Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 3 November 2025 – Tuesday, 11 November 2025

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

Name of Registrant:	**Terry Foley**
NMC PIN:	11L0424E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (14 March 2013)
Relevant Location:	Cardiff, Carmarthen, and Yorkshire
Type of case:	Misconduct
Panel members:	Chris Weigh (Chair, lay member) Julia Briscoe (Registrant member) Katherine Richards (Lay member)
Legal Assessor:	Nigel Mitchell
Hearings Coordinator:	Eric Dulle
Nursing and Midwifery Council:	Represented by Vida Simpeh, Case Presenter from 3 November 2025 – 7 November 2025 Represented by Rowena Wisniewska, Case Presenter from 10 November 2025 – 11 November 2025
Mr Foley:	Present and unrepresented on 4 November 2025 and 5 November 2025 morning Not present and unrepresented on 3 November 2025, 5 November 2025 afternoon – 11 November 2025.
Facts proved:	**Charges 1, 2a, 2b, 2c, 2d, 3a, 3b and 3c.**

Facts not proved:	**N/A**
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Foley was not in attendance and that the Notice of Hearing letter had been sent to Mr Foley's registered email address by secure email on 25 September 2025.

The panel was aware of evidence of Mr Foley replying to the Nursing and Midwifery Council (NMC), from the same email address that the notice of hearing was delivered to and was satisfied that this was his email address.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mr Foley

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

Ms Simpeh informed the panel that letters were sent to Mr Foley on 2 October 2025 and 22 of October 2025, asking if he would be attending. Mr Foley replied on 21 October 2025, indicating "*yes, I will be attending*".

Ms Simpeh further referred the panel to an email from the NMC dated 27 October 2025 informing Mr Foley that the hearing would be held virtually, instead of physically as was originally planned.

Mr Foley responded on 28 October 2025 indicating that he wanted the hearing to be held in person as this would be both in the public interest and his own interest.

The NMC replied on 29 October 2025, indicating that the hearing would be held physically, and asked him to again confirm his attendance by 30 October 2025.

Ms Simpeh referred the panel to email dated 2 November 2025 from Mr Foley requesting an adjournment of today's proceedings for a period of one week. In the email, Mr Foley indicated that he was seeking an adjournment because he was not informed that this hearing would be proceeding in person until recently.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to deny Mr Foley's application for an adjournment and to proceed in his absence. In reaching this decision, the panel has considered the submissions of Ms Simpeh, the documentary evidence from Mr Foley, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General*

Medical Council v Adeogba [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mr Foley has informed the NMC that he has received the Notice of Hearing;
- The panel is not certain that adjourning would secure his attendance at some future date;
- One witness has attended today to give live evidence, three others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019 - 2021;
- It would be in Mr Foley's own interest to proceed expeditiously;
- There is no realistic chance of concluding the case if it only begins next week, as the hearing is only set to be heard for two days next week;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Foley in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Foley's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge

That you a Registered Nurse:

1. At York and Scarborough Teaching Hospitals NHS Foundation Trust in November 2019:

a. Left a patient in soiled clothing overnight.

2. At Cardiff and Vale University Health Board in December 2020:

a. passed wind on numerous occasions in the presence of staff and patients.
b. laughed when asked not to pass wind.
c. said words to the effect of ''I can't help it, it just slips out I've had a few dicks in my time and there is no good dick in Cardiff.''
d. Made comments of a sexual nature to colleagues and within hearing of patients.

3. At Hywel Dda Local Health Board on 18 June 2021:

a. left one or more patients in an exposed condition.
b. failed to dispose of medical waste.
c. left treatment area unclean and/or untidy.

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

Background

The charges arose whilst Mr Foley was employed as a registered nurse with different agencies. On 2 July 2021, the NMC received a referral raising concerns about Mr Terry Foley.

The initial concerns have not been progressed due to a lack of evidence. However, through enquiries with various agencies that Mr Foley has worked with, there were several additional concerns identified with Mr Foley's practice between 2019 and 2021, all of which follow a similar pattern:

- Whilst at Cardiff and Vale University Health Board, it was alleged that, in December 2020, whilst on shift, Mr Foley passed wind on numerous occasions in front of patients and staff. When confronted about this, Mr Foley laughed it off and made inappropriate comments to staff and patients including *"I can't help it, it just slips out because I've had a few dicks in my time and there is no good dick in Cardiff*" It was also alleged that Mr Foley passed wind inappropriately on numerous occasions.
- Whilst at Hywel Dda Local Health Board on 18 June 2021, Mr Foley left a patient exposed for an extended period, did not dispose of waste, and failed to keep a room tidy.
- It was further alleged that in 2019, whilst working in York and Scarborough Teaching Hospitals NHS Foundation Trust, Mr Foley left a patient in urine and made illegible records. It was also alleged that, while working in York, in August 2020, he did not carry out appropriate observations.

