Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 2 – Monday 15 September 2025

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

Name of Registrant:	**Kelsey Ellen Abbott**
NMC PIN:	13L1017E
Part(s) of the register:	Nurses part of the register Sub part 1 RNC, Registered Nurse – Children - 6 January 2014
Relevant Location:	Sheffield
Type of case:	Misconduct
Panel members:	Clara Cheetham (Chair, Lay member) Vivienne Stimpson (Registrant member) Raj Chauhan (Lay member)
Legal Assessor:	Graeme Sampson (2 and 4 September) John Bassett
Hearings Coordinator:	Rebecka Selva
Nursing and Midwifery Council:	Represented by Iwona Boesche, Case Presenter
Miss Abbott:	Not present and not represented at this hearing
Facts proved:	Charges 1, 2, 5, 7, 8, 9a, 9b, 10, 11 and 12
Facts not proved:	Charges 3, 4, 6
Fitness to practise:	Impaired
Sanction:	**Striking-off order**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Abbott was not in attendance and that the Notice of Hearing letter had been sent to Miss Abbott's registered email address by secure email on 4 August 2025.

Further, the panel noted that the Notice of Hearing was also sent to Miss Abbott's representative at the Royal College of Nursing (RCN) on 4 August 2025.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Miss Abbott

The panel next considered whether it should proceed in the absence of Miss Abbott. It had regard to Rule 21 and heard the submissions of Ms Boesche who invited the panel to

continue in the absence of Miss Abbott. She submitted that Miss Abbott had voluntarily absented herself.

Ms Boesche referred the panel to the documentation from the RCN which included an email dated 1 September 2025:

> *'Thank you for your emails.*
>
> *Please note our member will not be in attendance tomorrow and will not be represented in her absence.'*

Ms Boesche also informed the panel that the Deputy Registrar's refusal of Miss Abbott's agreed removal application was communicated to both Miss Abbott and the RCN on 1 September 2025 at 16:45 and no further communication has since been received.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Miss Abbott. In reaching this decision, the panel has considered the submissions of Ms Boesche, the email received from the RCN, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the circumstances, as well as the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Abbott;

- Miss Abbott and the RCN have confirmed that they will not be in attendance;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Eight witnesses are scheduled and due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the patients and clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses to recall events accurately; and
- There is a strong public interest in the expeditious disposal of the case.

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

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

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

At the outset of the hearing, Ms Boesche made a request that this case be held partly in private on the basis that proper exploration of Miss Abbott's case involves references to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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 or by the public interest.

The panel determined to go into private session only in connection with Miss Abbott's [PRIVATE] as and when such issues are raised in order to protect her right to privacy.

Details of charge (as amended)

That you, a registered nurse:

1. On a date or dates around 18 November 2021 shared information regarding Patient B's death with Patient C and/or Patient D without clinical justification.

2. On one or more occasions including on 25 November 2022 shared information about your pregnancy with Patient E.

3. On one or more unknown dates shared information about your pregnancy with one or more other patients.

4. On 25 November 2022 made an offensive comment to Patient E in connection with your pregnancy in that you said words to the effect of "I fucking hate it, I hate looking this way and being this way".

5. On an unknown date permitted Patient E to feel your pregnancy bump.

6. On an unknown date made an offensive comment to Patient E when asked whether you were pregnant, in that you said words to the effect of “did you think it was a fucking bag of crisps”.

7. On or around 8 April 2022 sent a Facebook friend request to Patient A.

8. Your conduct at one or more of charges 1 to 7 was in breach of professional boundaries.

9. Failed to comply with your pregnancy risk assessment in that you:

a) On one or more occasions between 23 September 2022 and 29 November 2022 entered the ward area alone when restricted from lone working;

b) On 25 November 2022 entered the seclusion area when you were restricted from interaction with unsettled patients.

10. On and/or after 24 April 2023 failed to provide Nightingale app and/or Primary Care Network (PCN) with a copy of your interim conditions of practice, in breach of condition 9 of your Interim Conditions of Practice Order.

11. Your conduct at charge 10 was dishonest in that you intended to mislead Nightingale app and/or Primary Care Network (PCN) by failing to disclose your interim conditions of practice.

12. On a date or dates on or after 24 April 2023 obtained nursing work through Nightingale app in breach of condition 1 of your Interim Conditions of Practice Order which required you to have one employer which must not be an agency.

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

Following the reading of the charges, the panel asked for points of clarification.

Ms Boesche clarified that in respect of charge 1, despite Miss Abbott's registration having lapsed at the material time, she submitted that Miss Abbott's name still appeared on the NMC register, she continued to work in the healthcare setting and revalidated her PIN on 10 November 2022. As such, Ms Boesche submitted that charge 1 would not require any amendment. Furthermore, in the course of the hearing Ms Boesche drew the panel's attention to the Nursing and Midwifery Order 2001 Article 22(3) which enables the panel to consider allegations of misconduct that arise out of matters that occurred when Miss Abbott's registration had lapsed.

Ms Boesche clarified that whilst charge 2 addresses Miss Abbott speaking about her pregnancy solely to Patient E, charge 3 addresses patients in general, other than Patient E, to whom Miss Abbott could have spoken about her pregnancy.

Background

Miss Abbott was referred to the NMC twice by the Hospital Director at Cygnet Healthcare Sheffield, which is a low secure mental health hospital for male and female adolescents, (the Hospital) and once by the Director of Nursing at the Nightingale App.

On 18 November 2021 Miss Abbott shared the circumstances of a patient's death (Patient B) with another patient on the same ward. The information she shared included the ligature used by the patient who had died, and also that it was "*difficult to remove due to the amount of knots in the ligature*".

Miss Abbott then received a Stage 2 Final Written Warning to remain active on her file for 12 months for breaching professional boundaries in relation to sharing the information about a patient's death. Miss Abbott admitted to this concern at the local level and in her reflective statement, although she has sought to mitigate her culpability by stating that she shared the information for the purpose of addressing rumours and being honest.

On 8 April 2022, Witness 4 inspected the phone of Patient A and allegedly saw a Facebook friend request from Miss Abbott to the patient.

Following a pregnancy risk assessment which had been carried out on 23 September 2022. Miss Abbott was confined to specific low risk tasks, and either not supposed to be on the ward at all or at least always to be accompanied by another member of staff. Miss Abbott was allegedly seen by staff on a number of occasions on the ward at the Hospital, unaccompanied. This allegedly occurred during times when patients had been exhibiting risky behaviours, and on one occasion was allegedly soon after a patient's psychotic incident.

In October 2022, Witness 1 allegedly saw Miss Abbott in the dining room unaccompanied. Witness 8 came onto the ward and saw Miss Abbott chatting to Patient E and Miss Abbott allegedly hid her face behind a piece of paper and laughed.

On 5 November 2022, Witness 1 was sitting in the outside area of the facility with Patient E when Miss Abbott walked past them; the patient allegedly said, "*wow, you're definitely showing now*" and Miss Abbott allegedly replied along the lines of *"I fucking hate it, I hate looking and being this way*".

On another date, Miss Abbott was seen speaking to Patient E about her pregnancy, and allegedly said words to the effect of, "*did you think it was a fucking bag of crisps*." Witness 3 allegedly saw Miss Abbott allow Patient E to feel her belly.

Miss Abbott was suspended from work on 29 November 2022.

Sometime after leaving the Hospital Miss Abbott was employed as a nurse via the Nightingale App (the service provider) for University Health Service and University of Sheffield Student Primary Care Network ('PCN'). Not having disclosed to it her interim conditions of practice order, Miss Abbott allegedly carried out shifts as a vaccinator on a number of dates between April and June 2023.

Decision and reasons on application to admit the evidence of Witness 5

On day 1 of the hearing, Ms Boesche provided the panel with the statement of Witness 5 and informed it that he would be ready to give live evidence the following day, Wednesday 3 September 2025. She informed the panel that reason for the late production of the statement was due to Witness 5 having been overseas for some time.

The panel accepted the advice of the legal assessor.

The panel was of the view that, Witness 5's evidence speaks to charges 10, 11 and 12, and is therefore relevant. However, it is not sole nor decisive in respect of those charges.

The panel also considered that Witness 5's statement was sent to Miss Abbott and her legal representatives around 24 hours prior to Ms Boesche's application and that neither Miss Abbott nor her representatives had contested the admission of this evidence.

