Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 30 June 2025 - Friday, 4 July 2025
Monday, 7 July 2025 - Thursday, 10 July 2025

Virtual Hearing

Name of Registrant:	**Dianne Elizabeth Bailey**
NMC PIN:	85A2408E
Part(s) of the register:	Nurses part of the register Sub part 1 RN3: Mental health nurse, level 1 (22 March 1988)
Relevant Location:	Cheshire
Type of case:	Misconduct
Panel members:	John Millar (Chair, lay member) Sharon Peat (Registrant member) Emma Foxall (Lay member)
Legal Assessor:	Hala Helmi
Hearings Coordinator:	Yousrra Hassan
Nursing and Midwifery Council:	Represented by Aliyah Hussain, Case Presenter
Mrs Bailey:	Not Present and unrepresented
Facts proved:	Charges 1a, 1b, 1c, 1e, 1g, 1h, 2a, 2b, 2d, 2e, 2f, 4a, 4b, 4c, 4d, 4e, 4f, 5a, 5b, 5c
Facts not proved:	Charges 1d, 1f, 1i, 2c, 2g, 3
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Bailey was not in attendance and that the Notice of Hearing letter had been sent to Mrs Bailey's registered email address on 7 May 2025.

Ms Hussain, 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, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Bailey right to attend, be represented, call evidence, as well as applying for an adjournment and the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Bailey

The panel next considered whether it should proceed in the absence of Mrs Bailey. It had regard to Rule 21 and heard the submissions of Ms Hussain who invited the panel to continue in the absence of Mrs Bailey. She submitted that Mrs Bailey had voluntarily absented herself.

Ms Hussain referred the panel to the documentation from Mrs Bailey which included email correspondence which stated that Mrs Bailey was content for the hearing to proceed in her 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'*.

The panel decided to proceed in the absence of Mrs Bailey. In reaching this decision, the panel considered the submissions of Ms Hussain, and the advice of the legal assessor. It had regard to the factors set out in the decision of *R v Jones* [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Bailey;
- Mrs Bailey informed the NMC that she has received the Notice of Hearing on 6 May 2025 and confirmed that the hearing could proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A number of witnesses are due to attend;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019 and 2020;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Bailey in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email 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 to some degree. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Bailey's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charges

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

1. *Failed to ensure adequate medication management including*

    a. *failing to ensure medication opening dates were recorded*
    b. *failing to properly dispose of medication*
    c. *failing to ensure stock levels were only that which was required*
    d. *failing to ensure Hydroxocobalamin (B12) injections were administered every three months*
    e. *failing to ensure the medication fridge was kept between 2 and 8 degrees*
    f. *failing to ensure agency staff had individual medication logins*
    g. *failing to keep accurate records of medication administration, storage and disposal*

h. *failing to ensure stock check were undertaken*
i. *failing to ensure staff medication competencies were completed and recorded*

2. *Failed to ensure safe care was being provided to residents in that you,*

    a. *failed to ensure staff were inducted adequately or at;*
    b. *failed to ensure safe staffing levels at all times;*
    c. *failed to undertake any or any adequate employability risk assessments;*
    d. *failed to obtain and/or ratify employment references;*
    e. *failed to ensure staff were appropriately supervised;*
    f. *failed to address clinical practice concerns within the home;*
    g. *failed to inform the NMC of Colleague B's medication management and administration concerns.*

3. *On an unknown date undertook a medication competency test on behalf of Colleague E.*

4. *Between 2019 and September 2020 acted in a manner that was bullying and/or intimidating in that you,*

    a. *shouted at staff*
    b. *stated 'put our big girl knickers on'*
    c. *said they were 'uncaring, incompetent and shitty nurses really', or words to that effect*
    d. *spoke in a manner to belittle and humiliate staff*
    e. *made a Colleague A attended work whilst sick*
    f. *said the home was a 'shit hole', or words to that effect*

5. *On unknown dates made comments that were racially discriminatory in that you,*

a. *referred to Colleague A as 'little flip flop Filipino', or words to that effect*
b. *commented that Colleague A would cook and eat insects*
c. *stated Colleague A 'ran the unit like a Korean concentration camp', or words to that effect*

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

Details of charges as amended

Following issues raised by the panel Ms Hussain agreed with a number of minor amendments to rectify grammatical issues or to provide clarity**.** The panel accepted the advice of the legal assessor and made amendments to charges 1b, 1h, 2a, 4c, 4e.

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

1. *Failed to ensure adequate medication management including*

a. *failing to ensure medication opening dates were recorded*
b. *failing to ensure medication was properly disposed of*
c. *failing to ensure stock levels were only that which was required*
d. *failing to ensure Hydroxocobalamin (B12) injections were administered every three months*
e. *failing to ensure the medication fridge was kept between 2 and 8 degrees*
f. *failing to ensure agency staff had individual medication logins*
g. *failing to keep accurate records of medication administration, storage and disposal*
h. *failing to ensure stock checks were undertaken*

i. *failing to ensure staff medication competencies were completed and recorded*

2. *Failed to ensure safe care was being provided to residents in that you*

    a. *failed to ensure staff were inducted adequately or at all;*
    b. *failed to ensure safe staffing levels at all times;*
    c. *failed to undertake any or any adequate employability risk assessments;*
    d. *failed to obtain and/or ratify employment references;*
    e. *failed to ensure staff were appropriately supervised;*
    f. *failed to address clinical practice concerns within the home;*
    g. *failed to inform the NMC of Colleague B's medication management and administration concerns.*

3. *On an unknown date undertook a medication competency test on behalf of Colleague E.*

4. *Between 2019 and September 2020 acted in a manner that was bullying and/or intimidating in that you,*

    a. *shouted at staff*
    b. *stated 'put our big girl knickers on'*
    c. *said that they were 'uncaring, incompetent and shitty nurses really', or words to that effect*
    d. *spoke in a manner to belittle and humiliate staff*
    e. *made Colleague A attend work whilst sick*
    f. *said the home was a 'shit hole', or words to that effect*

5. *On unknown dates made comments that were racially discriminatory in that you,*

    a. *referred to Colleague A as 'little flip flop Filipino', or words to that effect*

b. commented that Colleague A would cook and eat insects

c. stated Colleague A 'ran the unit like a Korean concentration camp', or words to that effect

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

Background

Mrs Bailey was employed as the Home Manager for the Home. In this role, she held overarching responsibility for the leadership, staffing and had clinical and operational oversight of the Home, including ensuring a safe and appropriate environment for both residents and staff.

Concerns were raised regarding Mrs Bailey's performance whilst still in post. These included failures to conduct appropriate employment checks, risk assessments, and staff inductions; inadequate supervision of staff; failure to address concerns regarding the practice of a member of staff; and the improper completion of online training modules on behalf of Colleague E. Additionally, serious concerns were identified regarding Mrs Bailey's handling of medication, particularly around its safe storage management and disposal.

On 28 August 2020, while on holiday, Mrs Bailey received a text message alerting her to an incident at the Home. Upon her return on 7 September 2020, she was informed of her suspension. The following day, an internal investigation was initiated by Colleague F, who later concluded that the concerns raised against Mrs Bailey were substantiated. She subsequently resigned on 16 October 2020 and was referred to the NMC by Colleague F on 25 January 2021.

Statements obtained from staff during the course of the investigation outlined repeated failures by Mrs Bailey to maintain safe staffing levels and to ensure adequate supervision of the staff employed at the home. Further allegations pointed to instances of bullying and

intimidation by Mrs Bailey. These behaviours raised serious concerns regarding her professionalism, conduct, and integrity.