Decision and reasons on your application for adjournment

On day two of the hearing, you attended the hearing virtually and made a fresh application for an adjournment of this case for one week until Monday, 10 November 2025. You informed the panel that the NMC's allegations have put you under severe hardship. You

indicated that you feel you are at a disadvantage in this hearing, and that you have not been able to fully review and '*digest*' the documents.

[PRIVATE].

You further indicated that you believed that you would not be joining the meeting this week in any event, as you were told that the hearing would be held virtually, and when you indicated that you wanted the hearing to be heard in-person, you were under the impression that the hearing would be adjourned.

You told the panel that you are not legally trained and that you need another week to prepare to defend yourself. [PRIVATE]

[PRIVATE]

You have therefore asked for an adjournment for one week until 10 November 2025 for time to prepare your defence and make arrangements to attend in-person.

Ms Simpeh indicated that the NMC has already stated its case regarding proceeding in your absence and adopts those submissions for this application. She asked the panel to take into account the timeline of these proceedings, and the fact that you are only providing this update to the panel at the last minute. She further indicated that you were informed of the hearing that was taking place in advance of this hearing, and that the public interest in proceeding with this case outweighs the prejudice that you may face as a result of the case proceeding.

Ms Simpeh indicated that the NMC leaves it to the panel to decide whether to continue proceeding, or to adjourn the hearing.

The panel accepted the advice of the legal assessor.

The panel considered your application for an adjournment until 10 November 2025 for you to prepare your case. The panel decided to deny your application for an adjournment.

The panel took into account the submissions made by the NMC, the documentary evidence contained in your emails, as well as your submissions during the hearing. The panel considered the NMC Guidance, and in particular the need to maintain fairness to you and any parties concerned. The panel considered the stage the hearing has reached and that one witness has already given evidence. Finally, the panel considered that in its attempts to contact you, you could not be reached, despite no fewer than ten attempts to contact you via telephone and email since the hearing was adjourned to consider this application.

The panel considered that the concerns in this case go back to 2019 and there is a public interest in the expeditious disposal of this case. The panel considered that you have had notice of this hearing since 25 September 2025 and have had a number of opportunities to request an adjournment or provide the panel with your circumstances prior to this hearing.

Further, the panel was not satisfied that an adjournment of the hearing today would secure your attendance at a future date. In this regard, the panel considered your conduct leading up to and during this hearing, including that you repeatedly failed to attend at the scheduled times. The panel took particular regard to the fact that it had attempted to contact you at least 15 times over the past two days (between Tuesday, 4 November 2025 and Wednesday, 5 November 2025) to get you into this hearing, after you assured the panel that you would be in attendance. The panel was not satisfied that an adjournment would secure your attendance in the future, or that you would reliably attend.

As a result, the panel considered that it is in the public interest to continue this case and to reject this application for an adjournment.

Further, due to your non-attendance at this hearing, the panel concluded that it would proceed in your absence.

Therefore, the panel decided to deny your application and proceed in your absence.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mr Foley.

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

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

- Witness 1: Employee of Hywel Dda Local Health Board
- Witness 2: Employee at Cardiff and Vale University Health Board
- Witness 3: Employee at York and Scarborough Teaching Hospitals NHS Foundation Trust
- Witness 4: Employee at York and Scarborough Teaching Hospitals NHS Foundation Trust

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

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

Charge 1

"That you a Registered Nurse:

1. At York and Scarborough Teaching Hospitals NHS Foundation Trust in November 2019:

   a. Left a patient in soiled clothing overnight."

This charge is found proved.

In reaching this decision, the panel considered the documentary evidence and the written and oral evidence of Witness 3.

First, the panel was satisfied that in November 2019, Mr Foley was working at the York and Scarborough Teaching Hospitals NHS Foundation Trust.

The panel has seen documentary evidence in the form of a York Teaching Hospital Bank & Agency Complaint form completed by Witness 3 in which she confirmed that you were the night duty nurse working at the hospital overnight in November 2019 and that she followed you on a shift starting at 0800hrs the following morning.