As such and in the circumstances, the panel concluded that the admission of Witness 5's evidence would be fair and relevant.

Decision and reasons on application to amend the charge

On day 3, the panel heard an application made by Ms Boesche to amend the wording of charges 10 and 11.

The proposed amendment was to better reflect the evidence. It was submitted by Ms Boesche that there is no material change to the charge and considering Miss Abbott's disengagement with the proceedings, there is no prejudice or injustice in making the amendments.

10. On and/or after 24 April 2023 failed to provide Nightingale app **and/or Primary Care Network (PCN)** with a copy of your interim conditions of practice, in breach of condition 9 of your Interim Conditions of Practice Order.

11. Your conduct at charge 10 was dishonest in that you intended to mislead Nightingale app **and/or Primary Care Network (PCN)** by failing to disclose your interim conditions of practice. [amendments in bold]

The panel questioned whether, having heard from six witnesses thus far, if on the proposed amendment Ms Boesche wanted to recall any of the witnesses. Ms Boesche confirmed there was no need to recall any of the witnesses.

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 considered that Miss Abbott has had sight of all the evidence that the panel has before it.

The panel also considered the overarching principles of public protection and the public interest.

The panel was of the view that such amendments, as applied for, were in the interest of justice insofar as they would more accurately reflect the evidence. The panel was satisfied that there would be no prejudice to Miss Abbott and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow

the amendments, as applied for, to ensure clarity, accuracy and to better reflect the evidence before the panel.

Decision and reasons on application to admit hearsay evidence

On day 5, the panel heard an application made by Ms Boesche who referred the panel to specific parts of the exhibit bundle provided by the Hospital which are relevant and not sole or decisive to charges 2 through to 9:

- Local investigation report dated 31 January 2023
- Note of investigation meeting dated 24 January 2023
- Note of disciplinary meeting dated 17 March 2023
- Combined managerial and clinical supervision form dated 25 November 2022
- Local statement of Colleague 1
- Local statement of Patient E
- Local investigation dated 7 April 2022
- Note of meeting dated 25 April 2022
- Disciplinary outcome

Ms Boesche further submitted that it would be disproportionate to have Patient E attend the hearing as a witness as they are a vulnerable patient and it was considered by the NMC that participation may negatively affect their health.

Ms Boesche clarified that Colleague 1 had not been invited to give a statement to the NMC.

She also clarified that she would not make specific submissions in relation to Miss Abbott's training records (also included in the bundle) dated 12 June 2024 and stated that whether they are deemed relevant is for the panel to decide.

Ms Boesche also invited the panel to also accept Witness 9's evidence. She referred the panel to *Thorneycroft v NMC* EWHC 1565 (Admin). She submitted that Witness 9's evidence

is relevant to charges 10 and 11, is not sole or decisive and supports both Witness 6 and Witness 7's evidence. She informed the panel that every effort has been made by the NMC to secure Witness 9's attendance, but she had not responded.

The panel considered the local statements of Colleague 1 and Patient E to have some associated relevance, that neither is sole and decisive, and that their evidence supports other witnesses who have given statements and live evidence. However, it also considered the contents of both statements contain passages of double hearsay. Patient E's statement appears to be a report by an unknown person of what Patient E said. The statements are not dated nor signed, and they are vague in that they do not speak to any specific incident or charge. The panel further considered that there is no information before it as to why the NMC did not secure a statement from Colleague 1. In the circumstances, the panel therefore decided that it was not fair to admit the statements of Colleague 1 and Patient E.

In respect of the investigation reports and records of disciplinary meetings the panel considered that, they are not sole and decisive, and in terms of fairness, assist in providing Miss Abbott's version of events. The panel considered them to be relevant to the charges which are serious, and they support the evidence already received and verified by other witnesses, namely the ones who have attended and given live evidence. The panel noted that the investigation documents included additional purported, but unsubstantiated statements from Patient E and at least one other unknown person. The panel decided it would ignore any part of the record which refers to what Patient E or any other unverified person is alleged to have said. As such, the panel confirmed that it would ignore any

unidentified witness statements contained in the investigation reports or records of disciplinary meetings.

The panel considered the training records dated 12 June 2024. It concluded that it was fair to admit them but acknowledged that they would only become relevant if the next stage of the proceedings is reached.

The panel considered that Witness 9's evidence is not sole or decisive and speaks to charge 10 and 11. It noted that numerous phone calls and emails have been made in failed attempts to get in contact with Witness 9. As such, the panel are unaware of whether there is a good reason for her non-attendance. The panel considered the overarching principles of public interest and public protection and decided to accept Witness 9's evidence as it is relevant to the charges. However, in terms of fairness to Miss Abbott, the panel decided to redact paragraph 5 and the last sentence of paragraph 6 as they do not relate to the charges.

Decision and reasons on facts

In the absence of any clear and unequivocal admissions by Miss Abbott, the panel regarded all charges to be denied for the purposes of the hearing.

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 Ms Boesche.

The panel has drawn no adverse inference from the non-attendance of Miss Abbott.

The panel reminded itself that the findings of any internal disciplinary proceedings against Miss Abbott are irrelevant. It is for the panel to determine whether the charges are proved or not.

Similarly, the panel has drawn no adverse inference from the fact that Miss Abbott has sought voluntary removal from the Register. The reasons for the Assistant Registrar's refusal of the application are also irrelevant and have been ignored. However, the panel considers that it is right to record that the Assistant Registrar's letter details a further referral made in respect of a matter that is not before it. The panel has put the reference to this matter firmly out of its minds.

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: Student Psychologist at the time of the allegations at the Hospital
- Witness 2: Head of Social Work and Safeguarding Lead at the Hospital
- Witness 3: Clinical Team Lead and Nurse at the time of the allegations at the Hospital
- Witness 4: Mental Health Nurse at the time of the allegations at the Hospital
- Witness 5: CEO and owner of Nightingale App
- Witness 6: Practice Manager and Primary Care Network Manager for University Health Service and University of

	Sheffield Student Primary Care Network (‘PCN’)
• Witness 7:	Director of Nursing and Clinical Governance of Nightingale App at the time of the incidents
• Witness 8:	Ward manager at the time of the allegations at the Hospital

Before making any findings on the facts, the panel accepted the advice of the legal assessor. It considered the oral witness evidence and documentary evidence provided by the NMC. This included some responses by Miss Abbott and her representatives as part of the local and NMC investigations.

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

Charge 1

1. On a date or dates around 18 November 2021 shared information regarding Patient B’s death with Patient C and/or Patient D without clinical justification.

This charge is found proved.

In reaching this decision, the panel took particular account of the documentary and live evidence of Witness 2.

The panel referred to the statement of Witness 2:

‘Kelsey provided a written statement admitting that she did share information with two patients on the Ward about the death, including how the patient had died, and confirmed the method they had used.

In her statement Kelsey admitted she shared information in regard to the ligature used by the patient who died and also mentioned to one patient that it was “difficult to remove due to the amount of knots in the ligature”. Kelsey also confirmed to a patient that CPR was administered.’

The panel also considered the undated local statement of Miss Abbott collected by Witness 2 and provided to the NMC on 8 July 2024:

“*When I was taking Patient C home on leave a couple of weeks ago, on the journey home she was asking about the patient who had died on the ward earlier in year. She stated that they thought it was a ligature and asked if that was true so I said yes. Patient C then informed me that she had heard that the ligature was wet from … and wanted to know if that was why ’staff couldn’t get it off’. I told Patient C that I didn’t know if it was wet as I didn't cut it off but I did say it was fairly difficultto remove as it was tight there was multiple knots on it.”*

‘I had a similar conversation with Patient D about Patient B’s death…. She asked if staff had given CPR and I confirmed that we had, and we continued doing it until the ambulance arrived. Patient D wanted to know if we ‘had brought her back’ and I said that while I was doing CPR I didn’t…I had a conversation with Patient D a few days later about what happens to your body when you tie a ligature, but this wasn’t specifically about Patient B She wanted to know ‘why your face goes purple and gets swollen’ so I explained it’s because the ligature restricts blood flow to the brain.’