In summary, the concerns relating to Mrs Bailey's leadership, including inadequate staffing, medication management failures, and alleged bullying, reflect failures that may have compromised both the safety of residents and the working environment for staff.

Decision and reasons on application to admit hearsay evidence of Colleague D

The panel heard an application made by Ms Hussain under Rule 31 to admit the written statement of Colleague D (who was clinical lead of the Home at the time of the incident) as hearsay evidence. Colleague D was not present at the hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she declined to engage with the NMC.

Ms Hussain invited the panel to admit the hearsay statement of Colleague D into evidence on the grounds that it is both relevant and fair to do so, in accordance with the applicable legal test of relevance and fairness.

Colleague D joined the Home as a Unit Manager and was a Registered Nurse responsible for leading shifts, supervising care assistants and nursing staff, and ensuring the safe administration of medication. Her witness statement addresses critical aspects of the case, including the home's induction training programme and medication practices, and is therefore highly relevant. Her evidence reflects direct participation in and observation of the home's operational procedures.

Within a week of her employment, Colleague D raised concerns about the Home and resigned from her role as Unit Manager. Subsequently, she returned in an advisory capacity as Clinical Lead before ultimately resigning altogether. Despite her resignation, she continued to maintain involvement with the Home and was considered by others to be a standing part of the clinical leadership. Her unique position allows her to offer insight into

the clinical environment and practices at the relevant time, contributing to a fair and balanced understanding of the issues.

Ms Hussain submitted that the criteria for admitting hearsay evidence are met. In particular, the panel's attention is drawn to the principles in *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), which assist in guiding the decision to admit such evidence.

In conclusion, Ms Hussain submitted that Colleague D's statement should be admitted into evidence. It is clearly relevant to the issues in the case, and it would be fair, in all the circumstances, for the panel to consider it as part of the overall evidential picture. The statement will assist the panel in reaching a sound and informed determination on the facts.

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

The panel carefully considered the application to admit the witness statement of Colleague D as hearsay evidence. While the panel accepted that the statement was not the sole or decisive piece of evidence, and that Mrs Bailey, had received and responded to it, and challenged it. The panel determined that the statement should not be admitted.

The panel placed weight on the seriousness of the allegations and the potential consequences for Mrs Bailey. In such circumstances, it is essential that any evidence admitted be both credible and reliable. Colleague D's statement was neither signed nor dated, and she had wholly disengaged from the proceedings. Her refusal to cooperate with the NMC, despite her continuing status as a Registered Nurse, raised concerns about her credibility and commitment to professional standards.

While the NMC had taken steps to secure her attendance, the panel was not satisfied that all reasonable steps had been exhausted, especially in light of the seriousness of the allegations. Further, the absence of any explanation for her non-engagement and the inability to test her evidence through cross-examination rendered the statement inherently

unreliable. The panel noted that questioning the witness was particularly important given the strength and detail of the allegations in her statement, some of which extended beyond the scope of the charges as currently framed.

The panel was also mindful that Mrs Bailey was unrepresented at the time she received the statement, and that its admission would not provide the panel the opportunity question the witness. In light of these factors, the panel concluded that admitting the statement would compromise the fairness of the proceedings and would not assist in determining the facts, given that there was sufficient other evidence available.

Taking into account this statement contains evidence, which is not related to the charges, the panel determined to put this statement out of its mind entirely.

Accordingly, the panel declined to admit Colleague D's statement as hearsay evidence.

Decision and reasons on application to admit interview records as hearsay evidence

Although there was no application from the NMC to do so, the panel carefully considered whether to admit records of interviews held during the local investigation of those who were not present to give evidence at this hearing. It considered these to constitute hearsay. In doing so, it assessed the relevance and fairness of admitting each interview.

The panel accepted the advice of the legal assessor.

The interview record of Colleague G, the Home Administrator, was admitted. Her account provided insight into the allegations of racist and bullying behaviour, as well as management failings that led to staff turnover. The panel noted the statement was signed, dated and consistent with the broader evidential picture.

Colleague H's interview record, detailing daily incidents of bullying and humiliation, was also admitted. It was signed, dated, consistent with other evidence, and provided by an individual in an apparent position of responsibility. Although her exact role was not clearly stated, the panel found her account credible and relevant.

Colleague I's interview record, which included consistent evidence about staff meetings, was similarly admitted without issue.

Colleague K's, head housekeeper, interview record which included consistent evidence about the alleged bullying and intimidating behaviour, understaffing, cleanliness and the registrant's management style was similarly admitted without issue.

Colleague D's, unit manager, interview record, which included consistent evidence about the alleged failures in recruitment and induction, supervision, bullying and intimidating behaviour by Mrs Bailey and medicine administration was similarly admitted without issue. In contrast to her witness statement produced for the NMC proceedings, the interview record, as with the other interview records, was signed, dated and contemporaneous.

The panel did take into account that the content of the interview records were essentially challenged by Mrs Bailey**.** However, assessing all of the factors set out above, these interview records were deemed admissible by the panel, which confirmed it would apply appropriate caution in assessing the weight of this evidence, as guided by the legal advice received.

Decision and reasons on facts

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 drew no adverse inference from Mrs Bailey's absence when it came to its decision on facts. The panel noted that Mrs Bailey did not admit any of the allegations and the panel took into account her written responses in this regard.

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

- Witness 1: Regional Manager at Harbour Healthcare
- Witness 2: Deputy Manager at the Home
- Witness 3: Staff Nurse at the Home
- Witness 4: Staff Nurse at the Home
- Witness 5: Head of Governance for Harbour Health

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

The panel accepted the advice from the legal assessor that Mrs Bailey was to be considered a person of good character and as a result the panel was obliged to consider this in relation to her credibility in her written statements, and her propensity to act as alleged. The panel was advised that good character is not a complete defence and is to be taken into account in and amongst all of the evidence. The panel took into account Mrs Bailey's good character as advised.

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

Charge 1a

"That you, a Registered Nurse, whilst working at The Home as the Registered Manager between August 2019 and 16 October 2020

1. Failed to ensure adequate medication management including

a. Failing to ensure medication opening dates were recorded"

This charge is found proved

The panel first considered the stem of charge 1.

The panel took into account that charge 1 relates to Mrs Bailey's alleged failure to ensure proper medication management within the Home. This responsibility was explicitly outlined in both Harbour Healthcare's Medication Management Policy and Mrs Bailey's own job description. According to the policy, referenced in the policy review sheet exhibit; as a Registered Manager Mrs Bailey was required to maintain a complete and documented audit trail for all medicines, from receipt through to administration to the patient, destruction or return.

This obligation was reinforced through the evidence of Colleague F, Colleague L, and Colleague M, who all confirmed Mrs Bailey's accountability in this area. In addition to her internal responsibilities under company policy, Mrs Bailey was also the CQC-Registered Manager, meaning she held statutory responsibility for the day-to-day oversight of regulated activities at the Home. This placed her in a dual position of accountability; both as an employee under Harbour Healthcare and as a registered professional under the NMC.

The panel took into account Mrs Baileys position in respect of charge 1a to charge 1i included in the Royal College of Nursing letter dated 12 September 2022 and her reflection, which was that she accepted a general obligation as Home Manager to have

better oversight of medication audits and returns and if faced with similar situation, she would check that they were being carried out. Mrs Bailey criticised the vagueness of the evidence, and did not accept any of the allegations.