In the form, the witness provided details about a patient being laid on a bed with urine all over the floor in 3 places, and a comfort round had not been completed or filled in, as follows:

'During the below shift I went to perform personal cares on pt @ 0800 and found pt. laid in a wet bed. He was laid on 2 sheets and 2 blue Inco pads. There was urine all over the patients floor in 3 places ? been there all night. Pts. Comfort round not filled in. The documentation in the nursing notes is very untidy and in some places illegible.'

The panel also considered the following statement of Witness 3:

'I remember what was alarming was that it was dry urine on the patients bedding and clothes, which would indicate it had occurred some time before it was found by the day shift. That's what appalled me.'

In addition, the panel heard oral evidence from Witness 3 during the hearing. Witness 3 recalled the patient being left in bed with urine on his clothes which was dry in spots, which she considered as evidence that the patient had been left in that state overnight.

The panel considered Mr Foley's written response in which he said he was working within a culture of homophobia and bullying. When questioned about the culture of the Trust, Witness 3 was categoric in her view that she never witnessed any bullying or homophobia directed at Mr Foley.

When considering the evidence, the panel found Witness 3 to be thoughtful and straightforward when giving her oral evidence. It noted that the complaint form represents an account which was made soon after the events and was therefore almost contemporaneous in nature.

When considering the totality of the evidence, the panel found Witness 3 to be credible and concluded that it was more likely than not that Mr Foley left a patient in soiled clothing overnight as alleged. It therefore found this charge proved.

Charge 2a)

"At Cardiff and Vale University Health Board in December 2020:

a) passed wind on numerous occasions in the presence of staff and patients."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence, the written and oral evidence of Witnesses 2 and 4, and the written responses of Mr Foley.

The panel reviewed Witness 2's witness statement, wherein she indicated that Mr Foley continuously passed wind with other nurses present, as follows:

> *'I do remember that after he had been asked not to do it, he went into the IV lounge and bent down to canulate a patient and passed wind again. I pulled him to one side and asked him not to do this, but he was like 'oops' and didn't take it seriously. When he was being told not to do it, he just laughed it off.'*

The panel also noted that in oral evidence, Witness 2 recalled Mr Foley passing wind on numerous occasions in front of other nurses and within earshot of patients. She specifically recalled Mr Foley being asked to stop, to which he laughed in response.

The panel further noted Witness 2's written statement which indicates as follows:

> *'I think he had passed wind again in the Omnicell, in a second IV lounge. I remember saying can you not do that, we've already asked you, as I think someone else had already asked him to stop. He said 'I can't help it, it just slips out' and he turned it very sexual and said 'I've had a few dicks in my time and there is no good*

dick in Cardiff' … Patients could definitely hear as well as the Omnicell was opposite the IV lounge.'

The panel considered the response from Mr Foley, which was provided by him in a written document dated 7 January 2021, in which he stated [PRIVATE] during the incident in question, as follows:

'[PRIVATE] *but I had grown to like the department and the people of Wales and I recognised a responsibility during a pandemic not to go sick at the last minute and make things more difficult.* [PRIVATE]*.'*

During the oral evidence given by Witness 2, the panel explored, with the witness, Mr Foley's account and she was certain that Mr Foley did not make any reference [PRIVATE], nor provide any reasoning for his repeated passing of wind.

In addition, the panel had regard to Witness 2's written statement where she observed other nurses who were unhappy with Mr Foley's conduct and were uncomfortable with his actions. She stated this as follows:

'TF continually passed wind throughout the day in front of staff and patients. This was witnessed by an Emergency Nurse Practitioner, … who asked him to stop but he continued to do so.'

This evidence was confirmed by Witness 2 during her oral evidence.

Finally, the panel had regard to the oral evidence of Witness 4, who indicated that Mr Foley appeared to have intentionally passed wind. In particular, Witness 4 recalled Mr Foley putting his leg up on a chair whilst canulating a patient and appearing to deliberately pass wind. The panel considered that this diminishes the possibility that him passing wind in front of his colleagues was an accident.

The panel did note, during her oral evidence, Witness 4 was unsure of the date when events had taken place. The panel noted specifically that her exhibit reported these events as taking place in December 2021, but while checking other documentary evidence, noted that other witnesses recalled this taking place in December of 2020. Nonetheless, the panel was satisfied on a balance of probabilities that Witness 4 was very clear in her recollection of the events themselves, despite being uncertain about the date, and found her to be a credible witness. Further, the panel was satisfied on a balance of probabilities that Witness 2 and Witness 4 were speaking of the same events, and that their evidence was corroborative.

When considering the totality of the evidence, the panel concluded that it was more likely than not that Mr Foley passed wind multiple times on numerous occasions in front of staff and patients as alleged. It therefore found this charge proved.

