ms 5, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Amaning, on behalf of the NMC, to amend the wording of charge 2(c).

The proposed amendment was to remove the words '*to bed'*. It was submitted by Ms Amaning that whilst this proposed amendment has been made at a late stage, she submitted that it would not prejudice Mrs Palfrey because it would provide clarity and more accurately reflect the evidence.

The proposed amendment is as follows:

'That you, a registered nurse:
[…]
2. On 30 January 2023, in relation to resident A,
    a. […]
    b. […]
    c. Manually lifted him from the floor ~~to bed~~ without using a hoist.

[…]'

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Palfrey and no injustice would be caused to either party by the proposed amendment being allowed. It

determined that this amendment would not cause a fundamental differentiation to the charge. Whilst the panel accepted that there would be some prejudice to Mrs Palfrey given that she is not in attendance, the panel was of the view that the interest of justice in allowing the application outweighs this prejudice. The panel therefore determined that it was appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on facts

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

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Lead Nurse on General Medical Unit at Glaslyn Court
- Witness 2: Service Manager at Cwm Celyn Nursing Home
- Witness 3: Night Shift Care Assistant at Cwm Celyn Nursing Home
- Witness 4: Care Support Worker at Shaw Healthcare

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Mrs Palfrey.

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

Charge 1a)

That you, while a Nursing Team Leader, at Cwmcelyn Nursing Home,

1. On 28 January 2023, left the medication trolley,
    a. Unlocked.

The panel found this charge proved.

In reaching its decision the panel considered the evidence of Witness 2 and Witness 3 together with the responses from Mrs Palfrey.

The panel considered that it was unable to rely on the photograph of the unlocked medication trolley as there is insufficient evidence regarding its creation, who took the photo, when it was taken and why it was taken. Furthermore, in her oral evidence, Witness 3 could not recall whether she had taken the photograph.

However, the panel heard the oral evidence of Witness 3 in relation to her escalation of the medication trolley being unlocked which she witnessed. Witness 3's escalation of this unlocked medication trolley was confirmed in both the oral and written evidence of Witness 2 who was the Manager of the Home at the time of the incident. Witness 2 told the panel that she had dealt with this incident at the time following a report of the incident from Witness 3. Additionally, Witness 2 took the panel through the policies in place at the time of the incident, specifically that it was imperative that the medication trolley was not left unlocked or unattended. The panel determined that it is likely that Mrs Palfrey, as an

experienced registered nurse, would have been aware of her responsibility to ensure the medication trolley remained locked as per the medication policy. In addition Witness 3, a Night Shift Care Assistant, confirmed in oral evidence that she was aware of the importance of this policy.

Within the responses from Mrs Palfrey under a section titled '*left the medication trolley unlocked and unattended*', Mrs Palfrey wrote '*This must have happened when a medication was needed next door to the area I was working in'*.

The panel also considered Shaw Healthcare Medication Policy which states at 8.2.3 '*Do not leave the trolley when it is unlocked. The keys must have kept on the person administering medications'.* The panel determined that as the registered nurse on shift, it was Mrs Palfrey who had the duty to ensure that the medication trolley was not left whilst it was unlocked. Additionally, the panel considered that Mrs Palfrey has admitted that this had happened on 28 January 2023.

Given the evidence before it, the panel determined that on the balance of probabilities it is more likely than not, that on 28 January 2023, Mrs Palfrey left the medication trolley unlocked.

Charge 1b)

That you, while a Nursing Team Leader, at Cwmcelyn Nursing Home,

1. On 28 January 2023, left the medication trolley
    b. Unattended.

The panel found this charge proved.

In reaching its decision the panel considered Mrs Palfrey's responses outlined in a handwritten note attached to an email to the NMC dated 19 April 2023 and the Shaw

Healthcare Medication policy. The panel also had regard to its findings in relation to charge 1a.

Within the responses from Mrs Palfrey under a section titled '*left the medication trolley unlocked and unattended*', Mrs Palfrey wrote '*This must have happened when a medication was needed next door to the area I was working in'*.

The panel determined that as the registered nurse on shift, it was Mrs Palfrey who had the duty to ensure that the medication trolley was not left unattended. Additionally, the panel considered that Mrs Palfrey has admitted that this had happened on 28 January 2023.

