Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 17 November 2025
Thursday, 20 November 2025 – Friday, 21 November 2025
Monday, 24 November 2025 – Tuesday, 25 November 2025

Virtual Meeting

Name of Registrant:	**Gareth Christopher Edwards**
NMC PIN:	98B0059E
Part(s) of the register:	Registered Nurse – Learning Disabilities Nurse RNLD – (18 February 2005)
Relevant Location:	Wales
Type of case:	Misconduct
Panel members:	Derek Artis (Chair, Lay member) Emma Foxall (Lay member) Jason Flannigan-Salmon (Registrant member)
Legal Assessor:	Simon Walsh
Hearings Coordinator:	Abigail Addai
Facts proved:	Charges, 1(a)(i), 2(b), 3(a), 4, 5(a)(i), 5(a)(ii), 5(b)(i), 5(b)(ii), 5(b)(iii), 5(b)(iv), 5(c), 5(d)(i), 5(d)(ii), 5(e)(i), 5(e)(ii), 5(f), 5(g)(i), 5(g)(ii)
Facts not proved:	Charges 1(a)(ii), 1(a)(iii), 1(b), 2(a)(i), 2(a)(ii), 2(a)(iii), 2(a)(iv), 2(a)(v), 3(b), 3(c)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that an email had been sent on 1 October 2025 to an email address from which Mr Edwards' had communicated with the NMC. That email contained the Notice of Meeting. The panel noted that the formal Notice of Meeting was a template which had not been correctly filled in. Certain dates by which Mr Edwards was expected, under the Rules, to do certain things were not properly specified.

The panel accepted the advice of the legal assessor who directed the panel to Rule 11A(2)(e) and to Rule 34(3)(b).

After further enquiries, the panel were shown a further email sent on 1 October 2025, which specified the dates which were missing on the Notice of Meeting. The panel considered that the two emails if read together would satisfy Rule 11A.

Although the email address used to send Notices to Mr Edwards was not one he had notified to the Council as an address for communications, the panel, taking into account Mr Edwards lack of engagement, determined this was sufficient to satisfy Rule 34(3)(b).

In the light of all of the information available, the panel was satisfied that despite the errors within the Notice of Meeting, Mr Edwards has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

1) In respect of Patient A, on 11 June 2021:

a) Were hostile and confrontational;

i) Shouted and/or raised your voice at Patient A.

ii) Used intimidating body language.

iii) Conducted a 1:1 observation of Patient A, without any clinical justification.

b) Pushed them into a doorframe.

2) In respect of Patient B:

a) Between 17 July 2022 and 19 July 2022:

i) Failed to assist colleagues with their restraint;

ii) Did not respond to an alarm in a timely manner;

iii) Failed to assess them following a period of prolonged restraint;

iv) Failed to identify their PRN prescription;

v) Failed to administer their PRN medication in a timely manner.

b) Prepared an incorrect dose of oramorph.

3) In respect of Patient C, on 21 July 2022, when notified of concerns they were self-harming:

a) Failed to intervene;

b) Failed to refer to another member of staff;

c) Failed to record the concerns.

4) Between 11 and 15 July 2022 pre-potted medication for multiple patients otherwise than in accordance with policy and best practice

5) Behaved unprofessionally towards patients and colleagues in that:

a) On 17 July 2022, you swore at/in front of Colleague A saying:

i) “It’s fucking hot. I need to put my shorts on.”

ii) “Isn’t it time that you fuck off and get yourself home?”

b) On 17 July 2022 in respect of Colleague B, you:

i) Argued with them about Patient B needing to be reviewed and whether they were to have PRN medication.

ii) Told them you didn’t “give a fuck” in response to a request for Patient B to be reviewed and have PRN medication.

iii) Told them you “couldn’t be assed” in response to a request for Patient B to be reviewed;
iv) On a later escalation of Patient B in response to a request by Colleague B to further review Patient B said words to the effect of, “fuck it, my shift is nearly finished.”

c) On 21 July 2022, spoke aggressively and/or dismissively to Patient D in that Patient D approached you to discuss his day you refused to do so telling him you didn’t want to hear about his day or didn’t have time to hear about his day;

d) In respect of Colleague C:
i) In respect of 2) b), argued with them when they queried the dose of medication you prepared and was dismissive of the intervention saying words to the effect of “I’m the nurse.”
ii) As Colleague C was going to assist with an incident involving Patient B, you said words to the effect of “good fucking luck with that.”

e) In respect of Colleague, D:
i) Aggressively shouted at them to write a behaviour observation chart after a patient knocked over a cabinet;
ii) Slammed cabinets and stormed out of an office when asked to call the out of hours doctor for a patient;

f) Told Colleague D that you would administer an intramuscular injection to a patient “if she carries on”;

g) Used derogatory language when talking with and about unknown patients using words to the effect of:
i) “If it were up to me, I’d taser them all.”
ii) “They all have personality disorder and not learning disabilities.”

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

Background

On 7 December 2023, the NMC received an employer referral from Aneurin Bevan University Health Board ("ABUHB"), raising concerns about Mr Edwards.

The following concerns were reported:

- 11 June 2021: Mr Edwards was reported to have been hostile, intimidating and confrontational to Patient A. Patient A also alleged that Mr Edwards pushed her into her door frame on this date.

- 17 July 2022: Mr Edwards did not assist with Patient B's restraint or review Patient B. There was also a delay in administering PRN medication to Patient B on more than one occasion on this date.

- 17 July 2022: Mr Edwards used derogatory and inappropriate language towards colleagues on shift.

- 19 July 2022: Mr Edwards delayed the administration of two PRN medications on three separate occasions.

