Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 8 – Friday 12 December 2025
Monday 15 – Thursday 18 December 2025

Virtual Hearing

Name of Registrant:	**Francesca Clarke**
NMC PIN:	17F0809E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nurse – August 2018
Relevant Location:	Devon
Type of case:	Misconduct
Panel members:	Angela Kell (Chair, lay member) Claire Cawley (Registrant member) Tracy Jones (Lay member)
Legal Assessor:	Hala Helmi
Hearings Coordinator:	Shela Begum
Nursing and Midwifery Council:	Represented by Beverley Da Costa, Case Presenter
Miss Clarke:	Not present and unrepresented
Facts proved:	Charges 1a, 1b, 1c, 2a, 2b, 2c, 2d, 2e, 2f, 2g, 3a, 3b, 3c, 3d, 3e and 4
Facts not proved:	None
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 Miss Clarke was not in attendance and that the Notice of Hearing letter had been sent to Miss Clarke's registered email address by secure email on 7 November 2025.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Miss Clarke

The panel next considered whether it should proceed in the absence of Miss Clarke. It had regard to Rule 21 and heard the submissions of Ms Da Costa.

Ms Da Costa applied for the hearing to proceed in Miss Clarke's absence. She referred the panel to the documentation before it, highlighting repeated failed attempts by the NMC to engage with Miss Clarke, including returned correspondence. She relied in particular on a handwritten letter in which Miss Clarke expressly stated that she did not wish to be

involved in the proceedings now or in the future and that she was no longer interested in nursing.

Ms Da Costa submitted that this demonstrated a clear and voluntary decision by Miss Clarke not to engage. She submitted that there had been no application for an adjournment, and there was no realistic prospect that an adjournment would secure Miss Clarke's future attendance.

Ms Da Costa emphasised the seriousness of the allegations, involving a serious breach of professional boundaries investigated by the police, and submitted that it was firmly in the public interest for the matter to proceed without further delay. She submitted that any adjournment would cause undue delay and unfairness, particularly to the professional witnesses, including police and registered nurses, who had been warned to attend.

Ms Da Costa acknowledged the issue of fairness to Miss Clarke but submitted that any potential unfairness was outweighed by the public interest, given that Miss Clarke was aware of the charges, had chosen not to attend, and had already provided an account during a police interview under caution. On that basis, she invited the panel to proceed with the hearing in Miss Clarke's absence.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Miss Clarke. In reaching this decision, The panel has considered the submissions of Ms Da Costa, 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 Miss Clarke;
- Miss Clarke has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- Miss Clarke has previously informed the NMC that she has no intention of returning to nursing practice;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- 7 Witnesses have been warned to attend to give live evidence at this hearing
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018-2019
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Clarke in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she 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 Miss Clarke'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 Miss Clarke. The panel will draw no adverse inference from Miss Clarke's absence in its findings of fact.

Details of charge

That you a registered nurse, whilst working on a secure mental health unit at Langdon Hospital (the Hospital):

1. Between August 2018 – April 2019, acted in an unprofessional manner whilst on duty at the Hospital, in that you:
    a. On one or more occasions swore whilst on duty.
    b. On one or more occasions placed your feet up on a desk.
    c. On an unknown date inappropriately ran around with an unknown Patient pressing the alarms during the daily alarm test on Ashcombe Ward

2. Between August 2018 – May 2019 acted in breach of your professional boundaries, in that you on one or more occasions:
    a. Attended Holcombe Ward, without any clinical justification.
    b. Spent a disproportionate amount of time providing care to Patient A, despite you not being his named nurse and/or working on his ward.
    c. Supplied Patient A with cannabis at the Hospital.
    d. Supplied Patient A with alcohol at the Hospital.
    e. Communicated with Patient A, without clinical justification via:
        i. Text messages.
        ii. Telephone calls
    f. Around December 2019 acted in a flirtatious and/or inappropriate manner towards Patient A.
    g. Openly discussed your sexual activity whilst on duty on Ashcombe Ward.

3. On or around 16/17 May 2019 during the planning and/or the commission of Patient A's escape from the Hospital:
    a. Communicated with Patient A over the telephone.
    b. Provided Patient A directions to your home address.
    c. Left and/or provided Patient A, a key to enter your home address.
    d. Allowed Patient A, whilst they were absent without leave from the Hospital, to reside and/or hide at your home address.
    e. Inaccurately informed the Ward Manager, Colleague Z that a family member had died in order to leave work early.

4. Your actions in charge 3 e) above were dishonest in that you misrepresented that you had suffered a family bereavement in order to leave work.

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

Background

Miss Clarke qualified as a Mental Health Nurse in August 2018 and commenced her preceptorship in the same month at Langdon Hospital (the Hospital), working on Ashcombe Ward.

A referral was made to the NMC on 20 May 2019 by Devon Partnership NHS Trust (the Trust). The referral alleged that Miss Clarke had breached professional boundaries with a patient.

During the relevant period, Patient A was a serving prisoner convicted of grievous bodily harm, with a custodial sentence of seven years and eight months. On 21 March 2018, Patient A was transferred from His Majesty's Prison Channing's Wood to the Hospital for assessment and treatment under the Mental Health Act, having been diagnosed with, paranoid schizophrenia with a mixed personality disorder featuring emotionally unstable traits. The Hospital is a medium - and low - secure mental health facility that regularly receives sentenced prisoners requiring psychiatric treatment; Patient A was one such individual.

While Patient A was an inpatient at the Hospital, it is alleged that concerns arose about an unhealthy and unprofessional relationship between him and Miss Clarke. Despite receiving supervision and reminders regarding the need to always maintain professional boundaries, Miss Clarke and Patient A allegedly developed a personal relationship.

On 16 May 2019, Patient A was due to be transferred from Holcombe Ward to Ashcombe Ward. That morning, he requested escorted grounds leave, which was granted by the responsible clinician. While on that leave and accompanied by a healthcare assistant, Patient A absconded. Later that evening, police located him at Miss Clarke's home address, and he was returned to the hospital shortly thereafter.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Da Costa on behalf of the NMC for the panel to admit two police witness statements into evidence as hearsay evidence under Rule 31. She explained that both statements were created during the police investigation into Patient A's absconding from the Hospital. The first statement is from an admin coordinator who had worked as a receptionist at the Hospital until December 2019. The second statement was made by a registered mental health nurse who was employed at the Hospital during the relevant period.

Ms Da Costa emphasised at the outset that these witness statements were provided to the NMC in a redacted form, and that the police did not disclose the witnesses' names or identifying details. As a result, the NMC does not know the identity of either witness and Ms Da Costa clarified that the only information available about the statement makers is their job descriptions as they appear within the redacted statements. Ms Da Costa explained that because of this, the NMC had not identified the two people who provided these statements, obtained fresh unredacted statements, or arranged for them to attend the hearing to give live evidence. Accordingly, she formally applied for The panel to admit both statements as hearsay evidence.

Ms Da Costa then turned to the legal framework and reminded the panel that under Rule 31, it must consider whether the evidence is relevant to the issues before it and whether it would be fair to admit it. She submitted that both requirements were met. She then addressed each statement in turn.

In respect of the first statement by the Admin Coordinator, Ms Da Costa accepted that the statement includes matters beyond the charges, but emphasised the key passage – the second paragraph - where the witness describes the relationship forming between Miss Clarke and Patient A. The witness reports observing that Patient A was being escorted outside “most of the time” by Miss Clarke. She submitted that this is plainly relevant to the issue of boundary breaches and is consistent with other evidence, including the live testimony of Colleague A, who stated that Patient A would specifically request Miss Clarke for escorted leave and medication administration.

In relation to the second statement by the registered mental health nurse, Ms Da Costa submitted that it involves reference to several relevant issues in this case. She highlighted that the registered nurse outlines multiple concerns about Miss Clarke’s conduct, presentation, and behaviour on the wards, and records that she was sufficiently concerned to raise these issues formally by email in December 2018. She also refers to another colleague who similarly emailed senior staff with concerns. The nurse goes on to describe observations of the developing relationship between Miss Clarke and Patient A. Ms Da Costa submitted that this aligns with the oral evidence from at least three witnesses who have already indicated that multiple staff members repeatedly raised concerns about Miss Clarke’s conduct, professionalism, and relationship with Patient A. Thus, the statement provides further context and corroboration.

Addressing the requirements of Rule 31, Ms Da Costa submitted that the contents of both statements are directly relevant to the matters The panel must decide and that it would be fair to admit them. Although the witnesses are not available for cross-examination, she reminded The panel that Miss Clarke has voluntarily absented herself, and none of the other witnesses have been cross-examined either. The panel has still been able to test the

oral evidence through its own questioning and through questions asked by the NMC in fairness to Miss Clarke. In contrast, because the makers of these particular statements are unidentified, they cannot be called, but fairness is preserved because their statements can be tested against the live evidence already given, the live evidence still to come and Miss Clarke's own account provided during the police interview under caution.

Ms Da Costa then applied factors set out in the case of Thorneycroft. She accepted that hearsay should not be admitted as routine but submitted that the fairness assessment supported admission in this case. She reminded the panel that the absence of a witness goes to weight, not necessarily to admissibility and she submitted that the panel could assign what weight it deems appropriate having taken into account the lack of cross-examination. Ms Da Costa acknowledged the need for a cogent reason for non-attendance - she submitted that the non-attendance is not the fault of the NMC. The statements were redacted by police, leaving the NMC unable to identify the witnesses. She added that Miss Clarke has been fully aware of the statements for some time and has not objected to their inclusion, their contents, or their makers.

Ms Da Costa addressed whether the evidence is sole or decisive - she submitted it is not. Instead, the statements are supplementary and supportive of other witness testimony.

Ms Da Costa concluded that both statements are relevant and their admission would be fair. They provide additional context regarding long-standing staff concerns about Miss Clarke's conduct and her relationship with Patient A. She therefore invited the panel to admit them as hearsay.

When questioned by the Chair about what efforts were made to identify the witnesses, she clarified that the NMC had not returned to the police for further inquiries, emphasising that the statements were received redacted and that the case is now several years old. She told The panel that reopening such enquiries at this late stage - when the hearing is already underway - would not have been in the public interest or proportionate. She

therefore maintained her application and invited the panel to admit both statements 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.

