Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 11 August 2025 – Friday, 22 August 2025
Tuesday, 26 August 2025 – Friday, 28 August 2025
Monday, 15 December 2025 – Tuesday 23 December 2025
Monday, 5 January 2026
Thursday, 8 January 2026 – Friday, 9 January 2026
Tuesday, 7 April 2026

Virtual Hearing

Name of Registrant:	Deborah Ann Povall
NMC PIN:	96H0218E
Part(s) of the register:	Registered Nurse RNA - Adult (23 August 1999)
Relevant Location:	Shropshire
Type of case:	Misconduct
Panel members:	Richard Weydert-Jacquard (Chair, Registrant member) Rosalyn Mloyi (Registrant member) Alison James (Lay member)
Legal Assessor:	Michael Hosford-Tanner (11 – 22 August 2025, 15 – 19 December 2025, 5, 8 and 9 January 2026) Patricia Crossin (26 – 28 August 2025) Paul Housego (22 December 2025) Nigel Pascoe (7 April 2026)
Hearings Coordinator:	Dilay Bekteshi (11 – 28 August 2025) Jumu Ahmed (15 December 2025) Sara Glen (16 -17 December 2025) Bethany Seed (5 January 2026) Adaobi Ibuaka (18 – 23 December 2025, 8 -9 January 2026 and 7 April 2026))
Nursing and Midwifery Council:	Represented by Linzi McQuade, Case Presenter (11 – 18 August 2025) Represented by Alastair Kennedy, Case Presenter (19 – 28 August 2025)

	Represented by Vida Simpeh (15 - 21 December 2025) Represented by Samprada Mukhia (5, 8 and 9 January 2026) Represented by Nina Dunn (7 April 2026)
Miss Povall:	Present and not represented at this hearing
Facts proved by way of admission:	Charges 1, 6a)iii)
Facts proved:	Charges 2a, 3.1b, 4a, 4c, 4d, 6a)i), and 6a)ii)
Facts not proved:	Charges 2b, 2c, 3.1a, 3.2, 4b, 4e, 4f, 5, 6a)iv), 7a and 7b
Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (12 months)**

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms McQuade on behalf of the Nursing and Midwifery Council (NMC), under Rule 31 to allow the written statement of Witness 5 into evidence. She referred the panel to *Thorneycroft v NMC* [2014] EWHC 1565 (Admin).

Ms McQuade explained that the application has two parts. The first relates to the exhibits, specifically Appendix C to Appendix R, which contain notes from investigative interviews. These notes will be discussed by Witness 5, but the original note-takers are not expected to give evidence as witnesses. The second part concerns specific charges, particularly 5b) and 5c).

Ms McQuade submitted that regarding Appendix C – notes from a meeting on 2 August 2019 – the witness, a ward clerk, will not be giving evidence. She said that these notes were made during an investigation.

Ms McQuade submitted that there are nine investigation notes in total and that calling all witnesses would extend the hearing beyond 13 days. She submitted that these notes are not the sole evidence supporting the charges, as they cover different matters.

Ms McQuade submitted that Witness 5 was present at each meeting and can verify that the notes were accurately recorded, but she cannot comment on the content of the witnesses' statements. She submitted that there is no suggestion that witnesses had reason to fabricate their allegations. The note-takers were not part of the investigation; they simply recorded minutes. She submitted that not every witness needs to give evidence on every issue. She submitted that if the panel rejects this part of the application, the relevant parts of the exhibits can be redacted as hearsay and not considered as direct evidence.

Ms McQuade submitted that the second part of the hearsay application relates to charges 5b) and 5c). Ms McQuade noted that the NMC has not called the consultants themselves. She submitted that Witness 7 is the only witness relevant to charge 5b), making their evidence the sole and decisive evidence, though it can be challenged. For charge 5c), multiple witnesses, including Witness 1, can speak to the incident. She submitted that the NMC's statements are presented as truthful, with no suggestion of fabrication and there are several witnesses supporting these charges.

In relation to the first part of the application, you submitted that the hearsay evidence should not be permitted as you would not have the opportunity to challenge or discuss it in an open forum. Regarding the second part, you stated that you do not agree it should be admitted, as you could not assess its reliability. Therefore, you asked that the panel not admit the hearsay evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered the first section concerning Appendices C to R. It noted that these appendices form part of the investigation's outcome and the conclusions reached during the investigation. They provide background information and indicate whether the investigator obtained sufficient evidence to support the findings. However, the panel noted that there is no indication or signature confirming that the interview statements are a true reflection of what was said.

Furthermore, the panel recognised that these statements relate to different incidents and contain similar phrasing. The panel was unable to determine whether any of the statements were fabricated. It also noted that the charges are of a serious nature. The panel also noted that these statements are not the sole or decisive evidence. One of the witnesses will be present at the hearing, presenting an opportunity for cross-examination.

The panel considered that the background context provided is helpful and relevant. However, the panel noted that this information is not equivalent to sworn, cross-examined evidence. It is not the sole or decisive evidence underpinning the charges but rather background material, which should not be given significant weight when considering the substantive allegations.

The panel concluded that admitting this evidence would not constitute a fundamental unfairness. It will weigh this evidence alongside other evidence, but it does not place substantial reliance on it in comparison to the sworn evidence and evidence submitted by witnesses who are subject to cross-examination. Accordingly, the panel will treat it as background material rather than central to the fact-finding process concerning the allegations.

Given these considerations, the panel determined that it is fair and relevant to admit Appendices C to R, but would give what it appropriate weight once the panel had heard and evaluated all the evidence before it.

Regarding the second part of the application, the panel noted that it is relevant to charges 5b) and 5c). The panel recognised that these are serious charges; however, they are based solely on hearsay evidence. There is no direct evidence, such as written documentation or statements from the consultants involved, has been presented to support these charges.

The panel determined to refuse the application in relation to the evidence pertaining to charges 5b) and 5c). The panel noted that there has been no attempt by the NMC to secure attendance from the two relevant consultants, nor is there any witness statement from them. As the panel cannot hear from these witnesses or cross-examine them, and given the indirect nature of the evidence, the evidence was tenuous and insufficient.

The panel noted that the central issue for each charge relates to what the consultants allegedly said and it was the sole and decisive evidence. In light of these factors, the panel refused the application in relation to charges 5b and 5c.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms McQuade to amend the wording of charges 2b, 4c and 6a - c to refine the grammatical sense of them.

Ms McQuade proposed the following amendments:

> *2. Between 2018 and 2019, failed to demonstrate appropriate standards of leadership in that you.*
>
> *b) Manipulated bed allocations so as to secure ~~increased~~* ***a higher number of*** *admissions which resulted in premature patient discharges.*
>
> *4. Failed to provide or escalate care appropriately, in that you:*

c) On or around 6 July 2019, ~~requested to 'get a patient home tomorrow', despite that the patient had low haemoglobin levels and required a blood transfusion.~~ ***said you "need to get him (the patient) home tomorrow", or words to that effect***

6. *~~Bullied or intimidated colleagues in that you:~~* ***Bullied or intimidated colleagues in that on a number of occasions between 2017 and 2019, you were unprofessional and abrupt in your communication with colleagues, in that:***

    a. *~~As a Ward Manager, controlled and intimidated staff members.~~*
    b. *~~On a number of occasions between 2017 and 2019, were unprofessional and abrupt in your communication with colleagues.~~*
    a. On or around September-November 2018, in relation to Colleague C:
        i. During a morning handover, you said 'you could have apologised' to Colleague C when she arrived late
        ii. You were aggressive in your tone to Colleague C about the INR machine when she stepped in to help
        iii. In a text message to another colleague, said about Colleague C 'I had to stop myself from as I would rather gouge her eyeballs out and shove them down her throat'
        iv. Caused Colleague C to bring a grievance and resign.'

Ms McQuade submitted that the NMC is no longer insisting on adding in the charge in relation to dishonesty in charge 5. She submitted that the NMC offers no evidence in relation to charges 5b and 5c in the original schedule. She submitted that as a result of the panel's decision to not admit the hearsay evidence there is no realistic prospect of proving the allegations.

You said you are content with the changes as the meaning of the charge has not been changed. You said you accept the proposed amendments.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment to charges 2b, 4c and 6a - c, as applied for, to refine the grammatical sense.

In relation to Ms McQuade's submission to offer no evidence in relation to charge 5, the panel decided to accede to the NMC's application to offer no evidence in relation to charge 5.

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

Ms McQuade made an application that this case be held partly in private when any aspects relating to Colleague C's health or personal circumstances arise. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You did not oppose the application.

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

Having heard that there will be reference to Colleague C's health or personal circumstances, the panel determined to hold those parts of the hearing in private in order to protect Colleague C's privacy.

Reasonable adjustments made for Colleague C

Ms McQuade informed the panel that Colleague C has a nurse supporter with her this afternoon. She submitted that the nurse supporter is simply acting as a support person and will not have

any involvement in the evidence. She said that Colleague C [PRIVATE] reasonable adjustments are that all parties ensure that any questions asked are succinct and short.