- 21 July 2022: When Patient D was trying to converse with Mr Edwards, his response was "I don't have time to listen about your day" and slammed the door in Patient D's face. The staff raised further issues about Mr Edwards behaviour and language towards colleagues and patients.

- On an unknown date, Mr Edwards attempted to administer an incorrect amount of Oramorph to Patient B, which was corrected by a Healthcare Support Woker and another Staff Nurse before administration to the patient.

- On an unknown date, Mr Edwards was seen pre-potting patients' medications.

Mr Edwards was removed from clinical duties on 28 July 2022, following the allegations and an investigation and disciplinary process commenced. A disciplinary hearing took place on 30 October 2023. Mr Edwards was dismissed on 9 November 2023.

During the course of the NMC investigation, The NMC was made aware of further concerns regarding Mr Edwards' practice. The following concerns were reported by the ABUHB:

- When a junior member of staff raised concerns to Mr Edwards regarding Patient C's self-harming, Mr Edwards dismissed their concerns and did not review Patient C.
- Mr Edwards informed a staff member that at his previous place of employment, he submitted a job application for an autistic patient 'for fun', knowing that the patient was unable to carry out the job role. Mr Edwards found the fact that the patient was offered an interview 'funny'.
- On an unknown date, Mr Edwards shouted at his colleague "BOC please" and slammed the cabinets and stormed out of the office when the colleague asked him to contact the on-call doctor.
- General concerns about Mr Edwards' attitude and behaviour towards staff and patients.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case, together with the statement of case and the evidence matrix from the NMC. Mr Edwards provided no documents or comments for the panel to consider.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Band 2 Bank Staff Member for ABUHB and worked for [PRIVATE] at the time of the concerns;

- Witness 2: Registered Mental Health Nurse on Placement on [PRIVATE] at the time of the concerns;

- Witness 3: Head Occupational Therapist at ABUHB at the time of the concerns;

- Witness 4: Lead Nurse and Investigative Manager at ABUHB at the time of the concerns;

- Witness 5: Completing a three-month management placement as a Student Nurse and a Bank Healthcare Support Worker at [PRIVATE] at the time of the concerns;

- Witness 6: Staff Nurse at [PRIVATE] at the time of the concerns;

- Patient A: Patient on [PRIVATE] at the time of the concerns;

- Colleague A: Healthcare Support Worker and a Student Nurse at [PRIVATE] at the time of the concerns;

- Colleague B: Healthcare Support Worker on [PRIVATE] at the time of the concerns;

- Colleague C: Healthcare Support Worker on [PRIVATE] at the time of the concerns;

- Colleague D: Student Nurse on [PRIVATE] at the time of the concerns;

The panel also took into account the evidence of other witnesses that the NMC stated they felt supported the charges as they set out in the evidence matrix and witness exhibits. The panel also had regard to a local statement given to the investigation by Person A (Assistant Psychologist) and follow up answers to questions where she concluded that it was a true and accurate account.

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

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

Charge 1(a)(i)

1) In respect of Patient A, on 11 June 2021:

a) Were hostile and confrontational;

i) Shouted and/or raised your voice at Patient A.

This charge is found proved.

The panel first took into account the following section of Patient A's witness statement

> *' I can recall that Gareth and I had a conversation within the dayroom, which escalated my behaviour and caused me to want to harm myself.'*

Furthermore, Witness 5's witness statement which reads:

> *'Whilst I was sat down in the chair, I heard Gareth's voice shout from behind me. I did not hear what Gareth said, as the karaoke was playing loudly.'*
>
> *'It was not appropriate to shout at Patient A across the dayroom'*

The panel also noted that Mr Edwards had made admissions to shouting at Patient A within the notes from the disciplinary investigation:

> *'I did shout and with hindsight I probably should have gone over to her'*

The panel also had regard to the answers to questions put to Person A during the local investigation. Person A was an Assistant Psychologist who was present at the time of the incident:

> *'I just remember hearing angry shouting I don't recall the exact words but to tell you it was abrupt I was really shocked due to it being Learning Disabilities we don't really have staff talk like that to service users.'*

Having found that Mr Edwards shouted at Patient A, the panel went on to consider whether Mr Edwards' tone was 'confrontational' and 'hostile'. In doing so, it had regard to the following sections of Witness 5's witness statement:

> *'Gareth's tone of voice was domineering and authoritative. I felt as though I was back at school, witnessing a teacher tell a pupil off'*

'I was concerned about Gareth's behaviour during the incident as he stood in the staff office, looking through the glass at Patient A which antagonised her. The way that Gareth spoke to Patient A escalated her behaviour'

The panel found Witness 5's account consistent with the account given by Person A during the investigation meeting:

'There was no warning it was confrontational and was questioning what we have done'

The panel noted Person A's account contained within the local investigation report which states:

'Suddenly nurse GE shouted with a stern, hostile tone, demanding the singing/music to stop whilst looking at Patient A.'

The panel also noted that while Mr Edwards made admissions to shouting, he did not make admissions to being 'confrontational' and hostile'. However, it found sufficient evidence to show that on 11 June 2021, Mr Edwards was hostile and confrontational.

Therefore, the panel found charge 1(a)(i) proved.

Charge 1(a)(ii)

1) In respect of Patient A, on 11 June 2021:
ii) Used intimidating body language.

This charge is found NOT proved.

The panel was directed to the witness statements of Patient A, Witness 3, and Witness 5, and to the comments of Person A during the investigation. The panel read these statements very carefully, but could find no reference whatsoever to intimidating body language, and therefore found charge 1(a)(ii) not proved.

Charge 1(a)(iii)

1) In respect of Patient A, on 11 June 2021:

iii) Conducted a 1:1 observation of Patient A, without any clinical justification.

This charge is found NOT proved.

