# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Tuesday 6 May - Friday 16 May 2025**
**Wednesday 23 July – Friday 25 July 2025**

Nursing and Midwifery Council

2 Stratford Place, Montfichet Road, London, E20 1EJ

| | | |
|---|---|---|
| **Name of Registrant:** | **Tracey Rhian Hyde** | |
| **NMC PIN:** | 85D0056W | |
| **Part(s) of the register:** | RN1: Adult nurse, level 1<br>13 August 1988 | |
| **Relevant Location:** | Merthyr Tydfil & Tonypandy | |
| **Type of case:** | Misconduct | |
| **Panel members:** | Catherine Devonport | (Chair, registrant member) |
| | Asmita Naik | (Lay member) |
| | Colleen Sterling | (Lay member) |
| **Legal Assessor:** | Charlotte Mitchell-Dunn (Tuesday 6 May - Friday 16 May 2025)<br>Brett Wilson (Wednesday 23 July – Friday 25 July 2025) | |
| **Hearings Coordinator:** | Bartek Cichowlas | |
| **Nursing and Midwifery Council:** | Represented by Vida Simpeh, Case Presenter | |
| **Miss Hyde:** | Not present and unrepresented | |
| **Facts proved:** | Charges 1, 2a, 2b, 2ci, 2cii, 2d, 2e, 2f, 2g, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 4, 5a, 5b, 5c, 6, 7, 8, 9a, 9b, 10a, 10b | |

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|---|---|
| **Facts not proved:** | Charges 9c, 9d |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Striking-off order** |
| **Interim order:** | **Interim suspension order (18 months)** |

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Miss Hyde was not in attendance and that the Notice of Hearing letter had been sent to two of Miss Hyde's email addresses, one of which was her registered email address, by secure email on 3 April 2025.

Further, the panel noted that the Notice of Hearing was also sent to Miss Hyde's former representative at the Royal College of Nursing (RCN) on 3 April 2025.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Miss Hyde's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

**Decision and reasons on proceeding in the absence of Miss Hyde**

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

Ms Simpeh referred the panel to the documentation from Miss Hyde which included an email to the NMC dated 7 April 2025 in which she stated:

> '*I write to advise you that I will not be attending the hearing(s)*'.

Ms Simpeh also referred the panel to an email from the RCN dated 2 May 2025 which stated:

> '*Please note that we are no longer acting for Tracey Hyde. Please ensure that our name is removed from the record and that all future correspondence is sent direct to the registrant*'

Ms Simpeh submitted that it was clear the registrant had received the notice of hearing and made no application for an adjournment. She submitted that in the circumstances, there is no indication that Miss Hyde would attend at a point in the future should the hearing be adjourned. She therefore invited the panel to proceed in Miss Hyde's absence.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Miss Hyde;
- Miss Hyde has made it clear that she does not want to participate in her correspondence with the NMC.
- Miss Hyde has informed the NMC that she has received the Notice of Hearing;
- The panel has seen no evidence that Miss Hyde's absence is involuntary;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A number of witnesses have indicated availability to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice - the clients who need their professional services;
- The charges relate to events that occurred in 2016, 2018 and 2023 and further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is disadvantage to Miss Hyde in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, there is documentation contained in the hearings exhibits which indicates Miss Hyde's viewpoints at the time of the local disciplinary hearing. 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, the disadvantages of proceeding in her absence can be mitigated in part by the panel making allowances for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition exploring any inconsistencies in the evidence. Furthermore, the disadvantage is the consequence of Miss Hyde's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

**Details of charge**

That you, a registered nurse, whilst employed as a band 7 nurse at the Cwm Taf Morgannwg University Health Board ('The Health Board'):

1. On 18 January 2016 you:

    a. shouted and/or raised your voice at Patient A

    b. physically handled Patient A in an inappropriate manner

    c. failed to treat Patient A with dignity and respect

2. On one or more unknown dates you spoke about patients in a derogatory and/or unprofessional manner in that you:

    a. described patients as '*lazy'* or words to that effect

    b. said in relation to an unknown patient '*he's only come back to the UK for treatment that's all he's here for there's nothing wrong with him'* or words to that effect

    c. said in relation to an unknown patient:

        i. *'he is only here for free healthcare'* or words to that effect

ii. *'why can't he fuck off back to where he came from'* or words to that effect

d. described a patient with chronic cellulitis as having '*fat leg syndrome'* or words to that effect

e. when speaking about a patient with dementia said *'they're fucking nuts and need to get off my ward or I'll end up with dementia'* or words to that effect

f. described patients with depression and/or low mood as '*pathetic'* or words to that effect

g. said that a patient could not get out of bed because the patient was too fat or words to that effect

3. On one or more unknown dates you behaved inappropriately and/or unprofessionally towards your professional colleagues in that you:

a. raised your voice and/or shouted at colleagues

b. referred to a student nurse as '*useless'* or words to that effect

c. Told Colleague B to '*mind her own business'* and asked '*why can't you lot just come and do your job and keep your nose out of other people's business'* or words to that effect

d. said in relation to a doctor *'I wouldn't pay attention to that doctor, they're one of those bloody South Africans'* or words to that effect

e. referred to Colleague A as having come from overseas for '*free prescriptions or treatment'* or words to that effect

f. referred to two doctors as '*dumb and dumber'* or words to that effect

g. referred to a member of the occupational therapy team as '*stupid'* and said that he did not know what he was doing or words to that effect

4. Your actions at charges 2(b), 2(c), 3(d) and/or 3(e) were discriminatory in nature.

5. On an unknown date between August and September 2018 you spoke to Colleague A (a student nurse) in a belittling manner in that you said words to the effect of:

   a. '*what are you doing here'*

   b. '*You're not supposed to be here your mentor's not here'*

   c. Told Colleague A he *'shouldn't be in this profession if he had other commitments*'

6. On 3 July 2018 you inappropriately grabbed Colleague C by her arm and pulled her

7. On one or more unknown dates you failed to consider and/or follow the recommendations of your physiotherapy colleagues

8. On one or more unknown dates you did not engage effectively with the occupational therapy team and/or ensure that the therapy recommendations were implemented for patients on the ward

9. On one or more occasions in your position as ward manager failed to ensure that staff on the ward provided appropriate care to patients in that:

   a. staff used inappropriate manual handling techniques with patients

b. staff did not provide adequate pressure care to patients

c. staff did not provide adequate incontinence care to patients

d. staff did not provide appropriate care for a patient with lymphedema

That you, a registered nurse, whilst employed as a nurse at the Ty Nant Care Home:

10. On 24 June 2023 you:

a. Inappropriately handled and/or restrained Resident B

b. Did not complete an incident form following the incident with Resident B

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

**Decision and reasons on application to amend the charge**

The panel heard an application made by Ms Simpeh, on behalf of the NMC, to amend the wording of charge 5.

The proposed amendment was to change the pronouns from '*she'* to '*he*' in charge 5c to correct an error in the drafting of the charge in respect of Colleague A. It was submitted by Ms Simpeh that the proposed amendment would provide clarity and more accurately reflect the evidence.

"That you, a registered nurse:

5) On an unknown date between August and September 2018 you spoke to Colleague A (a student nurse) in a belittling manner in that you said words to the effect of:

a. …
b. …
c. Told Colleague A ~~s~~he *'shouldn't be in this profession if ~~s~~he had other commitments*'

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Hyde and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to accurately reflect the evidence.

The panel, while making its decision on the facts, decided, of its own volition, to make a further amendment to the charges. The amendment was to change the wording of charge 4 from using the word *'and',* to the use of '*and/or*':

4) Your actions at charges 2(b), 2(c), 3(d) and**/or** 3(e) were discriminatory in nature.

The panel was of the view that such an amendment was minor in nature and did not change the substance of the allegation. However, it would allow the panel to make findings in the alternative should it not find one or more of the sub-particulars proved. The panel was again satisfied that there would be no prejudice to Miss Hyde and no injustice would be caused to either party by the proposed amendment being allowed. Further, it would ensure that the matter was not under-prosecuted on the basis of a technicality.

**Background**

The NMC has received two referrals about Miss Hyde. The charges arising out of the first referral arose whilst Miss Hyde was employed as a registered nurse at Prince Charles Hospital (“the Hospital”).

Two student nurses raised issues regarding Miss Hyde's conduct, as well as about other members of staff on the Ward. An internal investigation was carried out in which a number of members of staff and student nurses were interviewed.

Members of staff from the physiotherapy team regularly attended the ward to assess patients. All these staff referred to Miss Hyde as being derogatory about their professional role, minimising patients' conditions, and failing to follow their recommendations.

There were reports from student nurses that staff on the ward were failing to follow proper manual handling techniques and failing to provide appropriate pressure area care. This may have led to an increase in pressure area incidents on the Ward.

There was evidence from a number of members of staff that Miss Hyde used inappropriate language during handover meetings to describe patients' conditions, for example *"nuisance", "lazy", "pathetic"*, and *"fat leg syndrome"*, and referring to their ethnicity or nationality.

Many members of staff referred to Miss Hyde's inappropriate conduct and attitude towards staff, including regularly shouting at staff on the Ward, and making derogatory comments about other members of staff (including about their nationality).

It was also reported that Miss Hyde's conduct and attitude toward patients was inappropriate. One incident was witnessed whereby Miss Hyde shouted at a patient who wanted to leave the ward and Miss Hyde, and other staff members carried her back to bed, saying she would inject her if she didn't calm down. Other incidents of poor patient

care were witnessed, including where Miss Hyde would argue with staff about patients in front of the patients.

On 3 July 2018 Colleague C was helping a patient to use the toilet as he had an IV line attached. Miss Hyde grabbed Colleague C by the arm and pulled her out of the bathroom telling her that she should not help the patient as he would have to do it himself at home.