You did not oppose those reasonable adjustments.

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

The panel noted that the special measures were not opposed by you. The panel accepted that there is a professional nurse advocate with Colleague C during the course of her evidence and will not take part in the evidence. The panel therefore decided to uphold the reasonable adjustments requested by Colleague C.

Further Rule 19 application in relation to witnesses

Mr Kennedy, on behalf of the NMC, made an application for parts of the hearing to be heard in private. He submitted that when he talks about special measures, he will make reference to personal matters relating to witnesses who are involved. During the course of the witnesses evidence, they may mention matters of a similar nature, he therefore submitted that matters relating to special measures and personal matters should be heard in private.

You supported the application.

The panel accepted the advice of the legal assessor.

The panel decided that where reference to health, personal or familiar matters should be heard in private, to protect the privacy and confidentiality of witnesses.

Application for special measures in respect of Witness 3, Witness 4, Witness 6 and Witness 7

Mr Kennedy made an application for special measures concerning witnesses Witness 3, Witness 4, Witness 6, and Witness 7. Concerning Witness 4, Mr Kennedy stated that she [PRIVATE] does not seek any special measures other than her request for questions to be kept short. She

would appreciate being given time to locate the appropriate passages in documents and may ask for breaks.

Regarding Witness 6, Mr Kennedy [PRIVATE] said that Witness 6 would prefer questions to be concise and would like regular breaks.

Regarding Witness 7, [PRIVATE] Witness 7 requests that questions be kept short and simple, and she may seek additional breaks.

In relation to Witness 3, Mr Kennedy said that [PRIVATE] She also feels that she may tend to talk excessively. She believes that clear and concise questions would greatly assist her.

Mr Kennedy submitted that there is nothing controversial about any of the requests. He submitted that keeping questions short is always a sensible approach and that taking regular breaks will allow the witnesses to decompress. He explained that the witnesses' statements articulate their experiences with you, which have not always been positive, thus revisiting these matters may be challenging for them. He submitted that these proposals are reasonable under the circumstances.

You acknowledged that these are sensible requests given the situation and did not oppose the special measures.

The panel decided to grant the application and allow the special measures for Witness 3, Witness 4, Witness 6, and Witness 7.

Interim order

The panel has considered whether an interim order is required in the specific circumstances of this case, namely adjourning part-heard with two charges found proved by way of admission. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interest.

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

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted that the NMC has now closed this case and it would not be fair for you to start your evidence this afternoon (28 August 2025). His submission is the matter be adjourned now until this hearing resumes in December 2025. He also said that the panel does need to address the question of whether or not an interim order is necessary at this stage.

Mr Kennedy submitted that the NMC is not seeking an interim order at this stage. There has been no interim order to date, and you have been free to work for the same organisation for a number of years without any issues. He submitted that the two charges found proved by way of admission do not raise public protection concerns to the extent that an interim order would be required. He further submitted that it is unlikely there will be a repetition in regard to working excessive hours. He also stated that, in terms of public interest, the bar is very high, and the facts of this case do not meet that very high standard on public interest grounds alone. However, he noted that it is a matter for the panel.

You submitted that your current role requires you to be a registered nurse. You work for a company that provides healthcare assessments. You explained that you do this four days a week and are able to compress your hours. You said you work full-time over four days, with one day being 7.5 hours and three days around 10 hours each. You said that your role involves talking to individuals who are not acutely unwell. Your job is to ascertain the impact of a person's health conditions on their day-to-day functioning.

You stated that you do not use social media or text messaging now. You explained that your role is hybrid, so some days you can be in the clinic, but that would only involve you and the person you are seeing, with either a receptionist or security present depending on the clinic. The rest of the time the work is done remotely. You said you have some contact with your colleagues and have been with that department for over six years, since leaving Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (the Trust). You said that you receive good feedback with no issues and have submitted your appraisals.

You submitted that an interim order would have a substantial impact on you financially and emotionally. You said that, while this process has been ongoing, being able to work has been

helpful. You described your current role as ‘solace’ and stated that, although there is some pressure involved, it is nowhere near the pressure of running a 30-bedded ward.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel carefully considered the submissions made by you and Mr Kennedy.

The panel noted that you work as a registered nurse for a healthcare assessment company and that you work four days a week, with flexible hours, and primarily remote work. The panel noted that your role is not high-pressure and involves assessing individuals who are not acutely unwell. The panel also noted that you have worked for the past six years without any restrictions.

The panel noted that there are no current public protection concerns arising from the charges provided by way of admission. The panel also accepts that the two charges found proved by way of admission do not, in their current form, raise concerns sufficient to impose an interim order, especially given that there has been no repetition of the issues and no evidence suggesting a risk of repetition. The panel therefore concluded that there are no public protection grounds for imposing an interim order.

The panel gave careful attention to whether an interim order would be in the public interest. The panel reminded itself that the imposition of an interim order on the grounds of public interest alone takes place in rare circumstances. In considering this application, the panel considered that it would be inappropriate and disproportionate to impose an interim order on public interest grounds alone.

Details of charge (as amended)

‘That you, a registered nurse:

1. Between June 2018 and June 2019, failed to preserve patient safety by working excessive hours.

2. Between 2018 and 2019, failed to demonstrate appropriate standards of leadership in that you:

    a) Failed to ensure staffing levels were adequate
    b) Manipulated bed allocations so as to secure a higher number of admissions onto the ward
    c) Your actions at charge 2b) above resulted in premature patient discharges.

3.1. Failed to maintain a patient's dignity in that you:

    a) On or around 4 June 2019, prioritised administration of a controlled drug administration for one patient over assisting an incontinent patient who had soiled themselves
    b) On or around 15 June 2019, declined to assist Colleague A with a patient's bypassed catheter and requested for him to continue with observations instead

3.2. Failed to maintain patient care by implementing rigid routines by making staff work from one end of the ward to another in the morning leaving high risk patients without any supervision.

4. Failed to provide or escalate care appropriately, in that you:

    a) At the end of 2018, regarding a patient who had not passed urine, told Colleague B 'to leave the patient and she will wee' rather than request a bladder scan
    b) On or around January 2018, failed to escalate care for a patient whose oxygen saturation had dropped
    c) On or around 6 July 2019, said "you need to get him (the patient) home tomorrow", or words to that effect
    d) Your words at charge 4c) above were said knowing that the patient had low haemoglobin levels and required a blood transfusion
    e) On or around 29 May 2019, you failed to isolate a patient who had not had an MRSA screen

f) On or around 27 April 2019, you did not record a patient's blood results on the handover notes.

5. Failed to complete necessary checks when discharging patients, in that you in the late afternoon in November 2018 discharged a patient who had raised concerns that she had no food at home.

6. Bullied or intimidated colleagues in that on a number of occasions between 2017 and 2019, you were unprofessional and abrupt in your communication with colleagues, in that:

    a) On or around September-November 2018, in relation to Colleague C:
        i. During a morning handover, you said 'you could have apologised' to Colleague C when she arrived late
        ii. You were aggressive in your tone to Colleague C about the INR machine when she stepped in to help
        iii. In a text message to another colleague, said about Colleague C 'I had to stop myself from as I would rather gouge her eyeballs out and shove them down her throat'
        iv. Caused Colleague C to bring a grievance and resign.

7. Demonstrated poor medication practices, in that you:
    a) On 23 October 2018 failed to check the handover notes before carrying out a drugs round
    b) As a result of your actions in 7a administered metformin to a patient when it was not appropriate to do so.

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

Background

On 16 December 2019, the NMC received a referral regarding concerns of bullying by you at Powys Ward, reported by staff in June 2019. The Trust conducted an investigation, during which

you were suspended but resigned before facing disciplinary action. Allegations against you include endangering patient safety by working excessive hours, poor leadership regarding staffing, and failing to maintain patient dignity by prioritising tasks over patient care. Additionally, there were allegations of failures to provide appropriate care for deteriorating patients, including neglecting to perform necessary checks and discharging patients without proper assessments. You are also accused of bullying colleagues and poor medication practices, such as incorrectly administering medication without reviewing handover.

Decision and reasons on application to amend the charge

During your cross examination, the panel heard an application made by Ms Simpeh on behalf of the NMC, to amend the wording of charge 3a.

The proposed amendment was to amend the wording of charge 3a. It was submitted that the incident referred to in Charge 3a, as per Witness 7's evidence, occurred in June 2019 and not April 2019 as the charge states. It was submitted by Ms Simpeh that the proposed amendment would provide clarity and more accurately reflect the evidence.

The proposed amendment would read as follows;

'That you, a registered nurse:

3. Failed to maintain a patient's dignity in that you:

    a) On or around 4 ~~April~~ **June** 2019, prioritised administration of a controlled drug administration for one patient over assisting an incontinent patient who had soiled themselves'

You indicated that your position was neutral in regard to the proposed amendment to charge 3a.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on facts

At the outset of the hearing, the panel heard from you, who informed the panel that you made full admissions to charges 1 and 6a(iii).