The panel was directed to the witness statements of Patient A, Witness 3, and Witness 5, and to the comments of Person A during the investigation. It noted that Patient A stated in her statement in the local investigation:

'Then I said I'm going to my room to strangle myself'

In Mr Edwards' answer to questions in the local investigation, he stated:

'Explaining I need be near you a reasonable line of sight since you have stated you are going to harm [sic]'

The panel also took into account Witness 3's witness statement which reads:

'When I interviewed Gareth regarding the incident, he did say that he was putting Patient A's safety first and I do not think that this was the wrong thing to do'

In light of the above, the panel found charge 1(a)(iii) not proved.

Charge 1(b)

1) In respect of Patient A, on 11 June 2021:

b) Pushed them into a doorframe.

This charge is found NOT proved.

The panel was directed to Patient A's local statement by the NMC. This statement was dated 11 June 2021.

> *'He came into my room and I told him to get out and he said no, I'm going out when you're going to hurt yourself. Then he pushed me into my door frame.'*

The panel was also directed to the witness statement of Patient A by the NMC. This statement was dated 19 September 2024. The panel read this statement very carefully, but Patient A does not mention a door frame.

> *'Whilst in my bedroom, Gareth restrained me. I do not know why Gareth restrained me. I believe it could be because I was trying to cause harm to myself. All I can recall is that Gareth grabbed my hands with his hands in an attempt to restrain me. I then punched Gareth. I cannot recall anything further including what Gareth said to me whilst inside of my bedroom or anything else about the incident. Gareth pushed the alarm to alert other staff on shift of the incident.'*

In answer to questions at the local interview, Mr Edwards answered: that he was by *'the door half in half out. Patient A swung her arm at me but missed and she barged my shoulder in trying to push me out of her room. Was in a side stance. She pushed me and the final push I fell out the room onto the floor'.*

The panel was of the view that there was a conflict in the evidence above, and determined that the NMC have not discharged its burden in establishing whether Mr Edwards pushed Patient A into a doorframe. Therefore, the panel found Charge 1(b) not proved.

Charge 2(a)(i)

> **2) In respect of Patient B:**
>
> **a) Between 17 July 2022 and 19 July 2022:**
>
> **i) Failed to assist colleagues with their restraint;**

This charge is found NOT proved.

The panel was directed to the witness statements of Colleague A, Colleague B, Witness 2 and Witness 4.

Colleague A said:

> *'As Gareth was the nurse in charge and medication nurse on shift, he was required to attend [PRIVATE] unit within a timely manner and help facilitate the restraint. What I mean by this is that Gareth was responsible for attending the [PRIVATE] unit and taking charge of the restraint by assessing the situation, ensuring that the restraint was safe and appropriate and then by following the medication PRN protocol that was in place'*

The panel noted that Colleague A was a student nurse, and was not persuaded that he either had sufficient seniority or expertise to establish for the panel a duty on an experienced colleague such as Mr Edwards.

Colleague B said:

> *'Usually whenever an incident occurs on [PRIVATE], the Nurse in Charge will attend the incident and ask what happened, try assist with the situation etc.'*

The panel noted that Colleague B was a Healthcare Support Worker, and was not persuaded that she either had sufficient seniority or expertise to establish for the panel a duty on an experienced colleague such as Mr Edwards.

Witness 4 said:

> *'The Staff caring for Patient B restrained Patient B and pulled the alarm for assistance with the incident. Gareth was the medication lead for the shift, which meant that he was responsible for assessing the situation and administering medication to Patient B.*
>
> *When Gareth attended the incident, he informed the staff that Patient B does not have PRN medication prescribed to him'*

The panel determined that Witness 4 does not identify any duty on Mr Edwards to assist colleagues with the restraint.

The NMC directed the panel to Witness 2. The panel carefully considered the evidence of Witness 2, but Witness 2 did not address this allegation at all.

The panel concluded that the NMC have not established any particular duty on Mr Edwards' with regard to the restraint.

In any event, if there had been a duty on Mr Edwards, the panel noted from Colleague A's witness statement that Mr Edwards '*was the only nurse on shift'* and '*it is possible that he could have been dealing with something else including another crisis'*. This does not show a failure by Mr Edwards to do something, it seems to suggest the opposite.

The panel found Charge 2(a)(i) not proved.

Charge 2(a)(ii)

2) In respect of Patient B:

a) Between 17 July 2022 and 19 July 2022:

ii) Did not respond to an alarm in a timely manner;

This charge is found NOT proved.

The panel was directed to the witness statements of Colleague A, Colleague B, Witness 2 and Witness 4.

None of the witnesses could assist the panel with what a 'timely manner' would mean when responding to an alarm.

The panel concluded that there was insufficient evidence to establish what a 'timely manner' means here. It also noted from the witness statement of Colleague A that

although there was a delay, Mr Edwards did in fact attend the incident in response to the alarm.

Therefore, the panel found Charge 2(a)(ii) not proved.

Charge 2(a)(iii)

2) In respect of Patient B:

a) Between 17 July 2022 and 19 July 2022:

iii) Failed to assess them following a period of prolonged restraint;

This charge is found NOT proved.

The panel was directed to the witness statements of Colleague A, Colleague B, Witness 2 and Witness 4.

None of the witnesses could assist the panel with what an 'assessment following a period of prolonged restraint' would mean.

The panel concluded that there was insufficient evidence to establish what a 'prolonged restraint' means here. The panel were not provided with any local policies, procedures or guidance from the Trust.

In light of the above, the panel found that there is insufficient evidence to prove that Mr Edwards failed to assess Patient B, following a period of prolonged restraint. Accordingly, the panel found Charge 2(a)(iii) not proved.