In relation to the specific dates in this charge (on a date or dates around 18 November 2021), although the panel noted that Miss Abbott’s local statement was undated, it noted

an email sent from Miss Abbott to Witness 2 on 1 December 2021 in which she '*adds'* to her previous statement:

> "*I wanted to add to my statement how much i love my job and for the first time in my life i feel like i belong somewhere. I feel like i now know the young people really well and only ever wanted to help by squashing rumours. I can see it may have not been appropriate for which i apologise."*

The panel considered the letter the RCN had sent on 22 August 2024 for the NMC case examiners:

> *'c) Inappropriately shared information with a patient(s) regarding the circumstances of a vulnerable patients' death*
>
> *Miss Abbott accepts this concern. She realises in hindsight that it was not appropriate to share the information in question. Her intention was to be honest with patients and to address the rumours that were circulating but she accepts this was not the correct approach to doing so.'*

The panel accepted the above evidence before it in respect of charge 1. It further determined that the contents within the RCN letter, are an effective admission on Miss Abbott's behalf.

In relation to the part of the charge which alleges 'without clinical justification', the panel had regard to Witness 2's evidence that:

> *"discussing other young people's care is a breach of confidentiality of the other young person. Discussing incidents with the other young people can be re-traumatising and impact on their mental health."*

It also noted Miss Abbott had received a stage 1 final written warning regarding this concern on 18 November 2021.

As such, it concluded that on a date or dates around 18 November 2021 shared information regarding Patient B's death with Patient C and/or Patient D without clinical justification and that consequently this charge is found proved.

Charge 2)

2. On one or more occasions including on 25 November 2022 shared information about your pregnancy with Patient E.

This charge is found proved.

In reaching this decision, the panel took particular account of the documentary and live evidence of Witness 1 and Witness 3.

Witness 1 statement:

> "*On Friday 25 November 2022 between 4pm and 5pm I was sat on the bench outside Cygnet with Patient E. At this time Kelsey walked of the hospital and past us on the benches and said to her "wow, you're definitely showing now" and was referring to Kelsey's pregnancy. Kelsey replied to Patient E along the lines of "I fucking hate it, I hate looking and being this way". Kelsey stood chatting to us for a while before she left."*

Witness 3 statement:

> *"I witnessed Kelsey speaking with a female resident called Patient E. At the time of the conversation between Kelsey and the resident, Kelsey was pregnant*

with twins. The resident was asking her about her pregnancy. When the resident asked if Kelsey was pregnant, I recall Kelsey swore but in a joking manner as I detailed in my local statement something along the lines of 'did you think it was a fucking bag of crisps'".

This was corroborated by Witness 3's local statement in which she recalled the conversation she witnessed between Patient E and Miss Abbott:

'Kelsey: Of course, I am pregnant that is why you don't see me on the ward
Patient: How far gone are you
Kelsey: 31 Weeks
Patient: What are you having?
Kelsey: [PRIVATE]'

The panel referred to the letter from the RCN dated 22 August 2024:

'At the time, Miss Abbott was heavily pregnant, and this would be obvious to anyone who saw her. Miss Abbott would not bring this topic up herself but other, including patients, would ask her about it. Even in [Witness 1]*'s evidence she says, "*[Patient E] *said to her 'wow, you're definitely showing now'". Similarly,* [Witness 3] *says that "The resident was asking her about her pregnancy". On both occasions it was the resident who brough the issue up, not Miss Abbott.'*

The panel concluded that Witness 3's statement and live evidence was corroborated by the letter from the RCN and concluded that it was more likely than not that Miss Abbott had shared information about her pregnancy to Patient E.

Charge 3

3. On one or more unknown dates shared information about your pregnancy with one or more other patients.

This charge is found NOT proved.

The panel considered that the reference in the charge to *"one or more other patients"* indicates that the allegation is that Miss Abbott shared information about her pregnancy to other patients as well as Patient E.

In reaching this decision, the panel took particular account of the documentary evidence of Witness 8.

The panel referred to Witness 8's statement:

> *'I was made aware some patients knew of Kelsey's pregnancy, as she had told them herself. This is unacceptable in our environment'.*

The panel considered that, given its finding in respect of charge 2, it was possible that Miss Abbott may well have told other patients about her pregnancy.

However, Witness 8's statement in relation to this charge is hearsay and the NMC has not provided the panel with any evidence of direct observation to support this charge from any witness who has provided a written statement or given live evidence. As such the panel found that it did not have sufficient evidence to support this charge.

Charge 4

4. On 25 November 2022 made an offensive comment to Patient E in connection with your pregnancy in that you said words to the effect of "I fucking hate it, I hate looking this way and being this way".

This charge is found NOT proved.

In reaching this decision, the panel took particular account of the documentary and live evidence of Witness 1.

The panel first considered whether Miss Abbott had sworn when speaking to Patient E as the panel noted in the documentary evidence before it that Miss Abbott had stated numerous times that she had not. The panel referred to the letter from the RCN:

> *'b) made inappropriate comments and swore to and/or in front of patients*
>
> *The only inappropriate comments identified within the evidence is the suggestion that Miss Abbott swore to or in front of patients. Miss Abbott denies that she has ever done so and has set out in the enclosed reflection why it would not be appropriate to do so.'*

The panel also had sight of Miss Abbott's reflection which she produced for the NMC case examiner's decision enclosed in the RCN letter on 22 August 2024:

> *'Swearing in front of patients is behaviour that I would never do. I understand how important it is to maintain professional boundaries and that swearing in front of patients is not acceptable. I do not have any recollection of doing so; however, I understand that that kind of behaviour is not professional and is not best practice.'*

The panel referred to the Hospital's local investigation report dated 31 January 2023:

> *'Kelsey added if I had sworn at the patient, she would have reacted, but she didn't. I joked with her, but I didn't swear.'*

At the misconduct meeting 24 January 2023, Miss Abbott denied she had spoken in this way, stating she had said:

‘I don’t want it [this baby] *when its little but I can’t wait till it’s a bit older and can look at you’*

In her reflection, she denied she would ever swear in front of patients.

However, the panel also referred to the local statement of Witness 1:

‘On Friday 25th November 2022 between 4 and 5pm, I was sat on the benches with while she was on escorted leave. Kelsey walked out of the hospital past the benches and said “wow, you’re definitely showing now!” referring to her pregnancy bump. Kelsey replied something to the effect of “I fucking hate it, I hate looking this way and being this way” and stood chatting with myself and for a while before leaving work.’

The panel considered that this was consistent with Witness 1’s live evidence and her NMC statement:

‘At this time Kelsey walked of the hospital and past us on the benches and said to her “wow, you’re definitely showing now” and was referring to Kelsey’s pregnancy. Kelsey replied to Patient E along the lines of “I fucking hate it, I hate looking and being this way”. Kelsey stood chatting to us for a while before she left’.

The panel accepted the evidence of Witness 1 who was a credible and reliable witness. The panel noted that she had only recently started working on the same ward as Miss Abbott and, therefore, the panel considered that this was an incident that would have stayed in her memory. She recorded this incident in her local statement and the panel do not consider she had any reason to fabricate or exaggerate it. Furthermore, the panel heard evidence from Witness 3 who also stated that she heard Miss Abbott swearing on a different occasion.

The panel concluded that it was more likely than not that Miss Abbott did state words to the effect of 'I fucking hate it, I hate looking this way and being this way' to Patient E.

However, the panel has noted that the charge alleges that Miss Abbott "made an offensive comment to Patient E". This is in contrast to the regulatory concern which referred to Miss Abbott had "*made inappropriate comments and swore to and/or in front of patients*". Had the charge been drafted in this form, the panel would have found it proved.

The panel is of the view that, in order to find this charge proved, there must be some cogent evidence before it that Patient E did find the comment to be offensive. Alternatively, the comment must, by its very nature, be offensive in as much that it was an insult directed towards Patient E.

There is no such evidence, and it is evident that this was not an insult directed at Patient E, indeed, Witness 1 states that *"Patient E didn't say anything to me about it".*

In the circumstances, although the panel considered the comment to be highly inappropriate and unprofessional, it could not conclude that it was offensive. Consequently, this charge is not proved.

Charge 5

5. On an unknown date permitted Patient E to feel your pregnancy bump.

This charge is found proved.

In reaching this decision, the panel took particular account of the oral and documentary evidence of Witness 3.