A disciplinary hearing was held on 16 October 2019.

The NMC received a second referral from Silvercrest Care on 20 July 2023 when Miss Hyde was employed as Registered Nurse at Ty Nant Care Home ('the Home'). On 24 June 2023, Miss Hyde is said to have inappropriately restrained a resident. The Home started an investigation, but Miss Hyde resigned sometime shortly after 27 June 2023.

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

During the examination in chief of Witness 4, Ms Simpeh made a request that this case be held in partly in private on the basis that proper exploration of Miss Hyde's case may involve discussion of the health and private life of witnesses. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined to go into private session in connection with the health and private life of witnesses as and when such issues are raised in order to protect their privacy.

**Decision and reasons on application to admit hearsay evidence**

The panel heard an application made by Ms Simpeh under Rule 31 to allow the written statement of Witness 14 into evidence. Witness 14 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend today due to her inability to rearrange childcare responsibilities over the days she has been expected to attend.

In the preparation of this hearing, the NMC had indicated to Miss Hyde that it was the NMC's intention for Witness 14 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 14, Miss Hyde made the decision not to attend this hearing. On this basis Ms Simpeh advanced the argument that there was no lack of fairness to Miss Hyde in allowing Witness 14's witness statement into evidence.

Ms Simpeh referred the panel to the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). She submitted that the witness statement of Witness 14 was not the sole and decisive evidence in relation to any of the charges; there were no allegations made in the statements and as such it is unlikely that there would have been any challenge by Miss Hyde had she been present; and that there was a good reason for Witness 14's non-attendance, namely childcare responsibilities. Ms Simpeh therefore submitted it would be disproportionate to delay proceedings further to attempt to secure Witness 14's presence.

The panel accepted the advice of the legal assessor who referred it to the following cases: *Thorneycroft, NMC v Ogbonna* [2010] EWCA Civ 1216, *R (Bonhoffer) v General Medical Council (GMC)* [2012] IRLR 37**,** *El Karout v NMC* [2019] EWHC 28(Admin) and *Mansaray v NMC* [2023] EWHC 730 (Admin).

The panel gave the application in regard to Witness 14 serious consideration. The panel noted that Witness 14's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by her.

The panel considered whether Miss Hyde would be disadvantaged by the change in the NMC's position of moving from reliance upon the oral evidence of Witness 14 to that of allowing her witness statement into evidence.

The panel considered that as Miss Hyde had been provided with a copy of Witness 14's statement and, as the panel had already determined that Miss Hyde had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel considered the factors in *Thorneycroft*. The panel noted that there appeared to be no reason to fabricate any of the matters in the statement. It considered the statement potentially provided a positive view of Miss Hyde. The panel also acknowledged that the statement is not the sole and decisive evidence in any of the charges, given the other evidence brought by the NMC. The panel also considered that all reasonable steps have been taken in attempting to secure Witness 14's presence:

- The NMC had informed the witness in advance of the hearing that she was due to attend on day 1 and 2.
- The NMC sent the video call link to the witness on 2 May 2025.
- The NMC had obtained and contacted the witnesses' personal email address and telephone number after having received no response from the witness on her work email address.
- While the witness did indicate a narrow period of availability on day 3, there were delays to the hearing which rendered it impossible to hear her evidence at that time.

The panel also considered that the reason given for the lack of availability of the witness is sufficiently reasonable given the difficulty she indicated she would face in rearranging her childcare.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 14 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

**Decision and reasons on facts**

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

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

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

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

- Witness 1: Physiotherapy Technician at Prince Charles Hospital Tydfil ('The Hospital') at the time of the alleged incidents
- Witness 2: Student Nurse on placement at the Hospital at the time of the incidents
- Witness 3: Student Nurse on placement at the Hospital at the time of the alleged incidents
- Witness 4: Occupational Therapist and Team Lead for the Acute Medical

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|---|---|
| | Occupational Therapy Team at the Hospital at the time of the alleged incidents |
| • Witness 5: | Occupational therapist at the Hospital |
| • Witness 6 | Occupational Therapist in the Stroke Community Team at The Hospital |
| • Witness 7 | Band 5 Physiotherapist at the Hospital |
| • Witness 8 | Student Nurse on placement at the Hospital at the time of the alleged incidents |
| • Witness 9 | Acting Deputy Executive Nurse Director for Cardiff and Vale University Health Board at the time of the alleged incidents |
| • Witness 10 | Care home Advanced Practitioner at Silvercrest Care - Ty Nant Care home |
| • Witness 11 | Head of Nursing for Primary Care & Community Services within Cwm Taf University Health Board (the Health Board) at the time of the alleged incidents, Chair of the local disciplinary panel. |

- Witness 12 — Health Care Support Worker on Ward 7 ("the Ward") at Prince Charles Hospital ("the Hospital")
- Witness 13 — Deputy Manager at Silvercrest Care - Ty Nant Care home
- Witness 14 — Senior nurse for surgery at the Hospital at the time of the alleged incidents

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC as well as by the RCN and Miss Hyde.

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

**Charge 1a**

> "That you, a registered nurse, whilst employed as a band 7 nurse at the Cwm Taf Morgannwg University Health Board:
>
> On 18 January 2016 you shouted and/or raised your voice at Patient A "

**This charge is found proved.**

The panel took into account the evidence of Witness 1, a direct witness of the incident, who stated that '*The Registrant was standing near the patient and shouting at her*'.

The panel also had regard to the evidence of Witness 5, also a direct eye witness, who stated: '*The Registrant was arguing with the patient and both of them were getting*

*increasingly louder. The shouting back and forth caused the patient to become more distressed.*'

The panel also took into account the Datix incident report form provided by Witness 5 which also stated that the registrant was '*shouting loudly*'. The panel considered the Datix report form provided by Witness 1 in which she stated that Miss Hyde '*wasn't shouting, shouting but she had raised voice and she was in the patient's face*'. The panel considered that this did not contradict the fact that the tone used was inappropriate.

The panel considered the Disciplinary Hearing Notes dated 16 October 2019 provided by Witness 11, in which Miss Hyde is quoted to have said '*She was very loud and everything and of course I'm loud as well so I probably made her worse*.'

Given the evidence of direct eye witnesses, and Miss Hyde's acknowledgement of the events, the panel found that on the balance of probabilities, this charge is found proved.

**Charge 1b**

"On 18 January 2016 you physically handled Patient A in an inappropriate manner"

**This charge is found proved.**

The panel considered the written evidence of Witness 1, a direct eye witness of the incident, in which she states:

'*The Registrant then instructed three other staff members, I think one was a nurse and the other two were unqualified nurses … to each grab one of the patient's arms and legs and the Registrant held the patient's other arm. They lifted the patient up in the air from a standing position, each with their arm under one of the patient's limbs. They carried the patient from the entrance door of the Ward to Bay 3 which is*

*approximately 10-15 metres. The patient's clothes had ridden up exposing her underwear.*'

The panel took into account the oral evidence of Witness 1 in which she stated her opinion that this handling of a patient was '*disgraceful'* and outlined why it was inappropriate and not in line with the hospital policy. The panel took into account the Manual Handling Policy exhibited by Witness 1.

The panel considered Miss Hyde's response to the allegations in the Disciplinary Hearing Notes provided by Witness 11, in which she stated, '*basically we just did a Fireman's Lift on her.*'

The panel was of the view that the method of handling the patient was not appropriate in the circumstances. It found that it had sufficient information that the actions taken were not in line with the policy and posed a risk of harm. The panel found that on the balance of probabilities, this charge is proved.

**Charge 1c**

"On 18 January 2016 you failed to treat Patient A with dignity and respect"

**This charge is found proved.**

The panel took into account the witness statement of Witness 1 in which she stated, with respect to the incidents in this charge:

'*The Registrant was irate and aggressive towards the patient. The Registrant raised her voice even more saying "I've got a piece of paper here which says that I'm able to keep you here". She was referring to a Deprivation of Liberty (Dols) form. She was waving the paper at the patient when saying this.'*

…

‘*They lifted the patient up in the air from a standing position, each with their arm under one of the patient's limbs. They carried the patient from the entrance door of the Ward to Bay 3 which is approximately 10-15 metres. The patient's clothes had ridden up exposing her underwear*.’

…

‘*There were a lot of other patient's relatives and visitors on the Ward at the time who could have seen the incident*.

…

*‘I thought this was awful and that there was no respect for the patient's dignity. The patient was handled roughly which caused her to become distressed. I knew she was distressed because she was screaming when she was picked up*.’

The panel took into account treating patients with dignity and respect is a fundamental aspect of the nursing profession, and that nurses must adhere to this at all times. The panel was of the view that there were actions taken in this incident, namely the aggressive stance and the waving of the DoLs form, which did not fulfil this duty. The panel noted that the incident took place on the ward where other patients and visitors were present.

The panel considered Miss Hyde’s Response to this in the Disciplinary Interview Notes, where she stated, ‘*Her knickers weren’t on show because she had trousers on*’. However, the panel found the eye witness evidence from Witness 1 credible, that Patient A’s underwear was exposed and concluded this was a violation of Patient A’s dignity.

Therefore, on the balance of probabilities, the panel found this charge proved.

**Charge 2a**

“On one or more unknown dates you spoke about patients in a derogatory and/or unprofessional manner in that you described patients as ‘*lazy’* or words to that effect”

**This charge is found proved.**

The panel considered the Witness statement of Witness 1 who stated,

> '*If we asked the Registrant whether a particular patient had been out of bed and walking, she would respond saying that the patient can do more than they let on, they're just lazy and they are fine by themselves. I am not sure if anyone else witnessed these comments but I recall that it was mentioned informally in passing amongst the therapy staff. I cannot recall any phrases or conversations specifically*.'