Charge 2(a)(iv)

2) In respect of Patient B:

a) Between 17 July 2022 and 19 July 2022:

iv) Failed to identify their PRN prescription;

This charge is found NOT proved.

The panel was directed to the witness statements of Colleague A, Colleague B, and Witness 4.

None of the witnesses could assist the panel with what 'failing to identify their PRN prescription' would mean.

The panel concluded that there was insufficient evidence to establish a failure by Mr Edwards here.

Charge 2(a)(v)

2) In respect of Patient B:

a) Between 17 July 2022 and 19 July 2022:

v) Failed to administer their PRN medication in a timely manner

This charge is found NOT proved.

The panel was directed to the witness statements of Colleague A, Colleague B, Witness 2 and Witness 4.

The panel was not given evidence to establish what a 'timely manner' means here. The panel were not provided with any local policies, procedures or guidance from the Trust which assisted in this regard.

The panel referred to Witness 2's statement which stated:

> *'It would usually take around five minutes for the medication lead to attend the patient and administer the medication, however it can sometimes take longer than this if the medication lead is administering medication to another patient. When Witness 1 returned, she said Gareth would be with us shortly. However, it took approximately 10 or 15 minutes for Gareth to arrive with the medication'*

Witness 4 said:

> *'During the investigation, I discussed with Witness 2, how long it would take to respond to a request for medication within a timely and safe manner. I found that five to 10 minutes was reasonable if the staff member was not aware of the patient, layout of [PRIVATE] etc.*
>
> *' On 19 July 2022, Patient B was administered PRN olanzapine 5mg at 14:30pm and another 5mg at 18:50. Patient B was administered PRN lorazepam 2mg at 14:45, PRN promethazine 50mg at 19:15, and oramorph 5mg at 20:00pm. Oramorph is a morphine-based painkiller. I refer to Exhibit [PRIVATE].'*
>
> *'Five lots of PRN medication were administered to Patient B during the shift'*

This exhibit was not provided to the panel. The panel also reviewed the ABUHB Medicine Management Policy Code of Practice, and could find no reference to guide the panel to what time frame was meant by 'timely manner' as set out in the charge.

The panel found that the charge was unclear as to what constituted to a 'timely manner'. The panel therefore found charge 2(a)(v) not proved.

Charge 2(b)

> **2) In respect of Patient B:**
>
> **b) Prepared an incorrect dose of oramorph.**

This charge is found proved.

The panel was directed to the witness statements of Colleague C and Witness 5.

In reaching this decision, the panel took into account the formal investigation report and noted that Mr Edwards accepted the incident occurred:

‘Can you recall a near miss regarding the dispensing and administration of Oramorph medication – in that the wrong dose/ size of syringe was filled and was noticed by Band 3 HCSW Colleague C. Witness 5 was allegedly present, and the error was noticed before the medication was given?

Yes I can recall that, I had not long returned to the ward. The patient had been admitted when I was off the ward’

The panel found this to be consistent with Witness 5 and Colleague C’s witness statement where they state the following:

‘I did inform Gareth that he had prepared the incorrect dose of medication. I said something along the lines of “that is not the right dose, that’s ml and not mg”. Gareth then responded “oh, oh”’. Gareth did not say much. He asked Colleague C to come back (as she was stood by the doorway with the tray) and corrected his error.’(Witness 5)

I noticed that Gareth had prepared the incorrect dose of oramorph. Gareth had prepared a 5ml syringe of oramorph for Patient B. However, Patient B was usually given a small syringe of 0.5ml…. I could instantly tell that it was the incorrect amount because a small syringe of 0.5ml was always usually given to Patient B, and Gareth had prepared a large syringe’. (Colleague C).

Having regard to the above, the panel found there was sufficient evidence to prove that Mr Edwards prepared an incorrect dose of oramorph and found charge 2(b) proved.

Charge 3(a)

3) In respect of Patient C, on 21 July 2022, when notified of concerns they were self-harming:

a) Failed to intervene;

This charge is found proved.

The panel was directed to the witness statements of Witness 1, Witness 2, Witness 4 and Witness 6.

The panel first considered the following:

> *'Whilst cleaning her wound, it seemed that Patient C was potentially manipulating the wound. Rather than cleaning the outside of the wound, it looked as though Patient C was inserting her finger into the wound. I therefore left the office to go see Patient C and get a better look at what she was doing. However, she became agitated and defensive quite quickly and was annoyed at me asking her any questions about it. I was not entirely sure whether Patient C had definitely been manipulating her wound and she was not responding well to me so I felt as though I should obtain some senior support.*
>
> *I went back into the office, where Gareth was, and reported my concerns about Patient C. Gareth appeared irritated that I had raised the concerns to him. I cannot recall the conversation word for word, but I can recall that he did not appear to be concerned about Patient C and said to me "that's what she does, we can't stop that" and "there is nothing we can do". He was very dismissive, and his tone of voice was hostile. At no point did I witness Gareth go and check on or review Patient C.'*

The panel took into account Witness 2's witness statement where she says the following:

> *'I also informed Gareth of the concern that had been raised by the staff member as I did not think his response was appropriate. However, Gareth said that this was typical behaviour from Patient C and did not seem interested in continuing the conversation as "this is what she does". He was not supportive at all and did not take any steps to address the situation or prevent Patient C from self-harming. Although this was usual behaviour for Patient C, we have a duty of care to keep her safe and Gareth did not seem interested in doing so'*

The panel also noted that Witness 2's evidence corroborated Witness 1's evidence.

Further, it took into account that Witness 4 had reiterated these concerns in his witness statement to the NMC, stating that Mr Edwards did not take Witness 2's concerns seriously and offered her no support. The panel also noted that in the Investigation report, Mr Edwards could not recall the incident but said if he was on duty, he would have spoken about the issue with Patient C, and would have assessed the issue with members of staff.