In reaching its decision, the panel considered the submissions made on behalf of the NMC, the advice of the legal assessor, and the factors set out in *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). The panel also considered the overarching requirements of relevance and fairness under Rule 31.

The panel first addressed the question of relevance. It was satisfied that both statements contain material that is directly relevant to the issues The panel must determine, particularly in relation to Charges 2(a) and 2(b), which concern the developing relationship between Miss Clarke and Patient A and the alleged breaches of professional boundaries.

The panel noted that the registered mental health nurse's statement provides observations of Miss Clarke's conduct on the ward and her interactions with Patient A, which broadly align with evidence given by live witnesses. The administrative coordinator's statement contains relevant information relating to Miss Clarke frequently escorting Patient A outside, which is also consistent with evidence heard by the panel. The panel recognised that some parts of that statement concerned matters that are peripheral or purely contextual, and certain passages appear to contain third-hand information. The panel concluded that this additional material does not detract from the overall relevance of the statements but accepted that such sections would not assist in determining the specific charges.

The panel then considered whether it would be fair to admit the statements. It took into account that the statements were included in the bundles of evidence that had been

served on Miss Clarke, and that she was therefore aware of the evidence upon which the NMC sought to rely. The panel also noted that Miss Clarke had not raised any objection to the NMC relying on statements from unidentified employees. Further, it noted that Miss Clarke had voluntarily absented herself from the hearing and would therefore not be in a position to cross-examine witnesses even if they were identified and called to give live evidence. In those circumstances, the panel went onto consider whether any potential unfairness could be mitigated if these statements were admitted into evidence as hearsay.

The panel considered that the fact that the statements were produced during a police investigation, recorded formally by a police officer and accompanied by a statement of truth, increases their reliability. The panel was satisfied that there is no indication that the evidence has been fabricated and no evidence to suggest any motive for the makers to have done so.

The panel gave careful consideration to the fact that certain passages in the administrative coordinator's statement refer to matters that have not been corroborated elsewhere in the evidence. The panel agreed that it would be unfair to rely on those specific parts of the statement, particularly where the content could not be tested and did not relate directly to the charges. The panel therefore determined that it would exclude those parts from its consideration. It was satisfied, however, that the remaining content that bears directly on the issues is capable of fair assessment.

Turning to the Thorneycroft factors, the panel was satisfied that the statements are neither sole nor decisive evidence in relation to any of the charges. The panel has already heard evidence from several witnesses, together with contemporaneous documentation, that speaks to the same issues. The panel acknowledged that the statements cannot be tested through cross-examination because the identities of the makers are not known. However, it considered that the material can nonetheless be evaluated by reference to the extensive oral and documentary evidence already before it.

With regard to the reason for the witnesses' non-attendance, The panel accepted that their identities were not known prior to the hearing because their statements had been disclosed to the NMC in a heavily redacted form. While the panel considered that it would have been preferable for the NMC to have explored the possibility of identifying the witnesses earlier in the process, it accepted that, from a practical perspective, this would not be a reasonable or proportionate step at this late stage of proceedings. The panel also accepted that it would not be in the public interest to delay the hearing in order to pursue this line of enquiry. The panel was further satisfied that Miss Clarke had prior notice of the evidence and has not engaged with the process so as to raise any challenge to its admissibility.

Having considered all the evidence and submissions, The panel concluded that both statements contain relevant material and that their admission would be fair and in accordance with the Rules. The panel therefore allowed the application. However, it will disregard any passages within the statements that amount to third-hand information or relate to matters not directly observed by the witnesses and not connected to the charges. The panel will determine the appropriate weight to attach to the remaining content once it has heard and evaluated all the evidence before it.

Decision and reasons on facts

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

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

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:

- Police 1: Police Constable, Devon and Cornwall Police (at the relevant time)
- Police 2: Detective Constable, Devon and Cornwall Police (at the relevant time)
- Police 3: Detective Constable – Financial Investigator in the serious and organised crime investigation team, Devon and Cornwall Police
- Colleague A: Senior Nurse Manager, Langdon Hospital, Devon Partnership NHS Trust (at the relevant time)
- Colleague B: Senior Nurse Manager, Devon Partnership NHS Trust, Dewnans Centre, Langdon Hospital (at the relevant time)
- Colleague C: Preceptorship Lead, Torbay and South Devon NHS Foundation Trust (at the relevant time)
- Colleague Z: Ward Manager at Ashcombe Ward, Langdon Hospital, Devon Partnership NHS Trust (at the relevant time)

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 the NMC.

The panel took into account that Miss Clarke is a person of good character and that this was relevant to her credibility and her propensity to act as alleged.

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

Charge 1a

1. Between August 2018 – April 2019, acted in an unprofessional manner whilst on duty at the Hospital, in that you:
    a. On one or more occasions swore whilst on duty.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence before it.

It noted that in her witness statement, Colleague A stated:

> *"Around 4 weeks after Francesca started with us, concerns started to be raised regarding her professional boundaries and overall conduct in the way she presented herself around the workplace. The first time I noticed there was a problem I was down on Ashcombe Ward […], as there had been an incident on the ward. We were in a meeting and I noticed a woman was sitting in the chair, slouched and was acting cocky and swearing. I was shocked as it was in front of the Deputy Director. I later found out it was Francesca."*

Colleague A confirmed this account during her oral evidence, which the panel found to be credible and reliable as well as clear, consistent, and measured. The panel noted that Colleague A was a fair and balanced witness who, at other points in her evidence, spoke positively about Ms Clarke's clinical abilities. This, in the panel's view, enhanced her credibility, as her evidence was not exaggerated or motivated by any apparent animosity.

The panel also took into account that Colleague A's account was corroborated by that of the evidence from Colleague Z whose evidence set out that Miss Clarke had been spoken to about her professional conduct and communication. While Colleague Z's evidence was less specific as to particular words used, it supported the broader concern that Ms Clarke's language and demeanour on duty were unprofessional.

The panel noted the documentary evidence including notes of an internal interview dated 13 August 2019. The interview was conducted by Colleague B and she interviewed the Deputy Manager of Ashcombe Ward, Colleague D, for the purposes of an investigation conducted following Patient A's disappearance from the hospital. During that interview Colleague D stated:

> *"[Miss Clarke] probably did swear from time to time but I can't give exact examples that stuck out, there wasn't anything vile that comes to mind. It was almost like an outside language you'd use if you were speaking to your friends or you're in a social situation where everyone is matey, but she wasn't in that environment so shouldn't have spoken or conducted herself like that…"*

The panel placed limited weight on this evidence due to its speculative nature and the lack of direct observation by the witness himself.

However, the panel was satisfied that the direct, first-hand evidence of Colleague A, corroborated by the wider context of managerial concern documented within the material before it was sufficient to establish that Miss Clarke swore whilst on duty on one or more occasion. Accordingly, the panel found Charge 1a proved.

Charge 1b

1. Between August 2018 – April 2019, acted in an unprofessional manner whilst on duty at the Hospital, in that you:
    b. On one or more occasions placed your feet up on a desk.

This charge is found proved.

In determining this allegation, the panel again had regard to both documentary and oral evidence addressing Mis Clarke's posture and demeanour whilst on duty.

The panel relied on the evidence of Colleague A, who confirmed in her oral evidence that she had personally observed Miss Clarke placing her feet on a desk whilst on duty. Colleague A's evidence was clear and unequivocal when questioned directly by a panel member, and she confirmed that this behaviour was inappropriate in a professional ward environment.

This evidence was corroborated by the internal interview material attributed to Colleague D. In that interview, Colleague D stated:

> *"[Miss Clarke] wouldn't always use the most professional language, sometimes her body posture and the way she conducted herself wasn't always the most professional. […] She was quite loud, she'd have her feet on the desk sometimes and she'd be very slouchy, not all the time but she was…"*

Although Colleague D did not give oral evidence, the panel was satisfied that this interview record was properly exhibited through Colleague B, who confirmed that it accurately reflected what was said during the interview. The panel was therefore entitled to place weight on this evidence.

The panel noted that Ms Clarke was a preceptee at the material time and that expectations regarding professional behaviour would reasonably be under greater scrutiny given her early stage of practice and the need to model appropriate conduct.

Taking all of this evidence together, the panel was satisfied on the balance of probabilities that Ms Clarke did, on one or more occasions, place her feet on a desk whilst on duty, and that this amounted to unprofessional conduct. Accordingly, the panel found Charge 1b proved.

Charge 1c

1. Between August 2018 – April 2019, acted in an unprofessional manner whilst on duty at the Hospital, in that you:
    c. On an unknown date inappropriately ran around with an unknown Patient pressing the alarms during the daily alarm test on Ashcombe Ward

This charge is found proved.

In reaching its decision the panel took into account the documentary and oral evidence before it.

The panel had regard to Colleague A's witness statement in which she set out that:

> *"… there were numerous concerns raised about Francesca's general inappropriate behaviour on the ward with patients, for example, there is an alarm testing on the ward daily to check they are working and Francesca ran around with one of the patient's pressing them all."*

During her live evidence, Colleague A confirmed that, as a result of these concerns, she reviewed CCTV footage of the incident and personally observed Miss Clarke engaging in this behaviour.

The panel placed significant weight on the fact that Colleague A did not rely solely on reports from others but took the step of reviewing CCTV footage, thereby providing direct confirmation of the incident. The panel found Colleague A's explanation of the alarm-testing procedure to be clear and noted her explanation that the daily alarm test is a serious safety process designed to ensure that alarms function correctly and to reinforce their importance to both staff and patients. The panel accepted her evidence that Miss Clarke's behaviour undermined the seriousness of this procedure and risked sending an inappropriate message to patients about the use of emergency alarms.

The panel considered whether this conduct could properly be characterised as "inappropriate." It concluded that running around pressing alarms during a safety test, particularly with a patient, trivialised a critical security process and had the potential to compromise ward safety. This was especially significant in the context of a secure mental health ward, where alarms are a vital safeguard for staff and patients alike.
There was no evidence before the panel to suggest that Miss Clarke had any clinical justification for behaving in this way. Nor was there any evidence that she had been instructed to involve a patient in alarm testing. The panel therefore concluded that the conduct was inappropriate and unprofessional. Accordingly, the panel found Charge 1c proved.