The panel therefore finds charges 1 and 6a(iii) proved in their entirety, by way of your admissions.

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

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:

- Colleague A: Band 5 Staff Nurse at the Trust at the time
- Colleague B: Band 5 Staff Nurse at the Trust at the time
- Colleague C: Band 5 Staff Nurse at the Trust at the time
- Witness 1: Band 5 Staff Nurse at the Trust at the time
- Witness 2: Surgical Matron at the Trust at the time
- Witness 3: Patient Admission Co-Ordinator at the Trust at the time
- Witness 4: Staff Nurse at the Trust at the time

- Witness 5: Investigator for the Trust at the time
- Witness 6: Interim Director at the Trust at the time
- Witness 7: Band 6 Ward Sister at the Trust at the time

The panel heard your evidence under affirmation

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

The panel has taken into account that no specific patient was ever identified by those making allegations against you, even at the time of the Trust investigation in 2019, and that you have stated throughout that you have no recollection of the specific incidents alleged. As no patient was ever identified, no nursing or other medical notes have ever been presented to you or this panel. The panel has had to consider the statements of the NMC witnesses and their oral evidence very carefully and in some cases, where evidence outside of patient records was deemed to be insufficient, the panel has indeed found that the NMC have not discharged their burden of proof. The panel has also noted that the NMC have accepted that no patient suffered harm as a result of the matters alleged against you, though the panel has found that one patient had suffered a loss of dignity.

Decision and reasons on application to amend the charges

During its deliberations on facts, the panel found that charge 3c did not quite fit with the stem of the charge and should be its own standalone charge. The panel directed the Hearings Coordinator to enquire of both parties about this and if they would like to make any submissions.

You and Ms Simpeh submitted that you were both in agreement with this change.

Ms Simpeh further submitted to make an application to change charge 3 as a whole, and submitted to delete the stem of the charge *'failed to maintain patients dignity'* and to have charge

3a, 3b and 3c as standalone charges. This meant that charge 3a would be charge 3, charge 3b would be charge 4 and charge 3c would be charge 5.

The proposed amendment would read as follows:

3. On or around 4 April 2019, prioritised administration of a controlled drug administration for one patient over assisting an incontinent patient who had soiled themselves.

4. On or around 15 June 2019, declined to assist Colleague A with a patient's bypassed catheter and requested for him to continue with observations instead.

5. Failed to maintain patient care by implementing rigid routines by making staff work from one end of the ward to another in the morning leaving high risk patients without any supervision.

The panel heard and accepted the advice of the legal assessor, who also suggested alternative numbering to reduce confusion if the charges were amended.

The panel proposed the amendment would read as follows:

3.1. Failed to maintain a patient's dignity in that you:

a) On or around 4 April 2019, prioritised administration of a controlled drug administration for one patient over assisting an incontinent patient who had soiled themselves
b) On or around 15 June 2019, declined to assist Colleague A with a patient's bypassed catheter and requested for him to continue with observations instead

3.2. Failed to maintain patient care by implementing rigid routines by making staff work from one end of the ward to another in the morning leaving high risk patients without any supervision.

You and Ms Simpeh submitted that you were both in agreement with this change.

The panel determined that the stem of the charge was important and it should remain as removing it entirely would constitute a material change to the charges in that it would make them more serious. This would cause unfairness to you. The panel agreed to the numbering suggested by the legal assessor. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

The panel then considered each of the disputed charges and made the following findings. The panel bore in mind that a large part of the evidence before it came from the Trust and therefore there was no identification of patients and no clinical records associated with the patients provided. As a result, the panel had to consider the evidence presented by the witnesses and you on each charge individually.

Charge 1

This charge is found proved by admission.

The panel noted that although this charge was admitted by you, Ms Simpeh made it clear that there was no evidence that any patient suffered harm. The panel further noted that you stated that you recognised that your ability to think clearly and communicate with colleagues was affected by the long hours, and in hindsight had an impact on your ability to think clearly and communicate effectively with other staff members, which could have impacted patient safety.

Charge 2a

'That you, a registered nurse:

2. Between 2018 and 2019, failed to demonstrate appropriate standards of leadership in that you:

    a) Failed to ensure staffing levels were adequate'

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel had regard to your job description for your role as ward manager.

> *'10. Participate in the recruitment and selection process for staff for the ward. Processing post approvals and case onto vacancies and safe staffing levels are maintained.*
> *11. Ensure ward is staffed ad each shift and completion of daily IPAMS/Safer staying data...*
>
> *15. Co-ordinate staffing for the ward in conjunction with other Ward Managers within the Trust.'*

The panel also had regard to the written statement of Witness 5, the senior nurse who carried out the Trust investigation, which states;

> *'Regarding safe staffing, we heard from the Ward Sister that she raised concerns about safe staffing levels a number of times with Deborah but was made to feel belittled and ignored and was accused of being unable to handle her workload. A number of staff told us that if they mentioned concerns about staffing, Deborah would get angry and say things like "I'll just do it myself then." From looking at the staffing levels on the e-roster templates, we could see that the staffing level on the ward frequently didn't meet the 1:8 safe staffing level. That is, 1 Registered Nurse to 8 patients. That safe staffing level is not mandated but it's the Royal College of Nursing guideline for safe staffing and it's adopted by every Trust that I've worked at. Working at elevated patients ratios means that nurses time is constrained, disenabling care delivery, patient supervision and the ability to deliver holistic care.'*

This was further reiterated by Colleague A, Witness 4 and Witness 1 in their oral evidence, where they all stated that *'two nurses will have 10 patients and 1 will have eight when working with 28 patients.'* You also told the panel that there was a shortage of staff on some shifts.

The panel considered that Witness 2, who was your line manager at the time, stated that you did not escalate staffing issues to them. The panel had regard to Witness 2's statement, which states:

‘As stated above there were some gaps in vacancies... According to our records nothing had been flagged with regard to safety due to staffing levels for 2019.

Deborah has never raised concerns about staffing levels to me. She occasionally raised concerns about the skills mix of the staff on the ward.’

The panel also had sight of a letter from Witness 2 telling you to use bank and agency staff to fill shifts. You stated that you were unable to access temporary staff due to the hospital’s isolation and that you discussed staffing difficulties in various meetings and therefore assumed this was known. However, you accepted that you did not raise this issue formally. The panel noted that your job description makes it clear that ensuring adequate staffing levels was a part of your role. The panel determined that despite there being staffing challenges across the Trust, other people also involved in the recruitment process other than yourself and you requiring authorisation to utilise bank or agency staff, you remained responsible for staffing levels on your ward and could have done more to ensure that staffing levels were adequate.

Therefore, the panel found this charge to be proved.

Charge 2b)

‘That you, a registered nurse:

2. Between 2018 and 2019, failed to demonstrate appropriate standards of leadership in that you:

    b) Manipulated bed allocations so as to secure a higher number of admissions onto the ward’

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel heard evidence about the process for allocating beds which was done via the Bed Manager (Witness 3) the day before patients were due to arrive, as the Trust dealt mainly with elective surgeries with a few emergency admissions or transfers in. Witness 3 worked until 15:00 and did not work weekends. This role was therefore taken up by one of the ward managers or a nurse in charge in the Witness 3's absence. *"Nine out of ten times"* this role was said to be taken up by you. You stated that it was shared and that you took the role on more as you were at work more often than others.

The panel considered the witness statement of Witness 3, who stated that:

> *'I created bed allocations but Deborah would often change the allocations because she liked to choose the consultants that she wanted.*
>
> *Deborah would often accept patients even if the ward was under pressure and there was a likelihood they couldn't accommodate the extra patients. For example, if her ward was understaffed, she would still accept patients which could lead to unsafe practice and extra pressures for the staff. That is what it felt from what I witnessed.*
>
> *Any transfers, registrars and consultants are to contact me directly within my working hours, however, some consultants went straight to Deborah and bypassed me. Some consultants (not all of them) loved being on Deborah's ward so they contacted Deborah directly about patients' transfer to her ward, but I did not know those patients were coming and that was an issue because it was then difficult for me to carry out efficient patient allocation and planning. I am not sure what the trust's policy was as to whether the patients had to come to me for allocation or directly to the ward.'*

This was corroborated by Colleague A in oral evidence, who stated *'a number of consultants will do their best to get patients onto Powys ward.'*

In your oral evidence you denied changing patient allocations. You stated that the consultants would often come to you and ask you whether you could take their patients onto Powys Ward. Furthermore, you stated that consultants favoured your ward for certain procedures, such as hip and knee surgeries, while Clywd Ward mainly took spinal surgeries, as this was how the Trust

had worked historically. You said this was changed at some point, some consultants did not like the change:

> *'Not all the consultants had understood that no matter where they placed their patients across the units, the care would always be the same. Several consultants had a preference for Powys... 'consultants felt comfortable and familiar for her and kept wanting to bring patients to her ward, became a sticking point, escalated it to matron manager on fluid. Don't know if they had discussed with consultant and don't know if anything had changed.'*

Further, you said that when consultants approached you, you informed the Bed Manager of this and left the allocation to them. This was contested by Witness 3 who said in her witness statement that when consultants contacted you directly, *'….I did not know those patients were coming and that was an issue because it was then difficult for me to carry out efficient patient allocation and planning.'*

The panel had regard to the evidence of Witness 1, Witness 3, Witness 5 and Witness 6. The panel considered that the majority of this evidence was hearsay, in that it relayed what others (who are not identified) had said to senior staff. The panel noted that Witness 1 and Witness 3 gave some direct evidence that it was suggested to you that some patients could have been moved to a less busy ward but that you declined to do so as you liked *"Powys to be busy and its boring when its quiet"* and you *"would not allow"* Witness 3 to reallocate patients to a quieter ward.