Having considered all the evidence, the panel concluded that it was more likely than not that Mr Edwards failed to intervene when notified that Patient C was self-harming. Therefore, on the balance of probabilities, the panel found charge 3(a) proved.

Charge 3(b)

> **3) In respect of Patient C, on 21 July 2022, when notified of concerns they were self-harming:**
>
> **b) Failed to refer to another member of staff;**

This charge is found NOT proved.

The panel was directed to the witness statements of Witness 1, Witness 2, Witness 4 and Witness 6.

With regards to Charge 3b, the panel at the outset considered what Mr Edwards' duty was in relation to the incident on 21 July 2022.

The panel found no evidence to explain what duty Mr Edwards was under when he was notified that Patient C was self-harming. The panel was not provided with any local policies, procedures or guidance from the Trust. No witness addressed this question in any useful way.

Therefore, having considered all the evidence before it, the panel concluded that the NMC have not provided enough evidence to support what Mr Edwards' duty was and found charge 3(b) not proved.

Charge 3(c)

> **3) In respect of Patient C, on 21 July 2022, when notified of concerns they were self-harming:**
>
> **c) Failed to record the concerns.**

This charge is found NOT proved.

The panel was directed to the witness statements of Witness 1, Witness 2, Witness 4 and Witness 6.

In reaching this decision, the panel first had regard to the Investigation Report, and noted that Mr Edwards said the following in answer to a question from the investigator:

> *'There is written documentation…. Depending on the level of observations they were on. There would be a documented record and it would be taken to the next Multi-Disciplinary Team meeting or the Senior Nurse on call or during office hours the SHO would be called.'*

The panel also took into account the Trust's Clinical record policy, in particular the fourth bullet point of the section entitled 'the purpose of records':

> *'To provide a record of any problem that arise, and the action taken in to rectify them'*

The panel noted that there was a record made of the incident, namely in Patient C's clinical notes. The clinical notes outline the incident in detail, highlighting what had taken place and Patient C's attempts to self-harm. Although there was no evidence as to who had written the notes, the panel found this to be in line with Mr Edwards' comments in the Formal Investigation Report and the Trust's clinical record policy.

In light of the above, the panel concluded that the NMC did not discharge its burden to prove that the concerns had not been recorded, and found charge 3(c) not proved.

Charge 4

4) Between 11 and 15 July 2022 pre-potted medication for multiple patients otherwise than in accordance with policy and best practice

This charge is found proved.

The panel was directed to the witness statement of Colleague D.

Colleague D told the panel:

'During the morning of my shift on [PRIVATE], I witnessed Gareth pre-pot patient medication… I saw Gareth pre-pot at least three patients' medications'

The panel also took into account that during the local investigation, Mr Edwards had admitted to pre-potting medication.

The panel noted that there is no policy or best practice that approves pre-potting medication.

Accordingly, the panel found charge 4 proved.

Charge 5(a)(i) and Charge 5(a)(ii),

5) Behaved unprofessionally towards patients and colleagues in that:
a) On 17 July 2022, you swore at/in front of Colleague A saying:
i) "It's fucking hot. I need to put my shorts on."
ii) "Isn't it time that you fuck off and get yourself home?"

This charge is found proved.

The panel was directed to the witness statement of Colleague A where he states the following:

'I checked the office, medication room and then the break room and found Gareth putting his shorts on. Gareth said "its fucking hot. I need to put my shorts on."

'Gareth complained about the DATIX system. I felt as though he should have been the one to of completed the DATIX. After this, Gareth patted my back and jokingly said to me "isn't it time that you fuck off and get yourself home?". It was said in a matey, jokey way'

Mr Edwards told the investigator that he would not intentionally swear in front of patients but, having carefully considered the evidence, the panel concluded that is more likely than not that Mr Edwards swore at/in front of Colleague A. It had nothing to undermine Colleague A's account of the incident.

Therefore, the panel found charge 5(a)(i) and 5(a)(ii) proved.

Charge 5(b)(i), Charge 5(b)(ii), Charge 5(b)(iii), Charge 5(b)(iv)

5) Behaved unprofessionally towards patients and colleagues in that:

b) On 17 July 2022 in respect of Colleague B, you:

i) Argued with them about Patient B needing to be reviewed and whether they were to have PRN medication.

ii) Told them you didn't "give a fuck" in response to a request for Patient B to be reviewed and have PRN medication.

iii) Told them you "couldn't be assed" in response to a request for Patient B to be reviewed;

iv) On a later escalation of Patient B in response to a request by Colleague B to further review Patient B said words to the effect of, "fuck it, my shift is nearly finished."

This charge is found proved.

The panel was directed to the witness statement of Colleague B who said:

'When I asked Gareth for the medication, he said that Patient B is not due any PRN medication. I then informed Gareth that if he did not review Patient B I would escalate and make a complaint. Gareth said that he "didn't give a fuck"… During this conversation, Gareth also said that he "couldn't be fucking assed" and to "leave him be".

'I explained that Patient B's behaviour had escalated further. I also said to Gareth "are you taking the piss? Get down there and check on Patient B. Gareth replied, "fuck it my shift is nearly finished"

The panel noted Mr Edwards' comments to the investigator, namely that he could not recall having a conversation with Colleague B, but the panel had nothing to undermine Colleague B's clear and detailed account of the incident.

Therefore, the panel found charges 5(b)(i), 5(b)(ii), 5(b)(iii) and 5(b)(iv) proved.

Charge 5(c)

5) Behaved unprofessionally towards patients and colleagues in that:

c) On 21 July 2022, spoke aggressively and/or dismissively to Patient D in that Patient D approached you to discuss his day you refused to do so telling him you didn't want to hear about his day or didn't have time to hear about his day;

This charge is found proved.