In the local statement of Witness 3 stated:

‘Patient: Can I feel the [bump]
Kelsey: Yes, you can, and she stood by the door nurses door and the patient felt the bump and was quite excited’ [sic]

The panel found this to be consistent with Witness 3’s oral evidence and NMC statement:

‘The resident then asked if she could feel the [bump] *and Kelsey allowed her to.’*

The panel noted that there had been no response to this charge from Miss Abbott or her representatives. It found Witness 3’s evidence to be consistent throughout both the local and NMC investigations. Accordingly, it therefore found that it was more likely than not that this incident occurred as alleged and found it proved.

Charge 6

6. On an unknown date made an offensive comment to Patient E when asked whether you were pregnant, in that you said words to the effect of “did you think it was a fucking bag of crisps”.

This charge is found NOT proved.

In reaching this decision, the panel took particular account of the documentary and live evidence of Witness 3.

The panel referred to the local statement of Witness 3:

“I would not say she was swearing at the patient at all they were bantering.
The discussion was a s follows:
Patient: Are you Pregnant Kelsey

Kelsey: Do you fucking think it's a bag of crisps/chips (This was done in a sort of joking manner (Not sure, exactly how this was phrased)
Kelsey: Of course, I am pregnant that is why you don't see me on the ward
Patient: How far gone are
Kelsey: 31 Weeks
Patient: What are you having?
Kelsey: [PRIVATE]
Patient: Can feel the [bump]
Kelsey: Yes, you can and she stood by the door nurses door and the patient felt the bump and was quiet excited"

.

The panel also referred to the NMC statement of Witness 3:

'The resident was asking her about her pregnancy. When the resident asked if Kelsey was pregnant, I recall Kelsey swore but in a joking manner as I detailed in my local statement something along the lines of "did you think it was a fucking bag of crisps".'

The panel again noted Miss Abbott's reflection which she produced for the NMC case examiner's decision enclosed in the RCN letter on 22 August 2024:

'Swearing in front of patients is behaviour that I would never do'.

The panel accepted the evidence of Witness 3 who was a credible and reliable witness. She recorded this incident in her local statement and the panel do not consider she had any reason to fabricate or exaggerate it.

The panel has noted that the charge alleges that Miss Abbott *"made an offensive comment to Patient E".* This is in contrast to the regulatory concern which referred to Miss Abbott had "*made inappropriate comments and swore to and/or in front of patients*". Had the charge been drafted in this form, the panel would have found it proved.

The panel is of the view that, in order to find this charge proved, there must be some cogent evidence before it that Patient E did find the comment to be offensive. Alternatively, the comment must, by its very nature, be offensive in as much that it was an insult directed towards Patient E.

There is no such evidence, and it is evident that this was not an insult directed at Patient E, indeed, Witness 3 stated in her NMC statement that after making this comment:

> *"The resident then asked if she could feel the babies and*
> *Kelsey allowed her to.*
> *At the time when Kelsey allowed the resident to feel* [the bump] *Kelsey was stood by the nurses' door, the resident felt the bump and appeared quite excited for Kelsey.*

In the circumstances, although the panel considered the comment to be highly inappropriate and unprofessional, it could not conclude that it was offensive. Consequently, this charge is not proved.

Charge 7

7. On or around 8 April 2022 sent a Facebook friend request to Patient A.

This charge is found proved.

In reaching this decision, the panel took particular account the documentary evidence of Witness 4. In their NMC statement Witness 4 stated:

> *'On the mobile, belonging to patient A, I noticed a Facebook friend request to patient A from "Kels Abbott", I knew this name to be my colleague, Kelsey. Patient A clicked on the image from the Facebook friend request and the image confirmed*

to me this was Kelsey's Facebook account, and she had made a 'friend request' to patient A.'

The panel noted that this was consistent with the local statement Witness 4 had given on 7 April 2022:

"…. *requested that I take a look at Patient A's mobile phone and Facebook notification. I observed a friend request from 'Kels Abbott' on Patient A's phone. Patient A clicked the image and confirmed that this was indeed Kelsey Abbott, staff member."*

The panel referred to the local investigation report dated 7 April 2022:

'Kelsey was unable to recall when she had sent the friend request.
…
Kelsey gave permission for Ward social worker to check her phone. There was clear evidence that she had sent the friend request. Kelsey said that this could be due to the fact that she could have been on her phone in the night/early hours and not been aware she was sending the request'

The panel then referred to the investigation meeting dated 25 April 2022:

'Does anyone else have access to your account?
KA I have my account on a couple of devices, it's linked to my iPad and it's at home. I'm currently living at my dad's at the moment, but I can't see any of my family making the request. I don't let my family anything about the patients not even their names.'

The panel referred to the letter sent by the RCN for the NMC case examiner's decision on 22 August 2024:

‘d) Made a request on a social media platform to befriend a patient who was under your care

Miss Abbott denies this concern. She cannot account for how the social media request was made but has instructed that her young niece often plays with her phone and it may have been that she inadvertently sent the request.’

The panel also had sight of the picture taken of Patient A’s phone showing the friend request on Facebook sent from Miss Abbott. Witness 4 was taken to the screenshot of the Facebook friend request in the investigation report and confirmed to the panel that this is what she had seen. The panel considered the three accounts from Miss Abbott of how the friend request occurred which it considered to be vague and inconsistent. On the balance of probabilities, the panel found this charge proved. Balanced against the clear and consistent evidence of Witness 4, the panel determined that it was more likely than not that on or around 8 April 2022 Miss Abbott sent a Facebook friend request to Patient A. Therefore, this charge is found proved.

Charge 8

8. Your conduct at one or more of charges 1 to 7 was in breach of professional boundaries.

This charge is found proved.

In reaching this decision, the panel took into account its findings for charges 1, 2, 5, and 7.

The panel also referred to Witness 2’s statement:

‘In my professional opinion discussing other young people’s care is a breach of confidentiality of the other young person. Discussing incidents with the other young people can be re-traumatising and impact on their mental health.

For breaching professional boundaries in relation to sharing the information about a patient’s death Kelsey received a Stage 2 Final Written Warning to remain active on her file for 12 months. After this Kelsey was moved to another ward.’

The panel considered that in charge 1, Miss Abbott had shared with a patient confidential information about the death of a fellow patient without clinical justification. The panel determined that this could have impacted on the health and wellbeing of the other young patients, as well as being a serious violation of privacy by Miss Abbott. In acting as she did, she had not considered the right to privacy of the deceased Patient B and their family.

The panel considered that in relation to charge 2, Witness 1 in her live evidence stated that the staff at the Hospital had recently been on training about professional boundaries only days before Miss Abbott’s interaction with Patient E. She also explained to the panel that it was the staff who should be getting to know the patients in order to assist their recovery, not the other way around.

Miss Abbott sharing personal information about her own pregnancy with Patient E was not done for the therapeutic advancement of care for Patient E, but due to Miss Abbott’s own desire to share. In doing so, it was a breach of professional boundaries.

The panel was of the view that in relation to charge 5, it is unusual for a nurse to allow any patient, especially a potentially volatile patient, to feel their pregnancy bump. This presented a risk to this patient in that, due to their history and particular vulnerabilities, it could be emotionally triggering for them. It was also a risk to Miss Abbott, and potentially other staff, should the patient have reacted negatively. In the circumstances, the panel is satisfied that Miss Abbott’s conduct in this respect did breach professional boundaries.

The panel considered that in charge 7, Miss Abbott had initiated the friend request on Facebook which was not in the patient's best interest. Miss Abbott had taken the decision to make the request in her own interests with no clinical justification. The panel considered Witness 4's live evidence when she stated that crossing professional boundaries in this manner has a potential negative effect in that it might enable patients to manipulate staff for special treatment such as obtaining restricted items for them. Consequently, the relationship between staff and patient could stop being therapeutic and become potentially detrimental to the young patients. Witness 4 also stated that such perceived favouritism could cause disputes amongst the patients. The panel is satisfied that Miss Abbott's conduct in this respect did breach professional boundaries.

Therefore, in light of the panel's findings of charge 1, 2, 5 and 7 the panel found this charge proved.

Charge 9a and 9b

9. Failed to comply with your pregnancy risk assessment in that you:
a) On one or more occasions between 23 September 2022 and 29 November 2022 entered the ward area alone when restricted from lone working;
b) On 25 November 2022 entered the seclusion area when you were restricted from interaction with unsettled patients.

This charge is found proved in its entirety.