Charge 2b)

"At Cardiff and Vale University Health Board in December 2020:

b) laughed when asked not to pass wind."

This charge is found proved.

The panel considered Mr Foley's response and his explanation that his laughter was a reaction of embarrassment. The panel also heard from Witness 2 that notwithstanding Mr Foley wearing a facemask, she was certain that he was very dismissive and laughed because she heard him.

Therefore, for the same reasons mentioned above, the panel was satisfied that Mr Foley laughed when asked not to pass wind. The panel therefore found this charge proved on a balance of probabilities.

Charge 2c)

"At Cardiff and Vale University Health Board in December 2020:

c) said words to the effect of ''I can't help it, it just slips out I've had a few dicks in my time and there is no good dick in Cardiff.''

This charge is found proved.

For the same reasons mentioned above, the panel was satisfied that Mr Foley said words to the effect of "*I can't help it, it just slips out I've had a few dicks in my time and there is no good dick in Cardiff"* as alleged. The panel therefore found this charge proved on a balance of probabilities.

Charge 2d)

"At Cardiff and Vale University Health Board in December 2020:

d) Made comments of a sexual nature to colleagues and within hearing of patients."

This charge is found proved.

The panel was satisfied that Mr Foley made comments of a sexual nature to colleagues and within hearing of patients as alleged.

In particular, the panel heard from Witness 2 who adopted her statement as part of her oral evidence:

'We were handing over, and I think an elderly lady had fallen and

*had a bad laceration on her leg. One of the nurses had said that she had a nasty gash on her leg, Terry started to laugh and turned it into a sexual innuendo. I can't recall the exact words, but basically Terry was referring to the gash as a vagina, and he said this directly to (...*her*...). She pulled me to one side and said she was not happy, and it was inappropriate.'*

Witness 2 was clear that she heard these remarks, and it made her feel uncomfortable.

The panel considered Mr Foley's written response, where he stated:

'Furthermore, the lady with the nasty gash on her leg was just that, a very nasty wound and an onlooker stated that I should have chosen my words more carefully when stating that but communication and interpretations are not always as intended, especially with the aforementioned COVID measures blocking 90% of the communication meaning. I accept what that individual stated and I stated "ooooop's I should construct my sentences more carefully and my choice of words". I had not considered another meaning until pointed out but unfortunately that was an error on my part, though without thinking until the sentence was delivered already and not able to be stopped. …'

The panel considered Witness 2's oral evidence was consistent with her written accounts and noted that the written account was made shortly after the night in question. Additionally, the panel was able to question Witness 2 in relation to her recollection of events. The panel found her to be a credible witness who gave a clear account. Therefore, on a balance of probabilities, the panel preferred Witness 2's version of events over that of Mr Foley's.

The panel, having found the facts in Charge 2c) proved, went on to consider these comments and determined that they too were of a sexual nature and further, were made in the presence and hearing of colleagues and patients.

The panel therefore found this charge proved on a balance of probabilities.

Charge 3a)

"At Hywel Dda Local Health Board on 18 June 2021:

a) left one or more patients in an exposed condition."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence, the written and oral evidence of Witness 1, and the written response of Mr Foley.

The panel considered that Witness 1's evidence relates to her email which was dated 3 days following the incident and was satisfied that this evidence was near contemporaneous with the events.

The panel further considered the written witness statement of Witness 1 in which she recalls the events and indicates that she recalls the night vividly. The witness states that Mr Foley was on night duty on a Friday in the emergency department of [PRIVATE] and she was the sister in charge. In her email dated 21 June 2021, which was entitled 'Agency Nurses Concerns', she stated as follows:

> *'In my email I also raised concerns around him being allocated to clean resus (clean procedures and major 3s) and both rooms being untidy, and patients being exposed. The way I have worded this, I think it may have still been during covid. We had clean and dirty resus in covid, and the patients in clean procedures and major 3s were probably patients that had higher acuity, and needed a higher level of monitoring, observations, and care in meeting their needs.'*

The panel further reviewed written evidence from Witness 1, where she recalls seeing the patient in an exposed state and being concerned about how he was being treated, as follows:

> *'Regarding the email that I sent and questioned about by the NMC, I can remember walking in and seeing a naked [man] on a trolley and a real mess around him. His (Terry's) cohort of patients were in a real dishevelled sort of way and there were concerns about the care he was providing. The fact that I raised it means that I wasn't happy with what I observed and felt he was negligent towards these patients. On this occasion I remember being told about the conditions of the patients then walking over to see for myself. I believe that I possibly wouldn't have raised the concerns if Terry had given me a reasonable explanation as to why the patients and area around them were as I found them.'*

Finally, the panel heard oral evidence from Witness 1, who indicated that she observed Mr Foley on his phone throughout the shift.