The panel also had regard to the NMC Witness statement of Witness 5, who confirmed that Miss Hyde '*often referred to larger patients as being lazy*'. The panel also considered the Hospital Formal Investigation Interview Notes dated 27 August 2019 exhibited by Witness 5, and the Hospital Formal Investigation Interview Notes dated 10 March 2019 exhibited by Witness 2 which confirms the statements of Witness 1.

The panel considered Miss Hyde's response in the Disciplinary Interview Notes, produced by Witness 11 where she stated, '*I might have said like they were 'Lazy' as the fact that perhaps they don't want to get up and participate in Physio or OT'*.

Given the number of witnesses who corroborate the use of the word '*lazy'*, and the response by Miss Hyde in the Disciplinary Interview, the panel found this charge proved.

**Charge 2b**

> "On one or more unknown dates you spoke about patients in a derogatory and/or unprofessional manner in that you said in relation to an unknown patient '*he's only come back to the UK for treatment that's all he's here for there's nothing wrong with him'* or words to that effect"

**This charge is found proved.**

The panel considered the evidence of Witness 3. In his NMC witness statement, he states:

> '*On one occasion, I cannot recall the exact date, I was in the morning handover meeting … We were sitting in the handover room near the entrance to the Ward. The Registrant was speaking about a patient, I cannot recall his name. The patient was British and had recently come back home from living abroad. The Registrant said. "He's only come back to the UK for treatment that's all he's here for there's nothing wrong with him*".'

The panel noted that Witness 3's evidence was consistent with his Hospital Formal Investigation Interview Notes dated 14 March 2019.

The panel noted Miss Hyde's response from the Disciplinary Interview Notes provided by Witness, 11, where it is stated that:

> '*When these Allegations were put to Tracey she could not recall any of these Incidents adding that as Nurses they nurse people from all different backgrounds, Nationalities and Cultures.*'

The panel found Witness 3, who was a direct witness and gave sworn oral evidence, to be credible and consistent in the evidence he provided in his NMC witness statement and his account during the Hospital Formal Investigation Interview Notes dated 14 March 2019. The panel therefore found this charge proved on the balance of probabilities.

**Charge 2ci**

> "On one or more unknown dates you spoke about patients in a derogatory and/or unprofessional manner in that you said in relation to an unknown patient: *'he is only here for free healthcare'* or words to that effect*"*

**This charge is found proved.**

The panel considered the Witness statement of Witness 2 in which she stated:

> *'In relation to a patient who was from a Nepalese community in Brecon, the Registrant said that she thought that he was only here (meaning in the UK) for free healthcare. She said "why can't he just fuck off back to where he came from*"'

The panel noted that the Witness statement was consistent with the account in Witness 2's exhibited Hospital Formal Investigation Interview Notes dated 10 March 2019.

The panel noted that the registrant '*could not recall'* this incident, as quoted in charge 2b.

The panel found Witness 2, who was a direct witness and gave sworn oral evidence, to be credible and consistent in the evidence she provided in his NMC witness statement and her account during the Hospital Formal Investigation Interview Notes dated 10 March 2019. The panel therefore finds this charge proved on the balance of probabilities.

**Charge 2cii**

> "On one or more unknown dates you spoke about patients in a derogatory and/or unprofessional manner in that you said in relation to an unknown patient: *'why can't he fuck off back to where he came from'* or words to that effect"

**This charge is found proved.**

The panel took into account the same evidence as in charge 2ci. The panel noted that there was a discrepancy between the Witness Statement of Witness 2, where she uses the words '*fuck off back…'* and the Hospital Formal Investigation Interview Notes dated 10 March 2019 where she alleges Miss Hyde said, *'piss off back…'*. However, the panel found that

these words amount to the same effect. The panel therefore found that on the balance of probabilities, this charge is proved.

**Charge 2d**

> "On one or more unknown dates you spoke about patients in a derogatory and/or unprofessional manner in that you described a patient with chronic cellulitis as having '*fat leg syndrome'* or words to that effect"

**This charge is found proved**

The panel took into account the evidence of Witness 12, a direct eye witness to the incidents, who states:

> '*on one occasion, I cannot recall the exact date, I heard the Registrant use the term "fat leg syndrome" to describe a patient that had cellulitis … I do not think that the Registrant should have described the patient in this way because the comment was disrespectful and all patients should be treated with respect and dignity*.'

Witness 12 said in her live oral evidence that she asked Miss Hyde to explain Cellulitis, and Miss Hyde referred to the condition as '*fat leg syndrome'*. Witness 12 stated that this may have been Miss Hyde's way of explaining this condition in '*layman's terms'*. The panel considered that the use of these words is confirmed by other direct witnesses, in the evidence of Witness 2, and Witness 4.

The panel noted Miss Hyde's position, as appeared in the Hospital Formal Disciplinary interview notes dated 16 October 2019 exhibited by Witness 11, in which she states that she had '*never heard of that fat leg syndrome*'.

The panel concluded that it is more likely than not that Miss Hyde used the term *'fat leg syndrome'*. The panel heard evidence from multiple witnesses who directly heard Miss Hyde

use this term. It considered those witnesses to be credible and consistent in oral evidence. The panel found that on the balance of probabilities, this charge is proved.

**Charge 2e**

> "On one or more unknown dates you spoke about patients in a derogatory and/or unprofessional manner in that you when speaking about a patient with dementia said *'they're fucking nuts and need to get off my ward or I'll end up with dementia'* or words to that effect"

**This charge is found proved.**

The panel considered the NMC witness statement of Witness 2, a direct eye-witness, in which she states, '*When speaking about a patient that had dementia. the Registrant said "They're fucking nuts and need to get off my ward or I'll end up with dementia*"'. The panel took into account that this is consistent with the Hospital Formal Investigation Interview Notes dated 10 March 2019 exhibited by this witness. The panel found no specific evidence about the registrant's response.

The panel found that this witness was credible, gave sworn oral evidence and was consistent. The panel therefore found that this charge is proved on the balance of probabilities.

**Charge 2f**

> "On one or more unknown dates you spoke about patients in a derogatory and/or unprofessional manner in that you described patients with depression and/or low mood as '*pathetic'* or words to that effect"

**This charge is found proved.**

The panel took into account the witness evidence of Witness 8. In her witness statement, she states that *'If patients had anxiety or depression, the Registrant would describe them as pathetic*.' The panel considered Witness 8's exhibited Hospital Formal Investigation Interview Notes dated 23 March 2019 which is consistent with the account given in the NMC witness statement. The panel also found that Witness 2 confirms the use of these words in her witness statement.

The panel noted Miss Hyde's response in the Disciplinary Hearing Notes dated 16 October 2019 exhibited by Witness 11:

> '*I just wouldn't say it like that. I just wouldn't say pathetic. I just wouldn't. I just think you have given a patient information in a clear and concise manner and you should be doing it in a non-judgemental way. You shouldn't really say that you are pathetic, how would I know he might have come in last night. I don't know if he is pathetic. I don't know him*.'

The panel found that the allegation is confirmed by two direct eye witnesses who were questioned by the panel and found credible. The panel therefore found that on the balance of probabilities, Miss Hyde did describe patients as '*pathetic'* and as such this charge is found proved.

**Charge 2g**

> "On one or more unknown dates you spoke about patients in a derogatory and/or unprofessional manner in that you said that a patient could not get out of bed because the patient was too fat or words to that effect"

**This charge is found proved**

The panel took into account the evidence of Witness 4 who was a direct eye witness of this allegation. She states in her NMC witness statement: '*On one occasion around 2018, I*

*cannot recall the exact date, I heard the registrant comment that a patient could not get out of bed because the patient was too fat'*.

The panel did not find any specific response to this allegation from Miss Hyde.

Given that the panel was able to examine Witness 8, and that she was a direct eye witness who gave sworn live evidence, it found that this witness was credible. The panel concluded that it is more likely than not that Miss Hyde used these words or words to this effect to describe a patient. The panel therefore found that this charge is proved.

**Charge 3a**

> "On one or more unknown dates you behaved inappropriately and/or unprofessionally towards your professional colleagues in that: you raised your voice and/or shouted at colleagues"

**This charge is found proved.**

The panel considered the evidence of Witness 5. In her witness statement, she states:

> '*The Registrant did not have the best manner with staff. I thought way she spoke to all members of staff was awful. She was short and abrupt and would shout rather than have a discussion'*

The panel considered the witness statement of Witness 6 who says:

> *'The Registrant then became quite verbally loud. She was arguing with me and shouting saying that what I had said was not right'*

The panel found that Miss Hyde's shouting and/or raising her voice to staff was corroborated by a number of witnesses, including Witness 1 in her NMC witness statement, Witness 4 in

her NMC witness statement and in her Hospital Formal Investigation Interview Notes dated 13 August 2019, and Witness 14 in her NMC witness statement.

The panel considered some responses from the registrant. In the Disciplinary Hearing Notes dated 16 October 2019 exhibited by Witness 11, she stated:

> '*I might raise my voice but it is not shouting it is like a teacher would raise their voice to grab attention of a class. It is nothing malicious in it*.' (sic)

[PRIVATE]

[PRIVATE]

The panel considered the number of direct witnesses, all of whom describe Miss Hyde shouting or raising her voice, and all of whom were consistent and credible. The panel concluded that Miss Hyde did raise her voice and shout at her colleagues.

The panel therefore found this charge proved.