The panel considered both charge 9a and 9b together due to the proximity in time of the two events and the overlap of evidence for both charges.

In reaching this decision, the panel took particular account of the documentary evidence of Witness 1 and Witness 8.

The panel referred to Witness 8's statement:

'I cannot recall the exact date Kelsey told me she was pregnant. However, I know, as per procedure and policy I would have acted immediately in regard to removing her from the ward environment. The ward can be very volatile, and we had a duty of care to Kelsey. However, when I made this decision Kelsey was not happy with it. She argued with me for about a week stating that she did not want to be 'office based' and wanted to go onto the ward to assist with the patients.

…

In line with our processes at Cygnet. The pregnancy risk assessment was carried out with Kelsey and I on 23 September 2022, all pregnancy risk assessment is completed with the expectant person, Kelsey would have been fully aware of the restrictions put in place to protect her safety, as these would have been discussed in the meeting. Kelsey would receive a copy of the assessments for her own records.

…

So, I was shocked when I saw Kelsey in the seclusion area with a patient, on 25 November [2022], *after we had completed the pregnancy risk assessment. Seclusion is used as a short-term measure for very high-risk patients. I went into seclusion area and asked Kelsey to leave; she was reluctant to do so. This was not the first time I found Kelsey on the ward environment. I had also seen her on two or three other occasion and immediately asked her to leave the area.*

… .

It was also brought to my attention by other staff that Kelsey would often walk the corridors near the patients bedrooms alone and refused to come off the wards when she was told to by other staff, she would walk away from the staff and enter the patient bedrooms by herself, On one occasion Kelsey hid on the ward when staff were trying to remove her from the ward environment for her own safety.

…

I always spoke to Kelsey about why she would openly breach her safety and the safety of other staff by entering the ward whilst restricted, she wouldn't have a reason why but referenced that she was 'bored'.'

The panel had sight of Miss Abbott's pregnancy risk assessment form dated 23 September 2022 carried out by Witness 4, which outlined '*no lone working including 1:1's*'.

The panel also referred to Witness 1's statement:

'In early October 2022 just after I started at Cygnet, I was sitting in the dining room and could see Kelsey on the Ward. I found it odd that Kelsey was present as I am aware that pregnant people are not allowed on the ward. I know this because as a newcomer it was explained to me that if you're pregnant you take on more admin roles and you must be escorted on the ward due to the risk. Kelsey came over and sat with me and started chatting… Ward Manager came onto the ward and saw Kelsey chatting to me and Kelsey hid her face behind a piece of paper and was laughing. I found Kelsey's behaviour unprofessional and childish and could not understand why she did this. However, on reflection I realise she was attempting to avoid being seen by [Witness 8].*'*

The panel referred to the note of the disciplinary meeting with Miss Abbott on 17 March 2023, Miss Abbott stated:

KA: The risk assessment we did that one was written down, it said I can go on the ward but with certain conditions. We had a conversation like "can't go on my own but can with someone else". I had been on the ward with [Witness 8] …*The one time I went alone is because I needed a charger for my laptop. I did ring … but couldn't get through to anyone, but I need the charger as I was in ward round and needed to do the minutes… I had only gone into a patient's room when someone was outside.'*

…

'The allegations made against you are as follows, the alleged breach of your pregnancy risk assessment which includes entering seclusion on 25th November 2022 where there was a high-risk patient inside. It was reported that this made staff feel uncomfortable as it was a new and unsettled patient who had just physically assaulted staff member. You had a pregnancy risk assessment in place, and you had supervisions around not being on the ward on a lone basis and not being on the ward when it was unsettled. It was reported that you did not follow your risk assessment and went against the expectations clearly set out in the supervision by your ward manager by refusing to come back off the ward with your escorting staff on several occasions, you would walk away from them and go to patients bedrooms by yourself. You would also 'playfully hide' when asked to come off the ward. You accepted you did that?
KA: Yes

The panel questioned Witness 8 whether, as per Miss Abbott's explanation, she had entered the ward that day with Miss Abbott. Witness 8 denied this. Witness 8 confirmed that she went into the ward to find Miss Abbott already there. The panel noted that this was consistent with her statement.

'I witnessed Kelsey breaching the Risk Assessment already in place. I went onto the ward to complete a secluding review with a patient and Kelsey was already in the room. The seclusion room is through lots of locked doors, so Kelsey would have had to have fob her way through the doors, so I believe it was intentional that she went through to the seclusion room; she did not get lost. If a patient is in seclusion, it means they are deemed as high risk. For example, the patient may be high risk of being aggressive towards staff and/or other patients and/or a risk of being violent; so, I was very shocked that Kelsey was in there the seclusion room. When I entered the room, Kelsey seemed to be hiding behind the door from me as I entered. I immediately asked her to leave the ward, and she did not. I then did the seclusion review for the patient and came out of the room, at which point, Kelsey was still in there. I asked Kelsey what she was still doing there and asked her to

leave again and she made joke and laughed in response. I remember asking Kelsey to leave 3 times and she finally left after that.'

The panel also noted Miss Abbott's apparent admission within her reflective statement enclosed within the RCN's letter to the NMC case examiners:

'I shouldn't have gone into seclusion that was a very silly idea on my part'

The panel noted that the ward was classed as a 'secure' environment. Witness 8 explained the location, workings and purpose of the seclusion area in her live evidence; an enhanced secure area within the ward that could not be accessed by chance. Staff were not allowed on their own in the secure area under any circumstances. Witness 8 explained that the patients within the seclusion area were violent, aggressive and considered high risk. Witness 8 outlined that the seclusion area was only opened if five people, the full restraint team, were present.

The panel concluded that Witness 8's statements and live evidence of having seen Miss Abbott on the ward and in the seclusion area by herself when she was pregnant were corroborated by Witness 1 and Miss Abbott in the local investigation. Therefore, it decided that on the balance of probabilities, the panel found both charges 9a and 9b proved.

Charge 10

10. On and/or after 24 April 2023 failed to provide Nightingale app and/or Primary Care Network (PCN) with a copy of your interim conditions of practice, in breach of condition 9 of your Interim Conditions of Practice Order.

This charge is found proved.

In reaching this decision, the panel took particular account of the documentary and live evidence of Witness 5, Witness 6 and Witness 7.

The panel had sight of Miss Abbott's previous interim conditions dated 24 April 2023:

> *'9. You must immediately give a copy of these conditions to:*
>
> *a. Any organisation or person you work for.*
>
> *b. Any employers you apply to for work (at the time of application).*
>
> *c. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.'*

The panel noted that Witness 5 stated in his live evidence that Nightingale App do not consider themselves as an agency but as a marketplace that connects a locum to a service provider. Witness 5 explained that Nightingale App did not specifically employ Miss Abbott.

However, the panel considered that PCN is an organisation and therefore falls within the remit of interim condition 9a. The panel concluded that PCN was Miss Abbott's employer as it paid her for her hours worked. Therefore, Miss Abbott would have had the duty to disclose her interim order to it.

The panel referred to Witness 6's statement:

> *'I can confirm that at no point during the time whilst Kelsey worked as a vaccinator for City PCN did she disclose to us that she was subject to an Interim Order as imposed by the NMC. Had this information been disclosed to us, we would not have employed her within her role as a nurse/vaccinator.'*

The panel had sight of the dates, provided by Witness 6 and Witness 5, of the shifts Miss Abbott had worked as a vaccinator for PCN. These ranged between 26 April 2023 and 28 June 2023, covering 8 shifts in various locations.

The panel also referred to the evidence of Witness 7. In her NMC statement she said:

> *"As I understand, Kelsey had a period where she was not working through Nightingale and this was for a six-month period, when Kelsey returned to work, she sent a 'statement of entry' to our candidate team and failed to disclose any restrictions, therefore her profile was updated. Kelsey was initially onboarded to Nightingale app as part of the Covid vaccine programme before I joined Nightingale. She was able to update her account as a returning candidate. However, Kelsey was in touch with 2 members of the nightingale team and at no time did Kelsey state there were restrictions on her practice. As an organisation we have changed the onboarding process, having reviewed what happened in Kelsey's case."*

The panel considered that both Witness 6 and Witness 7 were consistent in their live and documentary evidence about never having been informed by Miss Abbott about her interim order. Consequently, the panel concluded that it was more likely than not that on and/or after 24 April 2023 Miss Abbott failed to provide Nightingale app and/or Primary Care Network (PCN) with a copy of her interim conditions of practice, in breach of condition 9 of her Interim Conditions of Practice Order. Consequently, it found this charge proved.