Charge 2a and 2b

2. Between August 2018 – May 2019 acted in breach of your professional boundaries, in that you on one or more occasions:
    a. Attended Holcombe Ward, without any clinical justification.
    b. Spent a disproportionate amount of time providing care to Patient A, despite you not being his named nurse and/or working on his ward

These charges are found proved.

In considering charge 2a, the panel took into account the evidence of Ms Colleague Z, who was Miss Clarke's line manager at the relevant time. In her witness statement, Colleague Z stated:

> *"I also had concerns raised from staff on Ashcombe ward around the conversations Fran was having in the office. […] There were also concerns raised from Holcombe ward staff that Fran had been going over there and doing the same sort of thing, definitely within the earshot of patients around the ward. […] I decided I needed to raise this formally with her as I had also been receiving complaints from Holcombe staff regarding Fran's relationship with one of the patients on that ward, They had fed back to me that Fran was popping over to Holcombe ward a lot, at least a few times a week and when staff in Ashcombe ward were looking for her, they couldn't find her."*

During her oral evidence, Colleague Z was unequivocal that Miss Clarke had no clinical justification to attend Holcombe Ward. She explained that Miss Clarke was a preceptee allocated to Ashcombe Ward and would not have been expected to cover breaks or provide support on Holcombe Ward. Colleague Z also stated that she explicitly instructed Miss Clarke not to attend Holcombe Ward unless there was a clear clinical justification. This instruction is recorded in supervision documentation dated 1 May 2019 in which it stated:

> *"We discussed that staff had reported that you have been spending time on Holcombe again. You reported that you have friends on the ward that you lift-share with and that you go over there to make arrangements. We discussed that the reason for you not going to Holcombe was due to concerns raised regarding your relationship with a patient. You agreed that this should be avoided to protect your reputation and to avoid the blurring of boundaries with the patient, but added that you had been trying to keep conversations with the patient short and less frequent. I informed you that I would be placing a note on your file to*

highlight again that you should not be spending time on Holcombe unless absolutely necessary, and that if this continued, we may need to go down a more formal route. You were understanding of this."

The panel had regard to further contemporaneous documentation which included Colleague D's supervision record dated 27 April 2019 which record discussions with Miss Clarke about concerns raised regarding her attendance on Holcombe Ward and reiterate that Ashcombe Ward was her allocated area of work. It stated:

"We spoke about concerns being raised in regards to her going to over to Holcombe ward. We discussed that Ashcombe is her ward and unless she has a reason to go to Holcombe she should not be going over there. We discussed that she has not had a handover regarding what has happened on that ward and could potentially be walking in to a dangerous environment. We discussed ringing wherever possible."

Further corroboration came from the evidence of Colleague A. In her witness statement at), Colleague A stated:

"After this, several different incidents started cropping up including Francesca visiting Holcombe Ward when she shouldn't have been.
[…]
Things then started to get worse after the New Year, she was frequenting Holcombe Ward more often"

The panel accepted that, on isolated occasions, Miss Clarke may have attended Holcombe Ward for legitimate reasons; however, the consistent evidence demonstrated that her attendance was frequent, persistent, and without clinical justification, and that this continued despite repeated instructions and warnings from management. The panel was therefore satisfied that Ms Clarke attended Holcombe Ward without clinical justification

and that this conduct amounted to a breach of professional boundaries. Accordingly charge 2a is found proved.

Turning to charge 2b, the panel noted that it was not in dispute that Miss Clarke was not Patient A's named nurse and did not routinely work on Holcombe Ward, where Patient A was based.

The panel again had regard to Colleague Z's evidence, in which she stated that Miss Clarke was frequently absent from Ashcombe Ward and was reported to be spending one-to-one time with Patient A. Colleague Z described this behaviour as flirtatious and stated that there was no legitimate reason for Miss Clarke to be spending such time on Holcombe Ward, particularly given her preceptee status. Although Colleague Z's evidence informed the panel that Miss Clarke later undertook overtime shifts on Holcombe Ward with appropriate approval, she explained that this did not account for the earlier and repeated concerns about her presence on the ward.

The panel also relied on the evidence of Ms Colleague A, who stated that Patient A would specifically request Miss Clarke to take him out on leave, would only accept medication from her, and appeared to expect her to meet his needs despite her not being his nurse. In her oral evidence, Colleague A explained that this behaviour was inappropriate and contrary to standard nursing practice, as it promoted dependency on a single nurse.

In addition, the panel considered supervision records and internal notes including Colleague D supervision notes which consistently document concerns raised by multiple staff members that Miss Clarke was spending a disproportionate amount of time with Patient A.

The panel also had regard to the Trust's Professional and Personal Boundaries Policy, which emphasises the need to prevent professional relationships from becoming compromised and sets out a non-exhaustive list of actions within a service user–patient relationship that may constitute inappropriate conduct and amount to a breach of

professional boundaries. The panel was satisfied that Miss Clarke's actions, which the evidence demonstrated involved her spending a disproportionate amount of time with Patient A, amounted to a breach of professional boundaries.

Taking all of this evidence together, the panel was satisfied that, between August 2018 and May 2019, Miss Clarke spent a disproportionate amount of time providing care to Patient A, despite not being his named nurse and/or working on his ward. The panel concluded that this conduct constituted a breach of her professional boundaries. Accordingly, charge 2b is found proved.

Charge 2c and 2d

2. Between August 2018 – May 2019 acted in breach of your professional boundaries, in that you on one or more occasions:
    c. Supplied Patient A with cannabis at the Hospital.
    d. Supplied Patient A with alcohol at the Hospital.

These charges are found proved.

In reaching this decision, the panel took into account the witness statement of Police 2 who conducted the police interview with Miss Clarke. His witness statement stated:

> *"During the interview ….*
> *… [Miss Clarke] admitted to supplying cannabis to [Patient A] and understood in doing so that she had committed an offence;"*

The panel also had regard to the Police's record of interview document which documented that during the interview Miss Clarke stated:

> *"But then that escalated and then I stated taking in cannabis. Er once I'd done it the*

once when I then tried to refuse the next time…
[…]
It would become you know at the end of the day you set a precedent.
[…].
You know you've done it once, you know that you can do it'"

The panel noted that the interview was conducted in a formal setting, that Miss Clarke had been offered the assistance of a solicitor (which she declined), and that the admissions were made voluntarily. It was satisfied that the evidence before it established that Miss Clarke supplied Patient A with cannabis and accordingly found charge 2c proved.

The panel was also satisfied that in supplying Patient A with cannabis her actions amounted to a breach of professional boundaries.

In relation to charge 2d, the panel again relied primarily on Miss Clarke's admissions during her police interview. The record of interview document before the panel sets out that during the Police interview, Miss Clarke stated:

"[Miss Clarke]: I'm just trying to think, yeah, alcohol um, there were times where he would ask me to go down and pick him up alcohol from Sainsburys, which is down the bottom.
[…]
[Police 2]: Okay alright, so you would get him alcohol, you would get the cannabis.
[Miss Clarke]: Yeah things like so vodka and um, decant it into a water bottle."

The panel noted that this information was volunteered by Ms Clarke and not elicited through leading questioning. The level of detail provided - including where the alcohol was purchased and how it was concealed - significantly strengthened the reliability of the admission.

Taking all of this evidence together, the panel was satisfied that, between August 2018 and May 2019, Miss Clarke supplied Patient A with alcohol at the Hospital on one or more occasions. The panel concluded that this conduct constituted a breach of her professional boundaries. Accordingly, Charge 2d is found proved.

Charge 2e

2. Between August 2018 – May 2019 acted in breach of your professional boundaries, in that you on one or more occasions:
    e. Communicated with Patient A, without clinical justification via:
        i. Text messages.
        ii. Telephone calls

These charges are found proved.

In reaching this decision, The panel took into account the evidence from POLICE 2. In his witness statement he stated:

> *"They too had extensive mobile phone and text contact whilst she was working and whilst not."*

The panel had regard to the Police record of interview, which recorded the following exchange in relation to these matters:

> *"[Police 2] Over the course of probably just about five weeks there's like 238 calls and texts between you guys. Would you say that's about right?*
>
> *[Miss Clarke] That wouldn't surprise me. That wouldn't surprise me.*
>
> *[Police 2] Okay, alright. Um, and obviously he's, he's called or text you 161 times so, so there's a lot of contact there isn't there…*

[Miss Clarke] Yeah.

[Police 2] …in a month. So is that, is that, I mean obviously I, we've pulled this, we've done the techy phone thing, um, but would you say that's about right?

[Miss Clarke] I'd imagine so, I mean I never counted them.

[Police 2] No. So that I mean, what is that daily?

[Miss Clarke] Yeah.

[Police 2] Yeah, right okay.

[Miss Clarke] Yeah, we both like, yeah, even on my days off."

The panel also had regard to the phone data documents downloaded by the Police and exhibited through the evidence of Police 3. These documents corroborated the number of phone calls and text messages exchanged between Miss Clarke and Patient A, as referenced in the Police interview.

The panel noted that Ms Clarke's responses during the police interview, including her acknowledgment that the volume of contact was likely correct and that it occurred even on her days off, indicated an acceptance of the extent of the communication.
The panel noted that this volume of contact occurred over a relatively short period and was wholly inconsistent with any legitimate clinical purpose, particularly given that Miss Clarke was not Patient A's named nurse and did not work on his ward. The panel was of the view that, as within any secure service, it would be inappropriate to exchange personal information including contact details with a patient as this would be deemed a breach of security. Further, the panel concluded that in the circumstances of this case, there was no clinical justification for the exchange or communication via personal mobile between Miss Clarke and Patient A. The panel therefore found that Miss Clarke communicated with

Patient A by text and telephone without clinical justification and in breach of professional boundaries.

Charge 2f

2. Between August 2018 – May 2019 acted in breach of your professional boundaries, in that you on one or more occasions:
    f. Around December 2019 acted in a flirtatious and/or inappropriate manner towards Patient A.