The panel therefore determined that, on the balance of probabilities, it is more likely than not that on 28 January 2023, Mrs Palfrey left the medication trolley unattended.

Charge 2a)

2. On 30 January 2023, in relation to resident A,
    a. Said you were present when he suffered a fall.

The panel found this charge proved.

In reaching its decision the panel considered the evidence of Witness 4 and Mrs Palfrey's responses.

The panel considered the oral evidence of Witness 4 who stated that he was in the room behind Mrs Palfrey when Resident A suffered a fall on 30 January 2023. This is confirmed by Mrs Palfrey within her written responses where she stated '*it was witnessed by myself*'.

The panel therefore found this charge proved.

Charge 2b

2. On 30 January 2023, in relation to resident A,
    b. Did not complete a top to toe check as required.

The panel found this charge proved.

In reaching its decision, the panel considered the evidence of Witness 2 and Witness 4 together with Mrs Palfrey's written responses.

The panel noted Witness 4 stated he was present at the time and confirmed that Mrs Palfrey did not complete a top to toe check. This is confirmed in the notes from Witness 2 of a meeting with Witness 4 and Resident A dated 30 January 2023, in which a question from Witness 2 regarding whether a top to toe check had been completed was answered by Witness 4 stating '*Not that I am aware of, we just lifted him up off the floor'.*

The panel considered whether a top to toe check was a crucial part of the procedure when a resident fell at Cwmcelyn Nursing Home. It noted the oral evidence of Witness 2 who stated that doing a top to toe check was a routine procedure to be followed when a resident had a fall. The panel noted the Shaw Healthcare Falls Management Policy which clearly outlines Mrs Palfrey's responsibilities in these circumstances. Witness 2 confirmed to the panel that there was no paperwork to state that there had been a top to toe check completed by Mrs Palfrey.

The panel noted the Incident Report Form dated 30 January 2023 completed by Mrs Palfrey, where there is no mention of doing a top to toe check.

Based on the above, the panel determined, on the balance of probabilities, that it is more likely than not that Mrs Palfrey did not complete a top to toe check on Resident A as required by the Shaw Healthcare Falls Management Policy following a fall on 30 January 2023.

Charge 2c

2. On 30 January 2023, in relation to resident A,
    c. Manually lifted him from the floor without using a hoist.

This charge is found proved.

In reaching its decision, the panel considered the notes from Witness 2 of a meeting with Witness 4 and Resident A dated 30 January 2023, the written and oral evidence of Witness 4 and the Patient Care Plan of Resident A.

The panel first considered the notes from Witness 2 of a meeting with Witness 4 and Resident A dated 30 January 2023, in which Witness 4 stated '*[…] when I went to Resident A's room he was sat up on the floor and* [Mrs Palfrey] *was holding in an upright position'* and '*we just lifted him up off the floor'.*

The panel also noted the oral evidence from Witness 4 in which he confirmed that a hoist was not used to move Resident A from the floor. This is supported in Witness 4's written statement '*the registrant said just lift Resident A. The registrant grabbed one arm and I grabbed the other, we lifted Resident A up and put him on the chair.'.*

The panel considered the Patient Care Plan of Resident A which states under the section 'equipment required' for 'assisting to get up off from the floor', '*full hoist or camel'.*

Based on all of the above, the panel determined, on the balance of probabilities, that it is more likely than not that Mrs Palfrey manually lifted Resident A from the floor without using a hoist following a fall on 30 January 2023.

Charge 2d

2. On 30 January 2023, in relation to resident A,
    d. Did not complete neurological observations.

This charge is found proved.

The panel made reference to the Shaw Healthcare Falls Management Policy which clearly identifies Mrs Palfrey's responsibility to undertake neurological observations in the event of a fall. This was confirmed by Witness 2. In addition, Witness 4 had confirmed that he did not see any neurological observations being undertaken by Mrs Palfrey.

The panel also relied on its findings at charge 2b, that Mrs Palfrey did not complete a top to toe check. In all the circumstances, the panel determined that it is more likely than not that Mrs Palfrey also did not complete neurological observations on Resident A following a fall on 30 January 2023.

Charge 3

3. Your actions at charge 2(a) were dishonest in that you recorded in resident A's notes that you were present when he suffered a fall when you were not, with the intention of any third party reading your notes believing them to be true.

This charge is found NOT proved.