**Charge 3b**

> "On one or more unknown dates you behaved inappropriately and/or unprofessionally towards your professional colleagues in that: you referred to a student nurse as '*useless'* or words to that effect"

**This charge is found proved.**

The panel considered the evidence of Witness 2. In her witness statement, she stated:

> '*One morning (I cannot recall the exact date) I was in the handover room on the Ward, waiting for the handover to start and I heard the Registrant talking about one*

*of the other student nurses. The Registrant was speaking to the other nursing staff saying that the student was useless and he did not know how to put a blood pressure cuff on, and why is he even here.'*

The panel also considered Miss Hyde's response to this allegation when it was put to her in the Disciplinary Hearing Notes dated 16 October 2019:

'*I mean they have got the theory haven't they but to me they haven't done it in practice and I wouldn't expect them to do a bp [blood pressure check] and I wouldn't say that about a student in a report anyway.*'

The panel considered the direct eye witness evidence of Witness 2 to be credible. The panel considered that Witness 2 was clear in her oral evidence about Miss Hyde's use of the word '*useless'.*

The panel therefore found that on the balance of probabilities, this charge is proved.

**Charge 3c**

"On one or more unknown dates you behaved inappropriately and/or unprofessionally towards your professional colleagues in that: you told Colleague B to '*mind her own business'* and asked '*why can't you lot just come and do your job and keep your nose out of other people's business'* or words to that effect"

**This charge is found proved.**

The panel considered the evidence of Witness 4. In her NMC witness statement, she stated:

'*I was about to leave the Ward and as I approached the nurses' station I told the Registrant about the fluid bag, The Registrant responded shouting at me to mind my own business. that it was nothing to do with me and said why can't you lot (meaning*

*the therapy staff) just come and do your job and keep your nose out of other people's business. I just explained that I thought she should be aware of it as I hadn't seen unattended fluid bags before and I left the Ward*.'

The panel considered that this account is consistent with the Hospital Formal Investigation Interview Notes dated 13 August 2019 exhibited by Witness 4.

The panel noted the response to this allegation by Miss Hyde in the Disciplinary Hearing Notes dated 16 October 2019 exhibited by Witness 11, in which she stated:

'*Well I might have said 'Mind your own business' because perhaps whatever was happening in that Cubicle wasn't anything to do with them. I might have said 'Mind your own business' but I might have said it jovial, I said to them: 'Mind your own business now. Go and do your work' or whatever you know*.'

Given the witness evidence of Witness 1 which is consistent, and the acknowledgement from Miss Hyde that she '*might have said'* those words, the panel found that Miss Hyde did use the words '*mind your own business'*. The panel found that this was not an appropriate way to communicate with colleagues. Therefore, the panel found that on the balance of probabilities, this charge is proved.

**Charge 3d**

"On one or more unknown dates you behaved inappropriately and/or unprofessionally towards your professional colleagues in that: you said in relation to a doctor *'I wouldn't pay attention to that doctor, they're one of those bloody South Africans'* or words to that effect"

**This charge is found proved.**

The panel considered the evidence of Witness 5. In her NMC witness statement, she states:

‘*On one occasion, I cannot recall the exact date but it was during the summer months of 2018, I was standing in the corridor of the Ward opposite the nurses' station … The Registrant was talking to someone, I cannot recall who, about one of the doctors and said loudly "I wouldn't pay attention to that doctor, they're one of those bloody South Africans". I am not sure which doctor the Registrant was referring to, nor the context of the conversation*.’

This account is consistent with Witness 5’s exhibited Hospital Formal Investigation Interview Notes dated 27 August 2019.

The panel noted Miss Hyde’s response in the Disciplinary Hearing Notes dated 16 October 2019 exhibited by Witness 11, in which she stated:

‘*There was no South African Doctor. There was a South African Therapist and I made a joke, I said: ‘Oh you know what these South Africans are like’ when she was listening to me and she was like me; she was the same type of person as me, she was laughing. I don’t know where [Witness 5] got that; there was no South African Doctor*.’

The panel found that the evidence of Witness 5, which was confirmed under affirmation, was consistent and that she was a direct eye witness. Further, the panel noted that during the Disciplinary Hearing Notes dated 16 October 2019 exhibited by Witness 11 Miss Hyde provided an explanation that she used those words as a joke. The panel did not accept that these words were a joke. The panel therefore found that, on the balance of probabilities, Miss Hyde did use words to the effect of *‘I wouldn’t pay attention to that doctor, they’re one of those bloody South Africans’,* and that this was inappropriate in the circumstances.

The panel therefore found this charge is proved.

**Charge 3e**

"On one or more unknown dates you behaved inappropriately and/or unprofessionally towards your professional colleagues in that: you referred to Colleague A as having come from overseas for '*free prescriptions or treatment'* or words to that effect"

**This charge is found proved.**

The panel took into account the evidence of Witness 8. In her NMC witness statement, she states:

*'On 3 July 2018 I had been working on the Ward and was heading to the canteen on my lunch break. I was walking down the stairs with the Registrant and another nurse…, who was also my mentor. I heard the Registrant speaking about one of the other student nurses, [Colleague A]. The Registrant made a comment … about [Colleague A] being here from oversees for free prescriptions or treatment. I was right in front of the Registrant when she said this.'*

This account is consistent with the Hospital Formal Investigation Interview Notes dated 23 March 2019 exhibited by Witness 8. The panel also considered the Hospital Formal Investigation Interview Notes dated 30 August 2019 exhibited by Witness 6, in which Witness 2 stated that Miss Hyde, with reference to Colleague A, said:

'*That he's not from here, why should he be here having free healthcare? He's not from this country. Did he think he would just come back and get nurse and just have free healthcare over here. She was just angry that he was on the ward*.'

In the Disciplinary Hearing notes dated 16 October 2019 exhibited by Witness 11, Miss Hyde stated the following, when asked whether she made comments about Colleague A being here (in the UK) for free prescriptions:

'*I didn't say that either. I didn't say that because that Student Nurse said in her initial thing that I said it in break and in the other thing then she said I said it on the stairs; and it's verbatim for when [Witness 2] said it and I didn't say that. Because I thought [Colleague A] was English to be perfectly frank with you.*'

The panel found that the sworn evidence of Witness 2 and Witness 8 was clear and that Witness 8 was a direct eye witness. The panel found that the consistency and clarity under examination, and the fact that there were multiple witnesses to this allegation, outweighed the account given by Miss Hyde. In these circumstances, the panel found that it is more likely than not that Miss Hyde referred to Colleague A as having come from overseas for '*free prescriptions or treatment'* or words to that effect". The panel concluded that this is not appropriate language to use in respect of a colleague and therefore concluded that this charge is proved.

**Charge 3f**

"On one or more unknown dates you behaved inappropriately and/or unprofessionally towards your professional colleagues in that: You referred to two doctors as '*dumb and dumber'* or words to that effect"

**This charge is found proved.**

The panel considered the witness evidence of Witness 6. In her NMC witness statement she states:

'*On one occasion, I cannot recall the date, I was standing opposite the Registrant near the nurses' desk. I heard the Registrant shouting at two doctors down the length of the Ward calling them "dumb and dumber*"'

This is consistent with the Disciplinary Hearing Notes dated 16 October 2019 exhibited by Witness 11, in which Witness 6 recounted that Miss Hyde shouted down the ward and referred to doctors as '*dumb and dumber'.*

The panel noted that the comment '*dumb and dumber'* was not put to Miss Hyde as part of the Disciplinary Investigation and therefore panel had no evidence of her response.

The panel considered the evidence for this charge came from multiple sources whom the panel found to be reliable and is consistent. Given this the panel concluded it is more likely than not that Miss Hyde used this language. Therefore, the panel found that this charge is proved.

**Charge 3g**

> "On one or more unknown dates you behaved inappropriately and/or unprofessionally towards your professional colleagues in that: You referred to a member of the occupational therapy team as '*stupid'* and said that he did not know what he was doing or words to that effect"

The panel considered the evidence of Witness 6. It noted a section of her NMC witness statement in which she states:

> '*At some point during my visit to the Ward, I was standing opposite the Registrant and she made a comment to me about one of my colleagues … who was a Band 6 OT at the time. She said "he's stupid he doesn't know what he's doing". I walked away and did not respond to the Registrant. I thought that it was not professional for the Registrant to speak about other members of the multidisciplinary team in this way*.'

The panel noted that this is consistent with the information in the Hospital Formal Investigation Interview Notes dated 30 August 2019 exhibited by Witness 6. The panel noted that the comment '*stupid'* was not put to Miss Hyde as part of the Disciplinary Investigation and therefore panel had no evidence of her response.

The panel considered that the account was provided by a direct eye witness to the incident. The panel found no evidence to undermine this and therefore found it more likely than not that Miss Hyde referred to a member of the occupational therapy team as '*stupid'* and said that he did not know what he was doing or words to that effect.

The panel therefore found this charge proved.

**Charge 4**

"Your actions at charges 2(b), 2(c), 3(d) and/or 3(e) were discriminatory in nature."

**This charge is found proved in part.**

The panel considered its findings at charges 2(b), 2(c), 3(d) and 3(e). The panel also took into account the definition of discrimination found in the Equality Act 2010:

'*A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others'*

The protected characteristics are:

- *age*
- *gender reassignment*
- *being married or in a civil partnership*
- *being pregnant or on maternity leave*
- *disability*

- *race including colour, nationality, ethnic or national origin*
- *religion or belief*
- *sex*
- *sexual orientation*

The panel also took into account NMC guidance title '*Misconduct'* reference FTP-2a, which confirms the definition found in the equality act.

The panel considered the charges in turn. The panel considered for charge 2b that it had no evidence that the patient towards whom the comments were directed falls within one of the protected characteristics, nor that the comments were intended to treat them unfavourably because of one of the characteristics. The charge refers to a patient coming back to the UK from overseas but does not indicate whether the patient fell within one of the protected characteristics, including race. The panel found charge 4 not proved in respect of charge 2b.