This charge is found proved.

In reaching this decision, the panel distinguished between the elements of “flirtatious” and “inappropriate” conduct.

The panel had regard to Colleague Z’s witness statement in which she sets out:

> *“On one occasion, I directly observed her with [Patient A] during the ward Christmas party and it made me feel uncomfortable. To give a bit of context, the medium secure facility has four locked wards, two at either end of a long corridor. The corridor has a café, outside area etc. that connects the wards together. This is where events like the Christmas party would take place so patients and staff of different wards could mingle together. However, for Fran this seemed very focused on [Patient A] she didn’t interact with any other patients. They were playing a board game where you throw balls in holes for points, and it seemed to have a flirtatious element to it. Although I can’t recall there being an obvious statement or action that made me feel she was being flirtatious, I remember feeling uncomfortable watching their interaction and it made me understand how people were concerned about her behaviour.”*

The panel noted that Colleague Z candidly accepted that she could not identify a specific statement or action that she would label flirtatious. However, the panel placed weight on her professional experience and her expressed discomfort, particularly given her familiarity with ward dynamics and appropriate nurse-patient interactions.

Having considered all of the evidence, the panel was satisfied that Miss Clarke acted in an inappropriate manner towards Patient A, in breach of her professional boundaries. While the panel was not satisfied that the conduct described within the evidence before it could be definitively characterised as flirtatious, it concluded that the conduct could clearly be defined as inappropriate, and in breach of professional boundaries. The panel therefore finds Charge 2f proved.

Charge 2g

2. Between August 2018 – May 2019 acted in breach of your professional boundaries, in that you on one or more occasions:
    g. Openly discussed your sexual activity whilst on duty on Ashcombe Ward.

This charge is found proved.

In reaching this decision, The panel took into account the evidence from Colleague A and Colleague Z.

In her witness statement, Colleague Z stated:

> *"Around this time, I also had concerns raised from staff on Ashcombe ward around the conversations Fran was having in the office. She was speaking loudly in the office about what she had done at the weekend, for example, people that she had been sleeping with, drinking with and some details that staff members felt were unprofessional. It was reported that the office door was open, so it was likely within the earshot of patients. There were also concerns raised from*

Holcombe ward staff that Fran had been going over there and doing the same sort of thing, definitely within the earshot of patients around the ward. They reported she was being loud and almost flirtatious, pushing her chest out and it was making staff feel uncomfortable."

The panel also had regard to a Trust investigation interview document. During the interview Colleague B, Colleague Z and Colleague E were present. It is recorded that Colleague Z stated:

"One of the main areas that Fran was working on in that time was around boundaries. So there were some concerns around conversations she'd been having in the ward office and sometimes the way she presented herself in a meeting or in handovers, quite slouched and laid back, quite loud. She could come across and be perceived as unprofessional at times, but to counteract that she had good clinical judgement, quite sound nursing skills, she understood patients well, she generally seemed to have a good therapeutic relationship with patients, albeit she needed to be reminded of some of her loudness, and being careful of language.
[….]
I can't remember who, reported that she'd been in the office talking about 'fisting' which obviously isn't something I would encourage my colleagues to be talking about in any kind of ward environment."

This was corroborated by Colleague A's witness statement in which she stated:

"She was also in the nursing office and talking sexually and patients could hear her. I felt the way she interacted with patients was inappropriate, they were unwell and needed support and it's as if she forgot she was a nurse and was speaking to them as if she was within their friend group."

The panel was satisfied that the consistent nature of the reports from multiple staff members, together with their appropriate escalation through formal channels, rendered the evidence sufficiently reliable to support its findings.

Taking all of this evidence into account, the panel was satisfied that, between August 2018 and May 2019, Miss Clarke openly discussed her sexual activity whilst on duty on Ashcombe Ward. The panel concluded that this conduct was unprofessional and constituted a clear breach of her professional boundaries. Accordingly, Charge 2g is found proved.

Charge 3a

3. On or around 16/17 May 2019 during the planning and/or the commission of Patient A's escape from the Hospital:
    a. Communicated with Patient A over the telephone.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Police 2 and the documentary evidence obtained during the police investigation.

During her police interview, Miss Clarke acknowledged that she had been in contact with Patient A in the period immediately preceding his escape. When asked about her awareness of his plans, she stated:

> *"[Police 2]: So on the day in question you were, how, how many days to him escaping were you aware that he was going to, can you remember?*
> *[Miss Clarke]: I can't remember if it was the day before or a couple of days before.*
> *[…]*
> *[Police 2]: Okay alright. So suffice to say he did escape, you are aware of that, and what sort of communication did you have with him around that time?*

[Miss Clarke]: Um, he rang me up on the phone asking me how to get to mine, because he got out of a taxi.
[Police 2]: Yeah."

The panel also considered the mobile telephone data obtained by the police, which demonstrated multiple telephone calls between a handset attributed to Miss Clarke and a handset confirmed to be in Patient A's possession on 16 May 2019. The call logs showed numerous outgoing calls from Miss Clarke's number to Patient A's number, including repeated calls on the morning of 16 May 2019, after Patient A had absconded from the Hospital.

The panel placed significant weight on this objective telephone data, which it found to be reliable and contemporaneous, and which corroborated Miss Clarke's admissions during her police interview that she had communicated with Patient A by telephone in connection with the events surrounding his escape.

Taking all of this evidence together, the panel was satisfied that on or around 16 May 2019 Miss Clarke communicated with Patient A over the telephone during the planning and/or commission of his escape from the Hospital. Accordingly, Charge 3a is found proved.

Charges 3b, 3c and 3d

3. On or around 16/17 May 2019 during the planning and/or the commission of Patient A's escape from the Hospital:
    b. Provided Patient A directions to your home address.
    c. Left and/or provided Patient A, a key to enter your home address.
    d. Allowed Patient A, whilst they were absent without leave from the Hospital, to reside and/or hide at your home address.

These charges are found proved.

In reaching this decision, the panel took into account the evidence from Police 2. His witness statement stated:

> *"We spoke about her assisting in [Patient A's] escape, she stated that she had left the keys to her flat for him to escape to, and that she had received a number of calls from him following his escape and directed him to her flat. She stated that when she was at the flat […], she found an excuse to leave the flat, stating that she would get some drugs for him that he was insisting."*

The panel also considered the police interview of Miss Clarke. In that interview, she admitted providing Patient A with directions to her home after he exited a taxi and became disoriented:

> *"[Police 2]: Okay alright. So suffice to say he did escape, you are aware of that, and what sort of communication did you have with him around that time?*
> *[Miss Clarke]: Um, he rang me up on the phone asking me how to get to mine, because he got out of a taxi.*
> *[Police 2]: Yeah.*
> *[Miss Clarke]: And um, he knew Teignmouth fairly well but he obviously didn't know it well enough in the way that I do.*
> *[Police 2]: Yeah.*
> *[Miss Clarke]: Um, so he got out of a taxi and he was confused and he was screaming at me um, down the phone, and I gave him directions to my house."*

The panel was satisfied based on the evidence before it that Miss Clarke provided patient A with directions to her home address. Accordingly, Charge 3b is found proved.
During her police interview, Miss Clarke also admitted leaving her house keys outside her property so that Patient A could enter:

> *"[Police 2]: Okay alright. And did you, I understand you may have left your keys somewhere else?*

[Miss Clarke]: Yes yes, I left my keys at my house (inaudible).
[Police 2]: Where did you leave them?
[Miss Clarke]: Under the bin.
[Police 2]: Okay."

The panel also relied on the evidence of attending police officers, who confirmed that when Patient A was located at Miss Clarke's address there were no signs of forced entry, strongly supporting the conclusion that he gained entry using a key. The panel was satisfied that Miss Clarke deliberately left or provided a key to Patient A to enable him to enter her home whilst she was at work. Accordingly, Charge 3c is found proved.

In relation to charge 3d, the panel considered evidence from police officer Police 1, Colleague B, and Miss Clarke's own police interview. The police interview recorded the following:

"[Miss Clarke]: So I lived in the attic apartment and I had to shout up to my window and he dropped the keys and he dropped the keys out and um, I went up and we had a fight.
[Police 2]: What did you have an argument about?
[Miss Clarke]: The fact that he had escaped and he was at my house, and I wasn't happy with it you know.
[Police 2]: No.
[Miss Clarke]: Ultimately I did what I did, but I wasn't happy with the circumstance.
[Police 2]: Yeah, yes.
[Miss Clarke]: And then he, he gave me some money, he had a lot of money on him, I remember that, a lot of money.
[Police 2]: What do you, what do you mean by a lot of money?
[Miss Clarke]: Like a lot of cash.
[Police 2]: What five hundred quid, a grand? A hundred?
[Miss Clarke]: About four, four or five hundred or so.
[Police 2]: Really, okay.

[Miss Clarke]: Like he had a lot of money. And he gave me some money and he made me go to Tes…Peacocks and buy him some jeans… He made me buy him clothes, all black.
[Police 2]: And you left, but I understand you may have seen some officers?
[Miss Clarke]: Yes, yeah and then I ran down to my friend's house.
[Police 2]: Is there any reason you didn't approach the officers at the time?
[Miss Clarke]: Because I was frightened.
[Police 2]: Okay, that's a simple question, probably a simple answer yeah.
[Miss Clarke]: I was in um, I was in a lot of shock and things like that."

The panel was satisfied, based on the record of interview, that Miss Clarke knowingly allowed Patient A to reside and hide at her home while he was unlawfully absent from the Hospital.

This was supported by witness statement of Police 1 who was the attending police officer which stated:

"As a result of this on the same day, I attended with other officers as we had reason to believe that the prisoner was at that location, I knew that this was the home address of Clarke, which was confirmed when I searched the flat and found documentation in her name. Prisoner A was located at the flat and subsequently returned to the Langdon Hospital."

The panel had regard to the written statement Police 1 made at the time of the incident which stated:

"i received information that a male known to have absconded from Langdon hospital at approximately 10:30hrs that day, where he was serving a custodial sentence for a serious assault… at 22:55hrs we arrived at [location 1]… the landlord stated '[location 2] is occupied by a young nurse called Fran. She usually

works night shifts.' the landlord gave me a key for the communal door and also a key for [location 2].