The panel first considered whether it was of the view that Ms Palfrey was present when Resident A suffered a fall. The panel had regard to the notes from an interview with Resident A and Witness 4 which was referred to in the witness statement of Witness 2. This document detailed a discussion between Resident A and Witness 4 in relation to who was present during Resident A's fall on 30 January 2023. The panel determined that Resident A's account was inconsistent and unclear in parts. Additionally, the panel noted that this is hearsay evidence and the appropriate weight must be attached.

The panel noted the direct evidence from Witness 4 who confirmed that he was present shortly after Resident A's fall and confirmed that Mrs Palfrey was present at that time.

In addition, the panel had regard to the written response provided by Mrs Palfrey in which she said that she was present during the fall. It also took into account its findings at charge 2a.

Taking account of all of the information, the panel was of the view that there was a lack of evidence to establish that Ms Palfrey was not present during the fall and accordingly her actions in recording that she was present were not dishonest. The panel determined that there was insufficient evidence to prove this charge.

Charge 4a

4. Between 2 December 2022 and 31 January 2023,
    a. Did not complete "Resident of the Day" records.

This charge is found NOT proved.

In reaching its decision the panel considered the record of discussion dated 31 January 2023, together with the witness statement and oral evidence of Witness 2.

The panel noted the following section of the record of discussion dated 31 January 2023 in which Mrs Palfrey responds to a query regarding Resident of the Day records:

> *'sometimes the screen is just different, it does my head in. I have to do it I cant just watch it being done …. I feel frustrated that I cant do these things and I cant get my head around it, I do try and start things, but then it's a different screen'*

The panel noted Witness 2's written statement in which she confirms that she had raised concerns about Mrs Palfrey not completing the Resident of the Day records. The panel noted Witness 2's evidence that the 'Resident of the Day' record was something put in

place by the Home, but the panel was not provided with written evidence of the guidance provided to staff or any policy that was in place at the time in relation to completing the 'Resident of the Day' records.

However, the panel also noted that Witness 2 stated that '*there is no evidence that the paperwork was not completed.'* This was reaffirmed in Witness 2's oral evidence to the panel in which she confirmed that the Home has changed recording systems and so there are no records for this time period.

The panel determined that given there are no records to confirm that a Resident of the Day was not completed by Mrs Palfrey, that there was insufficient evidence before the panel to make a finding on this charge. The panel noted that it is for the NMC to prove a charge on the balance of probabilities and due to this insufficient evidence, the panel determined that the NMC has not discharged this burden. The panel therefore found this charge not proved.

Charge 4b

4. Between 2 December 2022 and 31 January 2023,

    b. Did not complete resident medication records

This charge is found NOT proved.

In reaching its decision, the panel considered the oral and written evidence of Witness 2.

As in charge 4a, the panel considered that there was insufficient evidence before it to find this charge proved given that Witness 2 confirmed that are no clinical records from the Home between 2 December 2022 and 31 January 2023 as the Home has since changed recording systems.

In light of its decision at charge 4a, the panel found that the NMC has not discharged its burden of proof in relation to this charge. The panel therefore found this charge not proved.

Charges 5a, b and c

5. On an unknown date, in relation to resident B, did not,
    a. Complete any physical observations.
    b. Contact the out of hours GP.
    c. Complete any neurological observations.

These charges are found proved.

The panel decided to deal with charges 5a, b and c collectively as it determined that these sub charges all follow on from one another.

In reaching its decision, the panel considered the written evidence of Witness 2 and Mrs Palfrey's responses and the Shaw Healthcare Falls Management Policy and the local discussion document completed on 2 December 2022.

The panel had regard to the Shaw Healthcare Falls Management Policy specifically at 7.1.4 and the written and oral evidence of Witness 2. In Witness 2's written statement, she sets out the documentation that should have been completed and the processes that should have been followed by Mrs Palfrey after a resident suffers a fall.

The panel noted that Witness 2 in her written statement states:

> '*The Falls Management policy states that when an unwitnessed fall occurs, a top to toe assessment must be completed, with full physical observations and a neurological observation completed. This is set out within the post fall injury flowchart […] The post fall injury flowchart also states the registered nurse should contact the out of hours GP for advice'*

The panel also noted the discussion record dated 2 December 2022, in which Witness 2 asked Mrs Palfrey if she was aware of the Falls Policy for all to read and sign and the fall folder with the paperwork in it. Mrs Palfrey said she was aware when Witness 2 asked why she had not followed the protocol, Mrs Palfrey said '*in her opinion it was not needed'*.