The panel noted Mr Foley's response that he was the victim of a culture of jealousy amongst the permanent staff, and that the staff on the shift were very junior as were the site management and leadership. The panel found nothing in the evidence to support Mr Foley's assertions.

Mr Foley said:

> *'I tried to keep him covered as much as I could but due to his confusion he would take everything off and chuck it on the floor…'*

However, the panel also considered the evidence of Witness 1 who stated:

> *'I recall the night vividly, particularly the patient in clean procedures. There were sheets on the floor, and rubbish from clinical procedures left on the side, and the*

patient was not in bed properly, with their sheets off, and naked. This was a room that people walk past quite frequently, as it was on one of the exits to the department. I was incredibly shocked.'

The panel considered Witness 1's oral evidence was consistent with her written accounts and noted that the written account was made four days after the night in question. Additionally, the panel was able to question Witness 1 in relation to her recollection of events. The panel found her to be a credible witness who gave an accurate account. Therefore, on a balance of probabilities, the panel preferred her version of events over that of Mr Foley's.

The panel found this charge proved on a balance of probabilities.

Charge 3b)

"At Hywel Dda Local Health Board on 18 June 2021:

b) failed to dispose of medical waste."

This charge is found proved.

The panel accepted the evidence of Witness 1, specifically in relation to her saying:

'I recall the night vividly, particularly the patient in clean procedures. There were sheets on the floor, and rubbish from clinical procedures left on the side, and the patient was not in bed properly, with their sheets off, and naked. This was a room that people walk past quite frequently, as it was on one of the exits to the department. I was incredibly shocked.'

The panel noted Mr Foley's response, where he said that there was "*some mess, but this was left by the nurse on the days…*". However, when this was put to Witness 1, she stated

that "*there was no possibility of mess being left by a previous nurse*". She went on to say that she was certain of this because she checked the clinical areas of all patients at the beginning of her shift and found nothing of note. Furthermore, she checked again later in the shift and found there to be medical waste and general untidiness in relation to Mr Foley's patients.

For the same reasons as described above in 3a), the panel found on a balance of probabilities that Mr Foley failed to dispose of medical waste. The panel therefore found this charge proved on a balance of probabilities.

Charge 3c)

"At Hywel Dda Local Health Board on 18 June 2021:

c) left treatment area unclean and/or untidy."

This charge is found proved.

The panel accepted the evidence of Witness 1. In her statement, she stated:

> *'In my email I also raised concerns around him being allocated to clean resus (clean procedures and major 3s) and both rooms being untidy, and patients being exposed. The way I have worded this, I think it may have still been during covid. We had clean and dirty resus in covid, and the patients in clean procedures and major 3s were probably patients that had higher acuity, and needed a higher level of monitoring, observations, and care in meeting their needs.'*

In her oral evidence, Witness 1 stated that the untidiness presented a trip hazard, and the room was not fit for purpose.

The panel again noted Mr Foley's response, where he said that there was "*some mess, but this was left by the nurse on the days…*". However, when this was put to Witness 1, she stated that "*there was no possibility of mess being left by a previous nurse*". She went on to say that she was certain of this because she checked the clinical areas of all patients at the beginning of her shift and found nothing of note. Furthermore, she checked again later in the shift and found there to be medical waste and general untidiness in relation to Mr Foley's patients.

For the same reasons as described above in 3a), the panel found on a balance of probabilities that Mr Foley failed to dispose of medical waste. The panel therefore found this charge proved on a balance of probabilities.

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 Foley's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Foley's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Ms Wisniewska, on behalf of the NMC, invited the panel to take the view that the facts found proved amount to misconduct. She submitted that Mr Foley's conduct had breached 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and was serious. Ms Wisniewska referred the panel to several sections of the code which she submitted were engaged in this case.

Ms Wisniewska submitted that Mr Foley's conduct presents attitudinal failings. Ms Wisniewska stated that Mr Foley's failure to properly care for patients and his inappropriate behaviour in front of his colleagues significantly breached various sections of the NMC Code. Therefore, Ms Wisniewska submitted that Mr Foley's behaviour was a serious departure from the standards expected of a registered nurse.

Ms Wisniewska therefore invited the panel to conclude that the facts found proved in this case amount to misconduct.

