Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

12-16 May2025

10 George Street, Edinburgh, EH2 2PF

And

19 May 2025

Virtual Hearing

Name of Registrant:	Janette Donnelly
NMC PIN:	83B0581S
Part(s) of the register:	Registered Nurse – Adult Nursing
Relevant Location:	North Ayrshire
Type of case:	Misconduct
Panel members:	Clara Cheetham (Chair – Lay member) Margaret Marshall (Registrant member) Bill Matthews (Lay member)
Legal Assessor:	Trevor Jones
Hearings Coordinator:	Vicky Green
Nursing and Midwifery Council:	Represented by Alban Brahimi, Case Presenter
Mrs Donnelly:	Present and represented by Jennifer McPhee, Senior Solicitor at Anderson Strathern
Facts proved:	Charges 1.b.i, 1.b.ii, 1.c.i, 1.c.ii, 2.a, 2.b and 3
Facts not proved:	Charges 1.a and 2.c
Fitness to practise:	Stage not reached
Sanction:	Stage not reached
Interim order:	**Interim Suspension Order – 9 months**

Details of charge

That you, a registered nurse, while employed by the Millport Care Centre as the Home Manager:

1. On 19 February 2021:
    a. Did not use or consider using Diazepam when Service User A became agitated and/or to assist in the administration of the Covid vaccination; **[Not proved]**
    b. Were responsible for and/or contributed to the restraint of Service User A in that you:
        i. Restrained Service User A's head; **[Proved]**
        ii. Supervised and/or directed further restraint of Service User A by Colleague B and Colleague C. **[Proved]**
    c. After observing and/or being informed that the Covid vaccination for Service User A had been injected into their thigh through clothing:
        i. Informed Colleague A that you would not report the way in which the Covid vaccination was injected; **[Proved]**
        ii. Did not report that the Covid vaccination was injected into Service User A's thigh through clothing. **[Proved]**

2. Your actions as set out in charge 1b were not clinically justified in that:
    a. The restraint of Service User A was unnecessary; **[Proved]**
    b. The restraint of Service User A was not in line with their care plan; **[Proved]**
    c. You did not have appropriate training in restraint at the time. **[Not proved]**

3. Your actions as set out at charge 1c were dishonest in that you knew that you had a duty to report the administration of the Covid vaccination by Colleague A through Service User A's clothing. **[Proved]**

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

Decision and reasons on application to make further redactions to Colleague D's witness statement

The panel heard an application made by Ms McPhee, on your behalf, to redact additional parts of Colleague D's witness statement. She submitted that the information contained within paragraphs 27, 36 and 37 is prejudicial and should be excluded from evidence.

In respect of paragraph 27, Ms McPhee submitted that in her witness statement, Colleague D stated that Colleague B and Colleague C appeared to be *'shaken'*. She submitted that neither Colleague B nor Colleague C have been called to give evidence. Ms McPhee drew the panel's attention to Colleague C's local statement and submitted that there is no reference to the conversation with Colleague D or being in any distress. She also drew the panel's attention to Colleague B's local statement which did not mention what had been referred to in paragraph 27.

Ms McPhee submitted that paragraph 27 contains Colleague D's opinion which is not supported by any other evidence. She submitted that the inclusion of this information extends the scope of wrongdoing and is prejudicial to your case. Ms McPhee submitted that if the NMC intended to rely on this information, then it should have called Colleague B and Colleague C to give evidence. Furthermore, she submitted that Colleague D is not an expert witness, and that her opinion on how Colleague B and Colleague C presented is not relevant as it has not been charged.

In respect of paragraphs 36 and 37, Ms McPhee submitted that these contain information that has not been charged and is therefore prejudicial to you. She submitted that the entirety of paragraphs 36 and 37 should be redacted in fairness to you.

In response, Mr Brahimi submitted that paragraph 27 contains Colleague D's observation of Colleague B and Colleague C's demeanour and behaviour when she spoke to them following the alleged incident. He submitted that Colleague D is entitled to give evidence on this, it is an account of what she directly witnessed and the impact

on your Colleagues is relevant to the charges. Mr Brahimi submitted that Colleague D is attending the hearing to give evidence, and she will be subject to cross examination. In respect of paragraph 36, Mr Brahimi submitted that Colleague D provides an account of interactions and communications with you in respect of the matters that have been charged. He submitted that Colleague D's evidence is relevant and goes to her observations of your demeanour following the alleged incident. Mr Brahimi submitted that paragraph 37 also contains information about Colleague D's contact with you after the alleged incident.