The panel was directed to the witness statements of Witness 1 and Witness 6.

Witness 1 told the panel:

'I was in the office and observed Patient D approach the office in an attempt to tell Gareth about his day (I believe that he had been on leave during the daytime but cannot confirm for sure). About three seconds into his sentence, Gareth interrupted Patient D and in a raised voice said, "I don't have time to be listening about your

day" and said that he had stuff to do. Gareth's tone of voice seemed irritated and aggressive when he spoke to Patient D. Gareth then closed the office door on Patient D'

Witness 6 said:

'I cannot recall exactly what Gareth said to Patient D. However, I believe that it was something along the lines of "I do not want to hear about your day" or "I do not have time to hear about your day". Gareth was completely dismissive, and said this in a rude tone of voice. Gareth then slammed the door in Patient D's face.'

The panel took into account Mr Edwards' comments to the investigator, where he said he did not recall the incident but accepted it was inappropriate to close the door abruptly in the patient's face.

The panel had nothing before it to undermine either Witness 1 and Witness 6's account of the incident.

The panel found charge 5(c) proved.

Charge 5(d)(i), and Charge 5(d)(ii)

5) Behaved unprofessionally towards patients and colleagues in that:

d) In respect of Colleague C:

i) In respect of 2) b), argued with them when they queried the dose of medication you prepared and was dismissive of the intervention saying words to the effect of "I'm the nurse."

ii) As Colleague C was going to assist with an incident involving Patient B, you said words to the effect of "good fucking luck with that."

This charge is found proved.

The panel was directed to the witness statement of Colleague C who told the panel:

‘I raised to Gareth that he had prepared the incorrect dose of medication for Patient B. I cannot recall Gareth’s exact response; it was something along the lines of “I’m the nurse”

‘As I walked passed Gareth, he laughed and said “good fucking luck with that”.

This is further corroborated in Colleague C’s local interview notes dated 26 October 2022 and her local statement dated 26 July 2022:

‘ I went back to check with Gareth who appeared disgruntled that I had questioned his medication, he argued with me that it was correct’ (local statement)

‘Handover was not finished. Gareth came out looked and laughed and stated, ‘good fucking luck with that.’ (local interview notes)

The panel found nothing to undermine Colleague C’s account of the incident and found charges 5(d)(i) and 5(d)(ii) proved.

Charge 5(e)(i)

5) Behaved unprofessionally towards patients and colleagues in that:

e) In respect of Colleague, D:

i) Aggressively shouted at them to write a behaviour observation chart after a patient knocked over a cabinet;

This charge is found proved.

The panel was directed to the witness statement of Colleague D.

The panel noted that the word ‘aggressively’ was not used in Colleague D’s witness statement. However, the panel took into account the manner in which Mr Edwards spoke to Colleague D, and had regard to the following sections of Colleague D’s witness statement:

‘Gareth opened the door so hard that it hit the filling cabinet behind the door. Gareth then shouted to me “BOC (behaviour observation chart) please”.

The panel found Colleague D’s witness statement to be consistent with her local statement dated 25 July 2022, and local interview notes dated 26 October 2022:

‘There was one incident where a patient had knocked over one of the cabinets in the day room and Gareth came into the nurses station and shouted ‘BOC please’ (local statement)

‘He shouted BOC’ (local interview notes)

The panel found nothing to undermine Colleague D’s evidence. In light of the above, the panel determined that on the balance of probabilities that Mr Edwards did act in an aggressive manner and found charge 5(e)(i) proved.

Charge 5(e)(ii)

5) Behaved unprofessionally towards patients and colleagues in that:

e) In respect of Colleague, D:

ii) Slammed cabinets and stormed out of an office when asked to call the out of hours doctor for a patient;

This charge is found proved.

The panel was directed to the witness statement of Colleague D, who said when she told Mr Edwards to call the out of hours doctor for a patient, ‘*he had an extreme reaction. Gareth instantly started slamming the cabinets and said “I’m not ringing them I’m going to speak to Person B because I don’t agree with it” and stormed out of the room.*

The panel found Colleague D’s witness statement to be consistent with her local statement dated 25 July 2022 and local interview notes dated 26 October 2022, where she says the following:

‘The patient had requested to call the dr and I was asked by the lead nurse to tell Gareth to call them. Gareth was in the medication room when I relayed this to him, he then slammed the medication cabinet and raised his voice saying “I’m not ringing them”.(local statement)

He slammed the medication cabinet and shouted I am not going to do it as he didn’t agree with it.(local interview notes)

The panel found nothing to undermine Colleague D’s evidence, and found sufficient evidence to prove that Mr Edwards had slammed cabinets, and stormed out of an office when asked to call the out of hours doctor for a patient. Therefore, the panel found charge 5(e)(ii) proved.

Charge 5(f)

5) Behaved unprofessionally towards patients and colleagues in that:

f) Told Colleague D that you would administer an intramuscular injection to a patient “if she carries on”;

This charge is found proved.

The panel was directed to the witness statement of Colleague D who told the panel that Mr Edwards said the following:

“If she carries on, I’ll IM (intramuscular injection) her”

The panel found Colleague D’s witness statement was consistent with her local statement dated 25 July 2022 and local interview notes dated 26 October 2022, where she says the following:

‘He then said to me “if she carries on I’ll IM her” (local statement)

‘He said if she carries on, I will IM her (local interview notes)’

The panel found nothing to undermine Colleague D's evidence. The panel therefore concluded that it is more likely than not that Mr Edwards told Colleague D that he would administer an intramuscular injection to a patient if that patient "carried on".