The panel found that the charge is proved in respect of charge 2c. The panel noted that there is a protected characteristic engaged, and it is that of ethnicity, namely, the patient was Nepalese. It also bore in mind the Hospital Formal Investigation Interview Notes dated 10 March 2019 in which Witness 2 said the following with regards to Miss Hyde's reference to the Nepalese patient:

> *'When she was reading out his handover she said 'I don't know why he's here, he wasn't in this country 3 months ago, he used to live here maybe he got sick and just come back for free health care, why doesn't he just go back to where he came from?' She just wasn't happy about him being nursed on the ward whatsoever and she was saying horrible things about him.'*

The panel considered that this was evidence of Miss Hyde treating the patient less favourably to others. In all the circumstances the panel found that charge 2c was discriminatory in nature.

In respect of charge 3d, the panel found that this charge is proved. The panel found that the characteristic of nationality was engaged by reference to '*South Africans'* in the comments made. The panel found that there was less favourable treatment implied from Miss Hyde's attitude towards this nationality, in that she stated she '*wouldn't pay attention'* to South Africans as a result of their nationality. The panel concluded that this had the potential to create an exclusionary environment and therefore amounted to less favourable treatment. In all the circumstances the panel found that charge 3d was discriminatory in nature.

The panel found that this charge is not proved in respect of charge 3e. The panel concluded that it had insufficient evidence to demonstrate a link between the comment itself and this resulting in less favourable treatment from Miss Hyde towards Colleague A on the basis of his protected characteristic.

On the basis that the panel found the actions of Miss Hyde to be discriminatory in nature in respect of charges 2c and 3d, the panel found charge 4 proved.

**Charge 5a, 5b, and 5c**

> "On an unknown date between August and September 2018 you spoke to Colleague A (a student nurse) in a belittling manner in that you said words to the effect of:
>
> a. '*what are you doing here'*
> b. '*You're not supposed to be here your mentor's not here'*
> c. *'he shouldn't be in this profession if he had other commitments*'

**These charges are found proved.**

The panel considered the witness evidence of Witness 3. The panel noted the following part of Witness 3's NMC witness statement:

‘*I was in the handover room with the other nursing staff on shift that day, I cannot recall any of their names specifically. After handover the Registrant said to me "What are you doing here?". I told her that I'd come here on a nursing placement. Her reply was "You're not supposed to be here your mentor's not here". I explained that I don't have to work with my mentor on every shift. I am only required to work 40% of my hours with my mentor and for the other 60% I can work with any qualified nurse or staff member. The Registrant said that* [her mentor] *would be working tomorrow I said that I couldn't come in that day because I had work. The Registrant said that I shouldn't be in this profession if I had other commitments. The Registrant was in front of me, a couple of feet away when she said this to me*.’

He further stated in his NMC witness statement:

‘*I felt that* [Miss Hyde] *had belittled me in front of other people.’*

The panel found that this was consistent with the account in the Hospital Formal Investigation Interview Notes dated 14 March 2019 which Witness 3 exhibits. The panel noted Miss Hyde’s response in the Disciplinary Hearing Notes dated 16 October 2019 exhibited by Witness 11, in which she disputed Witness 3’s account of events.

The panel considered that the evidence of Witness 3 given under affirmation was reliable and credible. The panel found no reason to undermine the evidence of Witness 3. The panel therefore found charge 5a, 5b and 5c proved.

**Charge 6**

“On 3 July 2018 you inappropriately grabbed Colleague C by her arm and pulled her”

**This charge is found proved.**

The panel considered the Witness evidence of Witness 7, and Witness 8. The panel noted in Witness 7's NMC witness statement she states:

> '*As* [Colleague C] *was walking into the toilet, the Registrant was walking past and pulled the student by the arm out of the toilet. The Registrant used a force that was significant enough to make the student stumble backwards. I cannot recall which arm she grabbed. I do not know if the student was hurt as a result* … The *Registrant wrongfully manhandled a staff member without their consent. She failed to uphold clinical standards and a professional attitude*.'

This is confirmed by Witness 8 in her NMC witness statement and can be found in both Witness 7's exhibited Hospital Formal Investigation Interview Notes dated 2 August 2019, and in Witness 8's exhibited Hospital Formal Investigation Interview Notes dated 23 March 2019.

The panel noted that in the Disciplinary Hearing notes dated 16 October 2019 exhibited by Witness 11, Miss Hyde states that she 'doesn't recall' the incident taking place.

The panel considered that the evidence for this allegation was presented by two direct eye witnesses who it found credible and consistent. The panel found no reason to undermine their account of the incident. The panel therefore found that this charge is proved.

**Charge 7**

> "On one or more unknown dates you failed to consider and/or follow the recommendations of your physiotherapy colleagues"

**This charge is found proved.**

The panel considered the witness evidence of Witness 1, Witness 7, Witness 8, and Witness 9. The panel noted the following from Witness 9's NMC witness statement:

'*As part of the patient's care plans, multi professional staff are required to work collaboratively to deliver patient care which includes implementing therapy care plans. There is not a specific policy in place for this as multi-disciplinary working is integral to delivering patient care. The nursing staff, including the Registrant, would have known this as the NMC Code clearly states nurses must work in partnership with people to deliver care effectively.'*

The panel considered the following from Witness 7's NMC witness statement:

'*During the summer of 2018 I became aware that some members of the nursing staff (including the Registrant) on Ward 7 were not implementing the recommendations of the therapy team*.'

The panel bore in mind that during sworn oral evidence, Witnesses 1, 7, 8 and 9 all consistently and independently reported that Miss Hyde did not follow the recommendations of Physiotherapy staff.

The panel again noted Miss Hyde's response to the suggestion that she did not follow the recommendations of the Physiotherapists in the Disciplinary Hearing Notes Exhibited by Witness 11, was as follows: it was a '*lie because there is no advice that I've never taken on'.*

The panel considered the numerous sources of evidence, all of which described the same uncooperative attitude of Miss Hyde towards physiotherapists. The panel also considered Witness 9's statement and agreed that there is a duty under the NMC code of nurses to work cooperatively. Given the breadth of the evidence, and the lack of reason to undermine it, the panel found that Miss Hyde failed to work cooperatively with the Physiotherapists on the Ward. The panel therefore found this charge proved.

**Charge 8**

"On one or more unknown dates you did not engage effectively with the occupational therapy team and/or ensure that the therapy recommendations were implemented for patients on the ward"

**This charge is found proved.**

The panel noted the same part of Witness 9's statement as in charge 7. The panel also took into account the evidence of Witness 4, Witness 5, and Witness 6. The panel noted the following from Witness 4's NMC witness statement:

'*Against MH [manual handling] advice, nursing staff would hook patients up under the arms and take the weight of the patient. I knew this because the information reported back to the OTs from the Registrant was not reflected in their therapy assessments*.'

The panel bore in mind that during sworn oral evidence, Witness 4, Witness 5, Witness 6 and Witness 9 all consistently and independently reported that Miss Hyde did not follow the recommendations of Occupational Therapy staff.

The panel again noted Miss Hyde's response to the suggestion that she did not follow the recommendations of the Occupational Therapists in the Disciplinary Hearing Notes Exhibited by Witness 11, was as follows: it was a '*lie because there is no advice that I've never taken on'.*

The panel considered the numerous sources of evidence, all of which described the same uncooperative attitude of Miss Hyde towards Occupational therapists. The panel also considered Witness 9's statement and agreed that there is a duty of nurses to work cooperatively. Given the breadth of the evidence, and the lack of reason to undermine it, the panel found that Miss Hyde failed to work cooperatively with the Occupational Therapists on the Ward. The panel therefore found this charge proved.

**Charge 9a**

"On one or more occasions in your position as ward manager failed to ensure that staff on the ward provided appropriate care to patients in that: staff used inappropriate manual handling techniques with patients"

**This charge is found proved.**

In considering its finding on this charge, the panel considered witness evidence of Witness 1, Witness 2, Witness 4, and Witness 5. The panel bore in mind the following part from Witness 4's NMC witness statement:

'*I knew that if a patient had mobilised that an inappropriate MH* [manual handling] *technique would have been carried out by the nursing staff.*

*…*

*As WM* [Ward Manager] *the Registrant was responsible for ensuring that both she and the team used the correct MH techniques, and that all staff training was kept up to date, Part of her role would be to ensure that staff appraisals are undertaken for the ward team. I would expect this to form part of her job description however I cannot be certain. The appraisal template includes a section on ensuring that mandatory training is completed and is up to date. I know this through my experience in a managerial role as a Team Leader.'*

The panel also noted the Job Description of Miss Hyde's role, exhibited as part of Witness 6's Hospital Formal Investigation Interview Notes dated 30 August 2019. This states that Miss Hyde was responsible:

'*To manage a team of registered nurses, midwives or health visitors and to provide a 24 hour continuing responsibility for a ward or similar sphere of care*.'

The panel also noted its findings at charge 7 and 8.

The panel considered whether there was a duty to ensure that staff on the ward provide appropriate care to patients. In this, the panel considered the job description, and the standard responsibilities of a nurse in a senior position. It concluded that it is a duty of a ward manager to have oversight of the ward's delivery of care and the maintenance of proper standards, including using appropriate manual handling techniques.

The panel next considered whether Miss Hyde failed in this duty. The panel considered the numerous incidents of poor manual handling of which it had evidence, and the agreement of the four witnesses which stated that there was a failure on Miss Hyde's behalf. Given the consistent evidence to suggest that inappropriate manual handling techniques were used with patients which impacted their care, and on the basis that Miss Hyde had a duty to ensure that staff on the ward provided appropriate manual handling techniques in their care of patients, the panel found that it is more likely than not that Miss Hyde failed in her duty.