Mr Brahimi submitted that none of the evidence contained in the specified paragraphs is hearsay, it is directly connected and provides contextual information about your conduct. He therefore submitted that paragraphs 27, 36 and 37 should remain in evidence and not be redacted.

The panel accepted the advice of the legal assessor.

Paragraph 27

The panel had sight of paragraph 27 and noted that it contained Colleague D's opinion of how she found Colleague B and Colleague C to be after the alleged incident. Having regard to the charges, the panel was of the view that Colleague D's interpretation of her colleagues' demeanor was not directly relevant. Whilst Colleague D is attending the hearing to give live evidence and could be cross examined on this point, the panel noted that neither Colleague B nor Colleague C had been called to give evidence. In view of the above, the panel decided that it would be unfair to allow Colleague D's opinion of their demeanor into evidence. The panel therefore agreed to the requested redaction and only the following information contained within paragraph 27 will remain:

'27.I also spoke to [Colleague C] and [Colleague B] following the incident.'

Paragraphs 36 and 37

The panel noted that paragraphs 36 and 37 contained information about Colleague D's interactions with you following the alleged incident. The panel was of the view that this evidence is relevant, as it provides contextual information about what Colleague D is said to have directly experienced and observed. As Colleague D is attending the hearing to give evidence, the panel determined that it would not be unfair or prejudicial to you to allow these paragraphs to remain and your representative, on your behalf, will have the opportunity to cross examine her.

Decision and reasons on application to admit the evidence of Ms 1 (Registered Nurse and Regional Director of Sancturary Care, who conducted the local investigation into the alleged incident) as hearsay evidence

Before the NMC closed its case, Mr Brahimi made an application for the witness statement of Ms 1 to be admitted into evidence as hearsay pursuant to Rule 31(1) of the Rules.

Mr Brahimi referred the panel to the NMC Guidance on *'Evidence'* (Reference: DMA-6 Last Updated 02/12/2024) and to the factors set out in the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 at paragraph 56*:

> *1. 'Whether the statements were the sole and decisive evidence in support of the charges;*
> *2. The nature and extent of the challenge to the contents of the statements;*
> *3. Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
> *4. The seriousness of the charge, taking into account the impact which adverse findings might have on N's career;*
> *5. Whether there was a good reason for the non-attendance of the witnesses;*
> *6. Whether the Respondent had taken reasonable steps to secure the attendance of the witness;*
> *7. The fact that N did not have prior notice that the witness statements were to be read.'*

Mr Brahimi went on to address the panel on the factors set out in the case of *Thorneycroft*. He submitted that the evidence of Ms 1 is not the sole or decisive evidence and that Colleague D who is a direct witness, has provided live evidence at this hearing. Mr Brahimi submitted that the policy and procedure documents exhibited by Ms 1 are not contentious. In respect of the nature and extent of the challenge to Ms 1's evidence, Mr Brahimi submitted that she is not a witness of fact, and her evidence would be of assistance in determining what policies and procedures should have been followed in respect of Service User A.

Mr Brahimi submitted that there is no suggestion that Ms 1 had any reason to fabricate her evidence. He submitted that your denial of the charges does not amount to a suggestion that Ms 1's evidence was fabricated. Mr Brahimi submitted that the charges are serious, and if found proved, are likely to impact your practice. However, he submitted that charge 1 will predominantly be decided on the evidence of Colleague D.

Mr Brahimi submitted that Ms 1 had previously informed the NMC that she did not want to attend to give evidence. After being informed of her duties to the NMC as a registrant, she then agreed to give evidence and provided dates on which she would beavailable. Mr Brahimi submitted that the NMC had no prior knowledge of Ms 1's limited availability this week. In respect of you having prior notice of this application, Mr Brahimi submitted that as soon as it became apparent that Ms 1 would not be attending to give evidence, you were informed.

Mr Brahimi noted that this application was not opposed, and you requested for the hearing to proceed in the absence of Ms 1. He submitted that you will have the opportunity to provide evidence and, if the evidence of Ms 1 is admitted as hearsay, the panel will attach what weight it deems to be appropriate once it has heard all of the evidence.

Ms McPhee made no submissions in respect of this application.

The panel accepted the advice of the legal assessor.

The panel had regard to the NMC Guidance on *'Evidence'* and had particular regard to the section entitled *'Hearsay'*. The panel was also guided by the factors set out in the case of *Thorneycroft*.

The panel assessed all of the evidence before it and decided that the evidence of Ms 1 was not the sole or decisive evidence in this case. It had heard live evidence from Colleague D who was a direct witness to the alleged incident, and she was able to provide additional evidence about the policies and procedures in place at the Home at the relevant time.

