

**Nursing and Midwifery Council
Fitness to Practise Committee**

Substantive Hearing

Monday, 6 October 2025 – Friday, 10 October 2025

Monday, 13 October 2025 – Friday, 17 October 2025

Monday, 20 October 2025 – Friday, 24 October 2025

Virtual Hearing

Name of Registrant:	Acknowledge Ngwena
NMC PIN:	99H0595E
Part(s) of the register:	RNA: Registered Nurse – (sub part 1) Adult – Level 1 5 September 2002
Relevant Location:	Banbridge and Craigavon
Type of case:	Misconduct
Panel members:	Catherine Devonport (Chair, Registrant member) Genevieve Nwanze (Registrant member) Colleen Sterling (Lay member)
Legal Assessor:	Megan Ashworth
Hearings Coordinator:	Bethany Seed
Nursing and Midwifery Council:	Represented by Tom Hoskins, Case Presenter
Miss Ngwena:	Present and represented by James Halliday, instructed by Thompsons Solicitors
Facts proved by admission:	Charges 1(a), 1(d)(iv), 1(e), 1(f)(i), 1f(ii), 5(c), 7(a), 7(b), 8 and 10
Facts proved:	Charges 1(b), 1(c)(i), 1(c)(ii), 1(c)(iii), 1(d)(i) (to the extent that you did not ensure the records were kept), 1(d)(ii) (to the extent that you did not ensure that all induction records were counter signed), 1(d)(iii), 1(d)(v), 2(a), 2(b), 2(c), 3(a)(ii), 3(b)(i), 3(b)(iii), 5(a), 5(b), 6(a), 6(b), 9

Facts not proved:	3(a)(i), 3(a)(iii), 3(b)(ii), 4, 11
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on application to amend the charge

At the outset of the hearing, the panel heard an application made by Mr Hoskins, on behalf of the Nursing and Midwifery Council (NMC), to amend the format and numbering of charge 3.

The proposed amendment was to remove charge 1(d)(vi) and to reorder the contents of the charge into the current charge 3. It was submitted by Mr Hoskins that the proposed amendment would incorporate charge 1(d)(vi) into charge 3 and would provide clarity and more accurately reflect the evidence. He submitted that this amendment is in the interest of justice, and as it is an administrative amendment, causes no injustice to you.

The proposed amendment was as follows:

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

1. As of 24 March 2022 when the Regulation and Quality Improvement Authority (“RQIA”) inspected the Agency:
 - d. ~~In relation to staff at the Agency you did not ensure that:~~
 - vi. ~~all staff used appropriate manual handling techniques with service users including, but not limited to, the following:~~
 1. ~~Service User G~~
 2. ~~Service User E~~
 3. ~~Service User H~~
2. ...
3. ~~On one or more unknown dates you did not use appropriate manual handling techniques with the following service users:~~
 - a. ~~Service User B~~
 - b. ~~Service User C~~
 - c. ~~Service User I~~

In relation to manual handling techniques:

- a. On one or more unknown dates you did not use appropriate manual handling techniques with the following service users:**
 - i. Service User B**
 - ii. Service User C**
 - iii. Service User I**

- b. you did not ensure that all staff used appropriate manual handling techniques with service users including, but not limited to, the following:**
 - i. Service User C**
 - ii. Service User E**
 - iii. Service User H”**

Mr Halliday, on your behalf, did not oppose the proposed amendment as it is an administrative amendment that does not result in any injustice to you.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that the proposed amendment does not materially change the allegations, and that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It therefore determined that it was appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decisions and reasons to adjourn the hearing until 7 October 2025

Mr Hoskins informed the panel that further redactions to the NMC documents needed to be made before Witness 1 in these proceedings was called to give evidence. He submitted that the documents contained hearsay evidence, including anonymous hearsay, and information that could be prejudicial to you. He invited the panel to adjourn the hearing in order to allow him and Mr Halliday to work collaboratively to redact the documents. He submitted that this adjournment is in the interest of fairness to ensure that no prejudicial evidence is before the panel.

Mr Halliday supported this application.

The panel heard and accepted the advice of the legal assessor.

The panel determined to adjourn the hearing until 09:30 on 7 October 2025, in order to allow appropriate time for the documents to be redacted in the interest of fairness to you. The panel was satisfied that it could put any of the unredacted material that it has had sight of from its mind.

Details of charge (as amended)

That you, a registered nurse and as the Responsible Individual for Top Class Healthcare ("the Agency"):

1. As of 24 March 2022 when the Regulation and Quality Improvement Authority ("RQIA") inspected the Agency:
 - a. you did not ensure that the Agency was using staff rotas and/or a care planner to book calls to service users **[ADMITTED]**
 - b. you did not ensure that safeguarding records were kept/retained by the Agency **[PROVED]**
 - c. In relation to care calls provided by the Agency you:

- i. did not ensure that daily logs were returned to the Agency in a timely manner **[PROVED]**
 - ii. did not ensure that daily logs were kept/retained for one or more service users **[PROVED]**
 - iii. did not ensure that audits of daily logs were carried out **[PROVED]**
 - d. In relation to staff at the Agency you did not ensure that:
 - i. all new staff completed shadowing shifts or, alternatively, did not ensure that records of such shifts were kept **[PROVED]**
 - ii. all new staff received inductions and/or that new staff countersigned the induction records **[PROVED]**
 - iii. all staff had up to date training in place **[PROVED]**
 - iv. all staff received supervision or, alternatively, did not ensure that records of such supervision were kept **[ADMITTED]**
 - v. all staff received appropriate manual handling training **[PROVED]**
 - e. you did not ensure that an accurate list of services users was maintained by the Agency **[ADMITTED]**
 - f. In relation to quality/monitoring reports you:
 - i. did not ensure that monitoring reports were produced to a satisfactory standard **[ADMITTED]**
 - ii. did not ensure that you were reviewing such reports **[ADMITTED]**
- 2. You did not ensure that care calls were carried out by the Agency as required such that one or more calls were missed or conducted late/early including, but not limited to the following service users:
 - a. Service User C **[PROVED]**
 - b. Service User E **[PROVED]**
 - c. Service User F **[PROVED]**
- 3. In relation to manual handling techniques:
 - a. On one or more unknown dates you did not use appropriate manual handling techniques with the following service users:

- i. Service User B **[NOT PROVED]**
 - ii. Service User C **[PROVED]**
 - iii. Service User I **[NOT PROVED]**
 - b. you did not ensure that all staff used appropriate manual handling techniques with service users including, but not limited to, the following:
 - i. Service User C **[PROVED]**
 - ii. Service User E **[NOT PROVED]**
 - iii. Service User H **[PROVED]**
- 4. On one or more occasions you failed to maintain Service User B's dignity by leaving her unclothed in her chair **[NOT PROVED]**
- 5. In relation to Service User C:
 - a. on or around 14 January 2022 you demonstrated a poor attitude to Service User C's family member in response to being asked to return to Service User C's home **[PROVED]**
 - b. you inappropriately said to Service User C '*I wouldn't do this to you Service User C, I love you*' or words to that effect **[PROVED]**
 - c. you did not report to safeguarding an incident in which a carer had allegedly acted inappropriately in relation to Service User C's toileting **[ADMITTED]**
- 6. You did not ensure that carers at the Agency provided adequate care to Service User F on 25 January 2022 in that:
 - a. the carers did not ensure that Service User F consumed his medication **[PROVED]**
 - b. the carers did not prepare Service User F's breakfast **[PROVED]**
- 7. On at least one occasion after 11 March 2022 you carried out a visit to a service user in circumstances where:

- a. on 11 March 2022 you were told by an RQIA inspector that you should not conduct any visits to service users' homes or words to that effect
[ADMITTED]
 - b. on 11 March 2022 a protection plan was put in place that prevented you from carrying out visits to services users **[ADMITTED]**
8. During an RQIA inspection on 24 March 2022 when asked by an RQIA inspector whether you had been on any visits to service users since 11 March 2022 you said you had not or words to that effect **[ADMITTED]**
9. Your conduct in charge 8 above were dishonest in that you had in fact been on one or more visits to service users since 11 March 2022. **[PROVED]**
10. During an RQIA inspection on 24 March 2022 you told the RQIA inspector that there had been no accidents, incidents or safeguarding investigations since August 2021 **[ADMITTED]**
11. Your conduct at charge 10 above was dishonest in that you knew that there had in fact been one or more accidents, incidents or safeguarding investigations since August 2021. **[NOT PROVED]**

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

Background

The NMC received a referral on 15 April 2022 from Southern Health and Social Care Trust (the Trust), in relation to a number of allegations which occurred whilst you were the owner and the Responsible Individual at Top Class Agency (the Agency). You had set up

the Agency in 2019. On 19 August 2021, the Agency was subject to an unannounced Regulation and Quality Improvement Authority (RQIA) inspection following a previous Performance Notice issued against the Agency. At the time of the August 2021 inspection, all matters had been resolved, and the findings of the inspection team were that the Agency was providing safe and effective care. The allegations related to the period after that inspection, until a further unannounced inspection conducted by the RQIA on 24 March 2022. The Agency is an Independent Sector Domiciliary Care Provider. The Trust held a contract with the Agency, which commissioned Care Packages (including the provision of personal care to service users in their homes within the Trust's area) from the Agency.

You employed Person A to be the Registered Manager of the Agency between July 2021 and February 2022. Person A was a Registered Nurse and Registered Manager who had previously been involved in auditing and mock inspections at the Agency. Your position is that Person A sabotaged you and your business which was why the inspection in March 2022 revealed deficits in care and management at the Agency.

The RQIA received two whistleblowing referrals in relation to you and the Agency on 4 and 7 March 2022, involving a number of concerns directly related to the delivery of patient care. It is alleged that on 11 March 2022, you were told personally to cease patient care and verbally confirmed to the RQIA that you would do so. It is further alleged that you failed to abide by the instructions given by the body, and on 20 March 2022, you were in breach of the protection plan put in place by the RQIA. The whistleblowing referrals related to concerns about how the Agency operated, and specifically in relation to concerns about the staff being inappropriately trained. The anonymous referral on 7 March 2022 alleged that the referrer had attended a Service User's home and had seen that a staff member of the Agency had used the incorrect manual handling technique.

The Trust was then informed by the RQIA on 21 March 2022 that a further two whistleblowing reports had been received. The RQIA completed an unannounced inspection of the Agency in March 2022. On 4 April 2022, the RQIA invited you to a

meeting to discuss the proposal to cancel the Agency's registration with the RQIA. The meeting took place on 6 April 2022 and the RQIA issued a Notice of Proposal to cancel the Agency's registration on 11 April 2022.

The Trust informed you on 15 April 2022 that they had decided to cancel their contract with the Agency, with effect from 25 March 2022. The Trust made a referral to the NMC on the same date.

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

Mr Hoskins made a request that this case be held partly in private in relation to an application under Rule 22(5) of the Rules for the panel to direct that Witness 2 attend this hearing to give evidence. He submitted that his application would make reference to Witness 2's [PRIVATE] and therefore should be heard in private. The application was made pursuant to Rule 19 of the Rules.

Mr Halliday did not oppose this application.

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

The panel determined to go into private session in order to hear the application for directions to be made, in order to protect Witness 2's right to privacy.

Decision and reasons on application for the panel to make a direction for Witness 2's attendance at the hearing

Mr Hoskins made an application under Rule 22(5) of the Rules inviting the panel to make a direction for Witness 2 to attend this hearing to give evidence. Mr Hoskins submitted that Witness 2 was warned to attend the hearing on 8 October 2025, and at approximately 09:15 on the day, he and the Hearings Coordinator had conducted a pre meeting to discuss the procedure of giving evidence. He submitted that prior to the meeting, and in the pre meeting, there was no indication that Witness 2 would be unable to attend to give evidence. He informed the panel that at 09:56 on 8 October 2025, the Hearings Coordinator received an email from Witness 2, stating the following:

'Im so sorry to do this but I need to pull out of giving evidence. I really thought I could do it but I came off that video call [PRIVATE]. I thought I would be ok to do this but Im really not. Im so sorry to do this but I just dont feel able. I do hope my witness statement can still be used.

Im so sorry [sic]'

Mr Hoskins submitted that the Hearings Coordinator had invited Witness 2 to rejoin the hearing link to have a conversation about supporting them, but that no correspondence had been received. He submitted given the late-stage nature of this information, the panel could exercise its discretionary case management powers to direct that Witness 2 attend this hearing. He submitted that informal communication had been sought with Witness 2, but that there had been no response from the witness for approximately two and a half hours. He submitted that this application is appropriate at this time to try and secure Witness 2's attendance, rather than to proceed with a potential hearsay application in respect of Witness 2's evidence.

Mr Halliday submitted that he did not oppose the application. He submitted that the panel has a discretionary power to grant this application, and he invited the panel to consider all of the information before it prior to making any decision on the application.

The panel heard and accepted the advice of the legal assessor.

The panel first considered the relevance of Witness 2's evidence to the charges. The panel was satisfied that Witness 2's evidence is particularly relevant to the charges regarding the manual handling of several service users. The panel considered the chronology of events leading to Witness 2's attendance at this hearing. The panel noted that Witness 2's witness statement was prepared in 2022 and included a paragraph confirming that they would be willing to attend a hearing to give evidence. The panel noted that Witness 2 had been warned by the NMC Case Officer that they would be required to give evidence on 7 – 8 October 2025 and the NMC had received no information to suggest that Witness 2 had any reluctance about giving evidence. The panel further noted that Mr Hoskins and the Hearings Coordinator had completed a pre meeting discussion with Witness 2 which lasted approximately 20 minutes and there were no obvious signs of any reluctance from Witness 2 and that they had confirmed they would be ready for 10:00. The panel considered that the first indication of any reluctance on the part of Witness 2 was at 09:56, and in this email, Witness 2 provides some insight into their personal circumstances and [PRIVATE] which has led to their wish to pull out. The application was made by Mr Hoskins at approximately 13:00 on 8 October 2025.