Charge 11

11. Your conduct at charge 10 was dishonest in that you intended to mislead Nightingale app and/or Primary Care Network (PCN) by failing to disclose your interim conditions of practice.

This charge is found proved.

The panel referred to the case of *Ivey v Genting Casinos Ltd t/a Crockfords* [2017] UKSC 67 in determining whether Miss Abbott's conduct was dishonest.

In reaching this decision, the panel took into account the documentary evidence of Witness 7.

The panel had sight of an email Witness 7 sent to the NMC on 23 August 2023:

> *'…., her conditions of practice came to light through a random internal random audit process, conducted by one of our compliance team on 11/08/23. Prior to this date KA worked the 26, 27/04, 17,18,19, 23, 25/05 and 1,2,6,6,8,9,28/06 delivering housebound covid vaccinations for a PCN.*
>
> *As we are a digital platform I don't personally hold the job description for the role but this would usually be an independent working role where nurses would go and collect vaccines from the practice in the morning and go and visit patients in their home to deliver. This is work KA Joined Nightingale in 2021 to deliver prior to taking some maternity leave and before I joined the organisation.*
>
> *After I contacted the NMC helpline I was advised that I should let KA know that I would be making a FCP referral. I called KA to introduce myself and inform her that we had found she had restrictions the day before I made the referral. KA advised me that she hadn't broken her restrictions as she had only been advised not to work with vulnerable adults aged 18-24, that she had planned on telling the client she went to the interview with, about her restrictions should she be successful. She advised me that her referral was because she swore at a patient for asking if she was pregnant and that this had been referred because she had raised concerns about another staff member stealing. She was not able to give much explanation as to why she had not disclosed her restrictions to us other than she was embarrassed by them and that she didn't feel they related to this work. She asked me not to report her and then became angry with me and told me it was my fault she would*

be homeless…We cancelled her profile on the platform with immediate effect and I am currently reviewing it as a significant event.'

The panel considered Witness 7's statement:

'Kelsey had a period where she was not working through Nightingale and this was for a six-month period, when Kelsey returned to work, she sent a 'statement of entry' to our candidate team and failed to disclose any restrictions, therefore her profile was updated. Kelsey was initially onboarded to Nightingale app as part of the Covid vaccine programme before I joined Nightingale. She was able to update her account as a returning candidate. However, Kelsey was in touch with 2 members of the nightingale team and at no time did Kelsey state there were restrictions on her practice.'

The panel then referred to Miss Abbott's reflective statement enclosed in the RCN's letter:

'I did not mean to go against my conditions. I informed Nightingale by post I was under conditions; however, I didn't know who HR were, so I didn't want to email my conditions documents to just anyone as it wasn't something I wanted to broadcast to the whole company – just the people who needed to know. Therefore, I printed out the document and sent it to HR in the post.'

In applying *Ivey,* the panel first considered Miss Abbott's knowledge and belief as to the relevant facts. The panel considered that Miss Abbott's interim order hearing took place on 24 April 2023 and that she started her shifts as a vaccinator for PCN on 26 April 2023, a mere two days later. It noted that Miss Abbott was both present and legally represented at the interim order hearing and took the view that Miss Abbott would have had a robust explanation of the restrictions of the interim conditions at that time. It also noted that the determination document from the interim order hearing had been sent to Miss Abbott in a letter dated 26 April 2023 to her registered email address. Therefore, the panel is satisfied on a balance of probabilities that Miss Abbott did know of her obligation to notify

Nightingale App and/or PCN about the conditions on her practice and that this knowledge would have been fresh in her mind at the time. In this respect, the panel's finding is reinforced by its determination that Miss Abbott intentionally lied about her interim conditions to Witness 7, namely about being restricted only around working with 18–24-year-olds. The panel was of the view that this had been done by Miss Abbott with the intention of minimising the actual restrictions of her interim order. Furthermore, the panel's considered Miss Abbott's statement that she had sent a copy of her interim conditions in the post to Nightingale App's HR to be contradictory and implausible. If she had intended to disclose the interim conditions to Nightingale, she could have done so by email or telephone. The panel noted the evidence of Witness 7 when she stated that Miss Abbott had been in contact with two members of the Nightingale team at this time.

In the light of the above, the only proper inference that the panel can draw is that Miss Abbott failed to disclose the interim conditions of practice because she knew it would reduce her chances of obtaining employment.

Taking everything into account, the panel concluded that an ordinary and decent person would conclude Miss Abbott's conduct to be dishonest. Accordingly, the panel is satisfied on the balance of probabilities that Miss Abbott was dishonest in that she intended to mislead Nightingale app and/or Primary Care Network (PCN) by failing to disclose her interim conditions of practice.

Therefore, the panel found this charge proved.

Charge 12

12. On a date or dates on or after 24 April 2023 obtained nursing work through Nightingale app in breach of condition 1 of your Interim Conditions of Practice Order which required you to have one employer which must not be an agency.

This charge is found proved.

In reaching this decision, the panel took particular account of the documentary evidence of Witness 5, Witness 6 and Witness 9.

The panel referred to Witness 6's statement:

> *'I am aware that Kelsey was employed as a nurse via the Nightingale app and that she was allocated to carry-out some shifts at both Hanover and Porter Brook. I, however, have not met Kelsey in person before. I am aware that Kelsey was employed within the capacity of a nurse/vaccinator and carried out shifts in administering Covid-19 vaccinations to housebound patients on the following dates:*
>
> - *26 April 2023 (Porter Brook)*
> - *27 April 2023 (Porter Brook)*
> - *1 June 2023 (Hanover)*
> - *6 June 2023 (Hanover)*
> - *7 June 2023 (Hanover)*
> - *8 June 2023 (Hanover)*
> - *9 June 2023 (Hanover)*
> - *28 June 2023 (Hanover)'*

The panel also referred to Witness 9's statement:

> *'I can recall that Kelsey had carried out a small number of shifts for Broom Lane as a vaccinator, as she had worked the following dates:*
>
> - *18 May 2023*
> - *23 May 2023*
> - *25 May 2023'*

The panel noted Witness 5's evidence where he listed the shifts Miss Abbott had worked through Nightingale App:

26/04/2023 08:00 26/04/2023 14:45 00:00:00 Paid City PCN - Porter Brook (Housebound Vaccinations) Vaccinator Kelsey Abbott
27/04/2023 08:30 27/04/2023 14:00 00:00:00 Paid City PCN - Porter Brook (Housebound Vaccinations) Vaccinator Kelsey Abbott
17/05/2023 09:00 17/05/2023 14:45 00:00:00 Paid Handsworth Medical Centre Vaccinator Kelsey Abbott
18/05/2023 09:00 18/05/2023 17:00 00:00:00 Paid Broom Lane Medical Centre Vaccinator Kelsey Abbott
19/05/2023 09:00 19/05/2023 14:15 00:00:00 Paid Handsworth Medical Centre Vaccinator Kelsey Abbott
23/05/2023 09:00 23/05/2023 17:00 00:00:00 Paid Broom Lane Medical Centre Vaccinator Kelsey Abbott
25/05/2023 09:00 25/05/2023 17:00 00:00:00 Paid Broom Lane Medical Centre Vaccinator Kelsey Abbott
01/06/2023 09:30 01/06/2023 13:30 00:00:00 Paid City PCN - Hanover Medical Centre (Housebound Vaccinations) Vaccinator Kelsey Abbott
02/06/2023 09:00 02/06/2023 14:00 00:00:00 Paid Handsworth Medical Centre Vaccinator Kelsey Abbott
06/06/2023 09:30 06/06/2023 13:30 00:00:00 Paid City PCN - Hanover Medical Centre (Housebound Vaccinations) Vaccinator Kelsey Abbott
07/06/2023 09:30 07/06/2023 14:00 00:00:00 Paid City PCN - Hanover Medical Centre (Housebound Vaccinations) Vaccinator Kelsey Abbott
08/06/2023 11:30 08/06/2023 16:00 00:00:00 Paid City PCN - Hanover Medical Centre (Housebound Vaccinations) Vaccinator Kelsey Abbott
09/06/2023 09:30 09/06/2023 13:30 00:00:00 Paid City PCN - Hanover Medical Centre (Housebound Vaccinations) Vaccinator Kelsey Abbott
28/06/2023 09:30 28/06/2023 17:00 00:30:00 Paid City PCN - Hanover Medical Centre (Housebound Vaccinations) Vaccinator Kelsey Abbott

Having referred to *Kuzmin v General Medical Council* [2023] EWHC 60 (Admin) the panel considered that condition 1 should be given a purposive interpretation. Condition 1 should not be considered in isolation but should be considered in the context of the other conditions particularly conditions 4, 5 and 6 which required Miss Abbott to work under supervision, and have fortnightly meetings with a line manager, mentor or supervisor who must then submit reports on Miss Abbott's performance. The panel concluded that the clear purpose and spirit of the interim conditions were to ensure that Miss Abbott was consistently supervised, supported and appraised while they were in force. This could only happen if she were restricted to employment by one substantive employer and, therefore, the panel interprets condition 1 in this way.