The panel noted that you whilst you have denied all of the charges, you have not challenged Ms 1's evidence, and there is no suggestion that Ms 1 had any reason to fabricate her evidence. The panel acknowledged that the charges are of a serious nature, and that if found proved, your practice is likely to be adversely impacted. Whilst the panel was not satisfied that there was good reason for Ms 1's non-attendance, it was satisfied that the NMC had taken reasonable steps to secure her attendance. The panel was also satisfied that you were provided with notice of this application as soon as it became clear that Ms 1 would not be attending to give evidence.

The panel noted that Ms 1 carried out the investigation into the alleged incident and exhibited a number of documents. The panel therefore found that her evidence is relevant. The panel noted that you did not oppose this application and that you are legally represented. Having regard to all of the above, and to the question of fairness, the panel decided to grant this application and admit the evidence of Ms 1 as hearsay. Once the panel has heard all of the evidence in this case, it will attach what weight it deems to be appropriate to this hearsay evidence.

Background

The charges arose whilst you were employed by Sanctuary Care as a Service Manager at Millport Care Centre (the Home). Your employment with Sanctuary Care commenced on 6 August 2001. You were responsible for overseeing the supported living aspect of the Home which had a total of 18 service users receiving support. Your responsibilities also included overseeing nurses and care staff, ensuring policies and procedures were adhered to and that service users were well cared for. The Home specialises in caring for service users who have learning difficulties and mental health conditions that prevent them from living without care.

On 19 February 2021, Colleague A, a registered NHS nurse, attended the Home to administer COVID-19 vaccinations (the vaccination/ the vaccine) to residents and staff.

Service User A has a Learning Disability and Bipolar Affective Disorder. Her care plan provided that at times it was necessary for Service User A to be restrained for limited periods (no more than 3 minutes at a time) to allow for essential interventions such as feeding and personal care. Service User A was subject to Welfare Guardianship under the *Adults With Incapacity (Scotland) Act* (2000) and the Guardianship includes the powers for such basic interventions.

On 19 February 2021, Service User A was due to receive her second vaccination. Prior to the alleged incident, there were failed attempts to administer the COVID-19 vaccine to Service User A in the dining room, in that she had walked away on both occasions before the vaccine could be administered. Later that day, in addition to Colleague A, Colleague B and Colleague C, it is alleged that you assisted the administration of the vaccine to Service User A in her bedroom. Colleague D, who was also present in the room, but did not take part in the vaccine administration, is alleged to have witnessed you inappropriately restraining Service User A on the floor of her bedroom with the assistance of Colleague B and Colleague C, who you were also alleged to have been instructing during this event. Service User A is alleged to have been struggling strongly against the restraint, as well as shouting and screaming. It is alleged that despite Colleague A stating that she needed to administer the vaccination on bare skin, you told

her to administer it through Service User A's clothing and into her thigh, rather than into the usual place, being into the skin of the upper arm.

It is alleged that following the vaccination being administered inappropriately into Service User A's thigh, through her clothing, and whilst she was being forcibly restrained on the floor of her bedroom, you told Colleague A that you would not report the way in which it was administered and consequently did not report this.

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 Mr Brahimi and those made by Ms McPhee on your behalf.

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 witness, who was called on behalf of the NMC:

- Colleague D: Psychiatric Nurse employed at the Home at the time of the alleged incident.

The panel also heard evidence from you under affirmation.

Before making any findings on the facts, the panel accepted the advice of the legal assessor.

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

Charge 1.a.

1. On 19 February 2021:

    a. Did not use or consider using Diazepam when Service User A became agitated and/or to assist in the administration of the Covid vaccination;

This charge is found not proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague D and to your evidence.

The panel had regard to Colleague D's written statement to the NMC dated 17 January 2025 in which the following is stated:

> *'Ms Donnelly's use of restraint was also incorrect as physical restraint should be used as last resort. Ms Donnelly should have tried to calm Service User A verbally to administer the vaccine. If Service User A was still agitated, then chemical restraint could have been used as the next step. This involves administered Diazepam to Service User A to calm them down. If Service User A was still shouting and refusing the vaccine, then this should have been taken as a lack of consent and all efforts should have stopped. The vaccine should then be administered on a different date.*
>
> *As a psychiatric nurse, I should have been asked if I could assist with Service User A's vaccination, by providing medication such as diazepam in advance of the administration.'*

The panel had sight of Service User A's PRN (when required) Medication protocol in which it shows that Diazepam was prescribed. The panel noted that the reason for this medication was for *'Agitation/Anxiety'* and it could be administered if Service User A

became anxious and/or agitated or to prevent her from hitting out at staff and service users.