Submissions on impairment

Ms Wisniewska moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Ms Wisniewska referred the panel to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Ms Wisniewska submitted that the first three limbs of the test set out in *Grant* are engaged. She submitted that Mr Foley's conduct of leaving a patient in soiled clothes, distracting his colleagues by passing wind at work and making inappropriate sexual comments, and eroding the trust in his patients, placed patients at a real risk of harm. She further submitted that Mr Foley's conduct would bring the medical profession into disrepute and breached fundamental tenets of the profession by failing to promote professionalism and trust in the profession.

Ms Wisniewska further submitted that Mr Foley has breached each of the four fundamental tenets of the profession and has demonstrated no insight into his misconduct. She further submitted there is no evidence of remediation or strengthened practice. As a result, Ms Wisniewska submitted that this conduct is highly likely to be repeated, and that a finding of impairment on the grounds of public protection should follow.

Finally, Ms Wisniewska submitted that the conduct was sufficiently serious that a finding of impairment on public interest grounds is also necessary in this case.

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, *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Grant*.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code. It was satisfied that Mr Foley's actions amounted to breaches of the Code. Specifically:

1 Treat people as individuals and uphold their dignity

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

1.5 respect and uphold people's human rights

5 Respect people's right to privacy and confidentiality

5.1 respect a person's right to privacy in all aspects of their care

8 Work co-operatively

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

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

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

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

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

The panel was mindful that breaches of the Code do not automatically result in a finding of misconduct and went on to consider the seriousness of the conduct it had found proved.

The panel noted that Mr Foley's conduct consisted of a wide range of acts and omissions over the course of approximately two years in three different trusts. The panel went on to consider each charge found proved and make an assessment of whether the facts amounted to misconduct which was serious.

The panel found Mr Foley's conduct of leaving a patient in soiled clothing overnight compounded by the use of inappropriate absorbent dressings as a fundamental breach of good nursing practice. The panel found that although no actual harm occurred, it accepted the evidence from Witness 3 who stated this conduct could have compromised skin integrity, which could lead to serious infection, sepsis and even death.

Second, the panel considered Mr Foley's conduct of passing wind in front of patients and colleagues, and laughing when told not to, was highly unprofessional, inappropriate, and a breach of the NMC code, but did not rise to the level of serious professional misconduct.

Third, the panel considered Mr Foley's statement of "*I can't help it, it just slips out I've had a few dicks in my time and there is no good dick in Cardiff*" was highly inappropriate but

did not constitute serious misconduct. However, the panel found that Mr Foley's conduct of turning a serious cut on a vulnerable patient's leg into a sexual joke was reprehensible behaviour that did constitute serious misconduct. In particular, the panel found that Mr Foley's statement was made directly in the presence of a vulnerable patient who has just incurred a serious injury. The panel also noted that Mr Foley's statement was made directly in front of his colleagues who became incredibly uncomfortable to the point that a staff member found it necessary to speak with Witness 2 separately and express how inappropriate the comment was. The panel therefore found that Mr Foley's conduct of turning a serious leg injury of a vulnerable patient into sexual inuendo would seriously undermine the public's confidence and trust in the profession.

Fourth, the panel found that protecting a patient's dignity and privacy is a basic fundamental element of good nursing practice. The panel found that Mr Foley's conduct of leaving a patient naked, near an exit of a busy hospital emergency department, and potentially visible by other members of the public was a serious breach of the patient's privacy and constituted serious professional misconduct.

Fifth, the panel considered Mr Foley's conduct of failing to dispose of medical waste was a serious breach. Again, the panel found that keeping an area tidy and free of potential contamination is a fundamental and basic expectation of a nurse. The panel further found that medical waste has the potential to contaminate and could have created a serious infection risk and potential harm to patients. As such, Mr Foley's act or omission of failing to dispose of medical waste was a serious breach of the NMC Code.

Finally, and similar to the reasons noted directly above, the panel found that Mr Foley's conduct of leaving the treatment area unclean and untidy was also a serious breach. The panel found that leaving an area unclean and untidy could lead to potential contamination or tripping hazards. The panel also found that this conduct could lead to the treatment area being unfit for its purpose, especially in an emergency department where events are unpredictable. All of these issues posed a risk to patients, as well as the staff of the hospital. As such, the panel found Mr Foley's failure to maintain the cleanliness of the

treatment area to be a serious breach of the NMC Code and amounts to serious misconduct.