However, at this time Miss Abbott worked in several establishments in several locations. By working at several different locations with a variety of colleagues and with no specific supervision or supervisor Miss Abbott failed to adhere to the purpose of the interim order and the conditions that were designed to protect patients and the public.

Therefore, the panel is satisfied on a balance of probabilities that Miss Abbott was in breach of her interim condition 1 and found this charge 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 Miss Abbott's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

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

Ms Boesche invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of **'**The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Boesche identified the specific, relevant standards where Miss Abbott's actions amounted to misconduct.

Ms Boesche submitted that Miss Abbott's conduct, as detailed in the charges, fell significantly short of what would be expected of a registered nurse. She submitted that most of the identified concerns relate to breaches of professional boundaries. These include but are not limited to, speaking to patients about her pregnancy, letting a patient feel her pregnancy bump and also sending a Facebook request to a vulnerable patient.

Ms Boesche outlined that the remaining charges against Miss Abbott include those that relate to dishonesty.

Ms Boesche submitted that Miss Abbott's actions were a significant departure from the fundamental principles of the Code of prioritising people and promoting professionalism and trust.

Submissions on impairment

Ms Boesche 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).

Ms Boesche submitted that Miss Abbott's actions towards vulnerable patients exposed them to psychological harm and potential serious effects on their health. She reminded the panel that Miss Abbott had spoken of Patient B's death to Patient C and Patient D, expressed her negative feelings about her pregnancy to a volatile patient, and allowed the same patient to feel her pregnancy bump.

Ms Boesche submitted that Miss Abbott's conduct set out in the charges is, by its nature, capable of bringing the nursing profession into disrepute. She submitted that registered professionals occupy a position of privilege and trust in society and are expected at all times to be professional. She submitted that members of the public must be able to trust registered professionals with their lives and the lives of their loved ones, and trust that the professionals will not expose them to harm.

Ms Boesche submitted that Miss Abbott breached the fundamental tenets of prioritising people, preserving safety, promoting professionalism and trust.

Ms Boesche submitted that Miss Abbott has displayed limited insight into her actions and admitted that she spoken to a patient about the death of another patient. Ms Boesche outlined that Miss Abbott had tried to minimise her culpability by suggesting that she only did this to be honest and promote good rapport.

Ms Boesche reminded the panel that there is no insight into Miss Abbott's actions set out in the other charges. She submitted that Miss Abbott has not shown any attempt to strengthen her practice.

Therefore, Ms Boesche submitted that Miss Abbott's practice is currently impaired on public protection grounds.

Ms Boesche informed the panel that Miss Abbott has since left the nursing profession.

Ms Boesche submitted that Miss Abbott's practice is also impaired on public interest grounds. Ms Boesche submitted that breaching professional boundaries is serious, and dishonesty is so serious that it is likely to undermine the NMC's maintenance of professional standards and public confidence in the profession. She submitted that members of the public would be appalled to hear of a nurse failing to maintain proper professional boundaries and obtaining work dishonestly. She submitted that such conduct severely damages and undermines public confidence in the nursing profession and the NMC, as the regulator.

In response to panel questions Ms Boesche clarified that by not adhering to the rules set out in her pregnancy risk assessment Miss Abbott exposed herself and others to the risk of harm.

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), *Johnson and*

Maggs v NMC [2013] EWHC 2140 (Admin) and *General Optical Council v Clarke* [2018] EWCA Civ 1463.

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 Miss Abbott's actions did fall significantly short of the standards expected of a registered nurse and that Miss Abbott's actions amounted to breaches 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

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

5 Respect people's right to privacy and confidentiality

To achieve this, you must:

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

5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care

5.3 respect that a person's right to privacy and confidentiality continues after they have died

8 Work co-operatively

To achieve this, you must:

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.4 take account of your own personal safety as well as the safety of people in your care

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

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

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

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

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

23 Cooperate with all investigations and audits

To achieve this, you must:

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that in charge 1, Miss Abbott had seriously breached Patient B and their family's right to privacy, confidentiality and dignity. It considered that Miss Abbott showed a significant lack of understanding into how serious this misconduct was by attempting to minimise her actions within her reflective statement put forward by the RCN. The panel also considered that it was particularly unnecessary and unwise for Miss Abbott to mention details of the way in which Patient B had died to Patient C and Patient D given that they were highly vulnerable young patients who could have found this information emotionally triggering, as well as putting them at risk of using that information for their own self harm. The panel referred to Witness 2's statement:

'In my professional opinion discussing other young people's care is a breach of confidentiality of the other young person. Discussing incidents with the other young people can be re-traumatising and impact on their mental health.'

The panel considered charge 2 to be serious misconduct as the patients in this ward had significant vulnerabilities, and for a nurse to share strong negative feelings about her pregnancy in the way Miss Abbott did, was a breach of professional boundaries. It noted that this ward contained highly vulnerable young women including those who had traumatic histories of sexual assault and in Patient E's case, resultant pregnancy. There were also women who had experienced their own children having been removed from their care. The panel considered that other professionals would find this conduct deplorable.

The panel considered that in charge 5, Miss Abbott put herself at serious risk of harm by allowing Patient E to come into physical contact and feel her pregnancy bump especially given Patient E's volatile nature and traumatic history. The panel noted that, had the

situation negatively escalated, Miss Abbott's colleagues would have also been put at risk of harm as they would have had to intervene in order to protect her and her unborn babies. As such it found that there was serious misconduct.

The panel considered that in charge 7, for Miss Abbott to proactively initiate a friend request to a patient on Facebook is, in itself, is a serious breach of professional boundaries. However, the panel also took account of the particular vulnerabilities of the young patients in the ward. It referred to Witness 4's live evidence that breaching boundaries in this manner with these patients could have put Miss Abbott at risk of being manipulated into supplying them with restricted items, which in turn could have put those patients at risk of harm. It could have also created disputes amongst patients. Furthermore, the panel noted that Miss Abbott was an experienced nurse who had only recently taken part in professional boundaries training. It was of the view that the clandestine nature of Miss Abbott sending the friend request and in full knowledge of the risks of doing so was serious misconduct. The panel determined that this was an example of a deep-seated attitude of repeatedly disregarding rules that are in place to protect patients and staff.

In charge 9, the panel noted that Miss Abbott had a pregnancy risk assessment tool put in place, as well as a supervision meeting, in order to ensure that she and her colleagues would be protected. Miss Abbott had specific rules to which she knew she was expected to adhere, but she flagrantly disobeyed them within a very short space of time. In doing so, the panel noted that in the local investigation she had given the reason that she was *'bored'* and that her reaction at the time of being caught on the ward was by *'laughing and hiding'.* The panel noted that these were not isolated incidents but were repeated intentional acts and that Miss Abbott put herself and colleagues at a high risk of harm. As such, it found that this charge amounted to serious misconduct.

The panel considered its findings in relation to Miss Abbott's dishonesty including what she knew or believed about her actions, the background circumstances, and any expectation of her at the time. It has found that her actions were dishonest and that her

alternative explanations were implausible. The panel had determined that Miss Abbott was aware of what she was doing, and that her actions were premeditated.