The panel took into account that charge 1a concerns Mrs Bailey's failure to ensure that the opening dates of medications were properly recorded. This is a critical aspect of safe medication management, as certain medications have limited shelf lives once opened.

Colleague M provided clear and credible evidence on the importance of this practice. She explained that once medication is opened, it can lose its therapeutic efficacy over time. She gave the specific example of eye drops, which not only lose their effectiveness if used beyond their expiry period but may also pose a risk of causing infections.

Colleague L stated that:

> *"There were no recorded opening dates on either the boxes or bottles of medication which would appear to be poor practice from the nursing staff. However, this also demonstrated poor management of the home in not ensuring that staff were recording this information."*

Charge 1b

> *"That you, a Registered Nurse, whilst working at The Home as the Registered Manager between August 2019 and 16 October 2020*
>
> *1. Failed to ensure adequate medication management including*
>
> *b. failing to properly dispose of medication."*

This charge is found proved

This charge concerns Mrs Bailey's failure to ensure the proper disposal of medication at the Home. When examined, individual medication boxes were found opened and unsealed, and the larger cardboard container in which they were stored was also unsealed. Critically, the room where these medications were kept was left unlocked, therefore allowing unauthorised access by both patients and staff and posing a significant risk to resident safety.

This concern was first brought to light in August 2019, when Colleague M was instructed to carry out an internal investigation following a whistleblowing report. It was alleged that a night staff member had boasted about administering sedatives to a resident, having accessed these drugs from the unsecured medication return box. This incident underscored the serious risks associated with failing to dispose of medication properly.

Despite this warning, when Colleague M conducted a further review approximately one year later, she discovered that no improvements had been made. The same lack of control and security around medication disposal persisted, highlighting an ongoing and serious failure under Mrs Bailey's management to implement safe and compliant medication practices.

Charge 1c

> *"That you, a Registered Nurse, whilst working at The Home as the Registered Manager between August 2019 and 16 October 2020*
>
> *1. Failed to ensure adequate medication management including*
> *c. failing to ensure stock levels were only that which was required"*

This charge is found proved

The panel took into account that charge 1c concerns Mrs Bailey's failure to ensure that medication stock levels at the Home were maintained only at the quantities necessary for

safe and appropriate use. As Home Manager, Mrs Bailey had a clear responsibility to monitor and regulate medication supplies to avoid overstocking and ensure safe handling.

Colleague M, in her statement, explained that medication was ordered monthly. During her audit in August 2020, she expected that the home's medication stores would be approximately halfway depleted, reflecting routine use. Instead, she found that cupboards were overstocked, in some cases exceeding 100% of expected quantities. She noted that prescription medications were being ordered regardless of actual need, stating, *"they were just ordering and ordering."*

Colleague F's investigation corroborated this, he outlined the appropriate stock management process and noted its complete absence at the Home. There was clear evidence that regular stock checks were not being carried out, and that no meaningful oversight had been exercised over medication ordering or usage.

Collectively, this evidence demonstrated a significant and ongoing failure by Mrs Bailey to fulfil her duties in overseeing safe medication stock control, and a lack of action to minimise the risks associated with overstocking and inadequate record-keeping.

Charge 1d

> *"That you, a Registered Nurse, whilst working at The Home as the Registered Manager between August 2019 and 16 October 2020*
>
> *1. Failed to ensure adequate medication management including*
>
> *d. failing to ensure Hydroxocobalamin (B12) injections were administered every three months."*

This charge is found NOT proved

The panel determined that there was conflicting evidence in regard to this specific allegation. Mrs Bailey stated in her evidence that this was a responsibility of district nurses

who came to the home to administer medication and maintain their own records of doing so. There were no prescription charts, administration records or care records submitted to the panel by the NMC to indicate that these injections were required, administered or omitted. The panel was unable to conclude whose responsibility it was to ensure residents received there B12 injections when these were prescribed. Therefore, it was not possible to identify that Mrs Bailey failed to ensure that the injections were administered every three months.

Charge 1e

"That you, a Registered Nurse, whilst working at The Home as the Registered Manager between August 2019 and 16 October 2020

1. Failed to ensure adequate medication management including

e. failing to ensure the medication fridge was kept between 2 and 8 degrees"

This charge is found proved

The panel took into account that charge 1e relates to Mrs Bailey's failure to ensure that the medication fridge was kept within the required temperature range of 2°C to 8°C. Colleague L noted during her audit that the recorded temperature of the fridge was 12°C, well above the acceptable range on three sequential daily recordings. Additionally, the fridge was overstocked, which impeded proper air circulation, further compromising the safe storage of medications. There was no evidence of actions take to maintain the temperature of the medicines such removing them to another fridge or calling for the fridge to be repaired, replaced or supplemented.

In her statement, Colleague L explained that incorrect storage conditions can affect the stability and efficacy of medications. For instance, insulin, which could lose its therapeutic value if stored outside the appropriate temperature range.

This failure to monitor and maintain the correct temperature conditions placed residents at risk and reflected a lack of adequate oversight by Mrs Bailey in a key area of medication safety.

Charge 1f

"That you, a Registered Nurse, whilst working at The Home as the Registered Manager between August 2019 and 16 October 2020

1. Failed to ensure adequate medication management including

f. failing to ensure agency staff had individual medication logins."

This charge is found NOT proved

In her evidence, Colleague M highlighted that there was no clear process in place to ensure the safe use and accountability of passwords for electronic medication systems, among agency nurses. Mrs Bailey admitted in her response bundle that she was unaware of the passwords used by agency staff at the time. The panel acknowledged that there should have been a policy to ensure safe practice and accountability, with each nurse responsible for their own password to maintain security, transparency and to safeguard residents. However, the panel concluded that's Colleague L based her assessment on a discussion with a singular agency nurse who's details she could not provide. The panel concluded that there was insufficient evidence to prove that Mrs Bailey had failed in this regard. As such, the charge was not proved.

Charge 1g

“That you, a Registered Nurse, whilst working at The Home as the Registered Manager between August 2019 and 16 October 2020

1. Failed to ensure adequate medication management including

g. failing to keep accurate records of medication administration, storage and disposal.”

This charge is found proved

In relation to this charge, Colleague M provided detailed evidence highlighting significant failures in medication record-keeping at the Home. The Home used an electronic system to record medication stock and returns, but Colleague M found the records to be so poor that it was impossible to reconcile the data with the physical stock. She was unable to determine how long medications had been stored or to trace specific items, such as the sedative lorazepam, which had been referenced in a whistleblowing complaint.

Colleague M expected to find a clear audit trail documenting where returned medication was sent, ideally supported by a returns book and system records confirming that medications were returned to the pharmacy in a timely manner and signed for by an authorised collection service. However, there was no returns book available at the time of the audit and no entries in the electronic system detailing returns. Furthermore, there was an excessive volume of medication stock awaiting disposal, without any way to verify or track its quantity or status.

These findings constituted a breach of company policy. As per section 5 of the Harbour Healthcare *"Auditing and Monitoring of Medication"* policy applicable at the time in question, the Registered Manager was required to maintain a complete and documented audit trail for all medicines from receipt through to administration and/or disposal. Colleague M found no such audit trail in place, and no supporting records that could

account for the medications awaiting disposal. Her evidence illustrated a serious lack of oversight and failure by Mrs Bailey to fulfil her professional and managerial responsibilities in maintaining safe and accurate medication records.