The panel noted that the majority of this evidence is hearsay, and although there are some instances of direct evidence, this did not in the panel's view meet the threshold for "manipulation." The panel considered the Oxford English Dictionary definition of manipulation, which is *"to control someone, or something unfairly for personal advantage, often dishonestly…"* The panel determined that whilst the evidence suggested you may have influenced bed allocations to Powys Ward, it did not consider that you manipulated bed allocations so as to *"secure a higher number of admissions to the Ward."*

Taking the evidence before it into account, the panel determined that there was nothing to suggest that you had manipulated bed allocations as the charge suggested and that the NMC had not discharged its burden of proof.

Therefore, on the balance of probabilities, the panel found this charge not proved.

Charge 2c)

'That you, a registered nurse:

2. Between 2018 and 2019, failed to demonstrate appropriate standards of leadership in that you:

c) Your actions at charge 2b) above resulted in premature patient discharges'

This charge is found NOT proved.

In reaching this decision, the panel took into account its findings for charge 2b. The panel found that charge 2b was not proved and it therefore found 2c not proved.

Charge 3.1 a)

'That you, a registered nurse:

3.1 Failed to maintain a patient's dignity in that you:

a) On or around 4 June 2019, prioritised administration of a controlled drug administration for one patient over assisting an incontinent patient who had soiled themselves'

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel had regard to Witness 7's written statement;

'…I remember that the gentleman(patient 1) I called into a side room by to HCA's as they needed assistance, the patient was in a lot of pain, he had a fractured neck of femur. My colleagues were completing a a(sic) morning wash on him and had Patient 1 had his bowels opened and the were two HCA's needed my assistance in rolling the patient and need to roll and support him whilst the other was to wash his back and bottom. While we were doing this Deborah came into the side room and demanded that I came with her in order to assist her with administering a controlled drug pain killer to another patient (patient 2). The CD drugs had to be administered by the two trained nurses the second nurse witnessing and confirming the administration. So Deborah wanted me to be the second nurse while she was administering the CD drug even though there were other trained nurses to assist her with this at that moment. I said to Deborah that I would finish the morning wash of patient 1 and then would come to see her in a few minutes. Deborah insisted that I came with her before finishing the wash for patient 1. I again said I would not be long and she became more angry with me and kept demanding to come with her. So, myself and the two HACs had to roll patient 1 into his faeces.' [sic]

The panel considered that in Witness 7's written statement, that three people were there to wash the patient. However, there was no rationale given as to why that was the case, and no further witnesses to comment on it who were said to be present when the alleged incident occurred, one of whom is named, however the panel only heard evidence from Witness 7. Considering that you stated that you did not recall this incident and had no patient name given to you and therefore deny this charge, the panel was of the view that further evidence could have been made available to the panel, but it was not. The panel noted that the NMC gave no explanation for why further evidence was not provided.

Therefore, the panel determined that the NMC had not discharged burden of proof and therefore found this charge not proved.

Charge 3.1b)

'That you, a registered nurse:

3.1 Failed to maintain a patient's dignity in that you:

b) On or around 15 June 2019, declined to assist Colleague A with a patient's bypassed catheter and requested for him to continue with observations instead'

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel considered the evidence of Colleague A. In his written statement, Colleague A stated;

'…the incident took place on 15 June but I cannot remember now if it was in 2018 or 2019 due to the passage of time. However I remember what happened. Deborah was covering the night shift. At the start of the shift everything was fine and later we became busy. At about 6:30ish we had to take blood pressure manually and vital signs observations. While I was doing this, one of the female patients alerted me by saying to me that her catheter was bypassed and so she was wet.

I cannot remember that patient's name. At that time I had never dealt with a situation involving a bypassed catheter so I alerted Deborah about the incident and Deborah told be to continue with the observations instead of attending to the patent who had alerted me. I do not remember Deborah's exact words but her tone of voice was such that I did not feel I could challenge her.

However I felt that I should have prioritised the patient with bypassed catheter which Deborah prevented me from doing. When I alerted Deborah that the patient's catheter was bypassed she did not come to have a look at that patient.

As a result the patient was left wet which failed to preserve this patient's dignity. The patient did not make a complaint, however I felt that I had let that patient down by following Deborah's order to continue with the routine morning observations of other patients and not to prioritise the lady with bypassed catheter.'

This was further reiterated in Colleague A's oral evidence. The panel also considered the Investigation Meeting Notes of Colleague A, which took place on 5 August 2019, and was contemporaneous evidence.

> *'I have let down a patient and I am disappointed in myself. It was on the 15th June. It was a standard night shift with me, ... [Debroah Povall] signed herself onto the shift with me and that made me nervous about the shift. Observation was to be completed and [Debroah Povall] started one end and me the other …There was a catheter that had started bypassing so I asked [Debroah Povall] for support. She said 'no you're finishing observation first!' I went to bay 3 and left the patient wet in bed. I was told to just carry on. She was intimidating. I feel infuriated with myself to have let my patient down. Have let myself down and it is unacceptable. I couldn't stand up to her.'*

You told the panel that you did not recall the incident and therefore denied the charge. During your oral evidence, you stated that you would have known the importance of what Colleague A asked and in this type of instance, you would usually give guidance.

The panel noted that the evidence of Colleague A was consistent and reliable, and although he was the only witness to speak to this charge, the panel was of the view that he had no reason to fabricate. The panel noted that in both his witness statement and during oral evidence, Colleague A stated how this had affected him and how remorseful he was for not taking further steps to seek guidance from someone else to assist the patient. It further noted that the atmosphere you had created in the ward according to other witnesses was one where they felt intimidated and there was not a culture of speaking up.

Therefore, on the balance of probabilities the panel found this charge proved.

Charge 3.2

'That you, a registered nurse:

3.2 Failed to maintain patient care by implementing rigid routines by making staff work from one end of the ward to another in the morning leaving high risk patients without any supervision.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel considered the evidence of Witness 5, who had no direct knowledge of this incident, and who stated that:

> *'From a patient care perspective, what became very clear was that Deborah was highly regimented in her approach to patient care… when I asked Deborah about that in interview, and highlighted the lack of supervision of patients, she said she would reflect on it but still didn't think it was a problem. Deborah correctly instituted a safety huddle in the morning, which is good practice, but staff stated it was used as a method for controlling them – in that if they hadn't finished all their washes by the 10:30am meeting then the meeting was used to humiliate them in front of other staff members… thing reported by staff concerning patient care was that the doctors were encouraged by Deborah not to speak to the nursing staff about patient plans of care but to only communicate with her. Staff stated there were sometimes delays in Deborah then handing over plans of care to them which meant the patients had delayed plans of care…'*

In oral evidence and during panel questions, all witnesses were asked about the rigid routines on the ward and the impact this may have had on patient care. They all agreed that they were expected to work from one end of the ward to the other, to wash patients, and this was an expectation placed on them by you. Some said that they did not like doing this and would have preferred to wash their own allocated patients in their bays. Although staff identified that this negatively impacted on their preferred way of working and could have put patients at risk, there was no evidence that patients were harmed because of this.

You denied that you implemented rigid routines that put high-risk patients at risk of harm. You accepted that there were routines in place which you said were necessary for any ward environment, however you said that where there was a specific patient need, this would be dealt with at the time. You also said that patients were not left unsupervised as at that time of the morning, there were a lot of other professionals on the ward such as doctors, pharmacists and

physiotherapists who were doing their rounds as well as nurses who were administering medication. You said these staff were able to keep an eye on the patients while washes were being done. Further, you stated that the Trust had implemented *"intentional rounding"* which meant that patients on your ward needed to be checked on every two hours, and therefore they were not left unsupervised.

The panel did not accept that other professionals who were on the ward were a replacement for nursing supervision as they were engaged in other activities. It also did not accept that "*intentional rounding"* replaced nursing supervision that each patient required. However, the panel noted that although there was reference to some of the patients on the ward being older adults, and there being a high risk of falls inherent in the patient group being cared for due to the nature of their surgeries, the NMC when presenting the evidence to the panel, did not qualify what a high-risk patient meant. Furthermore, the panel noted that the evidence showed there were multiple witnesses that were not called who could have spoken to the charge. The panel were of the view there was insufficient evidence provided in relation to this charge and the NMC did not discharge the burden of proof.