[…]

At 23:10hrs i entered […] with my colleagues and went up all the stairs to locate [location 2]. I knocked on [location 2] and it sounded like there was a creak sound from the building but no one was replying to my knocking. There was no damage or sign of forced entry to the door. I opened the door with the key and shouted "this is the police, identify yourself". There was no reply and we systematically searched the flat. […] i then entered the lounge area where I saw pc Arscott placing a male in handcuffs. This male confirmed he was [patient a]. Due to the offending history of the male and the suspicious circumstances leading to him being located i had concerns for the occupant of the flat, Francesca Clarke. I said to 'is there anyone else here with you?" Replied "no". I then asked "where is Fran. The girl that lives here?" Replied "i don't know. Probably at a pub or something". I briefly checked the remaining areas of the flat for Clarke but she was not present. I had advised my colleagues that the landlord stated she was a nurse. This had raised our suspicion that she may be involved in absconding. I saw a letter on the kitchen worktop which was addressed to Francesca Clarke at the same address and [Police 4] showed me an NHS identity card which he had seen."

Colleague B's witness statement provided further context:

"Ms Clarke was aware that Patient A was absent without leave and should be detained at the hospital. I believe this would seriously affect Patient A's ongoing treatment because his level of security will now be increased. Ms Clarke had in her statement also disclosed to the Police that she had brought drugs to the hospital… However, when Patient A was found by the police in her house, the police said it was evident that marijuana had been used. Importantly, the patient was at Ms Clarke's house, Ms Clarke left work for home early… Ms Clarke did not inform anybody at the Trust that the patient was in her house."

Taking all of the evidence together, the panel was satisfied that on or around 16/17 May 2019 Miss Clarke allowed Patient A, whilst he was absent without leave from the Hospital, to reside and/or hide at her home address. The panel found that Miss Clarke knew Patient A had unlawfully absconded, nonetheless permitted him to remain at her property for a period of time, and took steps consistent with facilitating his presence there. This conduct amounted to a breach of professional boundaries. Accordingly, Charge 3(d) is found proved.

Charge 3e

3. On or around 16/17 May 2019 during the planning and/or the commission of Patient A's escape from the Hospital:
    e. Inaccurately informed the Ward Manager, Colleague Z that a family member had died in order to leave work early.

This charge is found proved.

In reaching this decision, the panel took into account the evidence from the police interview of Miss Clarke, together with the corroborative evidence of Colleague Z.

During her police interview, Miss Clarke admitted that she had provided false information to her manager in order to leave work early. The following exchange was recorded:

> *[Police 2]: And were you late that day? I seem to remember you may have been late.*
> *[Miss Clarke]: Yeah I think I was.*
> *[Police 2]: Do you know why?*
> *[Miss Clarke]: Yeah, I told, I told a lie to my boss to say that a member of my family had died, I wasn't actually going to come in. Um…*
> *[Police 2]: Why was that?*

[Miss Clarke]: Because of what he was planning on doing.
[Police 2]: Because you believed he was going to escape?

The panel regarded this as a clear admission by Miss Clarke that she deliberately misled her manager to secure permission to leave work early. This account was considered alongside the evidence of Colleague Z, who recalled Miss Clarke requesting leave and referring to a bereavement, although she could not recall the precise details of that conversation.

The panel placed primary reliance on Miss Clarke's own admission, which was clear, unequivocal, and made during a formal interview under caution. The panel was satisfied that the information provided to the ward manager was knowingly false and was given for the purpose of leaving work early.

Accordingly, the panel found Charge 3e proved.

Charge 4

4. Your actions in charge 3e) above were dishonest in that you misrepresented that you had suffered a family bereavement in order to leave work.

This charge is found proved.

In reaching this decision, the panel had regard to the test for dishonesty as set out by the Supreme Court in Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67.

The panel first considered Miss Clarke's actual state of knowledge and belief as to the facts. The panel was satisfied, based on Miss Clarke's clear admissions during her police interview, that she knew she had not suffered a family bereavement and that she deliberately provided false information to her manager in order to obtain permission to leave work early.

Having determined Miss Clarke's knowledge and belief, the panel then considered whether her conduct was dishonest by the standards of ordinary decent people. The panel

was satisfied that ordinary decent people would regard deliberately misrepresenting a family bereavement to an employer as dishonest conduct.

The panel noted that under the Ivey test there is no requirement that Miss Clarke appreciated that her conduct was dishonest by those standards. Applying the objective standard, the panel concluded that Miss Clarke's actions amounted to dishonesty.

Accordingly, the panel found charge 4 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Clarke'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, Miss Clarke's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Da Costa began by referring 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.'*

Applying that guidance to the facts, Ms Da Costa submitted that, notwithstanding Miss Clarke's status as a preceptee, she was a registered nurse who had behaved in a way that multiple other registered nurses considered improper, inappropriate, and a breach of professional boundaries. On that basis, she submitted that Miss Clarke's conduct clearly met the definition of misconduct.

Ms Da Costa invited the panel to take the view that the facts found proved amount to misconduct. In doing so, she referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code).

Ms Da Costa identified the specific and relevant standards which, in the NMC's view, Miss Clarke had breached, and which amounted to misconduct. She noted that, while the panel was not bound by the particular provisions she highlighted, they served to illustrate the nature and seriousness of the misconduct.

Ms Da Costa submitted that the panel had found boundary breaches that were inconsistent with acting in the best interests of Patient A. She further submitted that by leaving her own ward and patients to attend Holcombe Ward without clinical justification, Miss Clarke failed to act in the best interests of all patients for whom she was responsible.

Ms Da Costa submitted that the evidence demonstrated clear procedures, guidance, and support mechanisms regarding professional boundaries in such clinical environments, and that Miss Clarke failed to practice in accordance with that guidance.

Ms Da Costa acknowledged that the Code requires nurses to raise concerns promptly if issues arise that may prevent compliance with regulatory standards. She noted Miss Clarke's account that she felt threatened or placed in a vulnerable position by Patient A

and submitted that there was a duty to report those concerns in a timely manner to someone in authority.

Ms Da Costa submitted that the Hospital's patients required heightened care and caution, that manipulation was a known risk, and that safeguards were in place to protect both patients and staff. She submitted that Miss Clarke should have recognised the risk of harm and engaged with the available processes to reduce that risk.

Finally, Ms Da Costa submitted that Miss Clarke had failed to act with honesty and integrity, lacked awareness of how her behaviour could influence others, and failed to maintain objectivity and clear professional boundaries.

Ms Da Costa concluded by reminding the panel of the evidence that blurred professional boundaries can undermine patients' ability to view nurses professionally and may interfere with their engagement in treatment. Having regard to the definition of misconduct and the breaches of the Code, she submitted that Miss Clarke's conduct fell squarely within misconduct.

Submissions on impairment

Ms Da Costa 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 Da Costa submitted that if the panel found misconduct, it must go on to consider whether Miss Clarke's fitness to practise was currently impaired. She reminded the panel that there is no statutory definition of impairment, but that the NMC's fitness to practise

guidance poses the central question of whether the nurse can practise kindly, safely, and professionally.

Ms Da Costa submitted that the answer in relation to Miss Clarke was no. She referred to the evidence describing Miss Clarke as lacking professional boundaries, particularly in her interactions with Patient A. More broadly, she submitted that Miss Clarke had openly discussed private and sexual matters within earshot of patients, had been heard swearing, and had displayed unprofessional behaviour including slouching, putting her feet up on chairs, running around the ward, and pressing alarms with a patient. Such conduct, she submitted, could not be described as professional.

In relation to safety, Ms Da Costa highlighted that Miss Clarke had brought cannabis and alcohol into the Hospital, a setting caring for highly vulnerable patients with mental health conditions. She submitted that the effects of drugs and alcohol on such patients could be catastrophic, and that this behaviour was extremely serious and incompatible with safe or professional practice.

Ms Da Costa further submitted that Miss Clarke had been aware several days in advance that a patient - described as dangerous and previously convicted of grievous bodily harm, with a sentence exceeding seven years - was planning to abscond. Despite this, Miss Clarke had communicated with that patient over 238 times in the space of a month. She submitted that this conduct could not be said to demonstrate kind, safe, or professional practice.

Ms Da Costa also referred to Miss Clarke leaving her post on Ashcombe Ward to attend Holcombe Ward without any clinical justification, thereby leaving her own patients and colleagues without support. This behaviour was compounded, Ms Da Costa submitted, by the fact that Miss Clarke had been given clear directions not to continue this conduct, which she ignored and persisted in. She emphasised that impairment is a forward-looking assessment and that the Panel must consider whether Miss Clarke could be trusted to

practise safely and professionally in the future. In that regard, she submitted that the repetition of behaviour and the disregard of clear instructions were highly relevant.

Ms Da Costa then referred to the test set out in Grant, which requires panels to consider four questions when assessing impairment. She submitted that all four limbs were engaged. First, Miss Clarke had in the past acted, and was liable in the future to act, in a way that put patients at unwarranted risk of harm. Second, Miss Clarke had brought, and was liable in the future to bring, the nursing profession into disrepute, noting the seriousness of the case and the fact that it resulted in a dangerous individual absconding from Langdon Hospital. Third, Miss Clarke had breached fundamental tenets of the nursing profession and was liable to do so again. Fourth, Miss Clarke had acted dishonestly and was liable to act dishonestly in the future, noting that the Panel had found the dishonesty charge proved.

Ms Da Costa acknowledged that the case was an unfortunate one but submitted that Miss Clarke had chosen not to engage with the regulatory process. As a result, there was no evidence of meaningful remediation and nothing to allay the serious concerns or risks she posed. While she informed the panel that the NMC accepted that some limited remorse might be inferred from certain responses, Ms Da Costa submitted that this was insufficient given the gravity of the case. Accordingly, she submitted that there remained a risk of harm and a high risk of repetition.