The panel noted Mrs Palfrey's written response under a section titled '*did not undertake observations or an assessment of Resident B following an unwitnessed fall'* to which Mrs Palfrey stated:

> '*Resident B was checked over following a report of a fall by a carer, checked head back and buttocks as he said he had fallen off the edge of the bed – no obvious injuries observed […]'*

Whilst the panel acknowledged that there are no contemporaneous clinical records before them as Witness 2 no longer has access to the records from this time period, the panel considered that Witness 2's statement about this event together with the Discussion Record dated 2 December 2022, is sufficient for it to be satisfied that it is more likely than not that Mrs Palfrey did not complete any observations for Resident B on this occasion.

In light of the above, the panel determined that it is more likely than not that Mrs Palfrey did not complete any physical observations, contact the out of hours GP or complete any neurological observations in relation to Resident B.

Charge 5d

5. On an unknown date, in relation to resident B, did not,

    d. Record that he had suffered a fall.

This charge is found NOT proved.

In reaching its decision the panel considered the evidence of Witness 2, specifically their witness statement at which states:

'*Mrs Palfrey did not make a record of this fall, rather the Care Support Worker did (I cannot recall their name). I no longer have access to the records as above, the Home as subsequently changed its care record system. As Mrs Palfrey was the qualified nurse on the shift, Mrs Palfrey had a responsibility to complete all the necessary paperwork.'*

Whilst the panel acknowledged the Shaw Healthcare Medication Policy, it considered its findings at charges 4a and 4b that Witness 2 has stated that there are no longer any clinical records for this time period.

The panel found that the NMC has not discharged its burden of proof in relation to this charge. The panel therefore found this charge not proved.

Charge 6

6. On an unknown date, in relation to resident D, did not complete any observations

This charge is found proved.

In reaching its decision the panel considered the evidence of Witness 2 and the discussion record dated 2 December 2022.

The panel noted the following section of Witness 2's written statement:

'*When I came in the next day for my shift, I checked Resident D's daily records and noticed that Mrs Palfrey had not completed a single set of observations overnight. Mrs Palfrey could have delegated these observations, however, I had specifically asked Mrs Palfrey to complete them as Resident D was so unwell.*

[…]

Mrs Palfrey had a duty to complete physical observations on Resident D as I set this out within my instructions to Mrs Palfrey at handover. In addition, Mrs Palfrey had training on physical observations. This is a nursing basic and Mrs Palfrey would have learnt this skill while completing their nursing degree. The Home did not provide training on this issue as Mrs Palfrey was a qualified nurse, therefore, would have covered this in their training and experience as a nurse'

The panel had sight of the Discussion Record dated 2 December 2022 in which Mrs Palfrey states that she 'checked he was breathing'. The panel determined that checking a patient is breathing is not sufficient to amount to a clinical observation carried out by a registered nurse and it endorsed the above statement of Witness 2 as what would be considered a full observation.

Whilst the panel acknowledged that there are no contemporaneous clinical records before them as Witness 2 no longer has access to the records from this time period, the panel considered that Witness 2's statement about this event together with the Discussion Record dated 2 December 2022, is sufficient for it to be satisfied that it is more likely than not that Mrs Palfrey did not complete any observations for Resident D on this occasion.

Charge 7a

7. On 10 March 2023, in relation to resident C, did not
    a. Report a safeguarding incident

This charge is found proved.

In reaching its decision the panel considered the evidence of Witness 1.

It noted Witness 1's written statement which makes it clear that an incident was reported and goes into detail about the events of the safeguarding incident, explaining the harm that was caused to Ms 5. The panel considered the detail was sufficient to suggest, on the balance of probabilities, that this incident did occur.

The panel then considered whether Mrs Palfrey failed to report the safeguarding incident. The panel bore in mind the oral evidence of Witness 1 who explained that Mrs Palfrey had worked at Glaslyn Court Nursing Home previously and had also undertaken an induction when she had started her current employment, so she was aware of the safeguarding policies and procedures that were in place. The panel was of the view that as an experience registered nurse who also had experience at this Home, there was a duty for Mrs Palfrey to report this safeguarding incident.