The panel next considered whether it would be proportionate to exercise its discretionary case management powers to make a direction for Witness 2 to attend. The panel was satisfied that it would be proportionate to formulate a direction for Witness 2 to attend, given the relevance of their evidence. The panel determined that this direction could include reasonable adjustments to best support them in giving their best evidence.

The panel determined to make the following direction:

“The panel directs you to return to the hearing to give your evidence. This is because your evidence will assist the pane in its consideration of this case. If you can identify any special measures or reasonable adjustments which will assist you in giving your evidence, we would want to help and support with that. The panel

directs you to respond to the NMC by 17:00 on Thursday 9 October 2025 to arrange an appropriate time to give evidence. This will be no later than Monday 13 October 2025.”

This direction was given to Witness 2 by email following the panel's decision.

Decision and reasons on application for the panel to make an amendment to the direction for Witness 2 to attend the hearing.

Mr Hoskins informed the panel that Witness 2 had re-engaged with the Hearings Coordinator and confirmed that they would be available on the morning of 10 October 2025 but they would be at work, or they could be available on Tuesday 14 October 2025. He invited the panel to amend the direction in order for Witness 2 to give evidence on 14 October 2025.

Mr Halliday did not oppose the application.

The panel heard the advice of the legal assessor.

The panel confirmed on record that it was satisfied that the direction could be amended to allow scope for Witness 2 to attend on 14 October 2025 in order to prevent any barriers to them giving evidence. The panel was satisfied that it would not cause any undue delay to this case, and it was in the interest of fairness to allow Witness 2 to attend on 14 October 2025.

Decision and reasons on application to exclude parts of Witness 7's evidence

Mr Halliday made an application to exclude parts of Witness 7's evidence on the basis that it includes opinion evidence outside the scope of Witness 7's expertise. He submitted that

Witness 7 gives some evidence regarding the seriousness of the allegations made against you, despite not being an independent expert in this area. He submitted that opinion evidence provides weight to the evidence, and therefore it would be unfair for it to be considered by the panel in its deliberations wherein Witness 7 is not an independent expert on these matters.

Mr Halliday provided written submissions and made supplementary oral submissions. He submitted that it is not accepted that Witness 7 is entitled to give opinion evidence on the following grounds:

- He is not sufficiently independent from the parties or the investigations in this case.
- He has not provided his qualifications which would entitle him to give opinion evidence.
- There is no signed declaration in respect of the duties of an expert so as to ensure fairness to you.
- The panel does not require evidence on this matter as it goes outside of the charges that you face at this stage.

Mr Halliday further submitted that Witness 7's evidence will not assist the panel in its deliberations because the application of the NMC Code is a matter for the panel to determine. He submitted that this is an experienced panel, with knowledge of the NMC Fitness to Practise guidance and standards. He further submitted that the panel has the evidence of Witness 1, who has set out the relevant domestic framework in respect of the RQIA.

For those reasons, Mr Halliday submitted that the parts of Witness 7's evidence that stray into the realm of expert opinion evidence should be excluded from the evidence before the panel at this time.

Mr Hoskins also provided written submissions and gave supplementary oral submissions. He submitted that the NMC opposes this application to exclude parts of Witness 7's evidence.

Mr Hoskins submitted that Witness 7's evidence is relevant to the panel's deliberations on misconduct and impairment, which he suggested is a stage that will be reached given the admissions made by you, and notwithstanding any potential submissions on an application for no case to answer. He submitted that there may be a risk in excluding the evidence at this stage, given that its relevance to the issue of any misconduct or impairment is unclear before the panel makes its findings on the fact of this case. He submitted that Witness 7's evidence will assist the panel in its determination. He further submitted that Witness 7's evidence is not overly academic, and it provides the Trust's perspective from a more independent perspective with a higher degree of experience and expertise.

Mr Hoskins submitted that the admission of Witness 7's evidence is fair and does not impede your ability to challenge Witness 7's view through cross examination. He submitted that despite being aware of the documents of Witness 7, you have not challenged their evidence or instructed an expert witness of your own. Mr Hoskins further submitted that the distinction between witnesses of fact and opinion is not as clear cut as made out by Mr Halliday. He submitted that even if the panel was to be concerned that the independence of a witness giving an opinion was subject to a legal prohibition, there is nothing to suggest that Witness 7's independence has been eroded in the circumstances of this case.

Mr Hoskins submitted that Witness 7 is uniquely qualified to speak to the application of relevant standards and guidelines. He submitted that Witness 7 has knowledge of the particular circumstances of the Trust, the profile of service users and the contracted car packages during the COVID-19 pandemic. He submitted that Witness 7's qualifications are set out in his witness statement which is supplemented by a statement of truth. He submitted that if the panel is not satisfied by this, it can request further documentation regarding Witness 7's qualifications.

The panel accepted the advice of the legal assessor.

The panel first considered whether the opinion evidence of Witness 7 is admissible in any case.

The panel considered Witness 7's independence. It considered that Witness 7 works for the Trust that held a contract with you during the time of the allegations.

The panel also bore in mind that your referral to the NMC was made by the Trust. The panel recognised that Witness 7, as an employee of the Trust, is not fully independent from these proceedings. However, the panel accepted Mr Hoskins' submission that Witness 7 had no working relationship with you, and his personal knowledge of you was limited to your name and title. The panel accepted that you and Witness 7 interacted in a single meeting within the Trust.

The panel noted that there is not a formal declaration of independence in Witness 7's witness statement, but that there is a signed statement of truth which confirms that his statement is true to the best of his knowledge and belief. The panel also noted that Witness 7 is a registered nurse, with experience which would have been gathered since his registration in 1990.

In respect of Witness 7's expertise and qualifications, the panel noted that Witness 7 is the Directorate Professional Nurse Lead at the Trust, where he provides professional leadership to all staff at the Trust and ensures that staff are facilitated to provide high quality, safe and effective care. Witness 7 also represents the Adult Community Services (ACS) in regional groups and is responsible for setting direction in relation to patient and client safety, nursing workforce and education, quality and experience, Key Performance Indicators as well as research and development.

In his witness statement, Witness 7 further states:

'I also provide expert nursing advice and support on issues within the ACS Directorate related to patient / client safety, nursing workforce and education, quality and experience, both within the Trust and in the private and voluntary sectors.'

The panel noted that Witness 7 has over 35 years of experience as a nurse, and at the time of writing his statement in 2024, Witness 7 had been in his role for over two years. The panel also noted that at the time of the allegations, Witness 7 had been in post for approximately one month.

The panel bore in mind that there is case law that recognises that the demarcation between witnesses of fact and opinion in regulatory proceedings is not as distinguished in civil proceedings. The panel determined that in these particular circumstances, it is clear that Witness 7 has expertise in the matters of concern in this case which were developed within his role at the Trust.

The panel acknowledged that Witness 7 is not truly independent from you, in that Witness 7 works in a leadership role within the Trust and has responsibilities for supporting the Trust with matters of client and patient safety. However, the panel is of the view that there is sufficient independence between you and Witness 7 as you did not work together meaningfully within the Trust. The panel determined that, for the purposes of determining whether the opinion evidence is admissible, there is sufficient independence between Witness 7 and you.

The panel next considered whether Witness 7's evidence will assist the panel in its decision-making. The panel considered whether the opinion evidence offered by Witness 7 was broadly outside the knowledge of a panel. It considered that Witness 7 speaks to the internal framework and expectations of the Trust, not just the clinical matters that a registrant panel member may have knowledge of. The panel considered that the evidence that Witness 7 gives lies outside the knowledge that would ordinarily be expected of a lay

person. In light of this, the panel is satisfied that the opinion evidence of Witness 7 is likely to assist the panel with its decision making.

In all the circumstances, the panel determined that Witness 7 is sufficiently independent from you and has relevant expertise that falls outside the scope of what would ordinarily be expected of a lay person and will therefore assist the panel with its deliberations. The panel concluded that the opinion evidence of Witness 7 would be admissible.

The panel noted that Witness 7's opinion evidence will form part of the panel's deliberations on misconduct and impairment, which is not relevant at this fact-finding stage of the proceedings. However, it was satisfied that it could hear Witness 7's evidence in one sitting and consider the weight of the evidence in due course.

Decision and reasons on facts

The panel heard from Mr Halliday who informed the panel that you made full admissions to charges 1(a), 1(d)(iv), 1(e), 1(f)(i), 1f(ii), 5(c), 7(a), 7(b), 8 and 10

The panel therefore finds these charges above proved in their entirety, by way of your admissions.

Mr Halliday further submitted that you made a partial admission to charge 1(d)(i) in that you accept that a record was not kept for all shadowing shifts, but you deny that shadowing shifts were not completed. He further submitted that you made a partial admission to 1(d)(ii) in that you accept that not all induction records were countersigned but deny that new staff did not receive inductions.

The panel heard legal advice from the legal assessor regarding the partial admissions.

The panel determined that it would consider charges 1(d)(i) and 1(d)(ii) in due course, as these are not full admissions to those charges.

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

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: Inspector at the RQIA at the time of the allegations.
- Witness 2: Carer and Team Leader at the Agency at the time of the allegations.
- Witness 3: Community Nurse at the Trust at the time of the allegations.
- Witness 4: Monitoring Officer at the Trust at the time of the allegations.
- Witness 5: Relative of Service User C.
- Witness 6: Relative of Service User E.
- Witness 7: Directorate Professional Nurse Lead at the Trust.

The panel also heard evidence from you under oath.

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 both the NMC and you.

The panel considered your assertion that the various whistleblowing complaints, and the subsequent NMC referral, are the result of at least two individuals sabotaging you and the Agency. The panel carefully considered these allegations made by you to provide context to its deliberations.

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

Charge 1b)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

1. As of 24 March 2022 when the Regulation and Quality Improvement Authority (‘RQIA’) inspected the Agency:
 - b. you did not ensure that safeguarding records were kept/retained by the Agency”

This charge is found proved.

In reaching this decision, the panel considered whether, as the Agency’s Responsible Individual (RI), you had a responsibility to ensure that safeguarding records were kept and

retained appropriately. The panel accepted that as the RI, you had the right to delegate tasks to a manager.

The panel took into account the evidence of Witness 1, in particular their witness statement which states:

'Ms Ngwena also had an overarching responsibility in relation to the management of staff as the Responsible Individual by virtue of being required to ensure effective systems of governance and oversight are maintained within the Agency (as per the regulation in paragraph 11 above). Ms Ngwena would also have been responsible for ensuring that monthly quality monitoring reports are undertaken of the Agency which provides an analytical review of the Agency, which looks at recruitment, training, supervision/appraisals, accidents/incidents, safeguarding referrals, Northern Ireland Social Care Council ("NISCC")/NMC registrations of staff, complaints...'

The panel also had regard to the Statement of Purpose for the Agency, in particular the section titled "Safeguarding and Promoting Wellbeing." This documents states:

'Our full Safeguarding Policy includes procedures covering:

- Safe recruitment*
- Informing service users of their rights*
- Identifying potential abuse*
- Reporting suspected, alleged or confirmed cases of abuse*
- Confidentiality and record keeping*
- Managing emergency situations*
- Training and supervision'*

The Statement of Purpose for the Agency, which was published in February 2020, also states:

‘THE RESPONSIBLE PERSON / REGISTERED MANAGER

The person registered with The Regulation and Quality Improvement Authority as the

Responsible Person is:

Acknowledge Ngwena’

In light of the above, the panel considered that as the RI, you retained responsibility for oversight and governance of the Agency. The panel next considered whether, having delegated tasks to Person A as a manager, you had a duty to ensure that these tasks were undertaken, specifically in respect of keeping and retaining safeguarding records. The panel considered Witness 1’s witness statement, which states:

‘I was concerned with the safeguarding records at the Agency, as I would expect to see clear and robust records kept detailing any referrals, meeting minutes arising from this and any action plans. The Agency did not have any records, despite the fact that there were a large number of safeguarding concerns raised (as per information shared with RQIA from the Trust during the meeting on 23 March 2022’

The panel noted that in their oral evidence, Witness 1 confirmed that they had seen no record of some of the safeguarding concerns they had raised, which they stated they would have expected to see when conducting the inspection on 24 March 2022. The panel considered that in Witness 1’s statement, they stated:

‘...there were two concerns raised with the Agency, one in relation to potential action taken about a carer who was involved in a safeguarding concern, and another regarding an email found in the Agency’s complaints folder about a service user falling during a night visit, which resulted in a verbal warning being issued to a care worker.’

The panel also had regard to the Multi-disciplinary Meeting Minutes dated 23 March 2022, which are a contemporaneous record of a discussion regarding investigations into allegations of abuse of service users from the Agency. These minutes state the following:

'[Person B] advised that six investigations were active, and eight APP1s received in total, some of which were secondary to trust[sic] scoping exercises.'

The panel had regard to the RQIA Inspection Report dated 24 March 2022, which states:

'During the inspection the responsible individual stated that there had not been any accidents, incidents or safeguarding investigations since the previous inspection on 19 August 2021. RQIA had been made aware by the SHSCT of a number of ongoing safeguarding investigations. RQIA had not been notified of any incidents within this timeframe.'

The panel had regard to the Meeting Minutes from the RQIA's meeting with you, dated 6 April 2022 which states:

'AN was asked if she was aware of her responsibilities in relation to the reporting and recording of safeguarding incidents. AN was unable to provide this information.'

The panel noted that Witness 1 at the time of the incidents was an inspector for the RQIA, and it considered their evidence to be independent and credible. The panel noted that the live evidence given by Witness 1 was consistent with the contemporaneous documentary evidence.

The panel further noted that you had been the "Safeguarding Champion" at the Agency. Witness 1 in their oral evidence confirmed that being the Safeguarding Champion involved specific training to a higher level which would explain the processes of safeguarding and the steps to take if safeguarding referrals came to your attention.

The panel took into account the Adult Safeguarding Policy, published by the Department of Health, Social Services and Public Safety which the Trust has provided. It states that the role of the Adult Safeguarding Champion is:

*‘The role of the **Adult Safeguarding Champion** is:*

- To ensure accurate and up to date records are maintained detailing all decisions made, the reasons for those decisions and any actions taken;’*

The panel bore in mind your evidence, that you delegated the task of keeping and updating safeguarding logs to Person A. You stated in your evidence that you employed Person A as the Registered Manager of the Agency, and that you only noticed that the safeguarding records had not been maintained after Person A left the agency.

