Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 23 June 2025 – Thursday 26 June 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	Karen Margaret Nutbeam
NMC PIN:	81J2319E
Part(s) of the register:	Nurses part of the register Sub part 1 RN1, Registered Nurse - Adult (Level 2) (25 August 1994) Nurses part of the register Sub part 2 RN2, Registered Nurse - Adult (02 February 1984)
Relevant Location:	Surrey
Type of case:	Misconduct
Panel members:	Peter Fish (Chair, lay member) Margaret Stoddart (Lay member) Kate Jones (Registrant member)
Legal Assessor:	Monica Daley
Hearings Coordinator:	Bartek Cichowlas
Nursing and Midwifery Council:	Represented by Simran Ghotra, Case Presenter
Mrs Nutbeam:	Not present and unrepresented
Facts proved:	Charges 1a
Facts not proved:	Charges 1b and 2
Fitness to practise:	Impaired

Sanction:	**Conditions of practice order (12 Months)**
Interim order:	**Interim conditions of practice order (18 Months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Nutbeam was not in attendance and that the Notice of Hearing letter had been sent to Mrs Nutbeam's registered email address by secure email on 23 May 2025.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mrs Nutbeam

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

Ms Ghotra submitted that there had been no engagement with the NMC by Mrs Nutbeam since 2023 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.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mrs Nutbeam;
- Mrs Nutbeam has not engaged with the NMC for over 2 years and has not responded to any of the letters sent to her about this hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Three witnesses are due 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 2021
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events, and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Nutbeam in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the

evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Nutbeam's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge

That you, a registered nurse:

1. On 24 May 2021, failed to treat a resident in your care with dignity or respect in that you;
   a) shouted at Resident A
   b) pushed Resident A

2. By way of your actions at charge 1, demonstrated abusive behaviour toward a resident in your care.

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

Decision and reasons on application to admit written statement of Witness 1

The panel heard an application made by Ms Ghotra under Rule 31 to allow a further written statement from Witness 1 into evidence. This statement was signed on 10 June

2025 and therefore was served on Mrs Nutbeam after the 28-day notice period of hearing. Ms Ghotra submitted that this was a supplementary statement to the one already in evidence. The statement exhibited a copy of a resident's care plan, which Mrs Nutbeam had already seen. She submitted that the care plan is relevant to the Resident who is mentioned in the charges.

Ms Ghotra also submitted that as Mrs Nutbeam had already received the care plan, there was no lack of fairness to Mrs Nutbeam in allowing Witness 1's written statement into evidence.

The panel considered that the test to be applied was whether the evidence was relevant and whether given the late service, it was fair to admit the statement into evidence. Witness 1's statement exhibited evidence which had already been seen by Mrs Nutbeam before the 28-day period therefore there was no prejudice to her. The panel also considered that the evidence was relevant to the charges before it. It provided information about the health and capacity of Resident A which would be of assistance in considering the context of the actions of Mrs Nutbeam which are the subject of the charges.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the supplementary written statement of Witness 1.

Background

The charges arose whilst Mrs Nutbeam was employed as a registered nurse by Royal Alfred Seafarers Society ('the Society'). The Society referred Mrs Nutbeam to the NMC on 17 February 2022. A probationary review meeting was held on 8 June 2021 at which this incident was discussed.

On 24 May 2021 it is alleged that Mrs Nutbeam shouted at and pushed Resident A who lived in a residential care home for people with Dementia. The incident occurred during a

shift where Mrs Nutbeam was working with two Care Assistants, one of whom directly witnessed the incident, and one of whom was within earshot.

During the course of discussions with her employers after the event occurred, Mrs Nutbeam stated that as she was walking past the lounge, she heard somebody shouting for help and saw another resident, Resident B, slipping down in her chair. Mrs Nutbeam stated that at the time of the incident she was unable to do manual handling. She asked for help from the Care Assistants. It is alleged that during the course of these events, Mrs Nutbeam behaved inappropriately towards Resident A, as set out in the charges.

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 Ghotra on behalf of the NMC.

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

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: The Registered Home Manager of Belvedere House (“the Home”)
- Witness 2: Care Assistant at the Home
- Witness 3: Care Assistant at the Home

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

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

Charge 1a)

> "That you, a registered nurse, on 24 May 2021, failed to treat a resident in your care with dignity or respect in that you shouted at Resident A"

This charge is found proved.