The panel determined that the dishonesty displayed by Miss Abbott in charges 10, 11 and 12 was serious misconduct. It considered for a nurse to behave dishonestly is always serious, and in this case, it noted that Miss Abbott had not only been present at her interim order hearing when the conditions on her practice were imposed but was also represented by the RCN. However, within a short space of time, she had intentionally chosen to mislead PCN, book shifts for work and then continue in the nursing jobs she had obtained dishonestly. The panel considered that had Nightingale App not completed a random registration PIN sweep in August 2023, Miss Abbott would not have been exposed for her dishonesty and thus the protections put in place by the interim order panel to protect the public would have continued to be seriously undermined. The panel considered that this dishonesty by Miss Abbott was premeditated. She had had the opportunity to disclose her interim conditions during the application stage to either Nightingale App and/or PCN, at the interview stage and/or during the five months after she had been made subject to the interim order when she remained registered with Nightingale App. The panel referred to the email sent by Witness 7 to the NMC on 23 August 2023, which outlined that Miss Abbott had lied about the restrictions on her practice. It considered that Miss Abbott, in failing to adhere to her interim conditions, had not only placed patients and the public at a high risk of harm, but had also significantly undermined the regulatory process.

For all these reasons, the panel found that Miss Abbott's actions in charges 10, 11 and 12 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses/midwives 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 found that Patient A, Patient C, Patient D, Patient E, colleagues and the wider public were put at risk of physical and/or emotional harm numerous times as a result of Miss Abbott's misconduct. The panel determined that Miss Abbott's misconduct breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was also satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious. Therefore, the panel found that limbs a, b, c and d were engaged in respect of Miss Abbott's past behaviour.

In assessing whether Miss Abbott is liable in the future to cause unwarranted risk of harm, bring the profession into disrepute and/or breach one of the fundamental tenets of the medical profession the panel applied the test as set out in *Cohen v GMC* [2008] EWHC 581 (Admin) with regard to impairment:

a. is the misconduct easily remediable?

b. has the misconduct already been remediated?

c. is the misconduct highly unlikely to be repeated?

The panel noted that there has been no engagement from Miss Abbott in this hearing, no evidence of strengthened practice, and no further reflective account, references or testimonials submitted on her behalf. The panel was concerned by Miss Abbott's repeated failure to maintain professional boundaries, breach of patient confidentiality and non-disclosure of her interim order to employers. The panel determined that Miss Abbott's attempts to minimise her culpability, deliberately and repeatedly going against her professional boundaries training, pregnancy risk assessment, and her NMC interim order, showed evidence of deep-seated attitudinal issues. Given the seriousness of Miss Abbott's misconduct and the identified attitudinal issues demonstrated by the repeated and cavalier disregard for rules, regulations and policies, the panel doubted whether, in this case, the misconduct was easily remediable.

In any event, the panel found that Miss Abbott's conduct has not been remediated. Miss Abbott has not shown any development from the very limited insight she showed at the time of the local investigation and her last engagement with the Fitness to Practise process. The panel noted that it was only within days of the interim order hearing that Miss Abbott had embarked on her protracted dishonest conduct. She has failed to show any evidence of recognising the effects of her misconduct and the potential for harm in respect of patients, colleagues and the public nor the impact on the wider nursing profession. The panel referred to her reflective statement enclosed in the RCN letter and considered that Miss Abbott had fallen short of holding herself fully responsible and had sought to make excuses and blame others. In the absence of any new reflective statement submitted before this panel, there was no indication that her views had changed and consequently the panel found that there was a high risk of repetition.

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

The panel bore in mind 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 as a reasonable, informed and fair-minded member of the public would be extremely concerned if a finding of impairment were not made for a nurse who had demonstrated such serious and repeated breaches of professional boundaries, patient confidentiality, and had intentionally misled employers by not disclosing the conditions of her NMC interim order. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore it also found Miss Abbott's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel determined that Miss Abbott cannot practise in a kind, safe, or professional manner and it was satisfied that Miss Abbott's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Abbott off the register. The effect of this order is that the NMC register will show that Miss Abbott has been struck off the register.

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

Submissions on sanction

Ms Boesche informed the panel that in the Notice of Hearing, dated 4 August 2025, the NMC had advised Miss Abbott that it would seek a striking off order if it found Miss Abbott's fitness to practise currently impaired.

Ms Boesche submitted that the aggravating factors in this case are that: there is a pattern of unprofessional conduct over an extended period of time, dishonesty, that Miss Abbott has provided limited reflection or insight into her failings and that she breached her interim conditions of practice order.

Ms Boesche outlined the following mitigating factors; that Miss Abbott has responded to the concerns in her reflections enclosed in the RCN letter to the case examiners, Miss Abbot has apologised for her errors albeit this is non-specific and that there is some personal mitigation.

Ms Boesche submitted that this case is too serious to take no action or impose a caution order.

Ms Boesche submitted that a conditions of practice order in this case would not be appropriate as Miss Abbott has previously breached her interim conditions of practice order imposed on 24 April 2023 hence there is no realistic prospect that further conditions would be adhered to. She also outlined that there are no workable conditions to address the attitudinal concerns arising from Miss Abbott's dishonesty.

Ms Boesche submitted that a suspension order would not be appropriate as, in reference to NMC Guidance, this is not a case which involves a single instance of misconduct where a lesser sanction is not sufficient, nor can it be said that there is no evidence of harmful/deep seated attitudinal problems.

Ms Boesche submitted that the misconduct is suggestive of a consistent pattern of failure to meet required standards as well as attitudinal issues. She outlined that Miss Abbott's

current demonstration of insight is limited, and it cannot be said that there is no risk of her repeating the concerns. Ms Boesche reminded the panel that there is no evidence of strengthened practice.

Ms Boesche informed the panel that Miss Abbott has been subject to an interim suspension order since October 2023.

Ms Boesche submitted that the repeated pattern of patient-facing concerns suggests that Miss Abbott prioritised her own interests above those of her patients. As such, the allegations raise serious questions about Miss Abbott's trustworthiness and professionalism. Ms Boesche further submitted that Miss Abbott blatantly defied her interim conditions shortly after they were imposed and therefore her conduct is incompatible with remaining on the register.

Ms Boesche submitted that striking off would be the only sanction sufficient to maintain professional standards and protect the public.

Ms Boesche submitted that in considering proportionality, a striking off order would not negatively impact upon Miss Abbott's livelihood as she is no longer working in the nursing profession.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of misconduct over a period of time
- Self-serving and protracted dishonesty
- Evidence of deep-seated attitudinal concerns
- Breached interim conditions of practice order
- Abuse of a position of trust
- Limited insight into failings
- Misconduct which put vulnerable patients, colleagues and herself at risk of suffering harm.

The panel also took into account the following mitigating features:

- Apology and some remorse in her reflective statement in respect of charge 1
- Personal mitigation including financial hardship at the time of the allegations

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues identified.

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 Miss Abbott's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Abbott's misconduct was not at the lower end of the spectrum. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Abbott's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of

the charges found proved in this case, the identified deep seated attitudinal issues and that Miss Abbott has previously breached an interim conditions of practice order. The panel noted that Miss Abbott had taken part in professional boundaries training only recently before the incidents at the hospital that triggered the first fitness to practise referral. It was of the view that the misconduct identified in this case, in particular the dishonesty, was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Miss Abbott's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

…

Having found that none of the aforementioned factors are applicable in Miss Abbott's case, the misconduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that Miss Abbott had already been under a period of interim suspension since October 2023, but that during this time there had been no evidence of any willingness by Miss Abbott to strengthen her practice. The panel was therefore of the view that a further period of suspension would serve no useful purpose. In any event, it also determined that the serious breach of the fundamental tenets of the profession evidenced by Miss Abbott's misconduct, including her long-standing deception, together with deep seated attitudinal concerns is fundamentally incompatible with her remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Miss Abbott's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel considered that Miss Abbott breached her interim order within a matter of days of it being imposed with the intention of personal financial gain and with flagrant disregard of the risks to patients under her care. The panel was of the view that the findings in this particular case demonstrate that Miss Abbott's actions were too serious to allow her to continue to remain on the register. To do so 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 Miss Abbott's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself 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.

Interim order

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

The panel accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Boesche. She submitted that an interim suspension order is required to cover the 28-day appeal period on both public protection and public interest grounds. She invited the panel to impose the interim suspension order on the same factual basis as the substantive striking off order.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's

determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any potential appeal period.

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

This will be confirmed to Miss Abbott in writing.

That concludes this determination.