Charge 1h

"That you, a Registered Nurse, whilst working at The Home as the Registered Manager between August 2019 and 16 October 2020

1. Failed to ensure adequate medication management including
h. Failing to ensure stock checks were undertaken."

This charge is found proved

The panel took into account that this charge concerns Mrs Bailey's failure to ensure that routine and accurate stock checks of medication were carried out at the Home. Evidence from multiple witnesses pointed to systemic deficiencies in the recording, monitoring, and reconciliation of medication stock under her management.

Colleague L and Colleague M both explained that at the time of their audits one year apart there was no accurate stock taking or monitoring process in use. Neither nurse could reconcile the stock being held at the time with the electronic record due to incomplete or missing information. It was clear to them both that regular stock checks and reconciliation were not being carried out as required.

Colleague F provided further context, explaining that excess stock can accumulate due to early ordering, limited prescription quantities, or residents passing away before medication is administered. However, even in such cases, it is the Home Manager's responsibility to monitor and manage excess medication. He confirmed that in this instance, medication had been allowed to build up in locked areas, and no effective measures had been taken to address or reduce the surplus.

The panel noted in her response to the particular allegation Mrs Bailey stated:

> *"On reflection I should have on a regular basis worked beside those involved and administered medication myself weekly and checked the stock each month when the new cycle began. I should of ensured all actions were completed after the audit which I am sorry."*

Taken together, this evidence supports the conclusion that Mrs Bailey failed in her duty to implement and oversee essential medication stock checks, contributing to the accumulation of unmonitored and unmanaged medication stock, contrary to both professional and organisational standards.

Charge 1i

> *"That you, a Registered Nurse, whilst working at The Home as the Registered Manager between August 2019 and 16 October 2020*
>
> *1. Failed to ensure adequate medication management including*
>
> *i. failing to ensure staff medication competencies were completed and recorded."*

This charge is found NOT proved

The panel considered the email from Colleague G, in which she stated that, upon request, she checked for the medication competencies of the home staff and found there were no records for Colleague E and Colleague N. However, the panel noted that Colleague G's comments in the email were not sufficiently precise to establish that the competencies had never been completed or that Mrs Bailey had failed to ensure they were done. The absence of records alone did not conclusively prove that the competencies were not completed, and the evidence lacked the clarity needed to show a definitive failure on Mrs

Bailey's part. Accordingly, the panel concluded there was insufficient evidence to find the charge proved.

Charge 2a

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

2. Failed to ensure safe care was being provided to residents in that you

a. failed to ensure staff were inducted adequately or at;"

This charge is found proved

The panel took into account that Mrs Bailey denied this charge.

This charge concerns Mrs Bailey's failure to ensure that staff were properly inducted, which resulted in unsafe care being provided to residents. Colleague B, who joined the Home in July 2018, and had not completed her induction book by 15 February 2019, over seven months later. This is confirmed by a formal letter sent to her by Mrs Bailey.

Colleague F, in his witness statement, highlighted the inherent risks posed when a staff member operates without proper induction. Without a completed induction, there is no assurance that the individual is competent or fully informed of the policies, procedures, and expectations of care. This directly impacts the quality and safety of care delivered to residents.

Further, in her interview record Colleague D stated:

"*The induction was poor, on paper it looked good, in reality the admin actually did most of it. It was very chaotic, and most things were skimmed over or actually not delivered.*"

"The induction was signed off but nothing was really checked. My nursing induction was never completed."

The panel took into account that Mrs Bailey stated in her reflection:

"I was unaware of not signing induction book or following up the induction book of it as an oversight on my behalf. Clgue [sic] D after 3 months On reflection I should have monitored the induction books more closely…"

The prolonged failure to complete such a fundamental requirement under Mrs Bailey's management demonstrates a lack of appropriate oversight and governance, placing residents at risk and breaching the duty to ensure safe staffing practices.

Charge 2b

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

2. Failed to ensure safe care was being provided to residents in that you

b. failed to ensure safe staffing levels at all times;

This charge is found proved

The panel took into account that Mrs Bailey denied this charge.

This charge relates to Mrs Bailey's failure to ensure that safe staffing levels were always maintained within the Home. On 25 August 2020 Colleague F was informed by Mrs Bailey that there were no staffing issues prior to her going on holiday on that day. However, this was subsequently contradicted by an email from Deputy Manager, Colleague A, which prompted Colleague F to investigate further. His review of staff rotas revealed consistent shortfalls, particularly in domestic staffing.

The absence of domestic staff had a direct impact on nursing operations. Colleague A and Colleague O both described how clinical staff were frequently required to undertake domestic and carer duties, such as cleaning tasks, working in the kitchens or supervising lounges, detracting them from their primary roles. Colleague A described a prevailing culture where absent staff were not replaced, summarised by the phrase "*one down, carry on"* and noted that she rarely sought cover for staff absences, describing this as an unwritten policy enforced by Mrs Bailey.

Although the evidence varied slightly in focus, some witnesses emphasising nursing shortages, others domestic, the consistent theme was that staffing was inadequate and placed a significant burden on remaining staff. Colleague O confirmed that the Home was regularly understaffed during the first wave of the COVID-19 pandemic (April–September 2020), with frequent staff absences due to illness and limited availability of agency cover.

Despite some variation in witness accounts regarding whether the shortage was primarily among domestic or nursing staff, the cumulative impact on care delivery and staff welfare was clear. The failure to maintain safe staffing levels compromised both the operational functioning of the Home and the well-being of its residents and staff. As Home Manager, Mrs Bailey bore ultimate responsibility for ensuring safe and adequate staffing, and this duty was not fulfilled.

The panel found repeated evidence that a factor impacting on the level of understaffing related to finance. Within the documentation, including that presented by Mrs Bailey were references to her receiving a financial bonus based on the profit generated by the Home.

In her interview record Colleague G stated:

> "*her focus was always on agency and saving money."*

In the interview record of Colleague D she stated:

"Dianna only seemed to care about not using agency, she told her staff team that Harbour Healthcare had instructed her that agency could not be used. This meant staff working horrendously short, becoming exhausted, not getting breaks etc. Many eventually left as they could not stand it any longer."

Further, when questioned by the panel about this aspect Colleague F responded by stating that although the owners and directors of Harbour Healthcare regarded the safety and wellbeing of the resident as their paramount concern, he described Mrs Bailey's decision-making concerning staffing as being '*financially driven'.*

Charge 2c

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

2. Failed to ensure safe care was being provided to residents in that you

c. *failed to undertake any or any adequate employability risk assessments."*

This charge is NOT proved

The panel took into account that Mrs Bailey denied this charge.

There was evidence before the panel from Colleague F that in respect of two staff members, Colleague B and C, Mrs Bailey did not undertake sufficient employability risk assessments. However, there was no evidence before the panel relating to any other such omission by Mrs Bailey. As such there was no evidence before the panel that Mrs Bailey consistently did not undertake any or any adequate employability risk assessments as set out in the specific wording of the particular. The panel decided that the evidence in respect of only two staff members was not sufficient to prove the generality of the particular which indicated a consistent failure in her practice.

Charge 2d

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

2. Failed to ensure safe care was being provided to residents in that you

d. failed to obtain and/or ratify employment references."

This charge is found proved

The panel took into account that Mrs Bailey denied this charge.

The panel found charge 2d proved based on clear evidence of Mrs Bailey's failure to follow essential recruitment procedures. Colleague F confirmed in his statement that it is a mandatory requirement for every candidate's employment reference to be both obtained and ratified prior to appointment. Specifically, if a reference is received via email, it must be followed up with a phone call to the provider of the reference.