In reaching this decision, the panel took into account Resident A's Care Plan exhibited by Witness 1, a recording of a conversation between Witness 1 and Mrs Nutbeam during which the allegation was put to her ('the recording'), the oral and written evidence of Witnesses 1, 2 and 3, the local statements of Witnesses 2 and 3 given as part of the Home's investigation into the allegations, and the note of the probation meeting which Mrs Nutbeam attended on 8 June 2021.

The panel firstly heard from Witness 1, who although not a direct witness to the matters set out in the charge, gave evidence of a telephone call which occurred with Mrs Nutbeam and provided details of Mrs Nutbeam's responses to the allegations. She also provided contextual evidence about Resident A and the running of the home. The panel accepted her evidence.

The panel heard evidence from Witness 2. The panel found that Witness 2 was credible in giving her evidence and was measured in her approach. It noted that there was some discrepancy between her local statement which was made shortly after the incident on 25 May 2021, and her statement given to the NMC which was given in May 2023. In her NMC

witness statement, she stated that Mrs Nutbeam shouted at Resident A on two occasions. Once in the corridor when they were on their way to the lounge, and again when Resident A was in the lounge.

In relation to the shouting in the corridor, Witness 2 states in her written statement to the NMC the following:

> '*I followed [Mrs Nutbeam] into the corridor and another resident called [Resident A] was in the corridor … [Mrs Nutbeam] then shouted at Resident A telling her to "go away go away"".*

The panel noted that there was some inconsistency with the contemporaneous account given in the local statement. That note states:

> '*[Mrs Nutbeam] told her to "sush" 3 or 4 times in a very loud and aggressive manor*' [sic]

The panel noted that this interaction in the corridor was not witnessed or overheard by Witness 3. It also noted that, in Mrs Nutbeam's accounts to her employer, she stated she could not remember this particular incident. However, she accepted that she may have been speaking in a loud voice due to Resident A's hearing impediment.

In the light of all of the evidence, the panel was not satisfied that the NMC had proved on the balance of probabilities that Mrs Nutbeam shouted at Resident A in the corridor.

In relation to the interaction in the lounge, Witness 2 states that Mrs Nutbeam:

> '*was now shouting, loud, very, very loud that anyone in the building could probably hear. She was very aggressive in her manner it was not very pleasant it was very loud and high temper. I could see the anger in her face. She was shouting "get out, get out shush" that to me is anger*.'

The panel noted that this account is consistent with the account which Witness 2 gave contemporaneously, which states:

> '[*Mrs Nutbeam] was shouting at the top of her voice and aggressively "there is a lady falling here, get out, get out" (she said the words "get out" many times) … [Mrs Nutbeam] was shouting very aggressively'*

This was also consistent with the oral evidence she gave at this hearing. When asked to explain how she formed the opinion that Mrs Nutbeam's manner was very aggressive, she was able to articulate very clearly what she recalls in these terms '*the pitch of voice, you could see in her body language, in her face she was very aggressive, very angry'*

The panel also accepted the evidence of Witness 3. Witness 3 was also able to recall the interaction, although she accepted that she had not directly observed what had occurred. She stated to the panel that hearing shouting from staff was '*very unusual'* so this stood out to her.

Witness 3, in the amendment to her witness statement, stated that she was on her way to the Sluice room when she heard the interaction. She stated in her Witness statement that she:

> '*did not see Karen saying "go away, go away" I heard it, I would describe it as being said in a raised voice, but I did not see her facial expression or exactly how it was said*.'

The panel noted that this was consistent with her oral evidence and her local statement given contemporaneously.

The panel noted the recording, in which Mrs Nutbeam first states that the resident had hearing problems and that she 'had to speak louder' to her as she cannot hear. However, she later stated that she could not recall more details.

The panel found that, on the balance of probabilities, Mrs Nutbeam did shout at Resident A in the lounge. The panel found the evidence of both Witness 2 and 3 to be credible and consistent. The panel noted that the registrant did not deny raising her voice. It also noted that Witness 3 heard Mrs Nutbeam's voice in the lounge from the corridor, which she stated was not '*usual, you could sometimes hear the residents but not the staff*'. The panel found in relation to the interaction in the lounge, it is more likely than not that Mrs Nutbeam shouted at Resident A.