In your evidence you told the panel that Service User A was not agitated on that day, and that she was mostly calm and quiet and presenting in her normal way. You said that Service User A had previously received a COVID-19 vaccination and flu vaccinations without issue. You told the panel that when Diazepam had previously been administered to Service User A, this had at times caused her to become more agitated, with associated complications and side effects which had once led to her choking on food.

Whilst you told the panel that Service User A was not agitated prior to receiving the vaccination, the panel noted that there was evidence from Colleague A, Colleague B and Colleague C that she was. The panel heard evidence that Diazepam would have taken some time to take effect and Colleague D concurred in her evidence that it had previously had some negative side effects on Service User A. Although it was not contested that Diazepam was not used on this occasion with Service User A, the panel found no evidence that you had given no consideration of the use of Diazepam to assist in the administration of the vaccine. The panel therefore found this charge not proved.

The stem of Charge 1.b

b. Were responsible for and/or contributed to the restraint of Service User A in that you:

Before considering charges 1.b.i. and 1.b.ii., the panel first considered whether it could be established that Service User A was restrained. The panel had regard to the evidence of Colleague A, Colleague B, Colleague C, Colleague D and your evidence.

The panel noted that it is accepted that four staff members were in the room at the relevant time and that the evidence supports that Service User A was laid on the floor at the time the COVID vaccine was administered. In her statements in March and April 2021, Colleague B stated that she had her hands on Service User A's legs while

Service User A was on the floor to prevent her from kicking her legs. The panel also had regard to the evidence of Colleague C who said that he had his hands on Service User A's legs and that Colleague B had her hands on Service User A's arms. Whilst the panel acknowledged that the accounts of Colleague B and Colleague C about where their hands were was inconsistent, they both accepted that you were at the top of Service User A, at her head and shoulders, had your hands upon her, and that they had both had their hands on Service User A. Colleague D also provided consistent evidence about Service User A being restrained on the floor by you and Colleague B and Colleague C.

The panel had regard to Colleague D's local statement dated 18 April 2021 in which she stated the following:

> *'Service User appeared distressed as she was screaming and trying to get up from the floor but was unable to due to the position of Manager Janette Donnelly, Support Staff [Colleague C] and Support Staff [Colleague B].'*

The panel noted that you denied this charge and has taken full account of your evidence. However, apart from minor discrepancies, the panel found the hearsay evidence of the NMC witnesses to be largely supportive of the allegations, further supporting the reliability of Colleague D's account. Notwithstanding thorough cross examination, the panel found Colleague D to be consistent, credible and reliable.

Whilst the panel acknowledged that you and Colleague B do not consider that a restraint was in place, it considered that given that Service User A was on the floor with the hands of three people upon her, it was more likely than not that the reason for physical contact was to restrain her while the vaccination was administered. The panel noted that once the vaccine had been administered, all parties removed their hands and Service User A sat up. The panel therefore concluded that Service User A was restrained for the purpose of receiving the vaccination. As the most senior member of staff, and by having physical contact, the panel determined that you were responsible for and contributed to the restraint of Service User A.

Charge 1.b.i.

b. Were responsible for and/or contributed to the restraint of Service User A in that you:
    i. Restrained Service User A's head;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague D.

The panel heard oral evidence from Colleague D, and had sight of her NMC witness statement in which the following was stated:

> *'Once I had finished talking to the GP, I went to Service User A's room to check up on her. When I opened the door, I saw the support workers [Colleague C] and [Colleague B] restraining the Service User on the floor under the direction of Ms Donnelly.*
>
> *Ms Donnelly was on her knees by Service User A's head and was using her bodyweight and hands to hold Service User A's head in place. [Colleague C] was kneeling down and holding down the torso of Service User A. [Colleague B] was kneeling down on the floor, holding down Service User A's legs in place.'*

The panel also had regard to Colleague D's local witness statement dated 18 April 2021 in which she stated the following:

> *'On opening the bedroom door I was confronted with Service User on floor on her right side, Manager Janette Donnelly was knelt on floor with her hands on Service User 's head Support Staff [Colleague C] knelt on floor with her hands on Service User upper torso and Support Staff [Colleague B] knelt on floor with his hands on Service User legs.'*

In her oral evidence, Colleague D told the panel that she would never forget the sight that she was confronted with, that it was *'horrific'*, and that you had restrained Service User A's head with your hands.