Ms Da Costa submitted that Miss Clarke's fitness to practise was impaired on public protection grounds, due to the risk of harm and repetition. She further submitted that impairment was also established on public interest grounds. She reminded the Panel that public interest encompasses the need to uphold professional standards and maintain public confidence in the nursing profession. She submitted that members of the public would be alarmed if a finding of impairment were not made in such a serious case.

Finally, Ms Da Costa referred to the seriousness of Patient A's offending history, his dangerousness, and his clinical presentation. She submitted that Miss Clarke's

misconduct contributed to his absconding and that this had a significant impact on the nursing team and on other vulnerable patients. She concluded that, taking all matters into account, the NMC submitted that Miss Clarke's fitness to practise was impaired on both public protection and public interest grounds.

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

1 Treat people as individuals and uphold their dignity

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

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

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

***8** Work cooperatively*

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

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

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

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

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues
***9.2** gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*

13 Recognise and work within the limits of your competence
***13.1** accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*
***13.2** make a timely referral to another practitioner when any action, care or treatment is required*
***13.3** ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*
***13.4** take account of your own personal safety as well as the safety of people in your care*

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place
***14.1** act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*

15 Always offer help if an emergency arises in your practice setting or anywhere else
***15.3** take account of your own safety, the safety of others and the availability of other options for providing care*

16 Act without delay if you believe that there is a risk to patient safety or public protection
***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
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
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
20.1 *keep to and uphold the standards and values set out in the Code*
20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
20.3 *be aware at all times of how your behaviour can affect and influence the behaviour of other people*
20.4 *keep to the laws of the country in which you are practising*
20.6 *stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the proved facts amounted to misconduct, the panel considered not only the nature of the individual allegations but also the wider context in which they occurred. The panel expressly took into account Miss Clarke's status as a newly qualified nurse working in a preceptorship role, her relative inexperience, and the inherent vulnerability of a junior practitioner within a secure mental health environment.

The panel also considered evidence suggesting that Miss Clarke may have been susceptible to manipulation or influence, including concerns raised regarding the conduct of her mentor and Miss Clarke's account that she felt under pressure and threatened and assaulted by Patient A. The panel was careful to ensure that these matters were weighed fairly and were not overlooked. However, the information before the panel alluding to these issues was limited and Miss Clarke was not present at the hearing nor did not provide any additional information or evidence to clarify or substantiate the effect of these pressures or threats on her conduct. The panel was aware that the Police did not find evidence of any threats made by Patient A to Miss Clarke and took no further action with regard to the alleged physical and sexual assaults both in the Hospital and subsequently in Miss Clarke's home.

The panel was equally mindful that Miss Clarke had completed at least three years of nurse training, would have received extensive education on professional boundaries, and was subject to supervision, repeated guidance, and clear managerial instruction. Safeguards were put in place specifically to support her and to prevent professional boundary violations.

The panel also bore in mind the complex patient group and specifically Patient A who had a diagnosis of paranoid schizophrenia with a mixed personality disorder and emotionally unstable characteristics. The panel took into account the challenges the clinical team had experienced with Patient A's presenting features of manipulation, grooming and threats to kill. The panel had evidence of MDT meetings on 10 and 15 May 2019 which focused on the safeguarding of both patients and the clinical team in terms of Patient A's assessment

and treatment pathway. It is clear that Patient A has the capacity to manipulate and threaten his clinical team to meet his needs. When considering this the panel bore in mind Miss Clarke's lack of experience but also the significant amount of support and supervision both group and 1-1 which provided her with many opportunities to raise concerns. The panel also took into account the evidence of Colleague Z (Miss Clarke's line manager), who had supervised her and had addressed professional boundaries and her interactions with Patient A openly and honestly. The panel also noted Colleague Z's evidence that Miss Clarke had demonstrated that she was able to reflect and understand and work on feedback. There was a clear loop of learning and understanding.

The panel therefore approached each charge by balancing Miss Clarke's vulnerability and inexperience against the degree to which she would have been aware of her duty to meet professional standards and the explicit instructions given to her by her managers.

In relation to charge 1a, the panel recognised that nurses are required to maintain professionalism in their language at all times, particularly in clinical environments where vulnerable patients and colleagues are present. The panel noted that the swearing identified, while limited in scope and not directed at any specific person, blurred professional boundaries and demonstrated a lapse in the standards of conduct expected of a registered nurse. The panel considered that even casual or offhand use of inappropriate language in a clinical setting can undermine the therapeutic relationship with patients and compromise the professional environment, particularly when caring for prisoners detained under the Mental Health Act who are vulnerable and reliant on staff for their safety and care. The panel also observed that such conduct, by creating an informal or overly familiar atmosphere, risks diminishing the authority and professionalism required in interactions with patients and colleagues. Having regard to these factors, the panel concluded that Miss Clarke's behaviour in swearing on duty fell within the threshold of serious misconduct, as it was inconsistent with the professional standards expected of a nurse and had the potential to impact on patient care.

In relation to charge 1b, the panel acknowledged that this behaviour fell short of the standards of professional decorum expected of a registered nurse, particularly in a clinical setting. However, the panel considered that the conduct involved no interaction with patients and with no risk of harm. The panel noted that the allegation was narrowly framed and concerned a single type of informal behaviour and the panel did not have any wider context before it which was capable of elevating it beyond poor professional judgment. The panel concluded that such conduct, standing alone, while unprofessional, could not properly be characterised as meeting the seriousness threshold required to establish misconduct as set out in *Roylance*. Accordingly, the panel determined that Charge 1b did not amount to misconduct.

In relation to charge 1c, the panel found that Miss Clarke ran around the ward with a patient pressing alarms during the daily alarm test. In assessing misconduct, the panel attached significant weight to the context in which this behaviour occurred. The panel heard in evidence that the daily alarm test was a safety-critical procedure within a secure mental health environment, designed to ensure the effective functioning of alarms that protect patients and staff. The panel determined that Miss Clarke's behaviour undermined the seriousness of the alarm system and risked desensitising both staff and patients to alarm activations. In a secure setting, the panel considered that any conduct which trivialises or interferes with safety systems has the potential to compromise safety and security. The panel concluded that this conduct went beyond mere informality or poor judgment. It demonstrated a failure to appreciate the importance of safety procedures and fell seriously below the standards expected of a registered nurse working in a secure mental health hospital. Accordingly, the panel determined that Charge 1c amounted to misconduct.

In relation to charge 2a the panel found that Miss Clarke attended Holcombe Ward without clinical justification and despite being instructed not to do so. In considering misconduct, the panel attached weight to the repeated nature of this behaviour and the fact that it continued after concerns had been raised and documented in supervision. The panel noted that Miss Clarke was a preceptee nurse and that ward allocations and staffing levels

in a secure hospital are carefully managed for safety reasons. Attending another ward without justification had the potential to leave her own ward short-staffed and undermined management oversight. The panel concluded that this was not an isolated lapse. Miss Clarke's conduct demonstrated a disregard for clear managerial instructions and professional boundaries. In the panel's judgment, this conduct fell seriously below expected standards and amounted to misconduct.

In relation to charge 2b, the panel found that Miss Clarke spent disproportionate time with Patient A despite not being his named nurse and not working on his ward. In assessing seriousness, the panel considered the vulnerability of Patient A, the secure mental health setting, and the importance of maintaining clear therapeutic boundaries. The panel accepted evidence that Miss Clarke's behaviour contributed to Patient A developing a dependency on her which is contrary to evidenced based nursing practice. The panel considered that this behaviour risked compromising Patient A's care and undermining multidisciplinary working. The panel concluded that this conduct represented a serious breach of professional boundaries and therefore amounted to misconduct.

In relation to charges 2c and 2d, the panel considered the conduct found proved to be extremely serious. Supplying an illegal substance and alcohol to a detained mental health patient was unlawful, fundamentally incompatible with safe nursing practice, and posed significant risks to Patient A, the complex patient group, colleagues, and the wider public. The panel considered the risks associated with alcohol consumption in a secure mental health setting, including the potential for disinhibition, aggression, and interference with treatment.

The panel concluded that this conduct demonstrated poor judgment, boundary violations, and disregard for patient safety. The panel concluded that this conduct demonstrated a grave abuse of trust and a profound departure from professional standards. The panel concluded that Miss Clarke's actions in charges 2c and 2d amounted to serious professional misconduct.

In assessing whether the conduct proved under charge 2e amounted to misconduct, the panel took into account to the volume, frequency, and persistence of the communications between Miss Clarke and Patient A. These communications occurred over a sustained period, were non-clinical in nature, and took place without any legitimate professional justification. The panel concluded that this conduct represented a serious and ongoing breach of professional boundaries, undermined the therapeutic relationship, and fell well below the standards expected of a registered nurse. Accordingly, the panel determined that the conduct amounted to misconduct.

In respect of charge 2f, the panel found that Miss Clarke behaved towards Patient A in a manner that was inappropriate and unprofessional. The panel accepted the evidence of senior colleagues that the nature, tone and frequency of the interactions created an overly familiar and dependent relationship, which went beyond what was therapeutically justified. While the panel did not find that flirtatious behaviour was established, it concluded that Miss Clarke's conduct conveyed inappropriate messages and blurred professional boundaries. In the context of Patient A's vulnerability, this behaviour had the potential to interfere with the care he was receiving and risked fostering emotional dependency. The panel further concluded that the visible nature of the interactions risked undermining professional boundaries more broadly on the ward and put colleagues in a difficult position. In light of the vulnerability of Patient A and the impact on the wider clinical environment, the panel concluded that this conduct amounted to a serious departure from expected professional standards. Charge 2f therefore amounts to misconduct.

In respect of charge 2g, the panel found that Miss Clarke's behaviour to be wholly inappropriate within a clinical environment and particularly concerning in a mental health setting. The panel concluded that discussions relating to her sexual activity on a ward setting where patients and other staff could overhear represented a clear breach of professional boundaries and conveyed an unprofessional impression to patients. This conduct risked undermining therapeutic relationships, compromising the respect and confidence patients must have in clinical staff, and causing distress or confusion. The panel also found that Miss Clarke's conduct placed herself at risk, given the patient group.

The panel concluded that this conduct fell well below the standards expected of a registered nurse and had the potential to compromise patient care and the reputation of the profession. Charge 2g therefore amounts to misconduct.