In light of the above, the panel therefore found that on the balance of probabilities, it is more likely than not that Mrs Palfrey did not report a safeguarding incident in relation to Resident C on 10 March 2023.

Charge 7b

7. On 10 March 2023, in relation to resident C, did not

    b. Complete an incident form

This charge is found proved.

In reaching its decision the panel considered the local statement, written statement and oral evidence of Witness 1.

The panel considered the contemporaneous email from Witness 1 titled ‘safeguarding statement’ dated 16 March 2023 which details the incident in relation to Resident C. Additionally, in Witness 1’s written statement she states that she ‘would have expected Mrs Palfrey to make an incident report’.

The panel bore in mind the questions asked to Witness 1 in oral evidence, specifically in relation to the availability of computers for Mrs Palfrey to complete an incident form at the Home to which Witness 1 explained that there was also a physical noting system for incidents, and she explained that Mrs Palfrey could have written a note to pass on to managers or to those on the following day shift if she was unable to access a computer.

The panel also considered the Safeguarding Policy which makes it clear that a report should be made in the circumstances outlined in the contemporaneous email from Witness 1.

The panel therefore determined, that on the balance of probabilities, it is more likely than not that Mrs Palfrey had a duty to complete an incident form and that on 10 March 2023, in relation to resident C, did not complete an incident form.

Fitness to practise

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

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect,*

involving some act or omission which falls short of what would be proper in the circumstances.'

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

Ms Amaning submitted that the conduct in the charges found proved falls short of what is expected of a registered nurse. She reminded the panel that Mrs Palfrey was a registered nurse with significant experience spanning over 40 years and that at the time of the facts found proved she was responsible for the care of vulnerable residents. She submitted that the misconduct exposed the residents in question to a risk of harm through her actions.

Ms Amaning submitted that Mrs Palfrey's actions exposed the residents in question to a significant risk of harm. She submitted that a fellow practitioner would find Mrs Palfrey's actions deplorable.

Ms Amaning referred the panel to the Code, specifically sections 10.1, 10.2, 20.1 and 20.5 and 20.8. She submitted that Mrs Palfrey's failures are extremely serious and amount to misconduct given that they breached the fundamental and basic tenets of the nursing profession. She further submitted that these actions amount to a serious departure from the basic principles of nursing.

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

Ms Amaning submitted that as a result of this serious misconduct, Mrs Palfrey's fitness to practice is currently impaired. Ms Amaning referred to the case of *Grant* and submitted that the first three limbs are engaged. She submitted that Mrs Palfrey's actions put patients at a risk of unwarranted harm, put the profession into disrepute and showed a poor attitude from Mrs Palfrey toward patient safety and a failure to maintain proper nursing standards. She submitted that Mrs Palfrey's failures illustrate a disregard to residents' wellbeing and safety.

Ms Amaning then referred the panel to the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin). She submitted in relation to the first limb of Cohen that the conduct of Mrs Palfrey is not easily remediable given the repetition of her failures to undertake basic observations and follow protocol, policies and procedures. Ms Amaning submitted that Mrs Palfrey's actions suggest attitudinal concerns and a lack of remorse.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*

1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively

10 Keep clear and accurate records relevant to your practice
This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.
To achieve this, you must:

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

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations
To achieve this, you must:

18.4 take all steps to keep medicines stored securely

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to'

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 Mrs Palfrey's failures were serious given the repeated exposure of risk to vulnerable residents in her care. The panel was concerned that despite Mrs Palfrey's lengthy experience in the nursing profession and the intervention from Mrs Palfrey's managers, her actions were repeated and this continued to

put residents at a real risk of harm. Additionally, the panel determined that Mrs Palfrey's actions also led to a real risk of harm to her colleagues in that she encouraged another member of staff to lift a resident without using the appropriate equipment. The panel determined that Mrs Palfrey's actions amount to serious breaches of the fundamental tenets of the nursing profession.