Therefore, the panel found this charge not proved.

Charge 4a)

'That you, a registered nurse:

4. Failed to provide or escalate care appropriately, in that you:

a) At the end of 2018, regarding a patient who had not passed urine, told Colleague B 'to leave the patient and she will wee' rather than request a bladder scan'

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel considered the written statement of Colleague B, which stated that:

> *'Patient had had catheter removed at midnight and had still not passed urine by 4pm. Patient complained they did not feel comfortable as she had not passed urine for a long period of time. I had to leave shortly because I had child care commitments that day and I informed Deborah that the patient was not comfortable, but Deborah did not do anything about that and told me something like "leave the patient and she will wee".'*

This was further reiterated by Colleague B in her oral evidence. The panel further considered Witness 1's written statement which corroborated the evidence of Colleague B and explains why a bladder scan is needed if a patient could not pass urine freely.

> *'During the meeting with the staff from Powys ward, they raised a concern that Deborah had failed to ensure that a patient had received a bladder scan in a timely way. A bladder scan would be required to detect retention of urine in a patient who is unexpectedly unable to pass urine in the usual way. With retention of urine, a patient is unable to release their bladder; so urine builds up in the bladder and the bladder gets bigger. If the patient feels they need to pass urine or we notice they haven't done so for some time, then we should be scanning that patient's bladder. We need to understand what is going on and why the patient is not passing urine. The main reason for needing a bladder scan following surgery is often urinary retention. Some risks of the risks of harm resulting from untreated urinary retention are sepsis or perforation of the bladder. If perforation of the bladder occurs, the patient would require transfer to a general hospital for emergency treatment/surgery.'*

The panel heard evidence of when a bladder scan would be required, and that there was a bladder scanner available on the ward.

You told the panel that you could not remember anything in relation to this alleged incident as it was six years ago and you were never given details of the specific patient.

The panel found that Colleague B's evidence was reliable and consistent and preferred her evidence. It was concerned that a patient, who had not passed urine for between 13-16 hours

post-surgery after a catheter had been removed, was left and without further investigation, which would have been a bladder scan done by you or allocated to someone else by you.

Therefore, the panel considered the evidence before it, and on the balance of probabilities, found this charge to be proved.

Charge 4b)

'That you, a registered nurse:

4. Failed to provide or escalate care appropriately, in that you:

    b) On or around January 2018, failed to escalate care for a patient whose oxygen saturation had dropped'

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel considered that there was a lot of people involved with the care of patients and noted the written statement of Witness 4, who stated that;

> *'In early January 2018, around 7 or 8 January, an incident occurred with a male patient on the high dependency unit. The male was in his late 20's, early 30's and he had a condition that might have been cerebral palsy, although I cannot quite recall. He couldn't communicate verbally with us and his mum was his carer who was with him…I remember listening to handover recording that the patient's oxygen levels had remained low and that he had been suffering with a low blood pressure and that he was receiving a blood transfusion for this. His oxygen saturations had remained low/unrecordable throughout the day and from the handover I received it was thought that the cause of the low saturations was due to a low HB.*
>
> *The patient was unwell when I arrived. I remember speaking to [Witness 1] and coming up with a plan, we had the patient reviewed by the doctors who were fully aware of this*

patient at the start of the shift and outreach were aware [Person 1] was the nurse on outreach that night. The doctor advised to complete regular observations as the patient was completing a blood transfusion at the start of the night shift…From memory, he was a post operative patient. I looked after him on the night shift. On the first night shift, immediately post operation, he was fine and nothing seemed untoward. His oxygen levels dropped slightly the following morning but there was nothing alarming. I think his oxygen saturations we're 93/94%. I tried to put oxygen on him but he wasn't tolerating it. He had no signs of distress so I handed it over verbally to the nurse after handover for the dayshift.'(sic)

The panel noted that the evidence relied on for this charge was of Witness 4 stating someone told her that you had felt it was okay for the patient to remain on the ward and determined that this was anonymous hearsay, as it was the sole and decisive evidence. The panel noted that there were multiple other people involved, and no evidence presented by the NMC to say you were involved in this case. Furthermore, the panel noted in your oral evidence that you told the panel you could not be sure that you were working on the shift where this issue was alleged to have occurred. Therefore, the panel determined that the NMC had not discharged its burden of proof.

Therefore, the panel found this charge not proved.

Charge 4c) and 4d)

'That you, a registered nurse:

4.Failed to provide or escalate care appropriately, in that you:

c) On or around 6 July 2019, said "you need to get him (the patient) home tomorrow", or words to that effect'

d) Your words at charge 4c) above were said knowing that the patient had low haemoglobin levels and required a blood transfusion'

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence. The panel decided to take charges 4c and 4d together as the wording in charge 4d is consequent to 4c.

The panel considered the written statement of Colleague B, which stated that;

> *'I was on shift with the other staff nurse. I escalated patient's low HB level of 74 to Deborah, but she decided not to take any action. I was then quite new and I followed Deborah's advice and we could not question Deborah about her decisions because Deborah became angry and cross. She said 'you need get him (the patient) home tomorrow', but the other nurse said to me that the patient should have a blood transfusion because of the patient's low HB level. The other nurse and I asked the consultant about this and the consultant advised that the blood transfusion was required for that patient and this was done. It was a near miss incident caused by Deborah.*
>
> *There was no harm caused to the patient because the blood transfusion had been done.*
>
> *The normal procedure of discharging patient if HB is as low as 74 is that if a patient has an HB below 80 we need to raise a concern and to perform a blood transfusion for such a patient. But Deborah did not refer the patient with 74 HB to a consultant. We must always check HB level before discharging patients.*
>
> *If a patient with HB level as a low as 74 is discharged without a blood transfusion they may faint and lose consciousness.'*

This was also reiterated in Colleague B's oral evidence and was further corroborated by Witness 1 in her written statement:

> *'Another example of an incident which is mentioned in the notes is when the patient's haemoglobin (HB) count dropped to a critically low level of 73 but I was told that Deborah still wanted that patient to be discharged. I was a Sunday shift and it was stated in the hand over notes that the patent's HB level dropped to 73. One of the staff nurses, [Colleague B] worked on the previous day and stated that Deborah was aware that the*

patient's HB dropped to such a low level. I intervened and made sure that the consultant was contacted and the patient received blood transfusion.

The risk of discharging the patient early without the blood transfusion would have been that the patient could have had complications. A low HB could make the patient feel tired and short of breath due to decreased oxygen levels. The patient's low oxygen levels could have caused the organs to function incorrectly, such as an irregular heart beat. However, there was no harm caused to the patient because the blood transfusion was done prior to discharging them. Because there was no patient harm there was no DATIX report prepared for this incident as a result.

The risk of discharging the patient early without the blood transfusion would have been that the patient could have had complications. A low HB could make the patient feel tired and short of breath due to decreased oxygen levels. The patient's low oxygen levels could have caused the organs to function incorrectly, such as an irregular heart beat. However, there was no harm caused to the patient because the blood transfusion was done prior to discharging them. Because there was no patient harm there was no DATIX report prepared for this incident as a result.

The correct procedure for carrying out checks and treatment before discharging a patient like that is that the patient has to meet the discharge criteria from the medical and surgical aspects. In this particular case bloods should be checked prior to discharging. If patient's HB is low, like it was in this incident, we normally contact the registrar and the consultant to inform them and we ask them what treatment the patient required. For HB at the level of 73-74 the patient would receive blood transfusion.

It is stated in the investigation meeting notes … I was told that 'She (Deborah) had taken the decision the 73/74 count was okay. Other nurses may have just sent the patient home.' I disagreed with Deborah's clinical decision to discharge the patient in the circumstances because the patient was symptomatic of having a low HB and visually they had all the signs and symptoms of low HB.'

The panel considered your evidence where you stated that you would *"double check*" with a consultant, however noted that there was no evidence of this. You stated in oral evidence that in

these circumstances (this level of HB), you would check with the individual consultant if it was safe to send the patient home or whether they required a blood transfusion. However, you informed the panel that whilst you believe you would have done this, as you could not remember the alleged incident or the patient, you could not be sure that you had done this.

The panel further considered that the first part of Witness 1's evidence was hearsay. However, it was of the view it gave a background of what was happening and later Witness 1 goes on to give direct evidence.

The panel found Colleague B's evidence to be reliable and consistent. The panel preferred the evidence of Colleague B. The panel was satisfied that there was clear evidence before it that showed that the patient's haemoglobin was 73-74, and they only received a blood transfusion in the hospital ward because of another nurse, who disagreed with you, had contacted the consultant to have the patient treated when you wanted to discharge them.

Therefore, on the balance of probabilities the panel finds that charges 4c and 4d are proved.