The panel next considered whether this amounted to a failure to treat Patients with dignity and respect. The panel heard from Witness 1 who was the registered Home Manager. In her statement, she stated that she was really shocked by Mrs Nutbeam's response: '*I wanted to believe that a nurse would not do this'.* In her oral evidence, she told the panel about the nature of the Home, and the expectations of the staff when caring for patients with Dementia. The panel also noted that the NMC code, part 1, states that Registered nurses must '*treat people as individuals and uphold their dignity … treat people with kindness, respect and compassion*'. The panel concluded that treating patients with dignity and respect was a duty as a nurse.

The panel considered the care plan of Resident A, which states that she '*is hard of hearing, prefers to wear a hearing aid in her right ear only*'. The panel also considered the oral evidence of Witness 1 in which she stated that there was nevertheless '*no need to shout*' at this resident, which was an approach confirmed by Witnesses 2 and 3. Witness 1 explained that shouting would frighten and upset the resident and due to her dementia, Resident A would not understand why she was being shouted at.

The panel concluded that the circumstances of the resident's care, and the manner in which it found Mrs Nutbeam to address the resident on this occasion amounted to a failure

to treat the resident under her care with dignity and respect. The panel concluded that it was not necessary to shout at the patient at the time, and found it likely that Mrs Nutbeam got irritated with Resident A and lost her temper. The panel therefore found this charge is proved on the balance of probabilities.

Charge 1b)

> "That you, a registered nurse, on 24 May 2021, failed to treat a resident in your care with dignity or respect in that you pushed Resident A"

This charge is found not proved.

The panel considered the written and oral evidence of Witness 2, Witness 2's local interview notes, the recording, and the probation meeting notes of Mrs Nutbeam exhibited by Witness 1.

The panel considered the following extract from Witness 2 Witness statement:

> '*Resident A didn't leave so Karen put her hand on shoulder, I do not recall whether it was the right or the left and pushed Resident A out of the room. It was like she was guiding but was not a proper gentle lead. I don't think Karen pushed her to harm her more to move her out the way but the temper she was in could have tripped or fell or hurt herself*'

The panel noted that this was consistent with Witness 2's account in the oral evidence and in the contemporaneous local statement. The panel noted that in the probation meeting, Mrs Nutbeam states that she put her hand on the 'small of [Resident A's] back and moved her out of the way'.

The panel noted that there were no other witnesses to the events in the lounge.

The panel took ‘push’ in its ordinary meaning. The panel noted that there was no disagreement about whether there was some physical contact between Mrs Nutbeam and the resident.

The panel noted that there was some ambiguity in Witness 2’s description of the incident which she described as both ‘*pushing*’ or ‘*leading*’ Resident A. Mrs Nutbeam in her account stated that she placed her hand in the small of Resident A’s back and moved her out of the way.

The panel noted that Resident A was described to be unstable and as wearing shoes that were uneven by Witness 2. There was no evidence to suggest that Resident A became unbalanced as she was moved.

In light of the conflicting evidence, the panel could not be satisfied on the balance of probabilities that Mrs Nutbeam pushed Resident A.

The panel therefore found that this charge is not proved.

Charge 2

> “By way of your actions at charge 1, demonstrated abusive behaviour toward a resident in your care.”

This charge is found not proved.

In reaching this decision, the panel took into account its findings at charge 1.

The panel took the ordinary meaning of the word ‘abusive’ and was of the view that this meant more than unkind or unprofessional.

The panel noted that Mrs Nutbeam was working with vulnerable residents, and the charge

relates to a resident with dementia. The panel noted in its finding at charge 1a that Mrs Nutbeam acted unkindly and unprofessionally. However, whilst the panel accept that this was inappropriate, the panel was of the view that the conduct as found proved did not meet the threshold for it to amount to abuse by reference to the ordinary meaning of the word.

The panel therefore finds that this charge is not proved.

Fitness to practise

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Nutbeam'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 Ghotra invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Ghotra identified the specific, relevant standards where Mrs Nutbeam's actions amounted to misconduct, which she stated were terms 1 and 20. Ms Ghotra submitted that the panel found the conduct of Mrs Nutbeam as proved to be unkind and unprofessional. She submitted that the impact of the shouting, which breached these parts of the code, had a significant impact on a vulnerable resident. She submitted that such conduct as found proved was a clear example of misconduct, and brings the profession into disrepute.