The panel therefore concluded that, on the balance of probabilities, this charge is proved.

**Charge 9b**

> "*On one or more occasions in your position as ward manager failed to ensure that staff on the ward provided appropriate care to patients in that staff did not provide adequate pressure care to patients*"

**This charge is found proved.**

The panel considered the witness evidence of Witness 2 and Witness 14. The panel noted the following from the NMC witness statement of Witness 2:

> '*On numerous occasions when assisting the Health Care Assistants, we would roll a patient to check their pressure areas but the patient would be rolled for 10 -15 seconds at most and only their sacrum would be inspected. The patient would then be rolled back to the same position and that would be as far as the skin inspection*

*would go. The healthcare staff would then complete the skin bundle document inaccurately to say that all pressure areas had been checked when they had not been*.'

The panel noted the following from the witness statement of Witness 14:

*'As a result of the retrospective reviews DH had concerns about the number of Grade 2 pressure sores on the Ward. She was concerned that although staff had undertaken training pressure area management, it was not being put into practice. There was also a problem with staff not being aware of the available equipment'*

The panel also noted the Prevention and Treatment of Pressure Ulcer Policy exhibited by Witness 14.

The panel again concluded that owing to the seniority of her position as Ward manager, and given her job description, Miss Hyde did have a duty to oversee the Ward's delivery of care and the maintenance of proper standards, including appropriate pressure area care.

The panel had sufficient evidence to conclude that there was a failure to ensure that training was properly implemented in practice.

Given the consistent evidence to suggest that inappropriate pressure care was used with patients which impacted their care, and on the basis that Miss Hyde had a duty to ensure that staff on the ward provided appropriate pressure care in their care of patients, the panel found that it is more likely than not that Miss Hyde failed to ensure that staff on the Ward provided adequate pressure care to patients.

The panel therefore found that this charge is proved.

**Charge 9c**

"On one or more occasions in your position as ward manager failed to ensure that staff on the ward provided appropriate care to patients in that staff did not provide adequate incontinence care to patients"

**This charge is found not proved.**

The panel considered the witness evidence of Witness 2. The panel also considered the duties and responsibilities of management exhibited as part of Witness 9's Hospital Formal Investigation Interview Notes dated 27 August 2019.

The panel concluded that Miss Hyde did have a duty to ensure that staff provide adequate incontinence care to patients, as this was part of her responsibilities in her senior role. However, the panel bore in mind that the evidence relied on related to a single occasion and came from the evidence from a sole witness, Witness 2. The panel bore in mind the lack of corroboration of this incident and also the clinical disagreement between Witness 2 and a third party, namely, a Healthcare Assistant (HCA) as to the provisions of adequate incontinence care on that occasion. It therefore did not find, on the balance of probabilities, that there was a problem with the provision of incontinence care for which Miss Hyde had management responsibility.

The panel therefore found that the NMC had not discharged its burden of proof in showing the correct standard, and that this standard had not been reached. It found that this charge is not proved.

**Charge 9d**

"On one or more occasions in your position as ward manager failed to ensure that staff on the ward provided appropriate care to patients in that staff did not provide appropriate care for a patient with lymphedema"

**This charge is found not proved.**

The panel considered the witness evidence of Witness 2. The panel also considered the duties and responsibilities of management exhibited as part of Witness 9's Hospital Formal Investigation Interview Notes dated 27 August 2019.

The panel concluded that Miss Hyde did have a duty to ensure that staff provide adequate lymphedema care to patients, as this was part of her responsibilities in her senior role. However, the panel bore in mind that the evidence relied on related to a single occasion and came from the evidence from a sole witness, Witness 2. The panel bore in mind the lack of corroboration of this incident and also the clinical disagreement between Witness 2 and two third parties, namely, a nurse and an HCA as to the provisions of adequate lymphedema care on that occasion. It therefore did not find, on the balance of probabilities, that there was a problem with the provision of lymphedema care for which Miss Hyde had management responsibility.

The panel therefore found that the NMC had not discharged its burden of proof in showing the correct standard, and that this standard had not been reached. It found that this charge is not proved.

**Charge 10a**

> "That you, a registered nurse, whilst employed as a nurse at the Ty Nant Care Home, on 24 June 2023 you inappropriately handled and/or restrained Resident B"

**This charge is found proved.**

The panel considered the CCTV footage exhibited by Witness 10, and the witness evidence of Witness 10 and 13. The panel noted the following part of the NMC Witness Statement of Witness 13:

> *'Tracey got up to escort the resident into the lounge area. The CCTV shows the*

*resident did not want to go into the lounge area. It appears that Tracey is leading the resident into somewhere she doesn't want to go. Tracey has a hold of the resident's T-shirt and appears to be pushing the resident into the lounge where she doesn't want to go. To prevent this situation Tracey should have spoken to the resident in the dining room or asked another staff member to attention to the resident rather than taking the resident's hand and leading her out of the dining room. The CCTV shows Tracey seems to be forcing the resident to go into the lounge by the way she is holding onto the resident's t-shirt. Tracey is holding the resident's wrist and appears to have the other hand on the resident's back while leading the resident towards the door. After the scuffle at the door of the lounge, you can see Lynette attend. When Tracey realised the resident didn't want to go into the lounge, she had the opportunity to bring her back to the dining area and ask another member of staff to keep an eye on the resident. There were other staff members around at the time that could have helped to distract the resident while the handover was taking place' (sic)*

The panel noted that in her oral evidence, Witness 13 provided a clear account of what happened, why the actions taken by the registrant were inappropriate, what the risks were, and why they did not align with the Safeguarding policy and dementia policy, Moving and Handling policy and procedure, Restrictive Practices Including restraint and physical Interventions policy and procedure, which she exhibited. The panel noted that this view was corroborated by Witness 10.

The panel concluded from the footage it saw and the evidence it had that the actions taken and the techniques used by Miss Hyde on the Patient were inappropriate and presented a real risk of harm to the patient.

The panel therefore found that this charge is proved.

**Charge 10b**

"Did not complete an incident form following the incident with Resident B"

**This charge is found proved.**

The panel noted the witness evidence of Witness 13. The panel noted the following part of her Witness statement:

> *'An incident report wasn't completed for the incident. It was Tracey's responsibility to complete the incident report. We have a system called Qura which has everything to do with the resident in the system. Incident reports are filled in through that system for any resident who has been involved in an incident. The form is not exclusive to nurses, it can be filled in by anyone who has an interaction with a resident. It's down to the person who witnesses the incident to fill in the form. In this incident, it was Tracey's responsibility to fill in the incident form.'*

The panel also had regard to the Accident and Incident reporting policy and procedure exhibited by Witness 13, which states:

> *'Any manual handling injury or incident that occurs at work must be recorded and reported as soon as possible'*

The panel noted that failing to complete an incident form is against the policy. The panel agreed with Witness 13, and concluded it was Miss Hyde's responsibility to fill in a form as it is the responsibility of those who witness the incident to fill in the form. The panel deemed Witness 13 to be a consistent and credible witness, and it saw no reason to undermine her evidence.

The panel therefore found that Miss Hyde failed to fill in the incident report form. The panel concluded that this charge is proved.

This case concluded at this stage part-heard on Friday 16 March 2025, and resumed on Wednesday 23 July 2025.

**Decision and reasons on service of Notice of Hearing**

At the beginning of the resuming hearing, the panel was informed that Miss Hyde was not in attendance and that the Notice of Hearing letter had been sent to Miss Hyde's registered email address by secure email on 7 July 2025.

Ms Simpeh, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rule 32(3) 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 was given in writing within a reasonable period before the hearing and provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join. In the light of all of the information available, the panel was satisfied that Miss Hyde has been served with the Notice of Hearing in accordance with the requirements of rule 32(3).

**Decision and reasons on proceeding in the absence of Miss Hyde**

The panel next considered whether it should proceed in the absence of Miss Hyde. It had regard to rule 21 and the NMC guidance reference CMT-8 and heard the submissions of Ms Simpeh who invited the panel to continue in the absence of Miss Hyde. She submitted that Miss Hyde had voluntarily absented herself. She referred the panel to further communication from the NMC to Miss Hyde to which there was no response.

Ms Simpeh submitted that there had been no engagement at all by Miss Hyde with the NMC in relation to these proceedings and, as a consequence, there was no reason to

believe that an adjournment would secure her attendance on some future occasion. She further submitted that given the charges found proved, and the potential risk of harm to the public as a result, there was a strong public interest in the expeditious disposal of this case.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Miss Hyde;
- Miss Hyde has not engaged with the NMC and has not responded to any of the emails sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- The panel concluded that Miss Hyde voluntarily absented herself;
- There is a strong public interest in the expeditious disposal of the case, given that the hearing is resuming after finding numerous charges proved.

There is disadvantage to Miss Hyde in proceeding in her absence as 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, the panel is satisfied that the disadvantages in proceeding in her absence can be mitigated in part by the

panel, of its own volition, exploring any inconsistencies in the evidence and by drawing on Miss Hyde's viewpoints as documented at the time of the local disciplinary hearing.

In these circumstances, the panel decided that it is fair to proceed in the absence of Miss Hyde.

**Fitness to practise**

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Miss Hyde'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 Simpeh referred the panel to the case of *Nandi v GMC* [2004] EWHC 2317 (Admin) and submitted that whether the conduct is serious enough to amount to misconduct is a question for the skilled judgement of a panel. She invited the panel to find that Miss Hyde's conduct was sufficient to amount to misconduct.