The panel also noted your oral evidence, in which you stated that the Trust stopped sending APP1s in November 2021. You stated that you kept the APP1s in files in the office to maintain the records. The panel considered that this was inconsistent with the findings of the RQIA Report in March 2022.

In light of the above, the panel determined that there is sufficient evidence to find charge 1b proved.

Charge 1c)i)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

1. As of 24 March 2022 when the Regulation and Quality Improvement Authority (“RQIA”) inspected the Agency:
 - c. In relation to care calls provided by the Agency you:

- i. Did not ensure that daily logs were returned to the Agency in a timely manner”

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, the RQIA Inspection Report dated 24 March 2022 and your oral evidence.

In particular, the panel had regard to Witness 1’s statement that:

‘The Agency should have a separate record of call [sic] which has been completed, and these should be recorded in the service users’ daily logs. This should be signed and brought back to the Agency offices after visits are completed, and this should be audited so that any missed or late calls are noted. However, I found during my inspection that daily logs had not been returned in a timely manner by the Agency.’

Witness 1 confirmed in their oral evidence that the service users’ daily logs needed to be returned in a timely manner to identify any missed calls so that these could be audited for any issues or concerns. This was consistent with the findings in the RQIA Investigation Report dated 24 March 2022.

In the Meeting Notes between you and Witness 1 dated 6 April 2022, you stated the following:

‘AN advised that she was planning to collect daily logs weekly and filed and a monthly audit carried out once all records received.’

In your oral evidence, you confirmed that daily logs were kept in the service users’ homes, and in the office. You explained that you delegated responsibility for these logs to Person A and you expected the collection of the records weekly. You informed the panel that you

told Person A and Witness 2 to file these daily logs before they forgot, as the Trust may require them at any time.

For the same reasons as cited above for charge 1b, the panel determined that as RI of the Agency, you had a responsibility to ensure that daily logs were returned for all service users. The panel considered the evidence of Witness 1 to be consistent and credible and noted that some of the evidence was contemporaneous. The panel was of the view that your response to the allegation that you were “*planning to do it*” implies that you knew that it was not already being done. The panel noted that this was a task that you delegated to Person A. However, the panel was not satisfied that this prevented you from being accountable.

The panel determined that, on the balance of probabilities, it is more likely than not that you did not ensure that the daily logs for service users were returned to the Agency in a timely manner.

Charge 1c)ii)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

1. As of 24 March 2022 when the Regulation and Quality Improvement Authority (‘RQIA’) inspected the Agency:
 - c. In relation to care calls provided by the Agency you:
 - ii. did not ensure that daily logs were kept/retained for one or more service users”

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, the RQIA Inspection Report dated 24 March 2022, and your oral evidence.

In particular, the panel considered Witness 1's findings in the RQIA Inspection Report, which states:

'The daily logs for one service user were not available for review, despite the package of care having commenced in September 2021.'

This was reaffirmed in Witness 1's witness statement to the NMC, which confirmed:

'I had asked Ms Ngwena for daily logs for random service users. For one service user, no daily logs were available in their file [Service User S]. Their package of care commenced in September 2021 and the inspection was done in March 2022, and therefore at least five months of daily logs had not been returned.'

When asked about this in evidence, Witness 1 confirmed that they had asked for a random sample of service users, and that you had not been able to provide information to them regarding a process that was used to keep and maintain the daily logs. In cross examination, it was put to Witness 1 that the daily logs of the service user could have been removed by Person A or Witness 2 for malign reasons. Witness 1 confirmed that they could not comment on that and could only observe that the documents were not there for review when they conducted the inspection.

The panel took into account your oral evidence that you delegated keeping and maintaining daily logs for service users to Person A and Witness 2. However, the panel was not satisfied that this negated your responsibility to have oversight of the process by which daily logs were kept and maintained. The panel also noted that in your oral evidence, you did not dispute Witness 1's findings in respect of this allegation.

In these circumstances, the panel was satisfied that there was no robust system in place that staff at the Agency were following to ensure records were kept and retained by the Agency. The panel bore in mind that the evidence before it was only in respect of one service user. However, the panel determined that the NMC has discharged the evidential burden in respect of this charge, and it concluded that you did not ensure that daily logs were kept and maintained for at least one service user.

Charge 1c)iii)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

1. As of 24 March 2022 when the Regulation and Quality Improvement Authority (‘RQIA’) inspected the Agency:
 - c. In relation to care calls provided by the Agency you:
 - iii. did not ensure that audits of daily logs were carried out”

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 2, the RQIA Inspection Report dated 24 March 2022, the RQIA Call Log from 4 March 2022, your Interview Notes dated 6 April 2022 and your oral evidence.

The panel considered the RQIA Report which states:

‘There was a significant delay in the auditing of the logs, therefore any concerns identified could not be followed up in a timely manner. The lack of safe systems has the potential to place service users at risk of harm.’

The panel noted that in Witness 1's statement, they explained that in respect of the daily logs:

'I am aware that no audits were completed as, when an audit is done of daily logs, they are signed off by the auditor and the missed calls should have been identified.'

I asked Ms Ngwena how they were monitoring calls to service users, and what their auditing process was. I cannot recall the exact response Ms Ngwena gave, but they were not able to provide an explanation [...] The daily logs are returned to the Agency and should be audited to ascertain if there have been any missed calls which resulted in missed meals or medication, any early or late call or calls not in line with the service user's care plan.'

The panel noted that in your response to the RQIA Inspection Report in the meeting minutes from 6 April 2022, you stated:

'AN advised that she was planning to collect daily logs weekly and filed and a monthly audit carried out once all records received.'

The panel bore in mind Witness 2's witness statement, which in relation to the auditing of the daily logs, states:

'As a team leader, I should have assisted with auditing and filing care plans, but Ms Ngwena did not provide any training for this, and I therefore did not any[sic] involvement with this.'

The RQIA Whistleblowing Referral Call Log on 4 March 2022 states:

'Caller was put in charge of audits - daily records, food charts etc. Caller noted records had not been update [sic] in 6 months/year prior to her starting. Caller was not shown how to do these audits.'

In their oral evidence, Witness 2 confirmed that they were the anonymous whistleblower listed in the call logs. The panel considered that this evidence was consistent with the findings of Witness 1 in the RQIA Report. The panel also had regard to the oral evidence of Witness 2, in which they described that they were told to *“tick everything on the audit sheet”* and that the daily logs were thrown in drawers in *“chaos.”*

The panel considered your oral evidence that Witness 2 was responsible for completing the audits of the daily logs. You stated that Witness 2 had not been told to tick everything, as there were things on the sheet that would not have needed ticking. You stated that Person A should have been responsible for checking that Witness 2 was completing the audits. When you were asked in your evidence whether you were checking, you stated that you could have been, but that you were travelling from Northern Ireland to England where your [PRIVATE], so you were not checking regularly. The panel also noted your response when asked what efforts you were making to check that you said you were busy, under pressure and did not have time to check due to staff shortages.

The panel considered that this was a concession on your part that you had not been checking that the daily logs were audited. The panel bore in mind its earlier conclusion that as RI you had responsibility to ensure that the daily logs were audited. It noted that some responsibility lay with Person A and Witness 2, but that as RI you had overall oversight of this process within the Agency. Therefore, the panel determined that the audits were not completed, and you did not ensure that they were completed, and so this charge is found proved.

Charge 1d)i)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

1. As of 24 March 2022 when the Regulation and Quality Improvement Authority ('RQIA') inspected the Agency:
 - d. In relation to staff at the Agency you did not ensure that:
 - i. all new staff completed shadowing shifts or, alternatively, did not ensure that records of such shifts were kept"

This charge is found proved to the extent that you did not ensure that records of shadowing shifts were kept.

In reaching this decision, the panel took into account Witness 1's statement, the RQIA Interview Notes with Witness 2, the RQIA Interview Notes with you and your partial admission.

The panel first considered the evidence it has heard in respect of whether you did not ensure that such shifts were carried out. In particular, Witness 1's statement states:

'New staff members are required to have an induction lasting three full days and shadowing shifts of experienced staff members in keeping with minimum Standards...Upon my review of the records and files at the Agency during the inspection, I found no evidence that shadowing shifts had been undertaken.'

The panel noted the findings of the RQIA Inspection Report, that:

'A review of the records of new staff identified that they had not been provided with a three day induction period; the records of shadowing a suitably qualified and experienced person identified that some were not appropriately signed, hence there was inadequate evidence that these processes had been completed.'

The panel noted that there are no records before it to show that the shadowing shifts were completed. The RQIA report identifies that there were some records of the shadowing shifts taking place, but these were not adequately signed and therefore they were

considered inadequate evidence that the shifts had been undertaken for the purpose of the report.

The panel considered that in Witness 2's interview notes with the RQIA on 22 March 2022, they confirmed that:

'she shadowed other staff at the beginning – one of the ones she shadowed was a carer who was nearly sacked because of her behaviour.'

The panel noted the wording of the charge, and that the charge refers to ensuring that all new staff completed shadowing shifts. The panel noted that Witness 2 in their oral evidence described the shadowing shifts they had done as “*inadequate*” and the RQIA report confirms that there were “*some*” records, although these were not adequately signed.

In your oral evidence, you told the panel that new staff shadowed either yourself, Person A or Witness 2. You stated that the reason that there were no adequate records for the shadowing shifts was because staff members forgot to sign the records, but you maintained that the shifts took place.

The panel noted the legal assessor's advice that the panel could make reasonable inferences from the evidence provided but that it cannot speculate. The panel considered that the evidence before it is limited in respect of whether or not the shadowing shifts themselves took place. It considered that the NMC has not provided sufficient evidence to discharge the burden of proof that all new staff did not complete shadowing shifts.

The panel bore in mind that you had partially admitted this charge, in that you admitted that you did not ensure that a record was kept of the shadowing shifts. Therefore, the panel finds this charge proved to the extent that you did not ensure that an accurate record was kept for all new staff's shadowing shifts.

Charge 1d)ii)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

1. As of 24 March 2022 when the Regulation and Quality Improvement Authority (‘RQIA’) inspected the Agency:
 - d. In relation to staff at the Agency you did not ensure that:
 - ii. all new staff received inductions and/or that new staff countersigned the induction records”

This charge is found proved to the extent that you did not ensure that new staff countersigned the induction records.

In reaching this decision, the panel took into account the Agency’s Statement of Purpose, the evidence of Witness 1, the RQIA Inspection Report, Witness 2’s Interview Notes, the APP1 referral dated 4 March 2022 and your oral evidence.

The panel first considered whether all new staff to the Agency received inductions. The panel had regard to the Agency’s Statement of Purpose, which states:

‘We take great care in recruiting, training and supervising our staff. They possess a range of experience and qualifications in the care of older people and people with dementia; mental health problems; physical disabilities; sensory impairment; HIV/AIDS; and those recovering from illness, are ill, or are terminally ill.

- *The range of qualifications and training of the support workers employed by Top Class Health Care include:*
- *Structured Induction training encompassing the Common Induction Standards...*

The panel bore in mind the RQIA Inspection Report findings, specifically:

‘During the inspection it could not be evidenced that the responsible individual had ensured new staff were recruited using a robust and safe recruitment process, and had received appropriately structured induction, training and supervision.’

In Witness 1’s statement, they confirmed that:

‘Furthermore, there were no records to show induction had been completed with new members of staff, as Ms Ngwena was the only signatory on induction materials (i.e. there was no evidence that the inductee had completed the induction, and no evidence that staff received supervision).’

The panel also considered the Interview Notes of Witness 2, dated 22 March 2022 which state:

‘She wasn’t shown on the job , feels if she didn’t have experience in her own right she would have struggled , she advised there was no induction to any of the clients individually , wasn’t made aware of care plans, what the clients needed or how the equipment was used before she was thrown into runs , she advised that she learnt on the job’

The panel considered this evidence to be consistent with Witness 2’s account recorded in the APP1 referral dated 4 March 2022, which states:

‘Caller also raised concerns regarding lack of training, staff working without an AccessNI check being completed. Staff not being made aware of the policies and procedures.’

The panel noted your oral evidence that you completed inductions with all new staff. The panel considered that you described the induction process at the Agency in detail. You told the panel that new staff were invited to the office to complete all of the documentation needed for the role. You told the panel that at the induction you would see whether new staff could apply the training they had. You confirmed that the policies and procedures were provided to the staff for them to read.

The panel noted that there is some evidence that inductions took place, although the evidence of Witness 1 suggests that the inductions were not adequately completed. However, the panel noted that the charge does not reference the adequacy of the induction. Therefore, the panel could not be satisfied that you did not ensure that all new staff received an induction. The panel was of the view that the NMC has not discharged the burden of proof in respect of whether the inductions took place. The panel therefore determined that this charge is proved only to the extent that you did not ensure that the induction records of new staff were countersigned.

Charge 1d)iii)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

1. As of 24 March 2022 when the Regulation and Quality Improvement Authority (“RQIA”) inspected the Agency:
 - d. In relation to staff at the Agency you did not ensure that:
 - iii. all staff had up to date training in place”

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement, the APP1 referral dated 4 March 2022, the RQIA Inspection Report, the RQIA Call Log dated 4 March 2022 and your oral evidence.

In particular, the panel considered Witness 1's statement which states:

'I found, through looking at the staff training matrix, that a number of staff were not up to date with their training, and there were members of staff who had since left the Agency but were still listed on the training matrix.'

The panel considered in their oral evidence, Witness 1 confirmed that for the purposes of the RQIA Inspection, the usual process was to look at the training matrix rather than at individual training certificates in the interest of time. The panel considered this account to be consistent with the account of Witness 2, who had reported the lack of training in an APP1 referral to the RQIA's Guidance Team on 4 March 2022.

In the RQIA Call Log dated 4 March 2022, Witness 2 stated:

'Caller completed manual handling etc. in Belfast. Staff are not shown any policies and procedures (there aren't any). No accident/incident report forms. Staff are not trained in CPR - caller stated she had to perform CPR on a client who was unconscious. When caller asked re training etc. they were told 'just document it'.'