Submissions on impairment

Ms Ghotra moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin)*,* and the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

She invited the panel to make a finding of impairment on both the ground of public protection and public interest. Regarding the ground of public protection, she submitted that the first three limbs of the test in Grant were engaged and invited the panel apply the test set out in Cohen. She submitted that Mrs Nutbeam acted in a way which put a resident at an unwarranted risk of harm, and led to actual psychological distress, as the resident was seen crying as a result of the shouting found proved.

Ms Ghotra submitted that the failure to treat a patient in care with dignity and respect was an egregious breach of the fundamental tenets of the nursing profession, and would lead to an erosion of trust of the public.

Ms Ghotra submitted that a finding of impairment is a forward thinking exercise, and referred the panel to the NMC guidance reference FTP-15C. She submitted that Mrs Nutbeam has not demonstrated an understanding of the seriousness of the issues or effects of her actions. She also submitted that there was evidence of underlying attitudinal issues. Given all of the above, she submitted that there remains a risk or repetition, and invited the panel to find that Mrs Nutbeam's practice is currently impaired on the ground of public interest.

Further, Ms Ghotra invited the panel to consider the nature of the conduct, and that not finding impairment in these circumstances would lead to undermining of the confidence of the public in the nursing profession. She invited the panel to find impairment also on the ground of public interest to uphold public confidence in the profession.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments including Cohen and Grant.

Decision and reasons on misconduct

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

The panel was of the view that Mrs Nutbeam's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Nutbeam'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*

…

2 Listen to people and respond to their preferences and concerns

***2.6** recognise when people are anxious or in distress and respond compassionately and politely*

…

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*

…

***20.3** 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'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that in this instance, the loss of temper that led to shouting at a vulnerable resident had an impact on both the resident, who was left in tears, and on other members of staff. This represented a serious departure from the standards expected of a nurse. The panel reflected on how both members of the public and members of the profession would have perceived such an incident, and concluded that the angry and aggressive nature of the conduct, particularly towards a vulnerable resident, fell below expectations of the standards of a registered nurse.

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

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. 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) *…*

The panel found that through shouting at a vulnerable resident, as the panel found proved, a resident was put at risk of unwarranted harm. Further, the panel had evidence that this resident was caused emotional harm as a result of Mrs Nutbeam's misconduct, as the Resident is said to have been distressed and crying following the incident. In addition, taking into account the breaches of the Code, the panel was of the view that Mrs Nutbeam's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case is of the type that could potentially be addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Nutbeam has taken steps to improve her practice.

The panel noted that Mrs Nutbeam had not engaged with the NMC since 2023, and saw no evidence of any remediation, or that she had gained any understanding of how her misconduct had impacted on the residents, particularly Resident A, and on other members of staff. The panel saw no evidence of any insight. Further, it had some evidence of attitudinal issues as detected from the recording which formed part of the local investigation.

The panel therefore is of the view that there is a risk of repetition. The panel considered NMC Guidance FTP-15C which states that the likelihood of the conduct being repeated in the future may be reduced where:

- '*The nurse, midwife or nursing associate has demonstrated sufficient insight and has taken appropriate steps to address any concerns arising from the allegations.*
- *The behaviour in question arose in unique circumstances. While this may not excuse the nurse, midwife or nursing associate's behaviour, this may suggest that the risk of repetition in the future is reduced.*
- *The nurse, midwife or nursing associate has an otherwise positive professional record, including an absence of any other concerns from past or current employers and of any previous action by us or another regulatory body.*
- *The nurse, midwife or nursing associate has engaged with us throughout our processes.*'

In the absence of any evidence to support any of the above points, nor of any evidence to suggest remediation or mitigation of the risk of repetition, the panel was not satisfied that the misconduct as proved was highly unlikely to reoccur. Given this, and the nature of the

misconduct, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required. Given the care home setting, in which there were vulnerable residents, and the nature of the misconduct found proved, public confidence in the profession would be undermined if a finding of impairment were not made in this case. Therefore, the panel also finds Mrs Nutbeam's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months The effect of this order is that Mrs Nutbeam's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.
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 Ghotra informed the panel that in the Notice of Hearing, dated 23 May 2025, the NMC had advised Mrs Nutbeam that it would seek the imposition of a suspension order for a period of 12 months if it found Mrs Nutbeam's fitness to practise currently impaired.