The panel had sight of local meeting notes with Colleague B dated 20 April 2021 in which the following is stated:

> *"[Ms 2] asked if how she was being held. [Colleague B] replied that he had his hands placed on her legs and [Colleague C] on her arms and JD was at her head and shouders*."

> *'[Colleague B] was asked where everyone was at this point, he replied that [Colleague D] was on the phone to the GP, [Colleague C] was across from him, he thought [you were] at head and shoulders and the NHS nurse to the side of Service User A.'*

The panel also had sight of Colleague C's response during a local meeting:

> *'JD was at [Service User A's] head, kneeling on the floor, JD was talking but I don't know what she was saying I was talking to [Service User A].'*

In your evidence you told the panel that you were holding Service User A's hand in order to comfort her, that you were facing towards Service User A's head, but that you did not restrain her head.

The panel noted that you denied this charge and has taken full account of your evidence. However, apart from minor discrepancies, the panel found the hearsay evidence of the NMC witnesses to be largely supportive of the allegations, further supporting the reliability of Colleague D's account. Notwithstanding thorough cross examination, the panel found Colleague D to be consistent, credible and reliable. Having regard to all of the evidence, and having found that it was more likely than not that Service User A was being restrained, the panel found that it was also more likely

than not that you assisted in the restraint by holding and restraining Service User A's head. The panel therefore found this charge proved.

Charge 1.b.ii.

a. Were responsible for and/or contributed to the restraint of Service User A in that you:
    ii. Supervised and/or directed further restraint of Service User A by Colleague B and Colleague C.

This charge is found proved.

In reaching its decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague D, and it had regard to your evidence.

The panel had sight of Colleague D's NMC witness statement in which the following was stated:

> *'Upon seeing the situation, I told Ms Donnelly that this level of restraint was deeply inappropriate and that she could not do this. Ms Donnelly ignored my protests, telling me to "fucking shut up" and continued to shout at the support staff to keep holding Service User A down.'*

The panel also had sight of Colleague D's local statement in which she stated the following:

> *'I voiced that this behaviour towards Service User A was unacceptable and classed as restraint, however this was ignored. Manager Janette Donnelly remained shouting and screaming which was now directed at Support Staff [Colleague C] and [Colleague B].'*

The panel had sight of the local interview with Colleague B and noted the following:

'[Ms 2] asked [Colleague B] if he felt at any point, he could have said no he replied that there were 3 nurses there so that's why he didn't say anything but he did feel uncomfortable and felt it wasn't right.'

[Colleague B] stated that the NHS nurse had stated at this point that I don't think we will be able to do this, but JD replied 'just do it'! [Colleague B] was asked how did JD say this, how was her tone. [Colleague B] replied it was like an order."

The panel noted that you denied this charge and has taken full account of your evidence. However, apart from minor discrepancies, the panel found the hearsay evidence of the NMC witnesses to be largely supportive of the allegations, further supporting the reliability of Colleague D's account. Notwithstanding thorough cross examination, the panel found Colleague D to be consistent, credible and reliable. Having regard to all of the evidence before it, the panel was of the view that as the senior nurse present you supervised and/or directed further restraint of Service User A by Colleague B and Colleague C. Accordingly, the panel found this charge proved.

The stem of Charge 1.c

c. After observing and/or being informed that the Covid vaccination for Service User A had been injected into their thigh through clothing:

Before considering the particulars of charge 1.c, the panel considered whether the stem of the charge has been made out.

The panel had regard to the NMC witness statement, local statement and oral evidence of Colleague D. It noted that her evidence was consistent that you were aware of the vaccination having been administered through Service User A's clothing.

The panel also had regard to the evidence of Colleague B who, in his local meeting said that you were aware of the vaccination being administered through Service User A's clothing.

In your evidence you told the panel that as you were facing Service User A's head you were unaware that the vaccination had been administered through her clothing.

The panel noted that you denied this charge and has taken full account of your evidence. However, apart from minor discrepancies, the panel found the hearsay evidence of the NMC witnesses to be largely supportive of the allegations, further supporting the reliability of Colleague D's account. Notwithstanding thorough cross examination, the panel found Colleague D to be consistent, credible and reliable.

The panel accepted the evidence of Colleague D, that whilst you were knelt at the head of Service User A, you were facing down her body. The panel found that on the balance of probabilities, given that you were positioned in close proximity to Service User A and holding her head, it was not plausible that you would not have been aware of the vaccination having been administered through her clothing, or at least informed of it at the time. The panel therefore found that for this reason, as well as on the basis of all the evidence before it, the stem of the charge has been made out, and went on to consider the particulars of charge 1.c.