In the case of Colleague B, for example, there was no evidence that Mrs Bailey had taken any steps to record the reference received. Colleague F checked the personnel file and found no such record of any verification process having taken place. This lack of due diligence represented a significant breach of Harbour Healthcare's recruitment protocols and exposed the Home to avoidable risks, particularly in light of the wider concerns around the staff member's previous conduct.

Given Mrs Bailey's managerial responsibility for all aspects of recruitment, her failure to obtain and ratify employment references especially where the candidate had known risks, constituted a serious lapse in professional judgement and governance. Accordingly, the panel concluded that this charge was proved.

Charge 2e

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

2. Failed to ensure safe care was being provided to residents in that you

e. failed to ensure staff were appropriately supervised."

This charge is found proved

The panel took into account that Mrs Bailey denied this charge.

The panel considered that 'appropriate supervision' included regular one-to-one meetings, direct and indirect oversight of clinical practices, providing learning opportunities, and giving constructive feedback. These expectations were clearly set out in the employer's supervision policy, which required meaningful and documented supervision sessions in a private and appropriate setting, focused on competence, safeguarding, performance, and professional development.

However, the panel found that this standard was not met. Colleague F's evidence highlighted serious supervision gaps, particularly in the case of Colleague C, where issues relating to documentation and resident care were identified but never followed up or risk assessed. Moreover, Colleague G's interview revealed that no meaningful supervisions were conducted. Instead, generic pre-printed templates were left in a staff area for individuals to sign and return without discussion or individualised content, indicating that the process was superficial and not in line with policy expectations.

Further, the testimony confirmed that this generic approach was applied to multiple staff members, and when concerns about supervision and overdue appraisals were raised to Mrs Bailey by both Colleague G and Colleague A, they were ignored. Mrs Bailey failed to act on these concerns or engage in performance monitoring. The job description clearly

assigned responsibility for conducting staff supervision to the Home Manager, a duty Mrs Bailey neglected.

Overall, the panel found there was a systemic failure in the supervision process at the Home, for which Mrs Bailey, as Registered Manager, was responsible. The lack of meaningful oversight likely contributed to broader issues in staff performance and resident care.

Charge 2f

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

2. Failed to ensure safe care was being provided to residents in that you

f. failed to address clinical practice concerns within the home."

This charge is found proved

The panel took into account that Mrs Bailey denied this charge.

The panel found charge 2f proved, based on a consistent body of evidence showing that Mrs Bailey failed in her duty as the Home Manager, as outlined in her job description, to address clinical practice concerns.

"*Be responsible for promoting and safeguarding the welfare of those individuals they support*"

"*to provide leadership, administration, care and nursing, catering, housekeeping, laundry and people management functions…*"

This is reinforced within the NMC code:

> "*You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to."*

The failure to act on such concerns likely had a detrimental effect on the quality of care and support provided to residents, as issues raised by staff went unacknowledged and unrectified.

The lack of effective staff supervision meant that opportunities to identify and escalate clinical practice issues were severely limited. Without a clear process for raising concerns, it would have been difficult for staff to bring forward issues or for Mrs Bailey to take appropriate corrective action.

Colleague D stated that Mrs Bailey was aware of the failures within the nursing staff team but, although she acknowledged them, she never did anything to manage the people. She further stated that despite the issues in the service and some staff's poor performance in their roles Mrs Bailey did not utilise the Home's policies and procedures to address these concerns. Colleague D further emphasised Mrs Bailey's lack of management that existed across all areas of the Home, namely recruitment, staffing domestic/laundry/ care services, nothing was ever managed, people were simply blamed and belittled.

Additionally, in her interview record, Colleague G stated:

> *"Basically she just didn't manage the home or the staff, which is why we have so many complaints, safeguardings* [sic] *and such a high turnover of staff. She would not let the deputy manage the nurses, Colleague A was not allowed to performance manage them of* [sic] *challenge them in case they left."*

Colleague F's investigation report provided direct accounts from employees who stated that they had reported clinical concerns to Mrs Bailey, but that these issues were not

properly addressed. This pattern of inaction reflected a failure in leadership and clinical governance.

Of particular concern to the panel was the evidence of Colleague M which described how she found during her 2019 audit that there were large amounts of surplus medication being stored within the Home in a room which was unlocked. The medication was in an unsealed cardboard box which meant that staff and residents would have been able to access this inappropriately. This constitutes a clear and significant risk.

Additionally, within her statement Colleague A outlined:

> *"The understating did impact the care on the care for the residents. Some of the residents were not being turned in their beds, not being showered properly and instead just having a good wash."*

> "*We had several safeguarding's during this time, particularly with residents who developed pressure sores from not being turned."*

When a pressure sore is identified, this should be photographed and measured. The residents care plan and risk assessment should also be developed to ensure that this is actioned and evaluated.

> *"An audit then needs to be completed on the care plan and risk assessment to ensure that the care plan is being followed and to assess whether further treatment is needed."*

The evidence within the interview records of Colleague D clearly demonstrated that some care plans were not up to date and bore no relation to the resident's current status and needs. The panel viewed this as being a significant shortfall in the standards expected.

Taken together, the evidence demonstrated that Mrs Bailey was made aware by the Home staff, and those undertaking audits, of significant clinical concerns but that she failed to take any adequate responses to mitigate these issues.

Charge 2g

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

2. Failed to ensure safe care was being provided to residents in that you

g. failed to inform the NMC of Colleague B's medication management and administration concerns."

This charge is found NOT proved

The panel took into account that Mrs Bailey denied this charge.

This charge alleged that the Mrs Bailey failed to inform the NMC of Colleague B's medication management and administration concerns, despite Colleague B being subject to conditions of practice. The panel reviewed the interim conditions order and relevant correspondence but concluded that there was insufficient evidence to support this allegation.

Specifically, there was no clear information presented in Colleague F's written or oral evidence to confirm that concerns about Colleague B's medication management had been raised or substantiated during the relevant time. Furthermore, there was no definitive evidence that Mrs Bailey was obligated to notify the NMC of any such concerns.

Charge 3

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

3. On an unknown date undertook a medication competency test on behalf of Colleague E."

This charge is found NOT proved

The allegation related to Mrs Bailey completing a medication competency test on behalf of Colleague E, a healthcare assistant employed at the Home. Since Colleague E role involved administering medication, she was required to complete appropriate training and pass a competency assessment.

The NMC's case was that Colleague E did not complete this training herself, and that Mrs Bailey completed it for her. This was raised during Colleague F's investigation and was suggested to be the case in an email from Colleague G, dated 22 September 2020, in which Colleague G confirmed that Mrs Bailey completed all of Colleague E online training, despite her being paid for it.

The training system logs cannot confirm who completed the training, because Mrs Bailey and Colleague E lived at the same address and IP addresses were therefore inconclusive. There was no medication competency assessment on file for Colleague E, despite evidence that she had administered medication.

Colleague G does not provide any reasoning for her assumption and provides no further evidence on the matter. Both Mrs Bailey and Colleague E deny the allegation and a credible explanation has been provided. The panel found it can only give little weight to Colleague G's email account and noted that Colleague F does not deal with this issue in sufficient detail to enable the panel to find this particular charge proved.

Charge 4a

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

4. Between 2019 and September 2020 acted in a manner that was bullying and/or intimidating in that you,

a. shouted at staff."

This charge is found proved

The panel first considered the stem of charge 4, the panel referred to the NMC's definition of bullying, which includes unwanted behaviour that is offensive, intimidating, malicious, or insulting. Bullying may involve a misuse of power that undermines, humiliates, or causes physical or emotional harm, and can manifest as a single incident or a repeated pattern, whether face-to-face or via other means of communication.