In respect of charges 3a – 3d, the panel took into account that Miss Clarke deliberately facilitated the escape of a patient from a secure mental health unit who was a prisoner diagnosed with paranoid schizophrenia and known to be violent. It took into account that this involved Miss Clarke's communication with Patient A at a time when he was absent without leave, Miss Clarke providing directions to her home, facilitating Patient A's evasion of hospital supervision and supplying a key and allowing Patient A to reside at her home. The panel took into account that these actions were deliberate and premeditated. They go far beyond an isolated lapse in judgment and constitute a serious breach of professional boundaries. By actively enabling Patient A to escape and hide, Miss Clarke placed herself, the patient, and members of the public at significant risk. The Code emphasises that nurses must safeguard people from harm and the panel concluded that Miss Clarke's actions directly contravened this obligation. While Miss Clarke was a newly qualified nurse in a preceptorship programme, NMC guidance clarifies that all nurses, regardless of experience, are accountable for their actions. This panel considered that the misconduct was not a result of ignorance or inexperience, but a conscious decision to act outside professional norms. The panel therefore concluded that Miss Clarke's actions in charges 3a-3d fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charges 3e and 4 related to Miss Clarke knowingly misrepresenting her circumstances to her manager, stating that a family member had died, in order to leave work. The panel viewed this as a serious and deliberate deception. In particular, it determined that the nature of the falsehood was significant: it involved a personal and sensitive matter, which had the potential to cause distress to her manager and colleagues, and undermined the trust placed in her as a professional.

The panel considered that this behaviour cannot be characterised as a momentary lapse in judgment. Miss Clarke would have been aware of the professional standards, including the expectations around honesty, integrity, and reporting personal circumstances truthfully. Despite this, she chose to act dishonestly, demonstrating a conscious disregard for her professional obligations.

While her status as a newly qualified nurse is acknowledged, it does not mitigate the gravity of the misconduct. Nurses are accountable for their actions regardless of experience, and deliberate dishonesty of this nature is inconsistent with the core values of the profession. By misrepresenting a family bereavement, Miss Clarke breached a fundamental tenet of nursing professionalism, eroded trust in her professional conduct. The panel therefore concluded that Miss Clarke's actions in charges 3e and 4 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'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; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that Patient A was put at risk of harm as a result of Miss Clarke's misconduct. Patient A was a detained patient in a secure mental health setting, known to be vulnerable, impulsive, and subject to risk management under the Mental Health Act. Miss Clarke's repeated professional boundary violations, provision of substances and facilitation of Patient A's abscondment significantly undermined the safeguards designed to protect him, staff, and the public.

The panel acknowledged that Miss Clarke was a newly qualified nurse in a preceptorship post at the time of the misconduct. It noted evidence suggesting she may have been susceptible to manipulation or influence, and her own account that she felt threatened by Patient A. The panel also noted that professional conduct of her mentor was at times not professional and he did not act as a role model to positively influence Miss Clarke's conduct and professional boundaries. The panel, however, did not have a full picture of the extent of any manipulation, grooming or coercion by Patient A, as Miss Clarke did not provide this information to the panel and it only had limited references to these issues within the papers before it. As a result, the panel was unable to fully assess the impact of these factors on her decision-making or actions. The panel did however have information before it which demonstrated that Miss Clarke had been subject to supervision, and clear guidance. Despite this, she chose to leave her ward, engage with a patient from another area, and facilitate his escape, thereby breaching multiple fundamental principles of nursing practice.

Further, the panel determined that Miss Clarke's misconduct had breached the fundamental tenets of the nursing profession, including maintaining professional boundaries, acting with integrity, prioritising patient safety, and adhering to policies and

lawful instructions. The panel considered that the sustained nature of the professional boundary breaches, combined with the secure setting and the vulnerability of Patient A, elevated the seriousness of the misconduct well beyond isolated or minor departures from professional standards.

The panel found that Miss Clarke's misconduct brought the nursing profession into disrepute. The panel further considered that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel noted that during the police interview, Miss Clarke acknowledged certain aspects of her conduct and admitted some wrongdoing. However, there was no evidence before the panel to indicate that she fully appreciated the impact of her actions on Patient A, her colleagues, the nursing profession, or the wider public. Miss Clarke did not attend the hearing and has engaged very minimally with the regulatory process. There was no reflective statement, no expression of remorse, no acknowledgment of the full extent of her wrongdoing, and no evidence demonstrating an understanding of why her actions were wrong or how they affected Patient A, colleagues, the profession, or public confidence.

On the lack of evidence before it, the panel could not be satisfied that Miss Clarke has a developed understanding on into the seriousness of the professional boundary violations and dishonesty. It noted that insight is not merely an expression of regret, but requires a clear understanding of what went wrong, why it went wrong, and how similar conduct can be prevented in the future. There was no evidence before the panel that Miss Clarke has achieved this level of understanding, and as such, her insight was assessed as extremely limited.

The panel then considered remediation. The panel accepted the legal advice that remediation can take many forms, including reflection and learning, and does not require formal courses in every case. However, in this case, there was no evidence of any remediation at all. Miss Clarke had not demonstrated that she had taken steps to address the attitudinal and behavioural issues underlying the misconduct.

The panel therefore considered the risk of repetition. Applying the guidance given in Grant, the panel reminded itself that the question is whether Miss Clarke is “liable” to repeat such behaviour in the future, meaning there must be a real, rather than merely fanciful, risk of repetition. Given the seriousness of the misconduct, the lack of insight, the absence of remediation, and Miss Clarke’s non-engagement with the process, the panel concluded that there is a real risk of repetition.

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. It considered that a fully informed member of the public would be profoundly concerned if a nurse who had engaged in this type of conduct were found not to be impaired. The panel was satisfied that public confidence in both the nursing profession and the regulatory process would be significantly undermined if no finding of impairment were made.

A reasonable and informed member of the public would be particularly concerned by a nurse forming a personal relationship with a detained patient, facilitating that patient’s escape from a secure hospital, and misleading senior colleagues to conceal her actions.

The panel noted that while Miss Clarke was junior and there were potential pressures and influences acting upon her, these factors provide context but do not lessen her personal accountability. The misconduct was deliberate, planned, and executed in defiance of clear professional guidance, training, and supervision.

Accordingly, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made and therefore finds that Miss Clarke's fitness to practise is impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Clarke'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 Miss Clarke off the register. The effect of this order is that the NMC register will show that Miss Clarke's name 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

The panel had regard to the Notice of Hearing in which the NMC had advised Miss Clarke that it would seek the imposition of a striking off order if it found Miss Clarke's fitness to practise currently impaired.

Ms Da Costa began by directing the panel to its own determination. She read parts of the panel's decision aloud to the panel and submitted that it acknowledged that Miss Clarke was a junior nurse and may have been subject to pressures and influences; however, the panel's decision made clear that those contextual factors did not diminish her personal accountability. She highlighted that the panel had already found that the misconduct was deliberate, planned, and carried out in defiance of clear professional guidance, training, and supervision.

Ms Da Costa confirmed at the outset that the NMC's position on sanction had been clearly communicated to the registrant: the NMC sought a striking off order. She acknowledged that the panel was required to consider a range of factors before determining sanction, beginning with aggravating and mitigating features. While challenges and contextual pressures had been identified, she highlighted that the panel had agreed with the NMC that Miss Clarke remained fully accountable for her actions and conduct. Ms Da Costa then set out the aggravating factors relied upon by the NMC.

First, she submitted that Miss Clarke had placed vulnerable patients at significant risk of harm. This included Patient A, as well as other patients on Holcombe Ward for whom she had responsibility. By repeatedly attending Holcombe Ward without any clinical reason or justification, she left other patients unattended and at risk.

Second, Ms Da Costa submitted that Miss Clarke had breached professional boundaries with Patient A while he was an inpatient on Holcombe Ward and had continued that inappropriate relationship outside the nursing setting.

Third, she stated that there had been a serious failure to safeguard vulnerable patients. Ms Da Costa submitted that Miss Clarke had provided drugs and alcohol to Patient A while he was detained in a secure mental health unit and suffering from mental health conditions at the time.

Ms Da Costa further submitted that Miss Clarke had assisted Patient A to abscond from a secure mental health unit. This conduct placed Patient A at risk of harm and also posed a risk to members of the public, particularly in light of Patient A's conviction and the lengthy sentence he had previously received. She emphasised that the conduct amounted to a clear abuse of a position of trust. Finally, she highlighted the panel's findings of a lack of remorse, a lack of insight, and a lack of remediation, describing the case as a very serious one.

Ms Da Costa then turned to the mitigating factors, which she acknowledged the panel had properly identified and which could not be ignored. Miss Clarke was a recently qualified nurse and was working as a preceptee at the time of the incidents. She pointed out that the panel had also heard evidence regarding Miss Clarke's mentor and his conduct. Ms Da Costa suggested that, although he had not given evidence, it was possible that he had not been the best role model for Miss Clarke at the relevant time, and this was a mitigating factor that should be taken into account.

Having outlined the aggravating and mitigating factors, Ms Da Costa reiterated that the NMC's position was that a striking off order was the only appropriate sanction. She reminded the panel of its obligation to consider the full range of sanctions under the NMC's guidance, from taking no action through to striking off. She submitted that taking no action would be wholly inappropriate given the seriousness of the case. She added that a caution order would also be unsuitable, as this was misconduct at the higher end of the spectrum and involved dishonesty.

Ms Da Costa referred to the panel's findings that Miss Clarke had struggled with professional boundaries, had acted in defiance of directions and orders, had ignored workplace guidance and advice, and had been dishonest in her conduct. These features, she submitted, demonstrated attitudinal issues rather than deficits that could be remedied through conditions. Accordingly, no workable conditions of practice could be formulated to address the ongoing risk of harm posed by the registrant.