Charge 1.c.i.

c. After observing and/or being informed that the Covid vaccination for Service User A had been injected into their thigh through clothing:
    i. Informed Colleague A that you would not report the way in which the Covid vaccination was injected;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague D.

The panel also had sight of Colleague B's responses during a local meeting on 20 April 2021 in which he stated the following:

‘He described how attempts had been made to lower the leggings to access her thigh but this wasn’t possible, so JD told the NHS nurse just to do it. The nurse administered the injection through the leggings.’

The panel also noted Colleague C’s responses during a local meeting in which she said that she felt that the vaccination was going to *‘happen regardless’*.

In her witness statement to the NMC, Colleague D stated the following:

‘[Colleague A] then said that she needs bare skin to be able to administer the vaccine and asked if Service User A’s leggings are pulled down until there is enough skin to administer the vaccine.

Ms Donnelly then asked the support staff if they had a good grip, then looked at [Colleague A] and told her to “just administer it through the leggings”. After Ms Donnelly continued to shout at [Colleague A], [Colleague A] followed the instructions and administered the vaccine through Service User A’s leggings.

Once the vaccine was administered, [Colleague A] said to Ms Donnelly, “please don’t tell anyone I’ve administered the vaccine in this way”, to which Ms Donnelly said, “of course I won’t”. Ms Donnelly then released the patient who then got up and ran down the corridor waving her hands, screaming.’

The panel also had regard to Colleague D’s local statement dated 18 April 2021:

‘Manager Janette Donnelly continued shouting and screaming towards Support Staff [Colleague C] and [Colleague B] to get a hold of Service User , Manager Janette Donnelly then shouted at NHS Nurse [Colleague A], Hurry up WE (referring to herself and the two support staff [Colleague C] and [Colleague B) have a hold of her, (referring to Service User) to administer COVID19 Vaccine straight through Service User ’s leggings.

NHS nurse [Colleague A] in a scene of chaos, shouting and screaming administered COVID19 Vaccine straight through Service User leggings.

Once NHS Nurse had administered the COVID19 Vaccine to Service User, she looked at Manager Janette Donnelly and said, "please don't tell ……I've administered Vaccine in this way "Manager Janette Donnelly replied of course I won't.'

The panel also heard oral evidence from Colleague D which was consistent with her contemporaneous statement and NMC witness statement.

In your evidence you told the panel that you were not aware of the vaccination being administered through Service User A's clothing at the time of the incident and that this conversation did not take place.

The panel noted that you denied this charge and has taken full account of your evidence. However, apart from minor discrepancies, the panel found the hearsay evidence of the NMC witnesses to be largely supportive of the allegations, further supporting the reliability of Colleague D's account. Notwithstanding thorough cross examination, the panel found Colleague D to be consistent, credible and reliable.

The panel found that Colleague D's evidence was supported by the evidence of the support workers, one of whom was aware of the administration of the vaccine through clothing. The panel found that it was more likely than not that you were involved in the decision to administer the vaccine through Service User A's clothing. Having found that you were aware of the administration and involved in the decision to administer it in this way, the panel also found that, as a Registered nurse you would have been aware of the inappropriate nature of its administration. The panel determined that it was more likely than not that you informed Colleague A that you would not report the way in which the vaccination was injected. The panel therefore found this charge proved.

Charge 1.c.ii.

c. After observing and/or being informed that the Covid vaccination for Service User A had been injected into their thigh through clothing:
    ii. Did not report that the Covid vaccination was injected into Service User A's thigh through clothing.

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it. It had particular regard to the evidence of Colleague D and the evidence set out above in charge 1.c.i.

In your evidence you told the panel that you did not report that the vaccination was administered through Service User A's clothing as you were not aware that this had happened.

The panel was satisfied that you were aware that the vaccination had been administered through Service User A's clothing, and you did not report it. The panel therefore found this charge proved.

Charge 2.a.

2. Your actions as set out in charge 1b were not clinically justified in that:
    a. The restraint of Service User A was unnecessary;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it.

The panel had regard to the evidence of Colleague D in her local statement in which she stated the following:

‘Manager Janette Donnelly phoned unit 2 midmorning, to inform me to start taking Unit 2 service users to dinning [sic] room in unit 1 for their 2nd dose of COVID19 vaccine, supported by Support staff on shift. Manager Janette Donnelly also informed me that Service User would receive her 2nd dose of COVID19 vaccine in her bedroom, in Unit 2 and would be left until last to receive Vaccine.’