Ms Simpeh submitted that the panel should have regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision. She identified the specific, relevant standards where Miss Hyde's actions amounted to misconduct. She invited the panel to find that Miss Hyde's conduct as found proved in the charges breached parts 1, 8, 9, 13, and 20 of the Code, and fell far short of the standards expected of fellow practitioners.

Ms Simpeh referred the panel to specific findings of the panel. She submitted that Miss Hyde failed to work cooperatively with colleagues; that Miss Hyde failed to treat people with kindness and compassion; that on a number of occasions, particularly in relation to occupational therapists and physiotherapists, Miss Hyde did not work with colleagues to preserve the safety of those receiving care, nor to deal with differences of professional opinion with colleagues by discussion and informed debates, respecting their views and opinions and behaviour.

Ms Simpeh referred the panel to the NMC Fitness to Practise guidance on misconduct, reference FTP-2A, which, provides a number of behaviours which are more likely to suggest a risk of harm to the public and impaired fitness to practise, regardless of where it takes place. She submitted it outlines that discrimination, bullying, harassment and victimisation are some of those behaviours, and such conduct has been found proved in this case.

In addition, Ms Simpeh submitted that Miss Hyde failed to ensure, as Ward Manager, that staff provided adequate and appropriate care to patients. Specifically, she stated that there was consistent evidence of inappropriate pressure care used with patients which impacted their care.

Ms Simpeh invited the panel to have regard to the breaches of the code in relation to these charges, the fact that Miss Hyde's actions placed patients at risk and had a detrimental impact on colleagues. In her submission, Miss Hyde's conduct fell far below that which is expected of registered nurses and would be regarded as deplorable by fellow practitioners.

**Submissions on impairment**

Ms Simpeh moved onto 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin)*, Fopma v General Medical Council* [2018] EWHC 714 (Admin), and the NMC guidance on impairment, reference DMA-1.

Ms Simpeh submitted that there was repeated misconduct in that the incidents occurred over a period of time. They were not isolated and there was a repetition of her conduct, particularly in relation to manual handling. She further submitted that as Ward Manager, Miss Hyde failed to ensure staff were properly trained to deliver care to patients, and failed to follow appropriate policies, despite having been made aware of issues related to pressure sores.

Ms Simpeh submitted that Miss Hyde's conduct towards colleagues also placed patients at risk of harm because of the resulting effect of her actions. She referred the panel to evidence it heard, particularly from Witness 7 of the way in which colleagues had changed

their behaviour and delayed patient care. She submitted that as a result of this conduct, there was a serious and real risk of harm to patients.

Ms Simpeh submitted that there has been no evidence of insight, steps taken to remediate her conduct, engagement with the proceedings or of strengthening of practice. She submitted that there is a risk of repetition and a consequent risk of further harm to the public. She therefore submitted that Miss Hyde's fitness to practise should be found impaired on the grounds of public protection.

Ms Simpeh also invited the panel to find that Miss Hyde's fitness to practise is impaired on the ground of public interest. She referred the panel to the nature and seriousness of the facts found proved. She invited the panel to consider the evidence it heard that Ms Hyde's conduct was such that student nurses would specifically ask not to be put on this ward because of the reputation it had garnered as a result of her behaviour.

Ms Simpeh submitted that, as stated in the case of *Fopma v GMC*, if the panel were not to find impairment, it would be tantamount to an indication on behalf of the profession, that conduct of the kind need not have regulatory consequences. She submitted that in those circumstances and having regard to those concerns, a reasonable person and being aware of all these matters, would be shocked to find that there had been no finding of impairment. She therefore invited the panel to find Miss Hyde's fitness to practise impaired on the ground of public interest.

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

**Decision and reasons on misconduct**

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

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

> ***'1 Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> ***1.1** treat people with kindness, respect and compassion*
>
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***1.3** avoid making assumptions and recognise diversity and individual choice*
>
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***…***
>
> ***8 Work cooperatively***
>
> *To achieve this, you must:*
>
> ***8.1** respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
>
> ***8.2** maintain effective communication with colleagues*
>
> *…*
>
> ***8.4** 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***

*To achieve this, you must:*

*…*

***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*

***9.4** support students' and colleagues' learning to help them develop their professional competence and confidence*

***13 Recognise and work within the limits of your competence***

*To achieve this, you must, as appropriate:*

*…*

***13.2** make a timely referral to another practitioner when any action, care or treatment is required*

***20 Uphold the reputation of your profession at all times***

*To achieve this, you must:*

***20.1** keep to and uphold the standards and values set out in the Code*

***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]*

*…*

***20.10*** *use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel noted that the case law states that to amount to misconduct, the conduct must be sufficiently serious, and must be considered deplorable by the standards of nursing practitioners. The panel considered each of the charges and whether they amounted to misconduct and made the following findings.

The panel considered charge 1 in its totality. The panel bore in mind part 1 of the code which requires registrants to ensure that the rights and dignity of patients are upheld. In this instance, although the conduct occurred at a single point in time, the panel was of the view that depriving a vulnerable patient of their dignity in the manner found proved fell far short of the standard required of a nursing professional. The panel noted that handling a patient inappropriately, without their consent, and speaking to a patient in a raised voice would have caused distress, and was seriously unprofessional and inappropriate. The panel found that the conduct in this charge amounted to misconduct.

The panel considered charge 2. The panel considered the multiple instances of the manner in which Miss Hyde communicated with patients, and concluded that the words used by Miss Hyde were derogatory and unprofessional. It was of the view that, the regularity of this conduct, directed at numerous patients on various occasions, demonstrated that this manner of speaking to or about service users was habitual. The panel was of the view that regularly using such language in the workplace would be seen as deplorable by fellow practitioners, and was seriously below the standard required.

Given the repetition of this conduct over time, and the fact that these instances were corroborated by multiple witnesses, the panel found that this conduct amounted to misconduct and to be a breach of parts 1.1 and 1.3 of the code.

The panel next considered charge 3. The panel was of the view that the conduct found proved at charge three demonstrated inappropriate behaviour towards colleagues, and amounted to a breach of the code. Specifically, the panel found that it breached parts 8.1, 8.2 and 8.5, which relate to working cooperatively, and 20.2, 20.3, 20.5, 20.8 and 20.10, which relate to upholding the reputation of the profession at all times.

The panel noted that a ward manager holds a position of leadership, and is required to be a role model. The conduct found proved at this charge, namely shouting at colleagues, and on one occasion calling them ‘useless’, fell far below the expectation of a responsible and professional leader in Miss Hyde’s position. The panel considered that the charge related to multiple instances of unprofessional behaviour towards a number of colleagues. Given the range of the conduct and the unacceptable language used, the panel found that the conduct at charge 3 was sufficiently serious to amount to misconduct.

The panel next considered the conduct at charge 4. The panel determined that the discrimination in relation to charge 2c and 3d was serious. The panel was of the view that there were two incidents of discriminatory remarks which were made in conversations with colleagues with one remark directed towards a patient and the other towards another colleague. The panel found that such remarks were seriously unprofessional, particularly coming from someone in a position of leadership and influence. Considering the Code, the panel determined that such actions as proved in this charge were a breach of part 20.2. Therefore, given the conduct occurred on more than one occasion and given the nature of the remarks, the conduct at charge 4 fell far short of the expectations of a nurse in Miss Hyde’s position and amounted to misconduct.

The panel next considered the findings at charge 5. The panel noted that the facts found proved in this particular charge referred to a single event during which there was a

disagreement about the mentoring arrangement with a colleague. While not good practice, the panel found that the words used and the conduct generally at this charge were not sufficiently serious to amount to misconduct.

The panel next considered charge 6. The panel was of the view that such deliberate physical contact with a colleague, which caused her to stumble, was seriously unprofessional. The panel was of the view that this conduct breached part 9.3 and part 20 of the code. It considered it unacceptable and far below the standard expected to grab and push a colleague under any circumstances. The panel therefore found that the actions at this charge amounted to misconduct.

The panel next considered charge 7 and 8 together. These charges relate to Miss Hyde failing to follow the recommendations of physiotherapy colleagues and also the failure to engage effectively with occupational therapy colleagues to ensure that their recommendations were implemented for patients on the Ward. With regard to these charges, Miss Hyde did not work cooperatively to deliver patient care that is safe and effective. It heard evidence from multiple witnesses from both the physiotherapy team and the occupational therapy team, all of whom were consistent in their view that Miss Hyde had a continuous disregard of their views. The NMC code at part 8.1 requires nurses to respect the skills, expertise and contributions of colleague, and at 9.3 requires nurses to deal with differences of professional opinion with colleagues by discussion and informed debate. The panel was of the view that Miss Hyde breached these parts of the code, and that such a failure can seriously undermine the care of patients. Given that these breaches occurred on multiple occasions and affected multiple colleagues, it found that the conduct at these charges was sufficiently serious to amount to misconduct.

The panel next considered its findings at charge 9, and began with charge 9a. It noted the policy on manual handling. The panel was of the view that while there was an expectation on a senior nurse in a leadership position to ensure that the appropriate techniques were used on the ward, not all failures of staff to follow the policy would amount to misconduct on the part of the Ward Manager. However, the panel considered the numerous instances

of poor manual handling as indicated by numerous witnesses, the breadth of the reports, and the consequences on patient care. The panel was of the view that these repeated failures on the ward were sufficient to demonstrate Ms Hyde's serious failure in her responsibility to ensure that appropriate care was given, and was far below the standard expected of a nurse in her position. The panel therefore concluded that the failure to ensure proper manual handling at charge 9a did amount to misconduct.