In your oral evidence, you told the panel all of the training that would have been expected for new staff to have, such as manual handling and life support training. You told the panel that you kept track of the training completed by staff using a register of attendance. You informed the panel that it was the responsibility of Person A and the administrator of the Agency who had left, prior to the March 2022 inspection. You provided the panel with the RQIA Inspection Report from August 2021 where the RQIA had found that all training was up to date. You told the panel that you put trust in the wrong people to help with the administration at the Agency.

The panel also considered the Quality Improvement Plan included in the RQIA Inspection Report. It noted that in your response detailing the actions to be taken, you acknowledge that there are several steps to take to ensure that all new staff have up to date and sufficient training for their role.

The panel accepted your evidence that in August 2021, all of the staff training at the Agency was up to date as was evident in the report of the unannounced RQIA inspection on 19 August 2021. However, the panel was mindful that the charge relates to the 24 March 2022. The panel also accepted the evidence of Witness 1, who is an independent witness to you and the Agency, and their account is supported by the evidence of Witness 2. The panel was satisfied that there is evidence that on 24 March 2022, not all staff member's training was up to date and therefore it determined that this charge is proved.

Charge 1d)v)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

1. As of 24 March 2022 when the Regulation and Quality Improvement Authority (“RQIA”) inspected the Agency:
 - d. In relation to staff at the Agency you did not ensure that:
 - v. all staff received appropriate manual handling training”

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2, the RQIA Call Log dated 4 March 2022, Witness 2's interview notes dated 22 March 2022 and your oral and documentary evidence including bank statements evidencing payment to Person C for training.

In particular, the panel noted Witness 2's witness statement which states:

'When I attended double calls (i.e. calls to clients requiring two carers) with younger carers, who were new in their role, they would express concerns around manual handling, stating they did not feel confident as they had not received any training or have any experience in manual handling

...

I told Ms Ngwena in person, on multiple occasions (I cannot recall exactly when) that they should provide manual handling training to staff, and Ms Ngwena would say words to the effect of "yeah I'll look into that" but they did not ever seem to take action.'

The panel also had regard to the RQIA Whistleblowing call log from 4 March 2022, in which Witness 2 stated:

'Caller stated she is aware that a staff member did not receive manual handling training...'

This was further supported in Witness 2's Interview Notes with the RQIA dated 22 March 2022, where they stated:

'There was no hands on manual handling training given – there was equipment in the office but this was never used'

In their live evidence, Witness 2 further stated that they had not received any training between when they started the role in July 2021 until much later. Witness 2 told the panel that they only received manual handling training which Person A had organised, and that the hoist was in the office and *"gathering dust."* Witness 2 also told the panel that once Person A arranged it, they received manual handling from Person C. Witness 2 told the panel that carers were not confident, and some were making mistakes. The panel also

had regard to the Trusts' Manual Handling Policy, which outlines what manual handling technique would be appropriate.

The panel bore in mind your live evidence, in which you stated that all staff received manual handling training from Person C. You supported this by providing evidence of your training certificate and your bank statements including payments to Person C. The panel was not satisfied that this meant that all staff received manual handling training.

The panel considered that there is evidence that some manual handling training was done by you, Person A and Witness 2. It further considered your evidence that Person A should have made you aware if other staff required training as you would have organised it for them. The panel was of the view that Witness 2's evidence is consistent and supported by contemporaneous documents and bank statements, in that the bank statements demonstrate that there were no payments to Person C between July 2021 (when Witness 2 started employment at the Agency) and November 2021. Witness 2 stated that there was no practical training, and that they worked with people who did not have training. Therefore, the panel is satisfied that some members of staff at the Agency did not have appropriate manual handling training. Given its findings previously, the panel was also satisfied that you did not ensure that all members of staff had appropriate manual handling training. Therefore, the panel finds this charge proved.

The panel considered the evidence in respect of charge 1 within the context of your assertion that the allegations are the result of sabotage of you and the Agency. The panel considered that many of its factual findings in respect of charge 1 are based on the evidence of Witness 1, who was independent of you and the Agency and was also independent of Person A. Therefore, their evidence is not tainted by allegations of sabotage.

The panel noted that it has made reference to the evidence of Witness 2, who you allege has been part of the conspiracy against you and the Agency. In relation to the evidence of Witness 2 that is relevant to charge 1, the panel was not satisfied that there is any

objective evidence of sabotage. It was satisfied that in each instance in charge 1 where it had accepted the evidence of Witness 2, their evidence was not the sole evidence but was supported by other independent or contemporaneous evidence. The panel bore in mind that it will likely consider the evidence of Witness 2 in relation to other charges in due course, and it determined to consider your allegation of sabotage at each charge to ensure proper consideration is given to your defence.

Charge 2a)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

2. You did not ensure that care calls were carried out by the Agency as required such that one or more calls were missed or conducted late/early including, but not limited to the following service users:
 - a. Service User C”

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 2, the RQIA Interview Notes with Witness 2, the RQIA Investigation Report, the evidence of Witness 5 and your oral evidence.

The panel first considered whether there is general evidence of missed or late/early calls by the Agency. The panel had regard to Witness 1’s statement which states:

‘I reviewed a number of daily logs during an inspection and noted that there were a significant number of missed calls.’

The panel took into account Witness 2’s statement, which states:

‘Each call is scheduled for 30 minutes, making the call physically impossible to fulfil. Me and the other carers I was working with, would often be late to our calls because of this.’

This is supported by the evidence in the RQIA Interview Notes, in which Witness 2 states the following:

‘There was a lot of missed calls, people were missed off the rotas a lot , she would have been the one who would have flagged it to Cathy – if she hadn’t noticed a client wasn’t on the rota they would have been missed –this happened frequently –’

The panel noted that in your response to the RQIA Inspection Report dated 6 April 2022, you stated:

‘AN stated she did not believe there were missed calls as paperwork can be left in care workers’ cars and not always brought in the office but could provide no evidence to substantiate this view.’

The panel also took into account your live evidence. You informed the panel that there were some instances where you struggled to complete calls on time because you were struggling with staff shortages. When you were asked in cross examination whether you were made aware of late/missed calls, you told the panel that you were because you did not have enough staff.

In light of the above, the panel was satisfied that there is general evidence to suggest that there were missed calls for one or more service users.

The panel next considered whether there was evidence of missed or late/early calls to Service User C in particular. The panel took into account the oral and documentary evidence of Witness 5 and your evidence.

In Witness 5's statement, they state:

'On many occasions Top Class carers were late to calls, and I refer to the text message conversations [...] in which I have asked Ms Ngwena why the carers have not arrived, or Ms Ngwena informing me that carers would be late. These calls were, on average, 30 to 40 minutes late, with some visits being up to an hour late.

...

[PRIVATE].'

The panel had regard to the text messages between Witness 5 and you. The panel was satisfied that this was a contemporaneous record of several occasions where either yourself or other carers at the Agency were late to calls with Service User C.

The panel also had regard to the Scoping Exercise completed by Person D, the Social Worker, in respect of Service User C. In particular, it noted that Person D reported that:

'Family experience of Top class Agency (Missed calls, staff attitude, length of call)

- No missed calls, however 1 carer only at times.*
- Lateness of call, up to 1 hour late, mostly at tea call.*
- 'Cathy' always late and generally in the mornings when covering other staff.*
- 'Cathy' would have notified NOK [Witness 5] by text if she was going to be late, would have phoned when POC first started.'*

The panel considered that there is credible, consistent and contemporaneous evidence that there were several occasions on which Agency staff were late to calls with Service User C. The panel bore in mind its findings about your responsibility as RI, and it was satisfied that you did not ensure that calls were carried out on time. Therefore, the panel finds this charge proved.

Charge 2b)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

2. You did not ensure that care calls were carried out by the Agency as required such that one or more calls were missed or conducted late/early including, but not limited to the following service users:
 - b. Service User E”

This charge is found proved.

In reaching this decision, the panel took into account Witness 6’s live and documentary evidence, the Scoping Exercise completed by Person E, the RQIA Interview meeting with you on 6 April 2022 and the APP7 completed for Service User E.

The panel noted Witness 6’s witness statement, in particular:

‘I also had concerns around late and missed calls. On a number of occasions, Ms Ngwena had promised me that they would be attending a visit to my dad, but I had to phone them up and ask whether anyone would come out. There calls were sometimes attended as late as 22:00, when they were scheduled for approximately 19:00 to 20:00.’

In their oral evidence, Witness 6 was asked about whether they knew Person A. Witness 6 could not recall, but they said they could have spoken to them on the phone regarding Service User E.

The panel had regard to the Scoping Exercise form completed by Person F, another Social Worker, on 18 March 2022, which states:

*‘[Witness 6] (son) reports Top Class have missed calls around 2 times,
as they had staffing issues*

...

Have been up to 2 hours late’

The panel also noted the APP7 form completed in respect of Service User E, which states:

*‘It is evident that Top Class missed calls to [Service User E] after the AM call on
23/03/2022. No calls were provided 24/03/2022 and 25/03/2022.’*

In these circumstances, the panel was satisfied that there is contemporaneous and consistent independent evidence that there were missed/late calls by the Agency in respect of Service User E. Therefore, the panel finds this charge proved.

Charge 2c)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

2. You did not ensure that care calls were carried out by the Agency as required such that one or more calls were missed or conducted late/early including, but not limited to the following service users:
 - c. Service User F”

This charge is found proved.

In reaching this decision, the panel took into account Witness 3’s evidence and the care notes for Service User F.

In particular, the panel noted Witness 3’s statement, which states:

'I was scheduled to visit Service User F twice a day in order to administer insulin injections. My morning visits were at 09:00, so I could administer Service User F's insulin, and so that Top Class carers could arrive at 9:05 to make Service User F's breakfast and assist them in eating it.

On 25 January 2022, I arrived at Service User F's house at 09:00, and as I arrived the Top Class carers were already leaving (I am not aware of the carers' names). I did not have any discussion or handover with the Top Class carers.'

The panel was of the view that this provides clarity on when calls should have been made to Service User F. The panel noted that calls to Service User F before 09:00 would be too early, as the Agency carers had to make breakfast for Service User F within 15 minutes of them taking their insulin.

The panel bore in mind the daily care notes of Service User F, dated 25 January 2022. It noted that on this date, the carers arrived at 08:40, making them early for this call. The panel also had regard to the care notes for 18 January 2025, which also showed that the Agency carers arrived at 08:30, and left at 08:50.

The panel was of the view that there is contemporaneous and independent evidence that calls were made early in respect of Service User F. In particular, on 25 January 2022. Therefore, the panel was satisfied that you did not ensure that calls were carried out at the appropriate time, in that they were carried out early, in respect of Service User F. The panel therefore finds this charge proved.

The panel considered the evidence in respect of charge 2 within the context of your assertion that the allegations are the result of sabotage of you and the Agency. The panel considered that many of its factual findings in respect of charge 2 are based on the evidence of Witness 5, Witness 6 and Witness 3. These witnesses are independent of you, Witness 2, Person A and the Agency. The panel was satisfied that there is no objective evidence of sabotage in respect of charge 2.

Charge 3a)i)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

3. In relation to manual handling techniques:

- a. On one or more unknown dates you did not use appropriate manual handling techniques with the following service users:
 - i. Service User B”

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2’s evidence, the APP1 referral dated 4 March 2022, the Domiciliary Care Request for Service User B, the Manual Handling Risk Assessment for Service User B and your oral evidence.

In particular, the panel had regard to the evidence of Witness 2, which states:

‘I attended calls alongside Ms Ngwena to another client, [Service User B] (I cannot recall their surname) who did not have dementia and would be vocal about their concerns with Ms Ngwena’s rough manual handling.

...

Ms Ngwena was rough when washing and applying the cream, again rubbing up and down on [Service User B’s] legs vigorously, which caused [Service User B] to [PRIVATE].’

In respect of you using an inappropriate manual handling technique to pull Service User B up, Witness 2 states:

'When trying to stand [Service User B] up in the morning, Ms Ngwena would pull their arm, rather than hooking and scooping Ms Ngwena up under [Service User B]'s arm. I am aware this is inappropriate from the manual handling training I received from [Person A], as mentioned above.'

The panel had regard to the Domiciliary Care Request for Service User B, dated 22 December 2021, which states that Service User B required:

'Patient currently requiring Ax2 with personal care and dressing tasks secondary to reduced standing tolerance and reduced AROM in bilateral knees. Reduced function of right upper limb notes...

Bed: Ax2 required with all bed mobility secondary to reduced function of right upper limb and reduced AROM in bilateral knees.

...

Patient requiring Ax1 for lie-sit bed transfer, however required Ax2 with sit-lie transfer to assist lower limbs into bed and Ax2 to reposition in bed due to poor mobility.'

In addition, the panel noted the most recent Manual Handling Risk Assessment for Service User B, dated 23 December 2021. It noted that Service User B required assistance with sit to stand transfers and used the Stedy safe system when required. The panel also considered the Trust's Manual Handling Policy, which described the steps necessary to complete a sit to stand from chair move with two carers using a cross-body hold. In light of this, and Witness 2's reference to "hooking and scooping" Service User B's arms to lift them, the panel was not satisfied that Witness 2 understood the appropriate manual handling technique to use with helping Service User B from sit to stand.

The panel considered your response to this allegation. The panel noted that in your Interview Notes, dated 25 April 2022, you stated:

‘Acknowledge stated that she would not respond to anyone in a rough way, clarification was given that it was physically rough and rushing [Service User B] was what had been reported. Acknowledge denied that she rushed or was rough with [Service User B] and that this was not possible with [Service User B] as a result of her physical presentation and she could not be rushed due to her condition.’

The panel considered this to be consistent with your oral evidence that you were not rough with Service User B. It also considered your evidence that you have 19 years of nursing experience with regular manual handling training. The panel noted that there have been no previous concerns about your manual handling. It also considered the evidence that you had been too rough in your application of the cream. The panel accepted your evidence that the District Nurse showed you how to apply the cream to Service User B.