In your evidence, you told the panel that Service User A did not have to receive her second vaccination on 19 February 2021 and that the NHS nurses would have been returning, and she could have had it then. This was supported by the oral evidence of Colleague D, as well as the NMC witness statement of Ms 1 in which she stated the following:

‘The covid injection did not have to be done at that particular time and it could have been rearranged if it was not possible to do it that day. The NHS staff were responsible for doing the covid injections. The NHS staff came to Millport from the local health centre and vaccinated staff and residents at Millport.’

The panel had sight of the Positive Behaviour Support – Sanctuary Care Policy dated 31 March 2020 and had regard to the following:

‘1.6 Restraint will only be used in circumstances which are legally and ethically appropriate and in order to ensure the safety of residents, staff and others.

1.8 Any form of restraint is only used as a last resort when all other courses of action have failed.’

The panel was satisfied that it was not essential for Service User A to receive the vaccine on 19 February 2021; it was your evidence that she could have received it at a later date. The panel also noted that the Policy sets out that any form of restraint must only be used as a last resort when all other courses of action have failed. Having found that it was not essential for Service User A to receive her second vaccination on 19 February 2021 the panel found that use of restraint to administer it was not necessary.

Charge 2.b.

2. Your actions as set out in charge 1b were not clinically justified in that:
    b. The restraint of Service User A was not in line with their care plan;

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it.

The panel had sight of Service User A's Positive behaviour care plan dated 4 September 2014 in which the following was stated:

> *'Service User A has a Learning Disability and Bipolar Affective Disorder, which has largely been resistant to treatment. There are times when it is necessary for Service User A to be restrained to allow for essential interventions such as feeding and personal care. Service User A is subject to Welfare Guardianship under the Adults With Incapacity (Scotland) Act 2000 and the Guardianship includes the powers for such basic interventions…*
>
> *…When restraint is used, it should be delivered by staff trained in a recognised restraint technique and should be used for the shortest period necessary.*
>
> *… There are times when Service User A requires to be redirected in order to prevent her coming to harm or to protect her dignity… if restraint is necessary, then the use of and duration of restraint should be recorded in Service User A's care notes.'*

The panel found that in applying an unnecessary restraint, your actions were not clinically justified or in line with Service User A's care plan. The panel therefore found this charge proved.

Charge 2.c.

2. Your actions as set out in charge 1b were not clinically justified in that:
    c. You did not have appropriate training in restraint at the time.

This charge is found not proved.

In reaching this decision, the panel had regard to all of the evidence before it.

The panel noted that the NMC had not provided evidence about what training you had undergone at the relevant time. When you gave oral evidence, the panel asked questions about your training record and you did not directly confirm whether you had completed the relevant restraint training. You said that as you are no longer employed by the Sanctuary Group, you were unable to access your training record or provide training certificates.

The panel found that the NMC had not discharged its evidential burden and found this charge not proved.

Charge 3

3. Your actions as set out at charge 1c were dishonest in that you knew that you had a duty to report the administration of the Covid vaccination by Colleague A through Service User A's clothing.

This charge is found proved.

In reaching this decision, the panel had regard to all of the evidence before it.

The panel had regard to the Sanctuary Group's Accident Reporting and Investigation – Group Procedure document dated 5 February 2021. It also had regard to the NMC witness statement of Ms 1 in which she stated the following:

'Ms Donnelly had ultimate responiblity [sic] for reporting any incident or accident that happened in the supported living areas. Sancutary [sic] Care has an internal

electronic reporting system called RADAR. Depending on the type of incident, there is email alert sent to the regional manager. If it is a serious incident, then the email alert goes to me and directly to the operations manager.

Depending on severity of incident, Ms Donnelly had to escalate to her regional manager, [Ms 2]. If the incident was an adult support concern then she should notify the Local Authority and the Care Inspectorate.

The Care Inspectorate regulate care providers in Scotland and use a system called eForums. Ms Donelly had to use eForums to notify the Care Inspectorate of any concerns.'

The panel had regard to the evidence of Colleague D who said she observed you telling Colleague A to administer the vaccination through Service User A's clothing which was supported by the evidence of Colleague B. The panel also had sight of evidence from Colleague C who stated that she felt that the vaccination was going to *'happen regardless'*.

The panel was satisfied that you would have been aware of the inappropriate nature of the vaccine's administration and were aware of your duty to report that it had been administered through Service User A's clothing, and you did not. The panel found that in omitting to report the incident, your actions were dishonest in that you sought to conceal the inappropriate administration. The panel found that your conduct was dishonest by the standards of ordinary decent people. Accordingly, the panel found this charge proved.