Accordingly, the panel found that Mr Foley's actions in charges 1, 2d, 3a) – 3c) did fall seriously short of the conduct and standards expected of a nurse and amounts to serious misconduct.

These acts and omissions put patients at a real and unwarranted risk of harm. Taking all of these failures into account, the panel found that Mr Foley's misconduct was a significant departure of what would be expected of a nurse and therefore amounts to a serious misconduct.

Decision and reasons on impairment

Prior to considering the matter of impairment, the panel considered the context in which the registrant found himself working at the time. The panel acknowledged that Mr Foley was working as an agency nurse during the pandemic, away from his family, working in unfamiliar departments and was likely unfamiliar with the team dynamics.

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

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

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

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

d) …

The panel found that the first three limbs of the *Grant* test were engaged in this case.

It found that Mr Foley put his patients at a risk of harm numerous times, in particular, the panel found that he failed to administer care properly, such as leaving a patient in soiled clothing overnight, failing to dispose of medical waste, leaving a patient in an exposed state, leaving the treatment area unclean and/or untidy, behaving so as to distract his colleagues and put patients at an unwarranted risk of harm. Further, the panel found no evidence or recognition that he should behave differently, no attempts to strengthen his practice, and in fact, demonstrated multiple attempts to shift blame onto others instead of taking responsibility.

All of these failures contributed to an unwarranted risk of harm to patients both at the time and in the future.

The panel went on to consider the second limb of *Grant* and found that by breaching the Code to the extent that he has and to the serious degree that he has, including everything from his actions or omissions towards his patients, as well as his behaviour in front of colleagues, Mr Foley has indeed brought the nursing profession into disrepute.

When considering the third limb of *Grant*, the panel found that Mr Foley breached fundamental tenets of the profession by failing to:

- prioritise the patients that he was overseeing;
- practise effectively by performing appropriate techniques when caring for patients, including failing to clean up his patients' environment and properly protect their privacy;
- preserve the safety of the patients by failing to ensure that they were in an

environment free from potential contaminations and leaving them in exposed conditions; and

- promote professionalism and trust of nurses who are there to protect vulnerable patients.

The panel considered that the final limb of *Grant* which relates to dishonesty was neither charged nor engaged in this case.

The panel went on to consider the case of *Cohen* and whether Mr Foley's conduct was remediable. The panel found that this misconduct is potentially remediable and capable of being addressed in the sense that he could be trained on proper cleaning procedures, obtain insight into his actions and take steps to avoid doing them in the future.

The panel first considered whether he has shown any insight into his misconduct, in particular, whether there was any evidence that Mr Foley had reviewed and reflected on his own performance, recognised that he should have behaved differently and put measures in place to ensure he had strengthened his professional practice so as to ensure it would not be repeated.

The only insight the panel saw was that [PRIVATE] and noted Mr Foley's apology for the offence caused and that he would do his utmost to ensure it would not happen again. Mr Foley also stated that he did not realise his words used when referring to the cut on the vulnerable patient's leg would be offensive. However, the panel does not regard this as meaningful insight. In fact, there is evidence from his written replies that he has attempted to minimise the incident, deflect the blame on others and make excuses. He did not take responsibility for his role or responsibilities as a registered nurse in charge of vulnerable patients. The panel considered this to be evidence of an attitudinal issue which is of concern.

There is no evidence that Mr Foley has taken any steps to address his misconduct.

The panel therefore determined that there is a real risk of a repetition of Mr Foley's misconduct.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel concluded that a reasonable well-informed member of the public would be shocked and troubled if a finding of impairment were not made in these circumstances and therefore, the panel concluded that it is necessary in order to maintain public confidence. Furthermore, the panel concluded that fellow practitioners would find the conduct deplorable and therefore a finding of impairment is also needed to maintain and uphold proper standards of conduct in the profession. For these reasons, the panel considered a finding of impairment on public interest grounds is appropriate.

The panel concluded that failure to practise the utmost care and caution when caring for patients needs to be taken seriously and the lack of meaningful insight on the part of Mr Foley needs to be addressed.

The panel determined that not to make a finding of impairment would significantly undermine the public's trust and confidence in the nursing profession. It is also necessary to mark the seriousness of the misconduct and to uphold proper standards and conduct for members of the nursing profession.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. The effect of this order is that the NMC register will show that Mr Foley has been struck from the register.

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

Submissions on sanction

Ms Wisniewska informed the panel that the NMC was seeking the imposition of a striking-off order.