The panel applied this definition when evaluating the evidence and considered whether Mrs Bailey's conduct during the period between 2019 and September 2020 met this threshold. The panel considered whether Mrs Bailey's behaviour at each subcharge amounted to, for example, an abuse of power or whether it caused staff to feel intimidated, undermined, or emotionally harmed.

Mrs Bailey, in her written submissions denied the allegations of bullying behaviour and stated that:

"*I was always respectful and professional throughout my employment at the* [the Home]"*.*

In relation to charge 4a, Colleague O, in her witness statement, described a staff meeting in August or September 2020 where Mrs Bailey was *"ranting and raving".* She recalled Mrs Bailey standing in front of staff, appearing angry, shouting, and accusing them of being

“incompetent” and *“rubbish at their jobs”.* In oral evidence, Colleague O reaffirmed that shouting occurred, stating that her description would not have been used if shouting had not taken place.

Additional witness testimony corroborated this behaviour.

Colleague K, the Head Housekeeper, confirmed that Mrs Bailey raised her voice, made derogatory remarks such as *“I would hate to see the state of your houses”,* and swore during staff meetings. Colleague G similarly stated that Mrs Bailey’s involvement in addressing audit issues typically involved shouting at the staff concerned, rather than engaging constructively.

Taken together, these accounts provided clear evidence that Mrs Bailey shouted at staff on more than one occasion in a manner consistent with bullying and intimidation. The panel concluded there was a repeated pattern of inappropriate conduct and found the charge proved.

Charge 4b

“That you, a Registered Nurse, whilst working at ‘the Home’ as the Registered Manager between August 2019 and 16 October 2020

4. Between 2019 and September 2020 acted in a manner that was bullying and/or intimidating in that you,

b. stated ‘put our big girl knickers on’.”

This charge is found proved

Colleague O, in both her written and oral evidence, recalled that during a heated staff meeting, Mrs Bailey directly told her and another colleague to *"put their big girl knickers*

on" in the context of addressing ongoing staffing and performance issues. This comment was confirmed as being personally directed at her and a fellow staff member.

This incident was corroborated by Colleague D, who took part in Colleague F investigation. Colleague D confirmed that during the same meeting, Mrs Bailey berated staff and reduced Colleague O to tears. In addition to the remark itself, Mrs Bailey also accused staff of being incompetent and failing in their roles.

The panel considered this conduct to be clearly unprofessional. The language and tone used were inappropriate, humiliating, and belittling, particularly when delivered in a group setting. Addressing staff performance concerns in this manner, while raising one's voice, constituted behaviour that was demeaning and intimidating. The panel found that Mrs Bailey made this inappropriate remark in a professional setting.

Furthermore, the panel acknowledged the imbalance of power between Mrs Bailey, as Home Manager, and the staff she was addressing. The use of such language in a position of authority amounted to an abuse of power and fell squarely within the NMC's definition of bullying.

Charge 4c

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

4. Between 2019 and September 2020 acted in a manner that was bullying and/or intimidating in that you,

c. said they were 'uncaring, incompetent and shitty nurses really', or words to that effect."

This charge is found proved

Colleague O, in her statement, recalled Mrs Bailey shouting at staff and accusing them of being *"incompetent"* and *"rubbish at their jobs".* While not a direct quote of the words in the

charge, the panel found that the substance and effect of the language used aligned with the allegation.

The panel considered that the use of such language by someone in a position of authority was wholly inappropriate. It humiliated staff, undermined their professional dignity, and created a culture of fear and intimidation. The imbalance of power between Mrs Bailey and the staff further exacerbated the inappropriateness of her conduct. The panel concluded that this behaviour amounted to bullying, as defined by the NMC, and found the charge proved.

Charge 4d

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

4. Between 2019 and September 2020 acted in a manner that was bullying and/or intimidating in that you,

d. Spoke in a manner to belittle and humiliate staff."

This charge is found proved.

Colleague O, in her statement, described witnessing Mrs Bailey's bullying and intimidating behaviour during a staff meeting in August or September 2020. She recalled seeing this behaviour directed at both herself and colleagues.

Colleague A provided several compelling examples. She stated that Mrs Bailey had made two nurses, Colleague J and Colleague O, cry after publicly belittling them. Colleague A also described a meeting on 15 September 2020 in which she herself was made to feel *"guilty, humiliated, [sic] belittled,"* and recalled many instances where she was reduced to tears by Mrs Bailey's treatment of her in front of other staff.

Further supporting evidence came from Colleague H, who reported that Mrs Bailey regularly humiliated staff during meetings held in the reception area, often reducing them to tears. Colleague H explained that this behaviour occurred *“on a daily basis”,* contributing to high staff turnover and low morale. Colleague D also noted that Mrs Bailey was sarcastic and belittling toward staff, again citing incidents that left colleagues in tears.

The panel considered this body of evidence to be credible, consistent, and illustrative of a clear pattern of conduct by Mrs Bailey. Her repeated public criticism and undermining of staff, particularly in front of others, created a hostile and emotionally damaging work environment. The panel further considered the power imbalance between Mrs Bailey and those she managed, concluding that her conduct amounted to an abuse of authority and met the NMC's definition of bullying and therefore found charge 4d proved.

Charge 4e

“That you, a Registered Nurse, whilst working at ‘the Home’ as the Registered Manager between August 2019 and 16 October 2020

4. Between 2019 and September 2020 acted in a manner that was bullying and/or intimidating in that you,

e. made Colleague A attend work whilst sick.”

This charge is found proved

Mrs Bailey compelled colleague A to attend work despite her being unwell, thereby acting without compassion and disregarding her welfare.

Colleague A, the Deputy Manager at the time, gave evidence that in 2019, she was suffering from a chest infection on a day when the Clinical Commissioning Group (CCG) was due to visit the Home. Despite stating that she was unfit to work Colleague A was instructed by Mrs Bailey to attend. Colleague A stated that she told Mrs Bailey that there was no essential need for her to be present at the meeting as Mrs Bailey had the report

and all she had to do was read it. Colleague A said she was persuaded by Mrs Bailey to attend the meeting and that Mrs Bailey exerted pressure in a subtle manner, saying*, "She had her way of letting me know that I had to come."*

The panel noted that an external visitor from the CCG, upon seeing Colleague A's condition, excused her from the meeting. This incident not only highlighted Mrs Bailey's lack of empathy and poor judgement towards Colleague A but also showed a disregard for the health and safety of the Home's elderly residents, who could have been exposed to infection.

Mrs Bailey has stated that she cannot recall requesting Colleague A attend this meeting although acknowledged that Colleague A was unwell, she stated that: "[Colleague A] *was proud of her work and would have wished to be present."*

The panel considered Mrs Bailey's decision to require her deputy's attendance, despite illness, reflected a failure in leadership and an absence of reasonable consideration for her welfare. Accordingly, the panel found the charge proved.

Charge 4f

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

4. Between 2019 and September 2020 acted in a manner that was bullying and/or intimidating in that you,

f. said the home was a 'shit hole', or words to that effect."

This charge is found proved

This allegation was supported by Colleague D, whose account was included Colleague F's investigation. Colleague D reported that Mrs Bailey used the phrase in reference to the Home and also made further disparaging remarks, including describing the Home as

"disgusting and filthy" and telling kitchen staff that they *"looked like tramps".* While some of these additional comments were not directly pleaded in the charge, the panel considered them relevant in contextualising Mrs Bailey's overall attitude and language.