The panel considered whether Miss Hyde's failure to ensure proper pressure care at 9b was sufficient to amount to misconduct. The panel noted that the report into the care given at the Ward made by Witness 14 did not ascribe any blame for this onto Miss Hyde. While the panel acknowledged that this report was submitted as hearsay evidence, and the evidence of Witness 14 was not tested, the panel was of the view that there was insufficient evidence to show that the failures by Miss Hyde would be seen as deplorable by fellow practitioners.

The panel finally considered Miss Hyde's conduct at charge 10. The panel was of the view that the handling techniques Miss Hyde used were inappropriate, and did not align with the policy. However, given that this was a single incident, and the force used was not sufficiently serious to be considered deplorable by fellow practitioners, did not consider that the conduct at charge 10a amounted to misconduct. The panel also considered that an isolated incident of a record keeping failure as charged in 10b, while poor practice, was not so far below the standard expected of a nurse to amount to misconduct.

Having reviewed all the charges individually, the panel concluded that Miss Hyde's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

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

In coming to its decision, the panel had regard to the Fitness to Practise Library guidance titled ‘Impairment’, reference DMA-1, updated on 3 March 2025, which states:

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

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

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

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

*'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*

*a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

*b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

*c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

*d) …*

At the previous stage, the panel found that Miss Hyde lacked collaborative working, allowed manual handling which could have put patients at risk of harm, and didn't treat people receiving care with respect kindness and compassion. The panel also found that certain comments made by Miss Hyde were also discriminatory and derogatory. Miss Hyde did not respect the skill and expertise of colleagues and didn't deal with differences of professional opinion in an appropriate manner by failing to engage in discussion. The panel bore in mind the expectation on Miss Hyde, as a senior nurse and leader, to set a good example, which she failed to do.

The panel therefore was of the view that patients were put at an unwarranted risk of harm as a result of Miss Hyde's actions. The panel considers such misconduct to be serious, breaching the fundamental tenets of the nursing profession and therefore bringing its reputation into disrepute.

The panel, having considered whether Miss Hyde 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 whether Miss Hyde has in the past brought and/or is liable in the future to bring the medical profession into disrepute; the panel proceeded to consider the context of the concern.

Regarding insight, the panel considered that Miss Hyde has provided no evidence of insight, or reflection into the conduct. The panel has seen no evidence of strengthening of practice submitted in response to the NMC proceedings. The panel noted that the RCN, while still Miss Hyde's representative, had provided evidence of training dated 28 July 2020. However, the panel concluded that this training was not relevant to the current concerns as the training is out of date and the provenance of the documents is unknown in any case. As such, the panel did not consider this evidence to show up to date remediation. The panel also had no evidence of a record of safe practice since the charges found proved.

The panel acknowledged the numerous positive character and professional references provided by the RCN between September 2019 and July 2020. However, as these were now out of date, it was not satisfied that these testimonials demonstrated a mitigation in the risk of harm to the public, or sufficiently address the underlying concerns about Miss Hyde's practice.

[PRIVATE]

The panel also bore in mind the overall context of the working environment where Miss Hyde's behaviour had been accepted and gone unchallenged over a long period with any concerns raised being dismissed by management. The panel acknowledged the loyalty engendered by Miss Hyde among some subordinate staff in her team and also the respect for her clinical practice as shown by testimonials from a cross-section of hospital staff.

Nevertheless, the panel considered the timespan of the charges found proved, and noted that Miss Hyde's conduct did not occur as an isolated incident, but was spread over a long

period of time. Having in view the seriousness of the charges and the length of time over which they occurred, much remediation would be needed to demonstrate fitness to practise, and nothing of this kind has been provided. Furthermore, the charges found proved with regards to discriminatory conduct are indicative of attitudinal issues which are more difficult to address. The panel is therefore of the view that there is a risk of repetition, and a consequent risk of harm based on the lack of any evidence of insight, remediation and/or strengthening of practice, and the absence of any engagement with these proceedings. The panel therefore decided that a finding of impairment is necessary for the protection of the public.

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 needed to uphold proper professional standards and conduct and to maintain public confidence in the profession. It bore in mind the nature and seriousness of the charges, the fact that they occurred over a prolonged period of time and have not been remediated in any appropriate way. The panel considered the discriminatory behaviour and derogatory language which would be particularly shocking to the public. The panel was of the view that the reputation of the nursing profession would be seriously damaged, and public confidence in the profession would be seriously undermined if a finding of impairment were not made in this case.

The panel therefore found Miss Hyde’s fitness to practise impaired on the grounds of public interest.

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

**Sanction**

The panel considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Hyde off the register. The effect of this order is that the NMC register will show that Miss Hyde 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 Simpeh informed the panel that the NMC was seeking the imposition of a striking-off order.

Ms Simpeh referred the panel to NMC guidance reference SAN-1, SAN-2 and SAN-3. She submitted that there were a number of aggravating features. These included in her submission, several significant breaches of the code, and that Miss Hyde demonstrated a pattern of repeated conduct which impacted on patients and colleagues. She submitted that Miss Hyde failed to ensure that staff and herself followed manual handling policies, and her conduct caused reputational damage for the ward. She submitted that her discriminatory language makes this case particularly serious in accordance with NMC Guidance reference SAN-2. Ms Simpeh submitted that Miss Hyde has demonstrated no insight and has taken no steps since 2020 to strengthen her practice. She invited the panel to take into account that [PRIVATE] and her many positive character references may be mitigating factors.

Ms Simpeh invited the panel to consider the sanctions in turn, from the least to most serious. Given the nature and seriousness of the case, in her submission, an order which did not restrict Miss Hyde’s practice was not appropriate in these circumstances. She

further submitted that, as a result of the lack of engagement and the attitudinal concerns, a conditions of practice order would not sufficiently address the concerns.

Regarding the imposition of a suspension order, Ms Simpeh referred the panel to sanctions guidance reference SAN-3d. She submitted that a suspension would not be appropriate in this case, as there were numerous incidents of misconduct, and there was evidence of deep-seated attitudinal problems; she stated that Miss Hyde sought to minimise and excuse her conduct and, did not address her discriminatory and derogatory comments. She submitted therefore that the only appropriate sanction was a striking-off order. It was her submission that public confidence could not be maintained, and that public safety could not be protected should Miss Hyde remain on the register, and that her misconduct was fundamentally incompatible with being a registered nurse.

**Decision and reasons on sanction**

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

The panel took into account the following aggravating features:

- Failings whilst holding a position of seniority
- Lack of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put people receiving care at risk of suffering harm, directly and indirectly, including particularly vulnerable patients
- Discriminatory behaviour
- Conduct which led to reputational damage for the Ward

The panel also took into account the following mitigating features:

- A number of positive professional and character references which the panel noted were from five years ago and as such carried limited weight
- [PRIVATE]
- Indications of some workplace pressures around staffing, equipment and the nature of the workload

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

The panel next considered whether placing conditions of practice on Miss Hyde's registration would be a sufficient and appropriate response. The panel noted the following factors: the serious nature of the charges found proved in this case; Miss Hyde's history of a lack of engagement with the regulatory process; and its lack of knowledge of Miss Hyde's current employment status. The panel had no evidence before it to satisfy itself of Ms Hyde's willingness and/or ability to engage with any conditions imposed. The panel had no evidence before it to show that Miss Hyde had remediated any of the behaviours found proved. The panel had no evidence that she had properly addressed her derogatory

and unprofessional remarks to and about colleagues and patients nor was there any indication that Miss Hyde had addressed the attitudinal issues relating to her discriminatory behaviour. Therefore the panel found an absence of any mitigation of risk to the public. The panel was of the view that there are no practical or workable conditions that could be formulated which would adequately address the seriousness of this case and would not protect the public or the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*

The panel found multiple incidents of misconduct, relating to a range of patients and colleagues and spanning over a prolonged period of time.

- *No evidence of harmful deep-seated personality or attitudinal problems;*

The panel found that the numerous derogatory and discriminatory comments were indicative of deep-seated personality and attitudinal problems and that on various occasions Miss Hyde sought to minimise their significance.

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

The panel saw no evidence of current insight, remorse and strengthening of practice which would demonstrate that Miss Hyde does not pose a significant risk of repeating her behaviour.

The misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that there were fundamental questions raised about Miss Hyde's professionalism. The panel noted in particular the multiple and wide-ranging instances of derogatory language and discriminatory remarks, the harm caused to Patient A's dignity and the habitual poor treatment of colleagues and patients.

The panel was of the view that given the scope and seriousness of the charges found proved, the lack of engagement and the NMC's guidance on the effect of that on sanction in relation to cases involving discrimination, or evidence of a willingness to remediate. Miss Hyde's actions are fundamentally incompatible with her remaining on the register. It determined that to allow her to continue practising would seriously undermine public confidence in the profession and in the NMC as a regulatory body, and is the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Miss Hyde'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 a striking-off order would be sufficient in this case.

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

This will be confirmed to Miss Hyde in writing.

**Interim order**

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

**Submissions on interim order**

The panel took account of the submissions made by Ms Simpeh who referred the panel to the NMC guidance reference SAN-5 and INT-4. She submitted that, given the seriousness of the charges found proved which led to the imposition of a striking off order, an interim suspension order is necessary to protect the public and the public interest during the appeal period. She submitted that 18 months is an appropriate length of order to cover this time.

The panel accepted the advice of the legal assessor.

**Decision and reasons on interim order**

The panel was satisfied that an interim order is necessary to protect the public and to maintain public confidence in the profession and the NMC as a regulator. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision 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 a substantive striking-off order.

The panel therefore imposed an interim suspension order for a period of 18 months. The panel considered its finding of a serious risk of harm to patients and the public, and that Miss Hyde's conduct was fundamentally incompatible with remaining on the register. The panel determined that, given its decision to impose a striking-off order, it is necessary to address the public interest and public protection issues identified in the panel's determination.

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

That concludes this determination.