The panel found that Mrs Palfrey's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel finds that residents were put at risk and were caused physical and emotional harm as a result of Mrs Palfrey's misconduct. Mrs Palfrey's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight and strengthened practice, the panel considered that whilst Mrs Palfrey has responded to some of the allegations, there is no evidence of remediation. There is no information before it regarding Mrs Palfrey's steps to strengthen her practice or any expression of her remorse or insight. The panel was concerned about Mrs Palfrey's dismissive comments within the discussion notes dated 2 December 2022, the panel noted that Witness 2 raised the potential impact of Mrs Palfrey's actions on Resident B to which Mrs Palfrey did not respond with compassion or acknowledging the consequences of her actions on this resident. The panel also noted Witness 2's oral evidence to the panel when she stated that she arranged group training in light of Mrs Palfrey's lack of understanding of a computer system, however Mrs Palfrey did not attend this training and Witness 2 told the panel that this was because she '*did not like coming in during the day*'.

Whilst the panel recognised that Mrs Palfrey has had an unblemished career spanning over 40 years, the panel determined that given the lack of information from Mrs Palfrey regarding any insight, steps taken to strengthen her practice or any remorse by Mrs Palfrey, the panel determined that the past impairment, whilst remediable, has not been remedied by Mrs Palfrey.

The panel was of the view that there is a risk of repetition of these actions given the evidenced repetition of Mrs Palfrey's conduct. The panel was of the view that a risk of repetition remains given the lack of evidence of insight or strengthened practice by Mrs Palfrey. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold

and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because it found that an informed member of the public would be extremely concerned about Mrs Palfrey's actions given the heightened level of trust placed in registered nurses in care home facilities.

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

Sanction

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

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

Submissions on sanction

Ms Amaning informed the panel that in the Notice of Hearing, dated 3 December 2024, the NMC had advised Mrs Palfrey that it would seek the imposition of a striking off order if it found Mrs Palfrey's fitness to practise currently impaired.

Ms Amaning submitted that the aggravating features are that Mrs Palfrey has a lack of insight, shown no evidence of remorse, and her conduct put residents at a risk of physical

and mental harm. In terms of mitigating features, Ms Amaning reminded the panel of Mrs Palfrey's long-standing career.

Ms Amaning submitted that the concerns in this case are not solely centred on Mrs Palfrey's clinical practice as there are also underlying attitudinal concerns that she has repeatedly demonstrated.

Ms Amaning submitted that a suspension order would not be appropriate in this case because the conduct was not an isolated incident and there is evidence of a harmful or deep-seated attitudinal problem. She submitted that Mrs Palfrey's actions constitute a significant departure from the standards expected of a registered nurse and submitted that Mrs Palfrey's impairment is fundamentally incompatible with remaining on the register. She submitted that the public confidence in the profession cannot be maintained with Mrs Palfrey remaining on the register.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Repeated behaviour over a period of time spanning over two different employers;
- Vulnerable residents;
- Acts or omissions from Mrs Palfrey created a real risk of harm to residents;
- Lack of remorse or reflection;
- Lack of insight into failings;

- Attitudinal concerns in Mrs Palfrey's lack of acknowledgement of the impact of her actions when concerns were raised at a local level;
- Evidence of lack of engagement with support and training when offered by Mrs Palfrey's employer.

The panel also took into account the following mitigating features:

- Mrs Palfrey's long unblemished career.

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, protect the public or be in the public interest to take no further action.

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

The panel next considered whether placing conditions of practice on Mrs Palfrey's registration would be a sufficient and appropriate response. The panel is of the view that whilst there could have been practical or workable conditions that could have been formulated based on the charges alone, the panel determined that given concerns about Mrs Palfrey's attitude and her lack of remorse or insight, the panel could not be satisfied that Mrs Palfrey would engage or work within any conditions imposed. Additionally, the panel reminded itself of the evidence before it of Mrs Palfrey's lack of engagement with

steps put in place to support her by training during her employment and determined that this demonstrates why conditions of practice would not be workable.

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 conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that there is no evidence before it to suggest any form of mitigation or explanation of Mrs Palfrey's actions. The panel determined that the serious breach of the fundamental tenets of the profession evidenced by Mrs Palfrey's actions is fundamentally incompatible with Mrs Palfrey remaining on the register.

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

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

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

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

Mrs Palfrey's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings, together with Mrs Palfrey's attitudinal concerns and lack of insight or remorse, demonstrate that Mrs Palfrey's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Palfrey's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Mrs Palfrey in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Amaning. She submitted that it would be necessary and proportionate to impose an interim suspension order for a period of 18 months in order to adequately protect the public and maintain the public interest during the appeal period.

Decision and reasons on interim order

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

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

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

That concludes this determination.