The panel considered that both Witness 2 and you have been consistent in the evidence given in respect of this charge. The panel was not satisfied that Witness 2’s evidence was more credible than yours in respect of this charge. In light of the above, the panel considered that it could not be satisfied that it is more likely than not that you did not use the appropriate manual handling techniques with Service User B.

Charge 3a)ii)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

3. In relation to manual handling techniques:

- a. On one or more unknown dates you did not use appropriate manual handling techniques with the following service users:
 - ii. Service User C”

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, Witness 5's evidence, the Manual Handling Risk Assessment for Service User C, APP1 and APP7 for Service User C, the Scoping Exercise in respect of Service User C, the RQIA interview Notes with you dated 25 April 2022 and your evidence.

In particular, the panel notes Witness 2's statement, which states:

'[Service User C] could not stand or walk, and they were a high falls risk. Ms Ngwena and I needed to manoeuvre [Service User C] from their wheelchair into another chair, or from the bed onto a commode, or from the bed into their wheelchair. Rather than hoisting [Service User C], which would be the safest option, Ms Ngwena would insist on getting [Service User C] to stand and take a few steps to get to the other chair.'

The panel also had regard to the statement of Witness 5, who states:

'On multiple occasions, Ms Ngwena would make my mum stand up from a sitting position, unassisted or by just place [sic] their hand on mum's back, and expect my mum to move themselves into a wheelchair by shuffling a few steps to the side, and sitting down into the wheelchair.'

'My mum had very limited mobility and I felt this practice was unsafe. I would tell Ms Ngwena that it was too much to expect my mum to stand unassisted, and move themselves into the wheelchair. I told Ms Ngwena not to do this, and to assist my mum moving into the chair, but Ms Ngwena did not listen to my concerns.'

The panel considered that this evidence was supported by the Scoping Exercise completed by Person D in respect of Service User C, which states:

‘NOK reports that new staff introduced on 06.03.2022 and completed MH without reading MHRA, and at this time they were with ‘Cathy’ and ‘Cathy’ stated that client could stand by herself unaided, NOK had to step in to state that this was wrong and client required support of 2 staff as per Care Plan.’

The panel took into account the Patient Manual Handling Risk Assessment Form for Service User C, which describes that Service User C required sit to stand assistance with two carers and a cross-body hold.

The panel noted the APP1 referral in respect of Service User C, which states:

‘Reports To Class health care owener[sic] went out last week to service user with a new carer [Service User C]’s daughter spoke to the key worker and advised Top class HC owner[sic] told the carer [Service User C] can mobilise with one carer when her care plan says two is required.’

The panel noted that the live evidence of Witness 5 was consistent with the documentary evidence recorded at the time. Witness 5 confirmed in their evidence that you would sometimes say things like “you’ve got this, you can get up” to Service User C. Witness 5 told the panel that sometimes Service User C would shuffle to the point that their leg was shaking and they could not support themselves. Witness 5 described that they felt like you did not listen to their concerns, and that this happened quite a few times.

The panel considered that you deny this allegation. It bore in mind that in your interview with Witness 7, you stated:

‘Acknowledge denies having said same, and states she was very aware that client ws[sic] unable to mobilise and needed Ax2 staff for MH.’

The panel was of the view that there is consistency in the evidence provided by Witness 2, Witness 5 and there is documentary evidence that supports this version of events. The

panel considered that the actions attributed to you as described by Witness 2 and Witness 5 were contrary to the Manual Handling needs of Service User C. It noted that whilst it had not previously preferred Witness 2's evidence in respect of your manual handling of service users where it was the sole evidence in respect of a charge, it now had independent evidence that supported Witness 2's account. Therefore, the panel was satisfied that it was more likely than not that you did not use the appropriate manual handling technique in respect of Service User C.

Charge 3a)iii)

"That you, a registered nurse and as the Responsible Individual for Top Class Healthcare ("the Agency"):

3. In relation to manual handling techniques:

a. On one or more unknown dates you did not use appropriate manual handling techniques with the following service users:

iii. Service User I"

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2, the Interview Notes with Witness 2 dated 22 March 2022, the Trust's Manual Handling Policy and your evidence.

In particular, the panel considered the witness statement of Witness 2, which states:

'Rather than using a hoist (which would be the safest way to move [Service User I]), Ms Ngwena would try to lift her in bed. I frequently told Ms Ngwena that [Service User I] should have a hoist, as [Service User I] did not appear to be comfortable when being moved.

...

When moving [Service User I], I recall Ms Ngwena would grip onto [Service User I]'s wrists and arms to pull [them] up, rather than putting their arms underneath [Service User I]'s armpit to scoop her up.'

The panel also took into account the Interview Notes with Witness 2 dated 22 March 2022, in which Witness 2 states:

'...she was rough applying cream , breaking sores as she was being too rough , there was a lady with stiff shoulders, Cathy would have been rough and pulled the arms into the sleeves , some of the clients would have cried out...'

The panel considered that in your evidence, you deny this allegation. You told the panel that you would not have done this, as Social Services had provided a sliding sheet for this service user. You denied that you vigorously rubbed cream on Service User I, and told the panel you have 19 years of nursing experience, during which time you have also worked as a district nurse.

The panel considered that both Witness 2 and you have been consistent in the evidence given in respect of this charge. The panel was not satisfied that Witness 2's evidence was more credible than yours in respect of this charge. In light of the above, the panel considered that it could not be satisfied that you did not use the appropriate manual handling techniques with Service User I on the balance of probabilities. The panel therefore determined that this charge is not proved.

Charge 3b)i)

"That you, a registered nurse and as the Responsible Individual for Top Class Healthcare ("the Agency"):

3. In relation to manual handling techniques:

- b. you did not ensure that all staff used appropriate manual handling techniques with service users including, but not limited to, the following:
 - i. Service User C”

This charge is found proved.

In reaching this decision, the panel took into account Witness 5’s evidence, the Scoping Exercise completed by Person D and its previous findings in respect of charge 1d)v) that you did not ensure that all staff had appropriate manual handling training.

In particular, the panel noted Witness 5’s statement, that:

‘I had concerns with the manual handling techniques used by some carers at Top Class. I recall a carer (I cannot recall their name) who, on multiple occasions, would assist my mum getting up from a wheelchair on the commode by pulling my mum up by their arms. Mum had injured her arm so that it did not extend fully. I felt this method was unsafe, as it could have injured my mum’s arms.’

The panel also noted that in the Scoping Exercise, Witness 5 reported to Person D that:

‘MH standards concerning and seriously declined around Sep 2021 as reported by NOK. Carers described as not reading care plan or following MHRA, and would grip client by the arms to lift her. SW noted that MHRA updated by DCOT on 14.03.2022 and ‘Body Map’ completed on 11.03.2022.’

The panel considered that there is consistent and credible evidence that carers at the Agency did not use appropriate manual handling techniques in respect of Service User C. In light of the panel’s previous finding regarding charge 1d)v) and your responsibilities at the RI of the Agency, the panel was satisfied that you did not ensure that carers used the appropriate manual handling technique in respect of Service User C.

Charge 3b)ii)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

3. In relation to manual handling techniques:

- a. you did not ensure that all staff used appropriate manual handling techniques with service users including, but not limited to, the following:
 - ii. Service User E”

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 6’s evidence, the APP7 report for Service User E, the Scoping Exercise completed for Service User E and your evidence.

The panel noted that in the APP7 report for Service User E, reference is made to a telephone call from the Investigation Officer to Witness 6 regarding the “*potential drag lift.*” The panel also noted that in Witness 6’s statement, they state:

‘I had positioned my hand underneath Dad’s armpit, on the left arm, when the other carer came behind me and placed their hand underneath mine, and attempted to pull Dad up with force. I had to intervene and tell the carer to be careful, because I could feel the amount of force they were using, and I was concerned that this technique could risk dislocating Dad’s shoulder.’

However, in contrast the panel also noted that in the Scoping Exercise report, completed nearly two years before Witness 6’s witness statement, Witness 6 said that they had no concerns about the manual handling and that “*Top Class adhere to MH.*”

The panel took into account your live evidence. In particular it noted that you said you had not known about Witness 6 finding a carer using the incorrect manual handling technique, but that you had planned to send all new carers on manual handling training.

The panel was of the view that Witness 6 is the only witness that can provide evidence in respect of this charge. It noted that Witness 6 had been inconsistent with their account of manual handling and therefore the panel determined that there is insufficient evidence for it to be satisfied that it is more likely than not that it occurred. Therefore, the panel concluded that this charge is not proved.

Charge 3b)iii)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

3. In relation to manual handling techniques:

b. you did not ensure that all staff used appropriate manual handling techniques with service users including, but not limited to, the following:

iii. Service User H”

This charge is found proved.

In reaching this decision, the panel took into account Witness 4’s evidence, the Trust’s Manual Handling Policy, the APP1 for Service User H dated 28 March 2022, the Interview Notes with you dated 25 April 2022 and your evidence.

In particular, the panel noted Witness 4’s statement that:

‘When Service User H was assisted into bed it was evident that their feet was too close to the footboard of the bed and too far down from the pillow. The two carers

manoeuvred Service User H up the bed using an under arm lift repositioning the Service User onto the pillows at the top of the bed.

The use of this technique is concerning as there is a risk of injuring to the Service User and a risk of back or tissue damage to the carers themselves. I would have expected the carers to follow the Trust's Moving and Handling Procedure...'

In their live evidence, Witness 4 confirmed that they witnessed this occur and that it was the wrong technique to use. They also stated that this was a snapshot of manual handling at the Agency, rather than an overall picture.

The panel considered the APP1 referral, in which Witness 4 reported that:

'Carers x2 used an under arm lift to reposition service user up the bed as she was too close to the bottom. A slide sheet should have been used to adhere to Manual Handling Policy and procedures[sic]. Both carers admitted this under arm lift was used previously on a few occasions.'

In your Interview Notes dated 25 April 2022, you stated:

'Acknowledge states she requested sliding sheet and she was aware that not allowed to lift client in the bed. Acknowledge advised that a Sliding sheet was in the house, and therefore not sure why staff did not use this. Issued by District Nursing.'

The panel considered that there is direct, contemporaneous evidence that carers used an inappropriate manual handling technique in respect of Service User H. The panel also noted that this account has been consistent, and that Witness 4 gave evidence that the carers confirmed that this was common practice. The panel noted your evidence, that you had trained your staff in manual handling, but you could not explain why the staff members did not use the sliding sheet. However, given this panel's findings regarding your duty to ensure that all staff members had appropriate manual handling training, the panel

considered that there is sufficient evidence before it to conclude that you did not ensure that staff used the appropriate manual handling technique in respect of Service User H. The panel therefore finds this charge proved.

The panel considered its findings in relation to charge 3 and your allegations of sabotage. The panel noted that where it has found a charge proved, it has found consistent, independent evidence in support of its findings. The panel also noted that, where the evidence of Witness 2 has been the only evidence in respect of the charge, this panel has determined that the NMC has not discharged the burden of proof as it has not proven that Witness 2's account is more credible than yours. Therefore, the panel is satisfied that there is no objective evidence of sabotage in respect of charge 3.

Charge 4

"That you, a registered nurse and as the Responsible Individual for Top Class Healthcare ("the Agency"):

4. On one or more occasions you failed to maintain Service User B's dignity by leaving her unclothed in her chair"

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, the Interview Notes with Witness 2, the APP1 for Service User B and your evidence.

In particular, the panel noted that Witness 2's statement states:

'I also had concerns that Ms Ngwena would not preserve [Service User B]'s dignity, in that on multiple visits, Ms Ngwena would remove [Service User B]'s clothes and leave them sitting in their chair naked, without using a towel or cover to preserve

[Service User B]’s dignity. I told Ms Ngwena on a few occasions to cover [Service User B] with a towel, but Ms Ngwena did not respond to me.’

The panel noted that in their interview Notes, Witness 2 describes that you:

‘...put people in a commode she rushed them off it , didn’t cover people up with a towel, didn’t maintain dignity , one client cried as she was embarrassed as Cathy stripped her and left her on the commode with no towel...’

The panel considered that the APP1 dated 7 March 2022 in respect of Service User B states:

‘...caller alleges the care provider owner[sic] name Acknowledged is been[sic] neglectful and rough when completing hands on care to [Service User B], says she is rushing the care and this is having a negative impact on [Service User B]. [Service User B] reports to be frightened of the care provider, says she has made a previous complaint to the TRUST/RQIA...’

The panel noted that in their cross examination, Witness 2 confirmed that Service User B was left naked and that Witness 2 lifted up a towel to cover them to preserve their dignity. The panel also bore in mind your live evidence. You told the panel that you knew how to protect people’s dignity. You said that you would not have left a service user naked without a cover. You explained the steps you would take if you were washing and dressing a service user. You told the panel that you treat everyone with respect and dignity, and that Witness 2 never told you to cover up Service User B.

The panel considered that both you and Witness 2 have provided consistent evidence on this allegation. The panel also considered that you have consistently denied this allegation. It noted that you have years of experience as a district nurse, and this is the only allegation of this nature. The panel considered your evidence and that you were able to walk the panel through the steps you would take to wash and dress a service user.

Therefore, panel determined that NMC have not discharged the burden as one account is not more credible than another. The panel finds that this charge is not proved.

Charge 5a)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

5. In relation to Service User C:

- a. on or around 14 January 2022 you demonstrated a poor attitude to Service User C’s family member in response to being asked to return to Service User C’s home”

This charge is found proved.

In reaching this decision, the panel took into account Witness 5’s live evidence, the text messages from Witness 5 to Person A, the APP1 referral and your evidence.

In particular, the panel noted Witness 5’s statement, which states:

‘After both carers left (approximately 5 minutes after they left) when I was assisting mum on her chair, I noticed that her clothes were soaked through, as mum had been incontinent.

I phoned Top Class and spoke with Ms Ngwena [...] and asked for a carer to come back and help with my mum. [...] During the telephone call, Ms Ngwena was not happy about returning, and they had an angry tone of voice. I cannot recall exactly what Ms Ngwena said, but they were reluctant to return to my house, and eventually agreed to come back after a visit.

...