Charge 4e)

'That you, a registered nurse:

4.Failed to provide or escalate care appropriately, in that you:

e) On or around 29 May 2019, you failed to isolate a patient who had not had an MRSA screen

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel considered the witness statement of Colleague B who stated that;

*'It is written in the investigation meeting notes (**Exhibit GL/1**): 'May 29th 2019, the patient that hadn't had an MRSA screen she told me to put in a bay with others. I challenged her (Deborah) as this shouldn't happen.' The patient referred to in the notes could not be put in a bay with other patients if MRSA had not been done. This is because if the patient was MRSA positive we had to isolate them. We screen all patients for MRSA because of risk of infecting other patients. The patient before being screened should have been moved to the side room, but Deborah ordered to put the patient on the bay with the other patients. The other staff nurse told me not to put the patient on the bay, I said that to Deborah, and she shouted at me and humiliated me. In the end the patient went into the side room after she shouted and humiliated me. Deborah knew the patient should have been isolated and this was done, but if I had not confronted Deborah there could have been a risk of MRSA infection on the ward.'*

You told the panel that you did not remember this as it had been six years ago, and you were not given details of the patient. You also said it does not make sense for you to have not put a patient in a side room if one was available. Further, you identified that some patients had their MRSA swabs done prior to coming onto the ward in pre-operative clinic, however you identified that some patients who were transferred in, may have come in without a swab being done.

The panel was of the view that whilst Colleague B's evidence was clear and consistent, she does state that there were several other witnesses including a bed manager and a matron there who were not asked to give evidence on this. The panel found that there was no supporting evidence from other people that were present at the time, and once again, the patient was unspecified.

Therefore, the panel determined that the NMC had not discharged its burden of proof and accordingly the panel found this charge not proved.

Charge 4f)

'That you, a registered nurse:

4.Failed to provide or escalate care appropriately, in that you:

f) On or around 27 April 2019, you did not record a patient's blood results on the handover notes.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

When considering the evidence before it, the panel noted that there was documentary evidence that was referenced by the witnesses in both written and oral evidence that had not been provided to it.

The panel further noted that the information before it was taken from assumptions of the night staff about your involvement. However, without documentary evidence made available, the panel could not determine if this charge was proved. The panel considered that you could not recall this specific alleged incident nor were you provided with any details of the patient.

The panel was of the view that the NMC had not discharged its burden of proof and therefore found this charge not proved.

Charge 5

'That you, a registered nurse:

5. Failed to complete necessary checks when discharging patients, in that you in the late afternoon in November 2018 discharged a patient who had raised concerns that she had no food at home.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel considered the evidence of Witness 1, who stated that:

> *'In the notes … there is also the example of the lady being discharged in late afternoon and she had no food at home. She was sitting on the side by the window covered in blankets and worried about being discharged and taken home late on that day. As far as I remember there was no harm caused to the lady as a result, but I do not now remember the detailed facts of this incident including patient's name and their clinical condition, dates and I am not able to provide any relevant clinical patient records in relation to this incident either.'*

Although you said that you could not recall the alleged incident, you accepted that it would not be appropriate to discharge a patient without food, and that you would make suitable arrangements for food before discharge. Further, you said without the details of the patient being made available to you, there was nothing to say that you were looking after this patient.

The panel considered the wording of the charge and noted that in the discharge checklist there was no requirement for staff to check that patients had food at home prior to discharge. Although the panel heard that there were additional social circumstances checks that were to be done prior to discharge, it did not have sight of any other information that showed what these checks involved and if there was a duty to do the checks.

The panel therefore determined that the NMC had not put sufficient evidence before it to discharge the burden of proof.

Therefore, the panel found this charge not proved.

Charge 6a(i)

'That you, a registered nurse:

6. Bullied or intimidated colleagues in that on a number of occasions between 2017 and 2019, you were unprofessional and abrupt in your communication with colleagues, in that:
    a. On or around September-November 2018, in relation to Colleague C:

i. During a morning handover, you said ‘you could have apologised’ to Colleague C when she arrived late’

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel considered the written statement of Colleague C who stated that;

> *‘During a morning handover, I was a little late as I had picked a colleague up to give them a lift and we got stuck in traffic. We walked in and my colleague said sorry. Deb gave us a very dirty look and then made a snide comment “you could have apologised”. The handover is taped and the first person through the door said sorry so I thought she was being unreasonable. This made me feel embarrassed guilty for being late. I was helping two colleagues out at this time. I had already drove around an hour to get into work, so left earlier than normal to collect colleagues. I was unaware we were going to be late due to traffic and road works lights being in place. I hate being late for anything, but when we walked in the room you could feel the chill, and uncomfortable atmosphere with walking in late. I felt like I was a naughty school child late for class. Not a grown adult.’*

Colleague C further reiterated this in her oral evidence and was very clear about your behaviour towards her in this charge in particular.

You told the panel that it was unlikely that you would have responded in this manner to Colleague C because you knew that she was dealing with a lot outside of work so you would have been concerned about her. You said you would not have started handover and would have instead made inquiries about the two members of staff who had not arrived yet. You accepted however, that you may have communicated inappropriately because you had worked long hours which could have affected your communication with other colleagues.

The panel considered your own assessment on reflection of your communication style at the time in your oral evidence, was that your communication was: *“not fluffy”*, *“if there was something to be said, I would say it,”* and *“in my head, as a manager, my role was to help the staff, support*

the staff…if I'd had time off and leave, I was probably much more able to communicate that well, and more approachable. When I was tired, that side dropped. I was probably less approachable. The more tired I was, the more difficult I became to communicate with." Furthermore, the panel considered that in your evidence, you considered this communication style set out above could be *"intimidating"*, in particular when in discussion with a junior colleague in which there would have been a power imbalance.

The panel noted that at the time you were a new manager and inexperienced, with a tendency to micromanage people working with you. The panel noted that when looking at the context and background of the environment on Powys Ward at the time, which was created by you as described by a number of witnesses who said they never knew when they were going to get the good or bad side of you as your moods were changeable, it was more likely than not that you responded in this manner to Colleague C.

Therefore, the panel on the balance of probabilities found this charge proved.

Charge 6a(ii)

'That you, a registered nurse:

6. Bullied or intimidated colleagues in that on a number of occasions between 2017 and 2019, you were unprofessional and abrupt in your communication with colleagues, in that:

a. On or around September-November 2018, in relation to Colleague C:
    ii. You were aggressive in your tone to Colleague C about the INR machine when she stepped in to help'

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel considered the witness statement of Colleague C who stated that;

‘On the wards was a new INR machine for Powys ward to use. I used the machine on 11 November 2018. On 12 November 2018, one of my colleagues, … had tried to use it but couldn’t get it working. She had asked another colleague, …, to try it to see if she could get it working. Neither of them could so they came back to the ward to tell Deb. They were nervous to tell her they couldn’t get it working as it was a brand new tool.

I was in the room when they informed Deb that they couldn’t get the machine working. Deb had a look and said “It says it needs to scan code”. At this point I intervened thinking I was being helpful and mentioned that I had used it the day before and it had said the same thing to me, so I had needed to scan this strip that you needed to put in before it would work. I asked Deb, “is that what it’s asking you to do?” Deb snapped back at me and said it’s not asking her to scan a strip, it’s asking to scan a patient. She was very aggressive in her tone and I felt like she was saying I shouldn’t have spoken, not to poke my nose in. The tone she used made me feel really scared of her which meant she had the control. All I was doing was trying to help her. She then said something like, someone has been messing about with the machine. It costs a lot of money. I replied saying, “yes it is a shame what that machine costs”.

I felt like she was blaming me because I had used it the day before. I think the way she went about this was wrong. Alma hadn’t wanted to speak to Deb about the machine, she had sought advice from her colleague, as she was afraid of the reaction she would get back of Deb.’

You told the panel in your oral evidence that the machine was *‘frustrating to use’* and that you could see how that could have happened even though you did not remember anything. The panel noted that you also spoke about not meaning to come across aggressive.

Therefore, taking all the evidence into account, on the balance of probabilities, the panel found this charge proved.

Charge 6a(iii)

‘That you, a registered nurse:

6. Bullied or intimidated colleagues in that on a number of occasions between 2017 and 2019, you were unprofessional and abrupt in your communication with colleagues, in that:

a. On or around September-November 2018, in relation to Colleague C:

iii. In a text message to another colleague, said about Colleague C 'I had to stop myself from as I would rather gouge her eyeballs out and shove them down her throat'

This charge is found proved by admission.

Charge 6a(iv)

'That you, a registered nurse:

6. Bullied or intimidated colleagues in that on a number of occasions between 2017 and 2019, you were unprofessional and abrupt in your communication with colleagues, in that:

a. On or around September-November 2018, in relation to Colleague C:

iv. Caused Colleague C to bring a grievance and resign.'