Ms Da Costa then addressed the possibility of a suspension order. While acknowledging that suspension would temporarily remove Miss Clarke from the register, she submitted that it would not adequately address public protection or the wider public interest. She again reminded the panel that the misconduct was deliberate, planned, and executed in defiance of professional guidance, training, and supervision. She reiterated that the panel had also found no insight, no remorse, and no remediation. In those circumstances, Ms Da Costa submitted that permanent removal from the register was warranted. The conduct was fundamentally incompatible with continued registration, placed patients at real risk of

harm, and would bring the nursing profession into disrepute. A suspension order would therefore be insufficient.

Ms Da Costa concluded by submitting that a striking off order was the only appropriate and proportionate sanction. She closed her submissions by offering to assist the panel further if it had any questions or required clarification.

Decision and reasons on sanction

Having found Miss Clarke'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:

- The misconduct was deliberate, planned and sustained over a prolonged period rather than being an isolated lapse in judgment.
- Miss Clarke actively sought out Patient A, including attending wards where she was not allocated, demonstrating purposeful behaviour rather than inadvertent contact.
- The panel found a serious abuse of professional position and trust, particularly given the vulnerability of Patient A and the secure mental health setting.
- The misconduct involved multiple professional boundary violations, culminating in Miss Clarke's active role in the planning and execution of Patient A's absconding.
- Miss Clarke's actions placed Patient A, her colleagues, members of the public, and herself at risk of harm, particularly given Patient A's history of serious violence.
- The misconduct undermined security arrangements and safety protocols within a secure mental health hospital.
- Miss Clarke continued the misconduct despite repeated warnings, supervision, and supportive measures being put in place to address professional boundary concerns.

- The panel found extremely limited insight, with no reflective statement, no evidence of meaningful remediation, and no acknowledgement of the full impact of her actions.
- There was a lack of remorse for the impact on Patient A, colleagues, the profession, and public safety, with distress expressed primarily in relation to personal consequences.
- Miss Clarke demonstrated minimal engagement with the regulatory process, her account having been given in a police interview, with no substantive engagement thereafter.
- The misconduct involved dishonesty, which the panel regarded as particularly serious in the context of a wider premeditated plan to help Patient A to abscond.
- The seriousness of the context was heightened by Patient A's conviction for grievous bodily harm, increasing the risks associated with Miss Clarke's conduct.

The panel also took into account the following mitigating features:

- Miss Clarke was newly qualified at the time of the misconduct and undertaking her preceptorship.
- There was evidence that Patient A was manipulative, and that grooming behaviours had been identified by the multidisciplinary team in relation to other staff.
- Miss Clarke had received positive feedback regarding her clinical skills, with senior colleagues describing her as clinically competent aside from the conduct and professional boundary concerns.
- Concerns about Patient A's behaviour were recognised within the service, and risks were escalated, indicating that Miss Clarke was working within a challenging clinical environment.
- The panel acknowledged that supportive measures were available, although it noted that these were not effectively utilised by Miss Clarke.
- The panel noted that two senior clinical practitioners were concerned that more formal HR processes were not started earlier given the concerns around Miss

Clarke's conduct, however formal supervision and clear direction was given to Miss Clarke about her conduct.

- There was no evidence that Miss Clarke had previously been subject to regulatory findings, and her conduct appeared confined to the period in question.

The panel undertook a careful assessment of the seriousness of the case by reference to the SG. In doing so, the panel was mindful that seriousness is not determined solely by the presence of dishonesty or a single category of misconduct, but by a holistic evaluation of the nature, context, extent, and consequences of the conduct found proved.

A key feature of the case, and one which weighed heavily in the panel's assessment, was the presence of dishonesty. The dishonesty charge related specifically to Miss Clarke inaccurately informing her line manager that a family member had died in order to leave work early. The panel recognised that, taken in isolation, this could be characterised as a single dishonest act committed under acute stress, at a time when Miss Clarke knew Patient A had absconded and wished to leave work urgently. However, the panel considered that it would be artificial and inappropriate to assess this act of dishonesty in isolation from the wider factual matrix.

Although there was no separate charge alleging dishonesty by omission - for example, failing to disclose that Patient A was at her home, or failing to alert authorities promptly to the risks posed by his planned absconding - the panel concluded that the overall pattern of conduct demonstrated a sustained failure of honesty, openness, and candour. In particular, the panel considered that Miss Clarke had breached her professional duty of candour over an extended period by failing to disclose grooming behaviour, failing to raise safeguarding concerns, and concealing conduct that posed serious risks to Patient A, colleagues, and the public. This significantly elevated the seriousness of the dishonesty beyond a single impulsive lie. The panel therefore considered that the dishonesty was embedded within a wider pattern of deliberate and sustained misconduct. The dishonesty was not merely incidental but functioned to facilitate and conceal behaviour that exposed others to harm.

The panel then considered the SG's categories relating to abuse or neglect of vulnerable people and safeguarding failures and concluded that this guidance was clearly engaged. Patient A was a highly vulnerable individual, detained under the Mental Health Act in a secure setting, with significant mental health needs. The panel found that Miss Clarke's conduct amounted to a serious failure to safeguard Patient A and a disregard for the protective framework within which he was being cared for. Her actions also placed other patients, colleagues, and members of the public at risk, particularly during Patient A's period of absconding. The panel noted that the SG identifies cases as particularly serious where registrants abuse their position of trust, form inappropriate relationships with people receiving care, or expose others to harm by prioritising their own needs. While no finding was made of a sexual relationship, the panel was satisfied that there was an inappropriate and emotionally enmeshed relationship, breaching professional boundaries. The panel further concluded that Miss Clarke repeatedly failed to prioritise patient safety, professional responsibilities, and public protection.

The panel first considered whether to take no action but concluded that this would be wholly inappropriate in view of the seriousness of the case. The panel was satisfied that the misconduct found proved involved sustained and deliberate departures from fundamental professional standards, including serious failures in safeguarding, breaches of professional boundaries, and dishonesty. In these circumstances, taking no further action would fail to protect the public, would not reflect the gravity of the misconduct, and would undermine public confidence in the nursing profession and in the regulatory process. The panel therefore determined that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order but again concluded that this would be inappropriate. The SG states that a caution order may be suitable 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 carefully assessed the seriousness of Miss Clarke's misconduct and concluded that

it was **not** at the lower end of the spectrum. Rather, the misconduct occurred over a prolonged period, involved multiple distinct breaches of the Code, included elements of dishonesty, and exposed a highly vulnerable patient, colleagues, and members of the public to risk of harm. A sanction which did not restrict Miss Clarke's practice would therefore be insufficient to address the public protection and public interest concerns identified. The panel determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether the imposition of conditions of practice would be a sufficient and appropriate response. In doing so, the panel took account of the nature and seriousness of the misconduct found proved. The panel concluded that there were no practical, workable, or measurable conditions that could be formulated which would adequately address the concerns in this case. The misconduct did not arise from a lack of clinical competence or a discrete, remediable failing, but from attitudinal and behavioural issues, including a serious disregard for professional boundaries, safeguarding responsibilities, and professional integrity. The panel also noted that Miss Clarke had been subject to extensive supervision and support at the relevant time, which did not prevent the continuation and escalation of the misconduct. The panel also attached significant weight to the repeated and varied nature of the misconduct. This was not a single type of failing but a series of distinct and escalating incidents over time, including boundary breaches, inappropriate communication, supplying drugs and alcohol, facilitating absconding, dishonesty, and abandonment of professional duties. The panel regarded this breadth of misconduct as demonstrating a fundamental and systemic disregard for multiple core professional obligations. In these circumstances, the panel concluded that conditions of practice would neither sufficiently protect the public nor adequately reflect the seriousness of the misconduct.

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;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel determined that these factors were not present in this case. The misconduct was not a single incident but a pattern of behaviour over approximately six months, involving a range of serious breaches of professional standards. There was evidence of deep-seated attitudinal concerns, a lack of any real insight, and no meaningful engagement with the regulatory process. The panel was not satisfied that Miss Clarke had demonstrated sufficient understanding of the seriousness of her actions or of the risks posed to patients, colleagues, and the public.

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 the serious breach of the fundamental tenets of the profession evidenced by Miss Clarke's actions is fundamentally incompatible with Miss Clarke remaining on the register.

In light of these findings, the panel concluded that a suspension order would not be sufficient, appropriate, or proportionate, and would not adequately maintain public confidence in the profession.

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?*

The panel concluded that Miss Clarke's misconduct raised fundamental questions about her professionalism. Her actions constituted serious breaches of trust, involved dishonesty, and represented a sustained failure to safeguard a highly vulnerable patient and to protect the public. The panel was satisfied that her misconduct was fundamentally incompatible with continued registration as a nurse. Allowing Miss Clarke to remain on the register would undermine the need to protect the public and public confidence in the nursing profession and in the NMC as a regulator.

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 Miss Clarke'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 protect the public and 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.

In coming to this decision, the panel considered proportionality and the potential impact on Miss Clarke, namely financial, reputational and the impact upon her right to practise her profession. However, the panel concluded that in this case the need to protect the public and uphold the wider public interest outweighed her interests in this regard.

This will be confirmed to Miss Clarke 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 Miss Clarke's own interests until the striking-off sanction takes effect or an appeal is concluded. 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 Da Costa.

Ms Da Costa addressed the panel following its finding of impairment on two grounds: public protection and public interest. She noted that the panel had also found a real risk of repetition and had imposed a striking off order. She applied for an interim order to be imposed as there is a 28-day appeal period during which the striking order cannot take effect.

Ms Da Costa submitted that, given the panel's decision to impose a striking off order, the appropriate interim order would be an interim suspension order, as this would effectively mirror the substantive sanction. She sought the interim order on the same grounds as the finding of impairment, namely public protection and public interest.

In relation to duration, Ms Da Costa requested an interim suspension order for 18 months. While the initial appeal period is 28 days, she explained that if an appeal were lodged, the process of listing, hearing, and determining the appeal could take a significant amount of time. She added that, should Miss Clarke choose not to appeal, the interim order would fall away and the striking off order would then take effect.

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, as it was satisfied that this was necessary to protect the public and to uphold the wider public interest. The panel considered that, although the appeal period is 28 days, any appeal could take a significant time to be resolved, and an interim order of this length was proportionate to ensure ongoing public protection and to maintain public confidence in the profession and the regulatory process during that period.

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

That concludes this determination.