Ms Ghotra submitted that there were the following aggravating features: conduct which put people at risk of suffering harm; some emotional harm caused; and Mrs Nutbeam's lack of insight into the conduct.

Ms Ghotra submitted that an order which did not restrict Mrs Nutbeam's practice would not adequately address the public interest and public protection issues identified. She therefore submitted that taking no further action and a caution order would not be appropriate.

Regarding the imposition of a conditions of practice order, she submitted that there were no practical or workable conditions that could be put in place given the conduct which demonstrated attitudinal issues, the lack of remediation and the risk of repetition of these issues.

Ms Ghotra therefore submitted that a suspension order for a period of 12 months would be appropriate. She submitted that, although it is a single incident of misconduct, no lesser sanction would be sufficient to address the attitudinal issues and the risk of repetition. She submitted that for a striking off order to be appropriate, the misconduct must be fundamentally incompatible with nursing practice, and that in these circumstances, it would be disproportionate.

Decision and reasons on sanction

Having found Mrs Nutbeam'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:

- No evidence of insight and remediation
- Conduct which had the potential to put people at risk of suffering harm

The panel also took into account the following mitigating features:

- Single isolated incident
- [PRIVATE]

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the particulars 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. While the panel was of the view that a caution order may mark the public interest, it was not satisfied that it would adequately protect the public given the finding of a risk of repetition. The panel determined that, due to the public protection issues identified, an order that does not restrict Mrs Nutbeam's practice would not be appropriate in the circumstances.

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

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

- *No evidence of general incompetence;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it might be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that there was no evidence of whether or not Mrs Nutbeam would be willing to comply with conditions of practice. It noted that in her correspondence to the NMC, [PRIVATE], which may have impacted on her level of engagement. The panel also noted that immediately following the incident, there was some evidence of attitudinal problems. However, there was no evidence that this was sustained or deep seated.

The panel balanced this with the fact that this incident was a one-off incident and there was no evidence before the panel that Mrs Nutbeam had anything other than an unblemished career of a number of years during her practice as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, an experienced nurse should, where possible, be able to return to practice.

The panel next considered carefully whether it would be appropriate to make a suspension order. It noted its findings on the nature of the misconduct and the circumstances in which it arose and determined that, it would be disproportionate to impose a suspension order. The panel had regard of the need to balance the public interest with the interests of the registrant. It concluded that there were conditions of practice that it felt could adequately address the misconduct found proved.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession,

and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> ‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.
>
> 1. You must keep us informed about anywhere you are working by:
>   a) Telling your case officer within seven days of accepting or leaving any employment.
>   b) Giving your case officer your employer’s contact details.
>
> 2. You must immediately give a copy of these conditions to:
>   a) Any organisation or person you work for.
>   b) Any agency you apply to or are registered with for work.
>   c) Any employers you apply to for work (at the time of application).
>   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
>
> 3. You must tell your case officer, within seven days of your becoming aware of:
>   a) Any clinical incident you are involved in.
>   b) Any investigation started against you.

c) Any disciplinary proceedings taken against you.

4. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

5. You must ensure that you are supervised at any time you are working. Your supervision must consist of:
   a) Working at all times on the same shift as, but not always directly observed by, another registered nurse

6. You must meet with a senior registered nurse on a monthly basis who will act as your mentor.

7. You must keep a reflective practice profile. The profile will:
   a) Detail every case where you undertake or assist with care in challenging situations.
   b) Set out the nature of the challenging situation, the care given, and how you managed the situation.
   c) Be signed by your allocated mentor each time.
   d) Contain feedback from your allocated mentor on the standard of care given and the way in which you managed the situation.

   You must send your case officer a copy of the profile before the next review.

8. At your monthly meetings with your mentor you will:

a) Discuss your reflective practice profile.
b) Discuss your approach to professional conduct, behaviours, and stress management.

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well Mrs Nutbeam has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

This will be confirmed to Mrs Nutbeam in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Ghotra. She submitted that, given the nature of the substantive order, there remains a need to protect the public interest throughout the appeal period, and therefore an interim conditions of practice order is necessary for a period of 18 months.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to protect the public throughout any period of appeal.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mrs Nutbeam is sent the decision of this hearing in writing.

That concludes this determination.