I recall thinking Ms Ngwena's attitude was negative and they were unhappy about being asked to return. Ms Ngwena was very cross with me, and I felt their tone and demeanour was not friendly. I thought this, as Ms Ngwena had the audacity to blame me, stating that I had dressed mum in wet clothing.'

The panel considered that this is consistent with the text messages that Witness 5 sent to Person A, which read:

'Mums skirt and slip were wet and stinking...she had cheek to say mum should have said...'

The panel also noted the APP1 referral in respect of this event, where Witness 5 reported

'NOK requested carers return to provide person care to client and 'Cathy' described as being very 'angry' about having to return to client.'

In their live evidence, Witness 5 told the panel that you had an angry tone of voice, and that you were willing to return but that you were reluctant because you said you had checked Service User C before you left and they were apparently fine.

The panel considered that you have denied being angry at all. It had regard to your Interview Notes, in which you state:

'I was not angry at all and I even said to the daughter, you know how much I want to do things right always, sorry it was a mistake that we didn't notice that her dress was slightly wet and we were not even rushing to go.'

You told the panel in your evidence that you had not been rude or angry but that you had been talking in a low tone when on the phone to Witness 5 as you were in another service user's home. You said it was possible that Service User C had been incontinent immediately after you left.

The panel considered that both you and Witness 5 have provided consistent and credible evidence. The panel considered the context that has been provided to the panel, that the Agency were short staffed and rushed to make all calls in a day. The panel was of the view that it was probable that any delay could have caused frustration. The text messages are a contemporaneous record of the event. Witness 5 in the text messages refers to the fact that you were wearing gloves and therefore would not have known if Service User C's skirt was wet. The panel was of the view that the text messages were prompted by Witness 5's interaction with you on this day, and was satisfied that they record Witness 5's observations of your poor attitude at the time, in having to return to the call. The panel therefore determined to accept Witness 5's evidence in respect of this incident, and it considered that it was more likely than not that you demonstrated a poor attitude when asked to return. Therefore, the panel finds this charge proved.

Charge 5b)

"That you, a registered nurse and as the Responsible Individual for Top Class Healthcare ("the Agency"):

5. In relation to Service User C:

- b. you inappropriately said to Service User C '*I wouldn't do this to you Service User C, I love you*' or words to that effect"

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's evidence, the text messages from Witness 5 to Person A and your evidence.

In particular, the panel noted Witness 5's witness statement, which states:

'Ms Ngwena addressed my mum directly, and said words to the effect of "I wouldn't do this to you [Service User C], I love you", which I found to be emotionally manipulative, and an inappropriate thing to say to my mum. At this time, my mum had capacity to understand Ms Ngwena's comments.'

The panel considered that this is supported by the contemporaneous text messages to Person A, which state:

'how dare she come back in here telling my mum I love you [Service User C] I'd never do this purposely is like emotional blackmail as mum then got upset after saying I'd made a fuss about it and I could have easily changed her myself'

The panel noted that when Witness 5 was asked in cross examination why there was no mention of this incident in the Scoping Exercise with Person D, Witness 5 responded that they had definitely mentioned it, but they had sent the text to Person A right after the incident happened and so it was an accurate reflection.

The panel noted that you have denied this allegation, saying that these are not your words and this is not something that you would usually say. However, the panel considered that the text messages, which were sent almost immediately after your visit to Service User C's home, are a contemporaneous record of this incident. The panel was of the view that Witness 5's anger about the incident was prompted by an interaction between you and them which made them feel as though they had to raise a concern with Person A. The panel therefore determined to accept Witness 5's evidence, and it considered it was more likely than not that this incident occurred. The panel therefore finds this charge proved.

In respect of your allegations about sabotage, the panel noted that it had relied on the evidence of Witness 5, who is independent from you and the Agency. The panel was therefore satisfied that in relation to charge 5, there is no objective evidence of sabotage.

Charge 6a)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

6. You did not ensure that carers at the Agency provided adequate care to Service User F on 25 January 2022 in that:
 - a. the carers did not ensure that Service User F consumed his medication”

This charge is found proved.

In reaching this decision, the panel took into account Witness 3’s live and documentary evidence, the APP1 for Service User F dated 23 March 2022 and the daily care notes for Service User F.

In particular the panel had regard to Witness 3’s statement, which states:

‘I entered Service User F’s house, and noticed there was a pot of oral medication was left in an egg cup on Service User F’s kitchen table (I cannot recall what the medication in the egg cup was). This is a concern as the Top Class carers had not witnessed Service User F taking their medication, but on my review of Service User F’s notes (kept in their house) I saw that the carers had recorded that the medication had been taken.

I then observed Service User F taking their oral medication (which was left in the egg cup). I was concerned by the carer’s actions, as Service User F has dementia, and may forget to take their medication. Therefore, Service User F needs to be observed by a healthcare professional when taking their medication.’

The panel also considered the APP1 dated 23 March 2022, which indicated that concerns had been raised about the Agency’s carers following the scoping exercise in relation to

medications not being given at allocated times and medications being left out when the care plan commissions them for administering.

The panel had regard to the daily care notes of Service User F on 25 January 2022, which stated that *“meds given & will be taken when nurse has been.”* The panel also noted that this exact wording was used on numerous other dates. It further noted that on the dates where you attended Service User F’s home, you noted that their breakfast and medications were *“taken.”* The panel was of the view that this meant that when the carers attended Service User F’s home, the medication was dispensed but was not administered.

The panel had regard to your Interview Notes dated 25 March 2022, which state:

‘Acknowledge stated that client had capacity and questioned why staff had to give her tablets, this is why they left them for her at client’s direction despite administration being a commissioned task’

In your oral evidence, you confirmed that the carers knew they had to witness the medication being taken, and that the care plans would be in the service user’s folder. You said that you told the carers to check the care plans regularly for any updates. You stated that you spoke with Person A and other staff to ensure they did not leave the tablets, and no one had reported anything to you since then.

The panel considered that there is contemporaneous documentary evidence that the carers at the Agency did not ensure that Service User F took their tablets before leaving on 25 January 2022. Given this panel’s previous findings regarding your responsibility of oversight as RI, the panel was also satisfied that you did not ensure that Service User F consumed his medication on 25 January 2022. It therefore found this charge proved.

Charge 6b)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

6. You did not ensure that carers at the Agency provided adequate care to Service User F on 25 January 2022 in that:
 - b. the carers did not prepare Service User F’s breakfast”

This charge is found proved.

In reaching this decision, the panel took into account Witness 3’s evidence, the daily care records for Service User F and your Interview Notes dated 25 April 2022.

In particular, the panel had regard to Witness 3’s witness statement which states:

‘The carers had advised me (when they were on their way out of Service User F’s house) that they had not made Service User F their breakfast. Service User F needs to eat some food within 15 minutes of taking their insulin. I made Service User F some breakfast, administered their insulin, and assisted Service User F to eat their breakfast. I was concerned that Top Class carers had arrived earlier than scheduled (i.e. before 09:05) and had not fulfilled their task of making Service User F their breakfast, which is a concern because I am scheduled to arrive specifically at 09:00 to administer Service User F’s insulin, and Service User F needs to eat within 15 minutes after receiving this dose.’

The panel noted that the daily care records contradicted Witness 3’s evidence, as the records state that *“breakfast was made & left for when nurse has been.”*

However, the panel also took into account an email from Witness 3 to Person D, dated 25 January 2022 which states:

'I was in with [Service User F] this am for morning insulin and the carers had just left. Her medications were still in the egg cup in the kitchen. I made her breakfast and ensured meds were taken.'

The panel considered that this is contemporaneous evidence that supports Witness 3's evidence. The panel considered the evidence of Witness 3 as credible and consistent. It therefore determined to accept Witness 3's evidence over that of the daily log signed by the carers as the panel was not satisfied that these were an accurate record of the call on the day.

The panel further considered your Interview Notes dated 25 April 2022, in which you accepted that the timings of calls to service user's homes was an issue and that staff had been advised to follow the timings on the DC1.

In these circumstances, the panel was satisfied that the carers did not prepare Service User F's breakfast and that you, as RI, did not ensure that Service User F's breakfast was made.

In respect of your allegations of sabotage, the panel considered that its findings in charge 6 are based on the evidence of Witness 3 (who is independent of you and the Agency) and contemporaneous, documentary evidence. It was therefore satisfied that there is no objective evidence of sabotage that has been considered in relation to charge 6.

Charge 9)

"That you, a registered nurse and as the Responsible Individual for Top Class Healthcare ("the Agency"):

9. Your conduct in charge 8 above were dishonest in that you had in fact been on one or more visits to service users since 11 March 2022."

This charge is found proved.

In reaching this decision, the panel took into account your admissions at charges 7 and 8 that you had admitted carrying out a visit to a service user after 11 March 2022, when you had been told not to by an RQIA Inspector and a Protection Plan was in place. You also admitted that when asked by an RQIA inspector whether you had been on any visits to service users since 11 March 2022 you said you had not, or words to that effect.

The panel bore in mind the advice of the legal assessor in respect of charges relating to dishonesty. The panel first considered what you knew, or believed to be the facts of this specific circumstance at the time.

The panel considered the witness statement of Witness 1, which states:

‘As mentioned above, the Trust advised Ms Ngwena to not personally deliver care to service users, and the Trust put a Protection Plan in place stating that Ms Ngwena was not allowed to personally visit the homes of service users.

...

I followed up on whether the protection plan was being adhered to by asking Ms Ngwena if she had visited any service user or provided any form of care, to which she replied “no”.

Witness 1 further stated that:

‘I had a telephone conversation with Ms Ngwena on 11 March 2022 to inform them that we had received some concerns, and that they should not go out on visits to service user’s homes and instead they should liaise with the Trust with respect to any upcoming visits. I explained that the Protection Plan was in place to protect the service users, and Ms Ngwena understood this.’

The panel also had regard to the evidence of Witness 6, who confirmed that you had attended three visits, on separate occasions, and had not signed the daily care log as they had checked the record of the call afterwards. Witness 6 also provided screenshots of a Ring doorbell camera which show you attended the service user's home.

The panel considered the Meeting Minutes of the Trust, dated 25 March 2022 which state:

'SU known to Memory Team, APP1 relates to non-adherence to protection plan. SU's son confirmed AN attended SU's home on Saturday 19 and Sunday 20 March 2022 and provided direct care.'

The panel noted that in your oral evidence, you told the panel that you were panicked about clients who needed meals and personal care which is why you attended those calls. You told the panel that when questioned, you were scared to tell the truth, but you attended the calls in good faith. You told the panel that you were worried that if you did not attend the calls, you would face allegations of neglect of these service users. You confirmed that you did not forget that the Protection Plan was in place.

The panel was therefore satisfied that you knew that the Protection Plan was in place, you understood what it meant, and you knew that it was contrary to the plan to go to the service user's homes on calls. The panel was also satisfied that you had been told by Witness 1 to liaise with the Trust in respect of any upcoming visits. The panel noted that there were three known instances of you attending Service User E's home and providing direct care whilst the Protection Plan was in place. The panel noted that your evidence is that you breached the Protection Plan in good faith and in the interest of your service users.

The panel next considered whether this conduct was dishonest by the standards of ordinary decent people. The panel considered that when asked during the RQIA inspection whether you had attended any calls during the period in which the Protection Plan was in place, you said no. The panel considered that ordinary and decent people

would consider your actions to be dishonest. You knew it was in place, you confirmed you understood what it meant, and there were alternative arrangements that you were told about that should have been made to safeguard your service users. In these circumstances, the panel determined that this charge is found proved.

In respect of your allegations of sabotage, the panel considered that its findings on charge 9 arise out of your admissions to charge 7 and 8 and supporting evidence from Witness 1 and Witness 6 who are both independent from yourself, the Agency and Person A. The panel was therefore satisfied that there is no objective evidence of sabotage in relation to charge 9.

Charge 11)

“That you, a registered nurse and as the Responsible Individual for Top Class Healthcare (“the Agency”):

11. Your conduct at charge 10 above was dishonest in that you knew that there had in fact been one or more accidents, incidents or safeguarding investigations since August 2021.”

This charge is found NOT proved.

In reaching this decision, the panel took into account your admission to charge 10 that you told the RQIA inspector that there had been no accidents, incidents or safeguarding investigations since August 2021.

The panel first considered what you knew, or believed to be the facts of the particular circumstances at the time. The panel noted Witness 1’s witness statement, which states:

‘I was concerned with the safeguarding records at the Agency, as I would expect to see clear and robust records kept detailing any referrals, meeting minutes

arising from this and any action plans. The Agency did not have any records, despite the fact that there were a large number of safeguarding concerns raised (as per information shared with RQIA from the Trust during the meeting on 23 March 2022.)

...

I spoke with Ms Ngwena previously on 11 March 2022 to notify them that further safeguarding concerns had been raised, but I could not find any written account of the conversation made by Ms Ngwena. I would not have expected Ms Ngwena to complete an APP1 referral, as I was not able to tell Ms Ngwena about the specific allegations, but I would expect them to keep a record of the conversation in a file or with form of system where all safeguarding referrals are recorded and retained.'

Witness 1 also stated that:

'At every inspection, we discuss if there have been any incidents or safeguarding referrals, and when I asked Ms Ngwena about this, they advised that there were none. However, from me submitting two APP1s to the safeguarding team in the Trust, there were allegations made. Ms Ngwena was not aware of the details of the allegations, however, as stated above, RQIA would have expected her to have recorded this conversation on a document and kept in in her safeguarding file.'

The panel considered your evidence that you did not mention the safeguarding referrals in your meeting on 24 March 2022 as you believed Witness 1 already knew about the safeguarding investigations raised on 11 March 2022. The panel considered your evidence that you had not received an APP1 referral for the most recent incident and therefore you had no way of knowing about details of the incident.

The panel considered the evidence of Witness 1, who in their live evidence, stated that they had been clear in saying that the question was in relation to any safeguarding accidents, incidents or investigations that had been raised since August 2021.

The panel accepted your evidence that you thought that you were only being asked about any management concerns. The panel also accepted your evidence that Witness 1 already knew about the recent safeguarding referrals because they were the one to report them. The panel noted that this conflicted with the evidence of Witness 1, who stated in evidence that she had been clear about the question relating to safeguarding.