Some supporting information came from Colleague K, who stated in her interview record Mrs Bailey had told staff in a meeting that the home was *"filthy"* and *"I would hate to see that state of your houses".*

The evidence showed that Mrs Bailey spoke in a demeaning and unprofessional manner about the Home and its state of cleanliness, for which she was ultimately responsible for. This was a use of inappropriate language, from somebody in a leadership position, which contributed to a hostile and demoralising working environment. The panel concluded that her comments were likely to have had a belittling and humiliating effect on staff and found the charge proved.

Charge 5a

> *"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020*
>
> *5. On unknown dates made comments that were racially discriminatory in that you,*
>
> *a. referred to Colleague A as 'little flip flop Filipino', or words to that effect."*

This charge is found proved.

The panel had regard to the stem of charge 5, in considering whether the language used by Mrs Bailey met the threshold of racial discrimination. The panel was guided by the meaning of the term *"racially discriminatory",* rather than applying a strict legal test under the Equality Act 2010, since the statute was not directly pleaded in the charge. Nonetheless, the panel considered the definition under the Act to be helpful background particularly in understanding discrimination as the less favourable treatment of an individual based on a protected characteristic of, race or ethnicity.

The panel applied an objective test, consistent with case law such as *PSA v the GPHC and Ali* [2021] EHWC 1692, to assess whether the comments, according to an objective test would be considered racially discriminatory. The panel was guided by the definition of the objective test in the case of *Ali*. It was not necessary for the NMC to prove that Mrs Bailey had a discriminatory intent; rather, the focus was on the impact and nature of the language used.

In relation to charge 5a, Colleague A, confirmed in her witness interview that the phrase was used and stated, when asked by Colleague F:

"*Did DB ever call you anything similar' my little flip flop Filipino?"*

Colleague A replied:

"Yes she did."

The panel noted that Mrs Bailey denied any racist language but with regard this particular subcharge it preferred the clear and consistent written and oral evidence of Colleague A . The panel was of the view that Mrs Bailey had defined and identified Colleague A on racial lines by the use of the word Filipino. The term itself was unnecessary and inappropriate but when combined with the use of the words "*my little flip flop"* to predicate it Mrs Bailey was directly demeaning Colleague A's racial identity.

The panel determined, applying the objective test, that it found the phrase, referring to race, to be discriminatory and inappropriate.

The panel found charge 5a proved, concluding that Mrs Bailey referred to Colleague as *"my little flip flop Filipino"* or words to that effect, and that the comment was racially discriminatory.

Charge 5b

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

5. On unknown dates made comments that were racially discriminatory in that you,

b. commented that Colleague A would cook and eat insects."

This charge is found proved

This particular subcharge was supported by Colleague A's witness and oral evidence, as well as corroborating evidence from Colleague G, who recalled that Mrs Bailey made inappropriate comments such as the *"bugs/insects in the wok"* remark during public meetings.

The panel paid regard to the denial of any racially discriminatory language and conduct by Mrs Bailey. However, taking all of the evidence into account, the panel determined that this comment was not only culturally insensitive but also racially charged, perpetuating offensive stereotypes. On the objective test, the remark was deemed discriminatory as it differentiated Colleague A from others based on her ethnic background and a totally inappropriate and baseless reference to a cultural assertion of the eating of insects cooked in a wok.

The panel found charge 5b proved, concluding that Mrs Bailey made a racially discriminatory remark by suggesting that Colleague A would *"cook and eat insects".*

Charge 5c

"That you, a Registered Nurse, whilst working at 'the Home' as the Registered Manager between August 2019 and 16 October 2020

5. On unknown dates made comments that were racially discriminatory in that you,

c. stated Colleague A 'ran the unit like a Korean concentration camp', or words to that effect."

This charge is found proved

The panel accepted the evidence of Colleague A, who confirmed that the comment had been made by Mrs Bailey and also that Mrs Bailey had told her that Colleague E had also used it. There was also corroborating testimony from Colleague G, who stated that Mrs Bailey made the remark on multiple occasions. This included one instance where Mrs Bailey attributed the comment Colleague E, and another during a staff meeting. Given the consistency across witness accounts, recorded in contemporaneous interview notes, the panel was satisfied, despite Mrs Bailey's denial, of any racially discriminatory language, that on the balance of probabilities the comment was made. The panel found, after applying the objective test, that this was racially discriminatory as there was a completely unwarranted use of the word *"Korean"* to highlight that Colleague A was of Asian origin.

Fitness to practise

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

Submissions on misconduct

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

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

Ms Hussain identified the specific, relevant standards where Ms Baily's actions amounted to misconduct.

Ms Hussain reminded the panel that there is no prescribed burden or standard of proof at this stage; determining whether Ms Baily's conduct amounts to misconduct, and whether her fitness to practise is currently impaired, is a matter for the panel's independent judgment. Having found the charges proved, the panel must assess those findings against the NMC's Fitness to Practise Guidance.

Ms Hussain stated that the facts found proved at charge 1 concerns medication management. Ms Hussain submitted that evidence shows that, over a sustained period,

Mrs Bailey failed to maintain safe stock control, accurate records and secure storage, including refrigeration critical to maintain drug efficacy, thereby creating a real risk to residents.

Ms Hussain submitted that the facts found proved at charge 2 involved failure to ensure proper inductions, safe staffing levels, adequate supervision and verification of references. These omissions neglected the duty to manage resources and prioritise resident safety, rendering the service unsafe even in the absence of proof of actual harm.

Ms Hussain submitted that the facts found proved at charges 4 and 5 relate to the duty of honesty, integrity and professionalism. She submitted that Mrs Bailey's conduct towards colleagues fell below the standards expected of a Registered Nurse.

Submissions on impairment

Ms Hussain 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 Hussain submitted it is a question for the panel as to whether, Mrs Bailey's fitness to practise is impaired. Ms Hussain submitted that the NMC's guidance titled 'DMA-1' asks you to assess whether Mrs Bailey can still practise kindly, safely and professionally. As with misconduct, there is no burden or standard of proof; the panel must exercise its professional judgment.

Ms Hussain referred the panel to the *Grant* test and submitted that the first three limbs can be answered affirmatively. Although the misconduct concerns are in principle remediable, Mrs Bailey has denied all failings and has provided no evidence of insight or remediation.

Moreover, her absence from practice prevents her from demonstrating corrective action, and she gives no indication of returning to nursing. In the absence of any remedial steps, there remains a real risk of repetition. For both public protection and public confidence, Ms Hussain therefore submitted that Mrs Bailey's fitness to practise currently remains impaired.

The panel accepted the advice from the legal assessor.

Decision and reasons on misconduct

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

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

"1. Treat people as individuals and uphold their dignity

1.2 make sure you deliver the fundamentals of care effectively

3. Make sure that people's physical, social and psychological needs are assessed and responded to

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

8. Work co-operatively

8.2 maintain effective communication with colleagues

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

9. Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

9.1 provide honest, accurate and constructive feedback to colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10. Keep clear and accurate records relevant to your practice

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

11. Be accountable for your decisions to delegate tasks and duties to other people

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

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

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

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

18. Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

18.4 take all steps to keep medicines stored securely

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

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

25. Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel concluded that the matters found proved did breach the standards as set out above.

Mrs Bailey repeatedly and persistently failed to act to ensure that the welfare and care of residents at the home were her first priority and that their needs were met, she breached the most basic of nursing tenets, those which are essential for maintaining good health. The failures were wide ranging and over a long period of time. Mrs Bailey did not objectively appreciate, manage or tackle serious issues when they were repeatedly identified to her by a number of colleagues. Mrs Bailey demonstrated deep-seated attitudinal problems in that she consistently prioritised profit over the need for appropriate staffing within the Home and subsequent impact on people's care. Such blatant disregard for the health and welfare of those in her care must be taken extremely seriously.