Submissions on interim order

As this hearing has not concluded in the allocated time and will therefore adjourn before the next stage, in accordance with Rule 32(5) on the Rules, the panel invited submissions on whether or not to make an interim order.

Mr Brahimi submitted that in light of the panel's findings an interim order is necessary. He submitted that the findings raise public protection concerns and that the finding in respect of dishonesty is significant. Mr Brahimi's primary submission was that an interim suspension order is necessary to protect the public and meet the public interest considerations of this case.

Mr Brahimi submitted that there is a risk of repetition of the behaviour and a consequent risk of harm to patients if you were able to practise without restriction during the adjourned period. He submitted that Service User A was a vulnerable resident and whilst no psychical harm was caused, there is evidence that she suffered emotional harm following the incident. Mr Brahimi submitted that findings of dishonesty are serious and there is a risk that you would repeat this behaviour.

In respect of public interest, Mr Brahimi submitted that a fully informed member of the public would be deeply alarmed if you were able to practise without restriction in light of the panel's findings on the facts. He submitted that an interim order on public interest grounds is required to maintain the integrity of the nursing profession, to uphold proper professional standards and maintain confidence in the profession and the NMC as the regulator.

Mr Brahimi addressed the panel on the principle of proportionality, he submitted that an interim suspension order is likely to impact on your potential income. Whilst his primary submission was that an interim suspension order for 18 months is appropriate and proportionate, if the panel was minded not to impose an interim suspension order, he suggested some conditions that may be appropriate.

Mr McPhee submitted that an interim order is not necessary in the circumstances. She referred the panel to your bundle of documents which contained positive testimonials from past and current peers and managers. Ms McPhee submitted that the charges relate to an isolated incident in a long and previously unblemished career. She submitted that you have worked without incident since the charges arose four years ago and you are currently working for a supportive employer. Ms McPhee submitted that there is no immediate or real risk of harm to patients or the public if you were able to practise without restriction.

In respect of the public interest, Ms McPhee submitted that it is best served by allowing you to continue to practise without any unnecessary restrictions. She submitted that open reflection and learning should be encouraged rather than a punitive approach being taken. Ms McPhee submitted that this hearing is public and that these proceedings provide a degree of scrutiny. She submitted that as we have not reached stages two and three of the hearing, the panel is yet to consider any mitigating factors.

Ms McPhee submitted that as there is no evidence of a continued risk of harm an interim order is not necessary in any form. She submitted that the imposition of an interim order would have a detrimental effect on you financially and reputationally. Ms McPhee also submitted that any interim order should not be imposed for the maximum period of time as sought by the NMC.

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 for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the public protection and public interest considerations that have arisen from its findings. The panel found that you inappropriately and unnecessarily restrained a particularly vulnerable service user who lacked capacity. The panel also found that that you instructed another nurse to administer the vaccine through Service User A's clothing. Both of these incidents placed Service User A at a risk of physical

harm, and both Service User A and your colleagues at a risk of emotional harm. The panel also found that in concealing what had happened, this raised further public protection concerns.

The panel had sight of testimonials, and noted that you have practised without incident in the four years that have elapsed since the charges arose. However, the nature of the behaviour found proved against you relied on the reporting of the incident by another individual when you were under a duty to report it but chose not to do so. The panel also took into account that you were in a senior role and in position of trust and power when the charges arose which raised questions about your integrity. The panel therefore determined that there is a real risk of repetition of the conduct and a consequent risk of significant harm if you were able to practise without restriction.

The panel considered that in the light of the seriousness of the charges found proved, the particular vulnerability of Service User A, your senior role and position of power and the findings concerning dishonesty, the public interest is engaged. It was of the view that if you were able to practise without restriction for the adjourned period, public confidence in the profession would be seriously damaged.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the seriousness and nature of the charges found proved. The panel found that no workable conditions could be formulated to address the seriousness of the charges and dishonesty found. It considered that any conditions that would sufficiently address the concerns would be tantamount to a suspension. The panel therefore determined that an interim suspension order is necessary to protect the public and to address the public interest in this case.

The panel had regard to the principle of proportionality, and whilst it acknowledged the financial and reputational damage this order is likely to have, it was of the view that your interests are outweighed by the need to protect patients and the public and to uphold proper professional standards and maintain confidence in the profession and the NMC as the regulator.

As this hearing will be listed to resume as soon as possible, the panel determined than an interim order for 9 months is proportionate.

That concludes this determination.