The panel considered that you had a genuine belief that Witness 1 knew about the most recent referral, you did not have specific details as you had not received the APP1 and that Witness 1 was asking the question in relation to the management concerns.

In light of the above, the panel considered whether the ordinary decent person would consider your answer to be dishonest. The panel determined that in circumstances where there may have been a misunderstanding on your part of what Witness 1 was asking you, your answer to Witness 1 was not dishonest by the standards of ordinary decent people. Therefore, the panel concluded that this charge is not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your 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, your 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.*'

Mr Hoskins provided written submissions and made supplementary oral submissions. He 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.

Mr Hoskins identified the specific, relevant standards where your actions amounted to misconduct. He submitted that the charges found proved by the panel fall broadly into breaches of the Code in respect of failures to prioritise people, to ensure good governance of the Agency, to provide quality care and to keep accurate documentation. He submitted that your conduct fell short of the standard expected in the statutory guidelines of Northern Ireland in domiciliary care, Trust policies and procedures and by the Code.

Mr Hoskins submitted that in respect of charge 1, the breach of the relevant standards is set out in the RQIA Inspection Report of 24 March 2022 and the Interview with you dated 6 April 2022. He submitted that these breaches were not diminished by your allegation that Person A was sabotaging you, as you retained full oversight of the Agency. He submitted that separately, Person A left the Agency a month before the inspection.

Mr Hoskins submitted that in respect of the other charges, the opinion evidence of Witness 7 may assist the panel in its determination on the matter of the seriousness of your conduct. He submitted that Witness 7's evidence of the relevant practices and thresholds for seriousness is informative.

Mr Hoskins submitted that cumulatively, your actions constitute a total breakdown in the governance of the Agency and a failure to meet the proper standard of care for vulnerable service users on repeated occasions without justification. He submitted that the failures in governance had a demonstrable effect on the care provided to service users; whether the care was untimely, or inappropriate to the extent that it caused distress. He submitted that these actions were not a result of inexperience, they were either malign inactivity or wilful neglect.

Mr Hoskins submitted that your position within the Agency, in that you were the RI, increases the seriousness of your failings. He submitted that if the evidence is accepted by this panel, demonstrates that you were told about failures within the Agency by Witness 2, and you blocked attempts made by Person A to correct these failures and have subsequently blamed the failings on Witness 2 and Person A.

Mr Hoskins submitted that the evidence demonstrates a disregard for the need to protect patients from poor care; firstly, that you breached the Protection Plan, and secondly that you lied about this breach. In relation to dishonesty, he submitted that honesty is regarded as a cornerstone of the nursing profession and is especially serious given the vulnerable service users under your care. Mr Hoskins submitted that the nature, extent and effect of the facts found proved are serious, crossing the threshold into serious professional misconduct.

Mr Halliday submitted that you accept that the charges found proved by this panel cumulatively amount to misconduct. However, Mr Halliday on your behalf objected to some of the submissions made by the Mr Hoskins in respect of the seriousness of the misconduct. He invited the panel to attach little to no weight to the evidence of Witness 7

in its deliberations on the matter of misconduct as Witness 7's opinion evidence is based on information that was not before this panel as it has been redacted in the interest of fairness.

Mr Halliday submitted that many of the charges relate to your managerial skills rather than your clinical practice. He submitted that this does not necessarily decrease the seriousness of the misconduct, but it gives important context. He invited the panel to consider the charges related to dishonesty as a single instance and fleeting. He submitted that you accepted the action at the beginning of this hearing, but not the dishonesty element.

Submissions on impairment

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

Mr Hoskins submitted that the charges in the period post-dating August 2021 up to March 2022 demonstrate a repetition of a failure to demonstrate sustained improvement in the safe provision of care. He submitted that even if the panel determines that your conduct a charges 1 – 6 is remediable, there is limited evidence of remediation.

Mr Hoskins submitted that you have demonstrated limited insight into the nature of your responsibilities as RI, and you sought to blame others although there is no objective evidence to suggest sabotage. He submitted that there is limited evidence of apology for the standard of care received by vulnerable service users. He submitted that the panel may feel that the evidence of Witness 2, who described you as being “*all about money*” and your understanding of your role to be the business and financial aspects of

governance of the Agency is an attitudinal issue. He submitted that the panel may find that this is significantly more difficult to remediate. He submitted that the training courses relied upon are largely mandatory training or matters that you would have known about at the time of the allegations and therefore do not demonstrate any improvement or change. Mr Hoskins submitted that in light of this minimal insight and limited remediation, there is a significant risk of repetition in the future. He submitted that the *Grant* test is satisfied on the first three limbs.

Mr Hoskins submitted that in respect of the charges relating to dishonesty, there is no credible explanation or justification for the dishonesty found in respect of charges 8 - 9. He submitted that in the absence of insight or reflection in respect of your dishonesty, the *Grant* test is satisfied in relation to the fourth limb. Mr Hoskins further submitted that there is no evidence to suggest that you can practise in future with kindness and compassion. Therefore, he invited the panel to find current impairment on both public protection and public interest grounds.

Mr Halliday submitted that in evidence, you gave evidence in relation to what you would have done differently which is demonstrative of some reflection. He submitted that it is a matter for this panel to consider whether it accepts your evidence on what you would do differently in the future. He submitted that you have produced reflections on the issues which demonstrates your willingness to improve and continue to practice within the nursing profession in a safe and competent manner.

Mr Halliday submitted that the RQIA Reports for Top Class Nursing Services, (Sister Agency), do not demonstrate a spotless record. However, he submitted that it shows a commitment by you to improve and remediate the concerns found by a regulator. He submitted that there have been no issues raised (with the NMC) in respect of the running of the Sister Agency. Mr Halliday submitted that whilst your reflections could be improved, the panel have heard evidence of what you would do differently in the future. He submitted that the panel has objective evidence of your commitment to ensuring proper governance and working with your regulator to make sure you are compliant. Mr Halliday submitted

that you are working towards improving your practice. He submitted that there is voluminous and detailed evidence of CPD training you have completed. He submitted that you are in the process of competing a Level 5 qualification and you plan to do further training in safeguarding.

Mr Halliday submitted that may have been a risk of harm previously, however your sustained improvement and governance of the Sister Agency demonstrates that the risk of harm in the future is diminished significantly and does not require a finding of impairment. He submitted that the charges relate to governance issues and a single instance of dishonesty, and it is a matter for the panel to determine whether these bring the profession into disrepute. He submitted that the dishonesty was a single instance and does not suggest it was a habitual issue. He submitted that whilst dishonesty charges are serious, there is no suggestion that you will be dishonest in the future.

Mr Halliday submitted that you have nearly 20 years of experience working in the nursing profession without incident. He submitted that you have provided three character references, two of which are from people who work closely with you. He submitted that these may be informative in relation to your approach to practice and to your role as RI. He submitted that a finding of impairment is not necessary on the grounds of public protection or public interest.

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

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

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

...

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

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

8 Work cooperatively

To achieve this, you must:

...

8.2 maintain effective communication with colleagues

...

- 8.4 work with colleagues to evaluate the quality of your work and that of the team*
- 8.5 work with colleagues to preserve the safety of those receiving care*
- 8.6 share information to identify and reduce risk*

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

- 10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
- 10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
- ...*
- 10.5 take all steps to make sure that all records are kept securely*

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

- 11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions*
- 11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care*

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

...

16.3 *tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can*

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

To achieve this, you must:

19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 *identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered whether these charges amount to misconduct in respect of the overarching issues within the charges. The panel determined that charge 10, as a stand-alone charge, did not amount to misconduct. The panel concluded that its

findings that this had been a misunderstanding between you and Witness 1, did not require the panel to make an assessment at this stage on the matter of misconduct.

Management and governance issues

The panel considered that charges 1, 2, 3b)i), 3b)iii) and 6 relate to concerns about your management and governance of the Agency.

The panel noted that charge 1a, which you admitted, resulted in missed or early/late calls to service users who were vulnerable and reliant on the Agency carers for their personal and clinical care. The panel was of the view that having a working staff planner is critical for the provision of care, and you would have known the importance of this within your role. The panel was satisfied that this amounted to misconduct.

In respect of charge 1b, the panel was of the view that as RI, you had an obligation to ensure that accurate records of safeguarding concerns were kept in relation to your service users. The panel considered that this is fundamental to ensure continuity of care and to make sure that carers could meet the specific needs of your service users. The panel considered that as Safeguarding Champion of the Agency and a nurse with 19 years of experience, it was of particular importance that you ensured the proper maintenance of the safeguarding records. Therefore, the panel is of the view that this amounts to misconduct.

In respect of charge 1c, the panel considered that keeping and maintaining the daily records of care is a fundamental aspect of providing good care to service users. The panel considered that any inaccuracies or missing records result in inconsistent and unsafe care, in particular the missing records for one service user over a period of five months. It considered that by not ensuring that the daily logs were audited, the Agency was unable to identify any potential deficit in the quality of care being delivered by the Agency. Therefore, the panel was satisfied that charge 1c cumulatively amounts to misconduct.

In respect of charge 1d)i), 1d)ii) and 1d)iv) the panel considered that these charges were proved to the extent that you did not ensure that the records in relation to shadowing shifts and inductions were countersigned and you admitted that you did not ensure that records were kept in respect of supervision. The panel was of the view that these demonstrate poor practice, poor management and an over reliance on other staff members to keep records when you had overall oversight as RI. However, the panel was of the view that these relate to poor managerial skills, and do not meet the threshold for seriousness to amount to misconduct.

In relation to charge to charge 1d)iii and 1d)v), the panel was of the view that ensuring that staff members are appropriately trained is fundamental in the service of quality care to service users. The panel considered that there was a significant impact of staff members being inadequately trained on the service provided, particularly in respect of the manual handling of service users. It noted that incorrect manual handling can cause harm to both service users and the members of staff at the Agency. The panel also noted that there was some evidence of staff not having up to date CPR training, which it considered is important basic training. It further noted that this may have resulted in an inconsistent standard of care provided to service users. The panel was of the view that this amounts to misconduct.

In relation to charge 1e), the panel considered that you admitted this charge. The panel was of the view that having an inaccurate list of service users, including those who had passed away or left the service, is very poor practice. The panel considered that this could have resulted in missed calls and inconsistencies or duplications of care for service users. The panel considered that this had the potential to cause harm, and therefore it considered this to be misconduct.

In respect of charge 1f), you admitted that you did not ensure that the monitoring reports for the Agency were produced to a satisfactory standard, and that you were reviewing the reports. The panel considered that these reports would have contained important information from service users and their families regarding the standard and quality of care

that they were receiving. It considered that this could have caused important issues and concerns with the service to be missed, and therefore you would have been unable to track any deficiencies in the service. The panel was satisfied that this amounts to misconduct.

In respect of charge 2, the panel considered that there was a considerable detrimental impact on service users in instances where carers had early/late or missed calls. The panel noted that the timing of the care was particularly important in respect of medication administration and personal care. The panel was of the view that this represents a significant failure in ensuring the quality and standard of care for service users and therefore amounts to misconduct.

In respect of 3b)i) and 3b)iii), the panel considered the impact of you not ensuring that all staff members used the correct manual handling techniques in respect of service users. The panel considered that using the correct manual handling is important to ensure that service users and staff members are not physically injured whilst delivering and receiving care. As a result, the panel was of the view that not ensuring that staff were appropriately trained in manual handling amounts to misconduct.

In respect of charge 6, the panel considered that not ensuring that the carer ensured that Service User F took his medication or had breakfast prepared so that he could have his insulin administered falls below the quality and standard of care expected. Service User F had mild cognitive impairments and diabetes, and subsequently there was a risk associated with the carer not ensuring that the medication was consumed or that his breakfast was prepared. Therefore, the panel was satisfied that charge 6 amounts to misconduct.

Your clinical practice

The panel considered that charges 3a)ii), 5 and 7 relate to concerns regarding your clinical practice.

In respect of 3a)ii), the panel considered that your failure to use the appropriate manual handling technique in respect of Service User C put both them and you at risk of physical injury. The panel noted that as a Registered Nurse with 19 years of experience, and with Service User C being described as a frail and vulnerable service user, the consequences of inappropriate manual handling techniques are potentially serious. Therefore, the panel was satisfied that your actions amount to misconduct.

In respect of charge 5a) and 5b), the panel considered that demonstrating a poor attitude towards a service user or their family is unprofessional. The panel considered that letting any frustration at being called back to a service users home show, or using unprofessional language is demonstrative of poor practice. The panel noted that this was a single instance of such conduct and therefore it was not satisfied that this amounts to misconduct.

In respect of charge 5c), the panel considered that the action of a carer acting inappropriately to a service user's toileting, and a subsequently failure to report this as a safeguarding incident may have put the service user at risk of abuse or neglect. The panel noted that you are an experienced nurse, and had been the Safeguarding Champion, and therefore this failure to report was serious. The panel considered that this amounted to misconduct.

Breach of the Trust's Protection Plan

In respect of 7a) and 7b), the panel considered that you admitted that you carried out a visit to a service user whilst there was a Protection Plan in place prohibiting you from visiting service users and having been instructed not to. The panel considered that the Protection Plan had been put in place by the RQIA to safeguard service users whilst an investigation into concerns about your practice was conducted. The panel considered that this disregard for the terms and purpose of the Protection Plan, and the instruction you had been given, demonstrated a shortfall in the professional standards expected of you.

The panel also noted that it found evidence of at least three occasions on which you attended a service users' home in contravention of the Protection Plan, which was demonstrative of a repeated disregard of the Protection Plan. Therefore, the panel considered this amounted to misconduct.

Dishonesty

The panel considered that charges 8 and 9 relate to the issue of dishonesty.

In respect of these charges, the panel considered the context that you had knowingly breached the Protection Plan and the instructions you had been given. The panel bore in mind that you had understood this instruction, and there were avenues you were aware of and could have taken to ensure that the standard of care for your service users was met by the Trust. In this context, the panel considered that your dishonesty, when asked about whether you had attended any service users' homes during the period in which the Protection Plan was in place, was serious. The panel considered that this is evidence of a potentially deep-seated attitudinal issue, and your conduct fell short of the expectations of honesty and integrity from nurses and therefore amounted to misconduct.