Mrs Bailey's actions towards her colleagues and staff amounted to serious misconduct given its nature which constitutes a lack of respect for, and bullying of, those who she was working alongside and managing. This included, making racially discriminatory comments to the deputy manager. The panel was of the view that Mrs Bailey's actions should not be regarded as inconsequential or excusable in any circumstance. The panel were appalled to see evidence of the trauma and distress caused to staff members, Colleague A and Colleague O, by Mrs Bailey. During their live evidence it was apparent to the panel that they have remained significantly impacted by the actions of Mrs Bailey.

The panel was of the view that Mrs Bailey's proved failings posed a real risk to resident's safety and to public trust in both the nursing profession and care-home management. In assessing that risk, the panel gave weight to the seriousness, duration and frequency of Mrs Bailey's persistent failings, particularly given the vulnerability of those in her care, and found that her conduct, could readily cause harm and undermine confidence in professional standards.

The panel found that each and every subcharge found proved fell far below the conduct and standards expected of Mrs Bailey at the time in question. The panel therefore found that each finding of fact constituted misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must 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"*

The panel found all three limbs of *Grant* engaged.

Mrs Bailey's misconduct put patients at an unwarranted risk of harm, breached the fundamental tenets of the nursing profession and brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Bailey has taken steps to strengthen her practice.

The panel took into account Mrs Bailey's previous good character. However, the panel was of the view that there is a risk of repetition based on the fact that Mrs Bailey's breaches were both serious and sustained over an extended period, demonstrating a deep-seated attitudinal failing rather than a one-off lapse. Despite staff raising concerns, she made no meaningful efforts to rectify the systemic problems in medication management, staffing and professional conduct. Her reflections show only minimal remorse and insight, offered belatedly and without concrete proposals for remediation. The panel was satisfied that there remains a high 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 is necessary to uphold confidence in the nursing profession and maintain its standards. Mrs Bailey's misconduct was not isolated but comprised a wide range of serious failures, sustained over an extended period. Taken together, these breaches struck at fundamental tenets of professional practice, placing patients at risk of harm and undermining the reputation of nursing and care-home management.

The panel observed that Mrs Bailey's remorse was both minimal and belated, largely limited to her colleagues, and that she showed scant insight into the serious concerns raised. There is no evidence that she has strengthened her practice or taken steps toward genuine remediation.

The panel, in determining the issue of whether or not Mrs Bailey's practice is impaired, asked itself if she could currently practice kindly, safely and professionally. As the answer

to that question is clearly that she could not, it concluded that Mrs Bailey is currently impaired on both the ground of public protection and the wider public interest.

Sanction

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

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

Submissions on sanction

Ms Hussain informed the panel that in the Notice of Hearing, dated 30 June 2025, the NMC had advised Mrs Bailey that it would seek the imposition of a striking-off order if it found Mrs Bailey's fitness to practise currently impaired. She submitted that taking no further action or a caution order is not appropriate because it would not meet the public protection issues identified or the public interest.

Ms Hussain submitted that a conditions of practice order is not an appropriate sanction because there are no conditions that can be formulated to protect the public and maintain public confidence.

Ms Hussain submitted that Mrs Bailey's fitness to practise is impaired on both public interest and public protection grounds, referencing NMC guidance 'SAN-1'. Key aggravating factors included the panel's finding that her misconduct placed patients at an unwarranted risk of harm and her abuse of a position of trust as the Registered Manager of the Home, where she failed to act in the best interests of residents and staff. Furthermore, the complete lack of insight shown by Mrs Bailey was highlighted as a

serious concern and considered an aggravating feature rather than a mitigating one. While it was acknowledged that Mrs Bailey has no prior fitness to practise history, this was the only mitigating factor presented.

As with all previous stages the panel took into account the written submissions and reflections submitted on behalf of Mrs Bailey.

Decision and reasons on sanction

Having found Mrs Bailey'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 Sanction Guidance (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:

- Serious misconduct at the higher end of the spectrum, involving a pattern over time.
- Abuse of power and trust, especially in Mrs Bailey's role as Home Manager where she was expected to maintain order and oversight.
- Racially discriminatory comments.
- Minimal insight into the seriousness or impact of her actions.
- Financially motivated decision-making, prioritising financial interests over patient care.
- No evidence of efforts by Mrs Bailey attempting to strengthen remediate her practice.
- Abdication of responsibility and core duties as a Registered Manager.
- Direct contribution to placing vulnerable patients at unwarranted risk of harm.

The panel also took into account the following mitigating features:

- Some positive testimonials submitted on behalf of Mrs Bailey.
- The incidents occurred during the COVID-19 pandemic, a time of exceptional stress and pressure on care homes.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Bailey's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Bailey's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Bailey's registration would be a sufficient and appropriate response.

The panel established that a conditions of practice order would not be appropriate or sufficient in Mrs Bailey's case. The nature of the concerns, particularly the deep-seated attitudinal issues, including racially discriminatory language are not matters that can be effectively addressed or remediated through conditions. Furthermore, there was no evidence of proactive efforts or a future commitment by Mrs Bailey to reflect, learn or change her practice or attitudes. In these circumstances no conditions of practice could address the matters found proved as a desire to improve is necessary for conditions of practice to be effective.

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

As the panel has already found, there is a pattern of serious misconduct over a period of time which demonstrated deep seated attitudinal issues by Mrs Bailey who was in a position of trust and also of power in the Home. She has shown minimal insight and there is a high risk of repetition of her misconduct which not only presented risk to vulnerable patients, but also bullying, intimidation and racially discriminatory language. In addition, Mrs Bailey persistently failed to respond to wide ranging concerns raised by different staff members and two external audits, about matters which put vulnerable residents at risk. Mrs Bailey chose to ignore those concerns.

As Mrs Bailey has demonstrated minimal insight into her behaviour and its impact on others. She displayed no compassion towards her colleagues when she caused them distress, there was no evidence of regard for the discomfort of residents whose hygiene and pressure care were neglected. In these circumstances, with the panel's view of callous disregard by Mrs Bailey, it found that a suspension order would neither provide adequate public protection nor uphold public confidence in the profession. Given the seriousness of the breaches and the level of risk involved, suspension was deemed neither sufficient, appropriate or proportionate.

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?*

With regards to these considerations the panel found that Mrs Bailey's conduct did raise fundamental questions about her professionalism, public confidence would be impacted if she was not removed from the register and that a striking-off order was the only sufficient sanction to protect patients, members of the public and maintain professional standards.

Mrs Bailey's actions were significant departures from the standards expected of a Registered Nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Bailey's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel was convinced that the only appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Bailey'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, 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 applied the principle of proportionality in considering the impact it would have, on Mrs Bailey's right to practice and the potential, financial and reputational impact on her. However, the panel concluded that the need to protect the public and uphold the public interest outweigh those considerations in this case.

Interim order

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

The panel took account of the submissions made by Ms Hussian. She invited the panel to impose an interim suspension order to reflect the panel's decision on sanction. Ms Hussain submitted that this would satisfy the grounds of public protection and the wider public interest.

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

Decision and reasons on interim order

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

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

stated that allowing Mrs Bailey to return to practice carries a significant risk of repetition and concern relating to her attitudinal issues and serious misconduct.

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

That concludes this determination.