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel considered the Witness statement of Colleague C, who stated that;

'I approached [Witness 2] and made an official grievance against Deb. [Witness 2] she told me to write a statement so I did that. I was then asked if I would sit in a room with Deb and talk through my issues with her. I can't recall if I said yes or no. I didn't think it would achieve anything. That's where it was left…

Eventually it all became too much for me so I started applying for other jobs at a result of how I was feeling at work. I didn't really want to leave the ward as I loved what I was doing there, but I couldn't work there with Deb anymore. I felt like I had been bullied for quite a long period of time, so I needed to go away and have a break from it all. Just needed to have time away from the ward. I handed in my resignation on 4/06/2020.'

The panel considered that there was evidence that Colleague C brought a grievance against you. The panel also noted that Colleague C did not resign until approximately seven months after you had left the Trust in October 2019.

The panel however was of the view that this charge could not be found proved, as the charge was drafted in a way that requires there to be a causal link between Colleague C's grievance against you, and her resignation approximately seven months after you left the Trust. The panel therefore concluded that the NMC had not discharged its burden of proof in relation to you being the cause of Colleague C's resignation.

Therefore, the panel found this charge not proved.

Charge 7a

'That you, a registered nurse:

7. Demonstrated poor medication practices, in that you:
   a) On 23 October 2018 failed to check the handover notes before carrying out a drugs round'

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence before it, including the witness statements, witnesses oral evidence, and your evidence.

The panel considered the witness statement of Colleague B, which stated that;

‘That morning Deborah came to work early at 5:30 am and she was doing her ward management work in the morning. I had the handover at 7 am from the staffs who had worked in the previous night, and Deborah started doing medication round at that time. At the handover my colleagues from the previous night shift told me that the doctor had said to them not to give metformin (which helps to lower blood sugar) to that patient. The metformin administration had not been crossed in the prescription chart. I told Deborah that the doctor had advised not to give metformin to the patient but Deborah had already administered it to them.’

You gave evidence that the first medication round was usually done after handover around 07:00 – 07:30, however, you sometimes came into work early, around 06:00 - 06:30 in order to do your ward management work and it was not impossible for you to do the medication round during handover as this occasionally did happen. You stated however, that you would check the handover sheet before starting the medication round, but do not recall this specific alleged incident.

The panel considered that the only evidence it had was the witness’ description that an oral handover of the doctors change to the patient’s medication had taken place. However, the charge refers to “*handover notes*” and there is no evidence that the relevant medication change would have appeared on those notes. The panel has not been provided with these handover notes in any event. The evidence does not show that you failed to check the handover notes.

The panel was of the view that the NMC had not discharged its burden of proof and therefore found this charge not proved.

Charge 7b

‘That you, a registered nurse:

7. Demonstrated poor medication practices, in that you:
b) As a result of your actions in 7a administered metformin to a patient when it was not appropriate to do so.’

This charge is found NOT proved.

In reaching this decision, the panel took into account the wording of this charge and its findings for charge 7a. The panel considered that the wording of charge 7b states '*as a result of your actions in 7a*'. The panel did not find charge 7a proved, and therefore the panel found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

Ms Mukhia 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 Mukhia identified the specific, relevant standards where your actions amounted to misconduct. namely: 1.1, 1.2, 1.4, 1.5, 2.1, 6.1, 8.2, 8.5, 8.6, 13.1, 13.2, 13.3, 16.4, 16.5, 17.1, 19.1, 20.1, 20.2, 20.3, 20.8, 20.10, and 25.1. Ms Mukhia also made reference to relevant case law; *Roylance v General Medical Council* [1999] UKPC 16, *Jackson J in Calhaem v GMC [2007]* EWHC 2606 (Admin) and Collins J in *Nandi v General Medical Council [2004]* EWHC 2317 (Admin).

Ms Mukhia submitted that the charges found proved each amounted to misconduct, particularly charges 4a, 4c, 4d and 6a)iii), to which she submitted amounted to serious misconduct. Ms Mukhia submitted that bullying and intimidating behaviour has no place in nursing and that such behaviour displayed by you had a negative effect on your colleagues and patient safety.

Ms Mukhia submitted that your behaviour was a very serious departure from the fundamental tenets of the profession and the professional standards and behaviour expected of a registered nurse, and therefore submitted that misconduct should be found on each of the proven charges.

You provided the panel with both written and oral submissions on misconduct.

You submitted to the panel that you fully accept the panel's findings and the implications of such findings. You submitted that as a registered nurse your role is to practise safely at all times., in line with the NMC code.

You highlighted to the panel the parts of the code you believe you had breached which included: 1.1, 1.2, 1.3, 2.1, 8.2, 8.6, 13.1, 16.4, 16.5, 19.1, 20.1, 20.3 and 25.1.

You submitted to the panel that as a nurse your fundamental role is to practise kindly with care, compassion, maintain standards and provide care within the scope of your practice. You further submitted that your role as ward manager highlights this even further, as you were in a position of trust meant to guide staff and provide safe care over the 24 hour period. In failing to do this, you submitted that you had not negated all the potential risks.

You submitted that you did not recognise this in yourself and it displays a lack of insight by you, at the time of the incidents. You submitted that the role of a nurse is a privileged one where you meet people at their most vulnerable. You submitted that you should have recognised that you

were not performing to the standards set out by the code of conduct and rightly expected by the general public.

You submitted that you should have addressed the staffing issues on the ward, and not accepted things as they were. You submitted that whilst you had highlighted staffing issues, it was your job to raise the issues through the proper channels open to you, and communicate more effectively as to the impact this was having on you, your staff and patient safety.

You submitted that you should have recognised how you were acting towards people, and that you failed to be kind, compassionate and caring to others, in particular Colleague C, and understand how your actions could have had an impact on her wellbeing.

You further submitted that you should have listened to those asking for support with patient care, and failed to respond to them which could have potential caused harm to others. You stated that you now see that by not fostering an open supportive environment this impacted on how people communicated in the team and with you.

Submissions on impairment

Ms Mukhia 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), *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin) and the NMC guidance DMA -1 and FTP-15.

Ms Mukhia submitted that limbs 1-3 of the *Grant* case were engaged in this case. Ms Mukhia referred the panel to NMC guidance FTP-15a, 15b and 15c.

She submitted that the concerns raised were difficult to address as your actions demonstrate an underlying problem with your attitude which could not be easily addressed. Ms Mukhia further submitted that in this case you disregarded patient care on a number of occasions knowing the

potential consequences and displayed bullying or intimidating behaviour towards your colleague which again indicates attitudinal concerns and is not easily remediable.

Ms Mukhia submitted that your insight was still developing in relation to charge 1. You admitted to charge 1 and stated you struggled with working excessive hours and wanted to fill in the gaps. Furthermore, you acknowledged the potential consequences of your actions. In relation to charge 2a, Ms Mukhia submitted that you denied not escalating the concerns around staffing levels but you accepted that you did not raise this issue formally. She submitted that your job description clearly sets out expectations on you as a ward manager in relation to ensuring safe staffing levels are maintained.

Ms Mukhia submitted that your insight into what you should have done as a ward manager and as a leader in such a situation is still limited, and that it may be beneficial for the panel to hear what you would or would not do in such a situation to ensure staffing levels are adequate.

With regards to incidents at charges 3.1b, 4a, c and d, Ms Mukhia submitted that you had first stated that you had no recollection of the various incidents that the panel have now found proved and therefore have not provided any insight or reflection in relation to those charges. Ms Mukhia further submitted that in relation to charges 6a)i), you did not have any recollection of stating *“you could have apologised”* and in relation to 6a)ii), you stated you could be aggressive with your tone but could not tell people how they felt. Ms Mukhia submitted that your evidence focused on how you could come across and that you didn’t intentionally mean to bully or intimidate, but it was limited when considering how your behaviour could have impacted Colleague C, who was impacted emotionally and mentally for quite a long time. Ms Mukhia submitted that the panel will note that such behaviour again was not a one off incident but in fact a pattern and raises attitudinal concerns which you had not yet addressed.

Ms Mukhia submitted that in relation to charge 6a)iii) you admitted the charge and insisted that it was not meant for Colleague C to have known about and it was unkind and unfair however, she submitted that you have not yet addressed the attitudinal concerns arising out of your actions and the impact such a comment would have on Colleague C, especially knowing that you were sharing such comments with another colleague. Ms Mukhia further submitted to the panel that you have not provided any reflection into what it means to be a nurse and acting kindly towards colleagues and patients and upholding the reputation of the profession at all times. Therefore, Ms Mukhia submitted that you have not really provided proper insight and have not fully

addressed the concerns raised in the charges found proved. Ms Mukhia's submissions were made before you had provided your latest reflective piece.

Ms Mukhia submitted that the panel, when considering how likely it is that your conduct would be repeated, should assess the extent of your insight into the concerns and consider whether you have taken steps to sufficiently address the concerns. Ms Mukhia submitted that your insight and reflection at present are limited and therefore, the concerns raised are not highly unlikely to be repeated.