The panel found that overall, your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In light of the above, the panel considered that the charges found proved amount to misconduct, with the exception of charge 1d)i), 1d)ii), 1d)iv), 5a and 5b.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your 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. 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/ 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) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that service users were put at unwarranted risk harm as a result of your misconduct. The panel was of the view that you, as RI, did not ensure that accurate safeguarding records were kept or that training standards of your staff were upheld. The panel was therefore satisfied that that first limb of the *Grant* test is engaged in respect of the past.

The panel considered that your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It noted that you had breached the fundamentals of care in respect of your service users, in that you did not treat service users as individuals or uphold their dignity. The panel considered that your failure to identify and report safeguarding concerns, poor clinical practice and disregard for

the Trust's Protection Plan demonstrates breaches of the fundamental tenets of the nursing profession that would bring the reputation of the nursing profession into disrepute.

The panel noted that your dishonesty demonstrates a failure to uphold your professional duty of candour and to uphold the fundamental tenets of honesty and integrity. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel considered whether the misconduct in this case is capable of being addressed. The panel noted that your misconduct can be categorised into managerial and governance failures, your clinical practice, your breach of the Protection Plan, and dishonesty.

Management and governance issues

The panel considered that the managerial and governance issues are capable of being addressed. It considered that the misconduct relates to poor record keeping, poor training of staff and safeguarding deficits which are all nursing skills and competencies that can be improved with proper training and insight. The panel considered that you have so far demonstrated little understanding of your role regarding these deficiencies at the Agency. It considered that you had made some admissions to the charges, but that you have demonstrated limited insight into this misconduct. The panel considered that you have done some training, including your CPD training and your Level 5 management qualification. The panel also considered that you have provided evidence of several RQIA Inspection Reports from the Sister Agency, which demonstrate that since the March 2022 inspection, you have been making steady and sustained improvements as RI of the Sister Agency. However, the panel considered that you have not yet provided evidence that all managerial and governance deficiencies have been remedied. The panel considered that the agencies, and identified deficiencies, are not entirely like-for-like. It was therefore not satisfied that the reports from the Sister Agency could be taken as remediation of your misconduct in this case.

In these circumstances, the panel considered that the misconduct is likely to be repeated due to your limited insight and lack of evidence of strengthened practice. The panel considered that you have not yet fully reflected on the impact these managerial and governance failings had on service users. The panel noted that there is some evidence of improvement in your management and governance skills, however it is of the view that this is not sufficient to demonstrate full remediation of the concerns at this stage.

Your clinical practice

The panel considered whether the misconduct relating to your clinical practice is capable of being addressed. The panel considered that this misconduct relates to your poor manual handling and failure to identify and report potential safeguarding concerns. The panel considered that these are fundamental skills and competencies for a nurse, which can be improved with proper reflection, insight and training. The panel considered that you have provided several training certificates post-dating the misconduct, including training on; Falls and Fracture Prevention, Adult Safeguarding Northern Ireland (Level 1), Moving and Handling Theory (L1 & L2), Safeguarding Adults L1&2 (Adult Support and Protection), Safeguarding Children L1 & L2 (Child Protection) and Moving & Handling (Practical – Top Class). The panel considered that you have done these relevant training courses, as well as other trainings on delivering patient centred care, mental capacity, dementia awareness as well as others which relate to the vulnerable client group in the domiciliary care setting. The panel was satisfied that the risk of repetition has been significantly reduced. The panel considered that you understand where your clinical practice can be improved to ensure that service users are protected in the future.

Breach of the Trust's Protection Plan

The panel considered that your misconduct in breaching the Trust's Protection Plan is remediable, with the correct insight and reflection. However, the panel considered that your conscious choice to act contrary to the Protection Plan demonstrates an attitudinal issue that is more difficult to put right. The panel considered that the Protection Plan was

in place to safeguard the service users under your care. The panel acknowledged that in your evidence, you explained what you would do differently in the future. However, the panel was not satisfied that you have demonstrated sufficient reflection or insight into the impact of your choice to contravene the RQIA Inspectors instructions and the potential impact of your actions on the service users. The panel considered the new RQIA Reports for the Sister Agency and considered that this is some evidence of your compliance with the regulatory framework. However, the panel considered that the risk of repetition remains, given the element of an attitudinal issue and your current limited insight.

Dishonesty

The panel considered that your dishonesty is misconduct that is exceedingly difficult to remedy. The panel noted that you had several opportunities to be honest about your breach of the Protection Plan. The panel considered that you had decided to tell a lie to the inspector, knowing that you had breached the Protection Plan on at least three separate occasions. The panel was of the view that this misconduct calls into question your character and integrity. The panel considered that dishonesty demonstrates a deep-seated attitudinal issue that is very difficult to put right. The panel considered that in your reflection you have not demonstrated any insight into your dishonesty. Without insight or understanding of why your actions would be considered dishonest by the standards of ordinary decent people, the panel is not satisfied that this has been remedied. In these circumstances, the panel considered that there remains a risk of repetition should similar circumstances arise in the future.

In respect of your managerial and governance misconduct, the breach of the Trust's Protection Plan and dishonesty, the panel considered that service users were put at unwarranted risk of harm, and there remains a risk of repetition in respect of these areas. Therefore, the panel determined that a finding of impairment is necessary on the ground of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because of the seriousness of the misconduct and the ongoing public protection concerns. It considered that in light of the seriousness of the misconduct, in particular the seriousness of the dishonesty, the reputation of the nursing profession and in the NMC as its regulator would be damaged if a finding of impairment was not made. The panel considered that your conduct fell short of the professional standards expected of a nurse. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. Therefore, also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your 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 you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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

Submissions on sanction

The panel heard evidence from you under oath.

In respect of the charges found proved, you told the panel that you would like an opportunity to remain on the NMC register and working as a Registered Nurse. You told the panel that it could impose any conditions it sees fit. You told the panel that you made some admissions to the charges, but that you would like to apologise for the dishonesty found by this panel. You told the panel that as a registered professional, you were supposed to be open and honest and uphold the duty of candour. You stated that in the future, you would reassure clients and work according to any conditions. In respect of the breach of the Trust's protection plan, you stated that you should share if you come across a challenge and you know that if you had spoken to the gateway before, you could have received advice from the social workers. You explained that your job is to protect clients and their families, and that you did not do this by not following the Protection Plan.

In respect of the dishonesty, you accepted that you had been dishonest. You told the panel that you now understood that although you felt you broke the Protection Plan in good faith, you should not have lied about it to Witness 1. You said that you were supposed to be open, but that you have learnt from this mistake. You stated that in future you need to stop and reflect on your actions, and you should not be overtaken by stress, confusion or fear. In respect of the breach of the Trust's Protection Plan, you told the panel that you imposed fear into the clients and their families, and you lost their trust in you. You stated that you accept your mistakes and take full responsibility for your actions.

In respect of the management and governance issues this panel found, you stated that you will make sure that all safeguarding complaints are well documented and the list of staff and clients is current. You explained that you would have further oversight of the auditing of documents and reports and that you will take actions with staff when issues are raised with you. You stated that this would promote the spirit of oneness and openness.

You told the panel that your dishonesty would have an impact on the reputation of the profession but that you have noticed the problem and the consequence of it and that you will not repeat it again.

When asked in cross examination, you explained that you had not previously accepted that you had been dishonest. You explained that you had been dishonest because you were scared and stressed about the consequences, in particular the consequence for you and the Agency. You explained that you know now that this was wrong, and you should have owned up to the mistake and not lied to Witness 1.

In respect of the breach of the Protection Plan, you accepted that you had visited a service user on more than one occasion and that this was serious. You told the panel that the more you breached the Protection Plan, the more serious your actions became. You accepted that the Protection Plan was required whilst the Trust investigated the complaints made about you to safeguard service users. You told the panel that you should have adhered to the Protection Plan.

When asked why you have now accepted the seriousness of your actions, and why you have accepted your dishonesty, you clarified that you have learned a lot from this hearing process and you can now reflect more on your previous actions.

Mr Hoskins informed the panel that the NMC had advised you that it would seek the imposition of a striking off order if the panel found your fitness to practise currently impaired. He submitted that a striking off order is the necessary and proportionate outcome given the seriousness of your misconduct, in particular the dishonesty. He submitted that you have demonstrated a lack of insight into your failings, that your dishonesty is serious, that there was a pattern of misconduct over time and service users were put at risk of harm. He submitted that an interim order has previously been imposed on your practice, and that you have still not demonstrated adequate reflection on your misconduct.

Mr Hoskins submitted that this case is at the upper end of the spectrum of seriousness. He submitted that given the seriousness of this case, taking no further action or imposing a caution order would be inappropriate and contrary to the panel's findings on impairment. He submitted that there are no workable and measurable conditions that could be imposed to mitigate the risk to the public in this case. He submitted that you have previously disregarded a regulatory intervention, in that you breached the Trust's Protection Plan, and therefore a conditions of practice order would be inappropriate. He further submitted that a conditions of practice order could be sufficient to address any clinical practice concerns, but that conditions would not address the issue of dishonesty.

Mr Hoskins submitted that a suspension order would not be the appropriate sanction in this case. He submitted that a suspension order would not be sufficient to protect the public, and that your misconduct raises fundamental questions about your ability to practise safely as a nurse. He submitted that this is not a single instance of misconduct, there is evidence of a deep-seated attitudinal issue and there remains a lack of insight. Therefore, he submitted that a striking off order is the only proportionate sanction to protect the public, to uphold professional standards and maintain public confidence in the profession.

Mr Halliday invited the panel to impose either a conditions of practice order or a suspension order. He submitted that you have no previous NMC regulatory proceedings against you, there was no abuse of a position of trust, and it is a matter for the panel to determine whether this was repeated misconduct given the relatively short time frame in which the misconduct occurred.

Mr Halliday submitted that you have made admissions to some of the charges, you have apologised for your misconduct, and you have provided evidence of continued upward progress in relation to the RQIA reports. He submitted that you have provided evidence of training, and you have demonstrated a three-year period in which there had been no

further regulatory concerns. He submitted that you have also expressed your willingness to comply with any conditions the panel sees fit to impose.

Mr Halliday submitted that if the panel disagrees that a conditions of practice order can mitigate any risk to the public, it could determine to impose a suspension order. He submitted that temporary removal from NMC register would protect the public and would maintain public confidence in the profession. Mr Halliday submitted that you had addressed the panel on the matter of dishonesty and want to work towards demonstrating further insight. He submitted that whilst the panel has determined that there is a risk of repetition, there is no evidence before the panel of a repeated breach of any other regulatory intervention such as the previous interim order. He submitted that the development of your insight means that the risk to the public is diminishing. He submitted that you are engaging and will continue to engage with the NMC to remedy your misconduct.

Mr Halliday submitted that your misconduct is not incompatible with remaining on the NMC register. He submitted that a striking off order is not the only sanction that would protect the public and meet the public interest. He submitted that imposing a striking off order would be disproportionate. He submitted that a 12-month suspension order would provide you with time to demonstrate further insight and strengthened practice for another panel to review in the future, and a striking off order would remain available to a future panel, should you not demonstrate any reduction in risk to the public.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found your 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:

- A pattern of misconduct over time;
- Lack of meaningful insight into your misconduct;
- Conduct which put vulnerable people receiving care at risk of suffering harm.

The panel also took into account the following mitigating features:

- Early admissions to some of the facts;
- Personal mitigation, in that you had staff shortages at the Agency.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *‘the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.’* The panel considered that your 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 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 panel considered that it found evidence of deep-seated attitudinal issues at the impairment stage of these proceedings. It

acknowledged that you have given evidence at the sanction stage during which you apologised for any harm caused and demonstrated some very limited insight into the impact of your dishonesty on service users and the wider public. However, the panel was not satisfied that you have fully reflected on your dishonesty, and therefore the risk of harm to the public has not yet been reduced in any significant way. The panel was also concerned about the practicality of imposing conditions at this time, considering that the issues arose whilst you were working as RI of the Agency without any person overseeing your conduct. The panel considered that a conditions of practice order would not be appropriately monitored or assessed. Furthermore, the panel concluded that the placing of conditions on your 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 considered that this was not a single instance of misconduct, and there is evidence of a deep-seated attitudinal issue. The panel noted that there has been no evidence of repetition of behaviour since the incident, however it was not satisfied that you have developed insight or strengthened practice to a level that would protect the public from any significant risk of harm. The panel considered that if a similar situation were to arise in the future, it has not seen evidence to satisfy itself that you would not repeat the misconduct found proved.

The panel had regard to the NMC Guidance SAN – 2 *Sanctions for particularly serious cases* (last updated: 6 May 2025) and in particular, cases involving dishonesty. The panel considered that your deliberate breach of the Trust's Protection Plan was very serious, and that your dishonesty raises questions about your character and professionalism in that you knowingly breached your professional duty of candour. The panel considered that those at risk of harm by your misconduct were vulnerable adults, and therefore it is a very serious case. 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?*

Your actions were significant departures from the standards expected of a registered nurse and breached fundamental tenets of the profession. In the panel's judgement, they are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you 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 appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should

conduct themselves, 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.

The panel acknowledges that this sanction will have an adverse impact on you, however it was of the view that your own interests are outweighed by the public interest in this regard.

This will be confirmed to you in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, and if you appeal until the appeal is disposed of, 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 your 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 Mr Hoskins. He submitted that an interim suspension order is necessary to protect the public and meet the public interest during the period before the substantive striking off order comes into effect. He submitted that an interim suspension order is necessary for 18 months to cover any period of appeal.

Mr Halliday submitted that you have been subject to an interim suspension order during these proceedings and it is a matter for the panel to consider whether an interim order is necessary in these circumstances.

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 striking off order. The panel therefore imposed an interim suspension order for a period of 18 months to protect the public during the period before the substantive striking off order comes into effect and any subsequent potential period of appeal.

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

That concludes this determination.