Charge 5(g)(i) and Charge 5(g)(ii)

> **5) Behaved unprofessionally towards patients and colleagues in that:**
>
> **g) Used derogatory language when talking with and about unknown patients using words to the effect of:**
>
> **i) "If it were up to me, I'd taser them all."**
>
> **ii) "They all have personality disorder and not learning disabilities."**

This charge is found proved.

The panel was directed to the witness statement of Colleague D which reads:

> *'I cannot recall the date or context in which I witnessed Gareth make inappropriate comments about patients. I know that Gareth made comments like "if it were up to me, I'd taser them all and "they all have personality disorder and not learning disabilities".*

The panel also noted that when asked by the investigator, Mr Edwards denied saying he would taser the patients. However, the panel concluded that it was more likely than not that Mr Edwards used derogatory language when talking with and about unknown patients.

The panel accordingly found charges 5(g)(i) and 5(g)(ii) 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 Mr Edwards' 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, Mr Edwards' fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC 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.

The NMC identified the specific, relevant standards where Mr Edwards' actions amounted to misconduct.

The NMC consider the misconduct is serious because Mr Edwards' actions fell significantly short of what would be expected of a registered nurse. They submitted that the areas of concern identified relate to unprofessional, rude and intimidating behaviour, failure to provide patient care when needed, and the incorrect handling of medication. The NMC submitted that the misconduct was a significant departure from the fundamental principles of the Code of prioritising people, practising effectively, preserving safety, and promoting professionalism and trust in the professions.

The NMC submitted that the panel should bear in mind its overarching objective to protect the public. 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. The panel was

referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin)

The NMC invited the panel to find Mr Edwards' fitness to practise impaired, and submitted that limbs 1-3 of the *Grant* test is engaged in Mr Edwards' case.

The NMC submit that limb 1 is engaged because Mr Edwards' actions put Patients A, B, C and D at a risk of unwarranted harm. Limb 2 is engaged because Mr Edwards' actions would shock a bystander should they learn of a nurse who did the following:

- Shouted and intimidated patients and colleagues.
- Failed to assist in the necessary patient care and respond to an emergency.
- Failed to administer medication and prepares a wrong dose and;
- Speaks in rude and unprofessional manner to patients and colleagues, and at times using derogatory language.

The NMC submitted that limb 3 is engaged because Mr Edwards breached the fundamental tenets of the nursing profession of prioritising people, practising effectively, preserving safety, and promoting professionalism and trust in the professions.

The NMC referred the panel to the comments of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) and asked it to consider the following:

- Whether the concern is easily remediable
- Whether it has in fact been remedied and;
- Whether it is highly unlikely to be repeated

The NMC submitted that Mr Edwards has not responded to the regulatory concerns or provided any evidence of strengthened practice, including retraining or insight into the seriousness of the alleged conduct. As a result, the NMC consider that there is continuing risk to the public due to Mr Edwards' lack of insight and strengthened practice.

With regards to public interest, the NMC submitted that a finding of impairment is required to declare and uphold proper standards of conduct and behaviour. The actions of Mr Edwards fell below the professional standards required of a nurse and engages the public interest. They submitted that members of the public would be appalled of Mr Edwards' conduct such as his failure to assist in the necessary patient care and responding to an emergency.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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.'

The panel was of the view that Mr Edwards' actions did fall significantly short of the standards expected of a registered nurse, and that Mr Edwards' 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***
> *To achieve this, you must:*
> *2.1 work in partnership with people to make sure you deliver care effectively*
> *2.6 recognise when people are anxious or in distress and respond compassionately and politely*

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

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

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

20.5 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.

The panel next went onto consider whether the matters found proved amounted to misconduct, and divided the charges into two themes; poor interactions with patients and colleagues and poor medication practice.

Poor interactions with patients and colleagues.

The panel identified serious behavioural and attitudinal concerns which spanned over a long period of time, and included a failure to respond to a patient self-harming and causing an adverse effect on a patient's well-being. The panel was concerned that Mr Edwards did not demonstrate empathy or interest in a vulnerable patient who was self-harming. It concluded that this was striking, given that he was the registered nurse looking after

vulnerable patients and was expected to intervene and provide support when necessary. Mr Edwards' failure to intervene raises serious concerns about his nursing practice.

The panel also noted that Mr Edwards frequently used derogatory language towards patients and colleagues, including telling a colleague he would taser patients and swore when speaking to colleagues at times.

Having regard to the above, the panel was satisfied that Mr Edwards' behavioural and attitudinal failings were serious and amounted to misconduct.

Poor medication practice

With regards to Charge 2b, the panel took into account its findings on facts and the Code breaches referred to above.

The panel determined that although Mr Edwards had prepared the incorrect dose of Oramorph (5ml), the error was identified by Witness 5 and Colleague C who informed Mr Edwards about his error, prior to the administration of medication to Patient B. Mr Edwards then corrected his error prior to the administration. The panel found no harm was caused to Patient B, given that the error was identified before it was administered. Therefore, the panel was not satisfied that this failing met the threshold of seriousness so as to amount to misconduct.

With regards to Charge 4, the panel also took into account its findings on facts and the Code breaches referred to above.

The panel was of the view that pre-potting medication was not best practice and did not align with policy. However, it did not consider that this was a serious breach. Further, the panel considered that the charge was associated with poor clinical practice.

Having looked at the charges in the round, except those relating to poor medication practice, the panel concluded that Mr Edwards' conduct was deplorable and fell below the standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:*
>
> *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 limbs, a, b and c are engaged in Mr Edwards' case.