Ms Wisniewska submitted that the following were aggravating features in this case:

- Mr Foley has demonstrated no insight into the misconduct;
- Mr Foley has demonstrated no meaningful understanding as to why what he did was wrong, and how his conduct negatively impacted the profession and his colleagues who were involved;
- Mr Foley failed to take responsibility for his comments regarding the leg wound, and chose to blame others instead;
- There are attitudinal issues present;
- There is no evidence of remediation; and
- Due to the lack of accountability and insight, there is a real risk of repetition.

Ms Wisniewska stated that there are no mitigating factors in this case but acknowledged the panel's decision that Mr Foley's conduct is remediable.

In respect of taking no action or imposing a caution order, Ms Wisniewska submitted that, given the panel's findings, this was not a case where either of those sanctions are appropriate as they do not mark the gravity of Mr Foley's actions or address the current risks posed to members of the public.

Ms Wisniewska went on to submit that a conditions of practice order would also not be appropriate in this case. She noted that Mr Foley has provided almost no insight into his misconduct and there is no evidence that he has taken any steps to address the concerns regarding his practice or conduct. She further noted that Mr Foley has displayed attitudinal issues. She submitted therefore that no workable conditions could be formulated that would address the concerns, and a conditions of practice order would not be sufficient to mark the gravity of the case.

Regarding a suspension order, Ms Wisniewska submitted that such an order would be not sufficient to address the risk posed to patients or the public's trust and confidence in the nursing profession or the NMC as a regulator. She submitted that a suspension order would not mark the seriousness of this case, nor would it maintain the public confidence in the nursing profession and the NMC as regulator. She further submitted that a suspension order would not be sufficient to protect the public from the risk of harm given the panel's findings that he is likely to repeat the conduct found proved, has attitudinal issues, and has taken no steps to remediate.

Ms Wisniewska submitted that a striking-off order is the appropriate order in this case. She submitted that Mr Foley's conduct is incompatible with him remaining on the register. In particular, she submitted that a striking-off order is the only sanction that will protect the public and maintain professional standards. She further submitted that the misconduct is serious enough to justify removing him from the register. She stated this is particularly true, given there was a sexual component with no insight, accountability or remediation. There are also attitudinal issues present as already noted.

Ms Wisniewska concluded by stating that in considering proportionality and in balancing the public interest and need for protection of the public against Mr Foley's own interests, the most appropriate and proportionate sanction in all the circumstances taking a holistic view of the case is a striking off order.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The panel has seen no evidence of any insight
- A pattern of misconduct and attitudinal issues over a period of time from November 2019 to June 2021
- Conduct which put patients at risk of suffering harm
- There is no evidence of remorse, remediation or efforts to strengthen his professional practice
- Although there is evidence of an apology, the panel determined this to be limited in nature
- The panel concluded that Mr Foley attempted to deflect blame and failed to take responsibility at the time of the incident and afterwards
- A failure to provide basic nursing care
- The conduct put vulnerable patients at unwarranted risk of suffering harm

The panel also took into account the following mitigating features:

- [PRIVATE]

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

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

The panel next considered whether placing conditions of practice on Mr Foley's registration would be a sufficient and appropriate response. The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on Mr Foley's 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 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;*

The panel found that none of these above factors lead to the suspension order being the appropriate order. On the contrary, the panel noted that there are attitudinal issues present, a lack of insight, a risk of repetition, and multiple instances of misconduct. The panel noted that making a suspension order when all of these issues are present would be contrary to the NMC Guidance and would not protect the public nor uphold public confidence in the profession. The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Foley's actions is fundamentally incompatible with Mr Foley remaining on the register.

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 Foley's 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 Foley's 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.

The panel found that there are fundamental questions relating to Mr Foley's professionalism. It considered the sexual element to the charges found proved, and the way in which Mr Foley conducted himself in front of vulnerable patients. Taking into account the facts of this case, the panel noted that a striking-off order would remove a nurse with attitudinal issues who has put patients at a risk of harm off the register. The panel also considered whether the public confidence in the profession could be maintained if a striking-off order was imposed and found that a lesser sanction of suspension would not be appropriate as described above.

While the panel did note that some of Mr Foley's conduct could be remediated through training, it found that the attitudinal issues would be significantly harder to address. The panel further considered that given the attitudinal issues present and the high risk of repetition, a lesser sanction would not be sufficient to protect the public and maintain professional standards.

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

The panel considered that this order was necessary to maintain 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 Foley in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Wisniewska. She adopted her submissions made during the striking-off order for this application and asked that an interim order be imposed for 18 months.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the 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 in order to protect the public and to uphold the public interest, during any potential appeal period.

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

That concludes this determination.