With regards to limb a, the panel was of the view that Mr Edwards' conduct in the past put patients at unwarranted risk of harm. The panel was concerned that a nurse in charge of vulnerable patients did not take appropriate steps to intervene when told by a colleague that a patient was manipulating their wound. It also noted that other patients were harmed by Mr Edwards' conduct, including his shouting causing an adverse impact on Patient A's well-being and shouting at Patient D for telling him about his day. In light of this, the panel concluded that Mr Edwards' conduct is likely to put patients at risk of unwarranted harm in the future.

The panel also found limb b is engaged. It noted that Mr Edwards' conduct was not isolated and he had received a first and final written warning regarding his conduct on 11 June 2021, for his actions towards Patient A. However, Mr Edwards went on to swear and

argue with colleagues and used derogatory language, including informing Colleague D that he would taser patients and administer an intramuscular injection to a patient if “she carries on”. Having regard to the above, the panel found that Mr Edwards’ conduct had brought the nursing profession into disrepute.

The panel finds that patients were put at risk and were caused physical and emotional harm as a result of Mr Edwards’ misconduct. Mr Edwards also failed to uphold the fundamental principles of the Code which are: prioritising people, practising effectively, preserving safety, and promoting professionalism and trust in the professions. As such, Mr Edwards’s misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mr Edwards has not provided the NMC any evidence to show that he understands the impact his behaviour had on colleagues or patients. Mr Edwards has also not demonstrated strengthened practice. As such, the panel could not determine that Mr Edwards has remediated the concerns identified.

The panel was of the view that there is a risk of repetition based on the absence of strengthened practice and insight. The panel also could not conclude that the risk has sufficiently been addressed or decreased. In light of this, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel determined that a finding of impairment on public interest grounds is required. The panel was of the view that Mr Edwards’ conduct demonstrate behavioural and attitudinal concerns which occurred over a prolonged period of time. Despite receiving a first and final written warning on 11 June 2021 by ABUHB, Mr Edwards went on to be hostile and confrontational among colleagues and patients and used derogatory language.

The panel also determined that members of the public would be appalled to hear that Mr Edwards failed to intervene when a colleague raised concerns that a patient was self-harming. Therefore, a finding of impairment is required to maintain public confidence in the nursing profession.

Having regard to all of the above, the panel was satisfied that Mr Edwards' fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the Registrar to strike Mr Edwards off the register. The effect of this order is that the NMC register will show that Mr Edwards 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.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 1 October 2025, the NMC had advised Mr Edwards that it would seek the imposition of a Striking-off Order if it found Mr Edwards' fitness to practise currently impaired.

The NMC submitted that the following aggravating factors are present

- Abuse of position of trust
- Lack of insight into failings
- Pattern of misconduct over time
- Conduct placing patients at risk of harm.

The NMC did not identify any mitigating factors.

The NMC submitted that a striking-off order is the only appropriate and proportionate sanction. They submitted that the regulatory concerns pose fundamental questions about Mr Edwards' professionalism and trustworthiness.

The NMC consider the regulatory concerns are sufficiently serious to warrant permanent removal from the register, and public confidence cannot be maintained if Mr Edwards is

not struck off the register. Therefore, the NMC invited the panel to impose a striking off order to protect patients, members of the public, and maintain professional standards.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The vulnerability of patients
- Conduct which put patients at risk of suffering harm.
- Failure to work in partnership with colleagues
- Lack of insight into failings
- A pattern of misconduct over a period of time

The panel also took into account the following mitigating features:

- On 17 July 2022, Mr Edwards was the only registered nurse on duty and covering two roles; medication nurse and nurse in charge.

As required by Article 29 (3) of the Nursing and Midwifery Order, 2001, the panel first considered (pursuant to Article (4)) whether to undertake mediation or to take no further action. It considered that neither of these outcomes would be appropriate as neither would restrict Mr Edwards' practice. The public would therefore not be protected and the public interest would not be satisfied.

The panel then moved on to consider the four available sanctions set out in Article 29(5) of the order. The panel determined that a caution order would again not be appropriate as it

would not restrict Mr Edwards' practice. The public would therefore not be protected and the public interest would not be satisfied.

The panel next considered whether placing conditions of practice on Mr Edwards' registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining and Mr Edwards has not engaged with the NMC. Furthermore, the panel concluded that the placing of conditions on Mr Edwards' registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

This was not a single instance of misconduct, but a number of incidents which took place over a span of time. There was evidence of harmful deep-seated personality or attitudinal problems towards vulnerable patients and colleagues.

The panel noted that Mr Edwards has not provided the NMC with any reflections or insight into why these incidents occurred, has shown no understanding as to his behavioural and attitudinal failures, and how this impacted his colleagues and vulnerable patients in his care. Without this insight and evidence of strengthened practice, there is a significant risk that the behaviour will be repeated.

The conduct, 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 found that Mr Edwards' conduct raises serious questions about his nursing practice and professionalism, given that he failed to intervene when a colleague informed him that a patient was self-harming, and frequently used derogatory language to patients and staff. As such, the panel noted that the serious breaches of the fundamental tenets of the profession evidenced by Mr Edwards' actions, is fundamentally incompatible with Mr Edwards remaining on the register.

Mr Edwards' actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Edwards' actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mr Edwards' actions in bringing the profession into disrepute by adversely affecting the

public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this 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 Mr Edwards 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, or is otherwise in the public interest or in Mr Edwards' own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC. The NMC submitted that if a finding of public protection is made and a restrictive sanction is imposed, the NMC consider an interim be made in the same terms as the substantive order. The NMC submitted this should be imposed on the basis that it is necessary for the protection of the public and is otherwise in the public interest.

The NMC further submitted that if Mr Edwards is impaired on public interest alone and his conduct is fundamentally incompatible, then an interim suspension order should be imposed.

Decision and reasons on interim order

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

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

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

That concludes this determination.