Ms Mukhia submitted that the wide ranging concerns raised about you, which include neglect of patient care, attitudinal concerns, bullying or intimidating behaviour, failure to preserve a patient's dignity and failure to act with kindness and respect towards patients and colleagues all indicate that the concerns are serious. She further submitted that should the panel not make a finding of impairment it would undermine the professional standards and the confidence the public places in the nursing profession. Ms Mukhia submitted that consideration should be given to what message would be sent to the public if a regulator does not mark the seriousness of your behaviour as such behaviour can negatively impact public protection as well as, the trust and confidence the public places in nurses, midwives, and nursing associates. Furthermore, she submitted that your actions demonstrated attitudinal issues in that you knowingly disregarded patient care and safety and bullied or intimidated your colleague.

Therefore, Ms Mukhia submitted that this is a matter in which impairment can be found on public protection and otherwise in public interest grounds.

You provided the panel with oral and written submissions on impairment.

You submitted to the panel the following;

> *'Since I resigned from the role and left the trust in 2019, many things have changed. I have had time to reflect, I see how tired I was, I see how I had got lost in a process, the line in my job description that stated I had 24 hour responsibility I did not cope well with, this scared me, I did not see this at the time. I have been supported by clinical supervision in early 2019, this was undertaken by a senior nurse from outside the trust. This was really helpful, it gave me time out, time to focus on myself and my actions, time to breath.*

I have also undertaken mindfulness training, which I practice on a daily basis, this has now become and integral part of me, this again helps by giving time out, time to breath.

I have been working in the same role as a functional specialist (title has changed due to change in contract) since February 2020, having taken a few months after resigning my role in the trust and starting a new job. This time was essential to ensure to give me time to recover and move forward. I recognised that I needed a role that allowed me to use my knowledge and skills but in a way that I was less pressured. I work in a role that provides a healthcare assessment for a government body. My role is to undertake an assessment of an individual, having prepared for this by accessing any information available, then undertake a structured assessment, I then evaluate all the information and use my knowledge of conditions, impact and process to assess any impact on day-to-day life, I then write a report for the government body. This role is hybrid, I work from home and attend clinic. Clinic is on a one to one basis, with set appointment times. I get good feedback from the team I work in and my team manager, I have provided my reviews as evidence. I also undertake the role of a buddy, this in ward terms would be a mentor, I support new starters to the company, by working alongside them and guiding in their decision making. I am active member of the team and am often asked for advice. I work well in this role and enjoy it. Work is internally and externally monitored via audit, which I often receive excellent feedback. I get good feedback from the individuals I assess. The company are supportive, provide training both face to face, virtual and electronically. They provide quarterly quality workshops, discussing any changes/trends. I have monthly 121's, I have never felt so supported to do my role. I have a much healthier work life balance. My plan for the future would be stay in this role and this company. I have been on the register and worked as a registered nurse for 25 years, I have a great knowledge and skill set. I feel I have found my nq `1, in my current role, a fine balance of being able to use my clinical knowledge and use my registration to support the individual I am engaging with at the time.

On a personal level, I have changed immensely since 2018/19, I have had an opportunity to look deep inside of myself and re-evaluate my own values, identify what is important to me and how I can keep that central to my thoughts and actions. This took me back to why I went into nursing to begin with, I quite simply wanted to do my best for my patients every single day. My values have not changed. What has changed is my self awareness, my

ability to manage my thoughts and feelings, to recognise when I need help or when to say no. This has not been an easy journey, looking deep into yourself and finding you are not the person you thought you were, or that the person you where had been lost in the hamster wheel of the day, is difficult however the 1st step is always to admit the failing and then work on how to find yourself again. With the support outlined previously and the passage of time, I have and continue on that journey.'[sic]

You further submitted to the panel that whilst it is impossible to change the past, you have continued to work in your current role, practicing safely with no concerns. You submitted that although your role does not include direct patient care and therefore could not directly address the concerns raised in charges 3.1b, 4a, 4c and 4d, it does include using your clinical knowledge. You do have sensitive discussions/conversations with individuals, often needing to escalate the safeguarding concerns or signposting to a GP.

You submitted that it is difficult to demonstrate a change in your relationship with others, however, in the last six years working within a team, you have daily contact/assessments with the general public and support others in their role in a formal or ad hoc way. You further submitted that you have received good feedback from your colleagues and there have been no concerns about you or your practice since 2020.

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, *Remedy UK v GMC* [2010] EWHC 1245 Admin, *Johnson and Maggs v NMC [2013]* EWHC 2140 Admin and Grant.

Decision and reasons on misconduct

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

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

*‘**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

1.5 respect and uphold people’s human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.6 recognise when people are anxious or in distress and respond compassionately and politely

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and

care setting and use the channels available to you in line with our guidance and your local working practices
16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so
16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection
To achieve this, you must:
17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to
20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first
25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken.'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel then went on to consider whether the charges found proved amounted to misconduct.

In relation to charge 1, the panel found that this charge amounted to misconduct. By your own admission working excessive hours had a negative impact on you, patient safety, your communication with staff and your ability to rationalise and prioritise patients.

In relation to charge 2a, the panel found that this charge amounted to misconduct. The panel considered that you had not formally raised understaffing issues with your line manager, or senior management, despite it being a long standing issue and having an adverse impact on patient safety, especially because your unit had a routinely high risk of falls and it impacted upon your staff's wellbeing. Furthermore, the panel bore in mind that your line manager had formally informed you in a letter that you must utilise agency and bank staff and only pick up an extra shift yourself if there was no other available option to you. The panel considered that multiple witnesses had raised concerns about the impact of being understaffed had on the level of patient care on the unit and that you had become unapproachable in their view on this topic.

In relation to charges 3.1b, 4a, 4c and 4d, the panel found that these charges amounted to misconduct. The panel considered these charges together as they all related to basic patient care which is a standard expected by a nurse. The panel considered that in these charges found proved, you demonstrated a clear disregard for patient safety and a disregard for supporting junior colleagues, especially in charge 3.1b where you had clearly breached patient dignity.

In relation to charge 6a)i) the panel found that this charge did not amount to misconduct. The panel considered that the manner in which you communicated to Colleague C was inappropriate but did not amount to professional misconduct on its own.

In relation to charge 6a)ii), the panel found that this charge amounted to misconduct. The panel found that you were aggressive in your communication towards Colleague C which was highly inappropriate and had a negative impact on her wellbeing and relationship with you.

In relation to charge 6a)iii), the panel found that this charge amounted to misconduct. The panel considered this sort of communication about a colleague to another colleague was highly inappropriate for a professional, whether it was said directly to the colleague, or as in this case, to another colleague.

Therefore, the panel found that your actions in charges 1, 2a, 3.1b, 4a, 4c, 4d, 6a)ii) and 6a)iii) 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, your fitness to practise is currently impaired.

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses/ with their lives and the lives of their loved ones. To justify that trust, nurses must be

honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel found that limbs a, b and c were engaged in this case. The panel finds that patients were put at risk and could have been caused physical harm as a result of your misconduct. The panel found that your misconduct, disregarding patient safety, disregarding supporting junior

colleagues and bullying of Colleague C, had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel in making their decision, had regard to the case of *Cohen*. The panel was satisfied that the misconduct in this case is capable of being addressed.

Regarding insight, the panel considered that in relation to charges 1, 2a, 6a)ii), and 6a)iii) you had demonstrated that you understood the impact of your failings particularly the impact of working excessive hours on yourself, patients and colleagues.

> *'With reflection and hindsight, I can see and understand that working excessive hours, will have impacted my ability to process, communicate and lead in an acceptable manner, which will have impacted my colleagues and patients. This at the time I did not see, with reflection I now do.'*
>
> *'I fully accept the findings of the panel and the implications of such findings. As a registered nurse my role is to practice safely at all times, in line with polices and NMC code. I accept that I have fallen short of this…I attribute this to having a direct impact on…, not escalating concerns around staffing upwards in a way that has been heard and acted upon.'*

The panel also noted that you demonstrated insight into the adverse impact of your communication style on your colleagues, especially on how you bullied Colleague C.

> *'Charge 1 and 2a*
>
> *With reflection and hindsight, I can see and understand that working excessive hours, will have impacted my ability to process, communicate and lead in an acceptable manner, which will have impacted my colleagues and patients. This at the time I did not see, with reflection I now do, I appreciate that whilst I have not purposely gone out to harm anyone, I had a responsibility to myself and others to manage my own wellbeing, that of others, work with others, and recognising the effect of long working hours does demonstrate lack of self-reflection at the time. I thought I was doing the best by the team/ward by not leaving gaps on the ward, however, see now I have come away from the environment that impeded me from doing my role appropriately. I attribute this to having a direct impact on how I have communicated with others, not escalating concerns around staffing upwards in a way that has been heard and acted upon. I see that I have failed in a vital part of my*

role to ensure appropriate staffing, I have just accepted that there are gaps, without the impact of fatigue I would potentially have seen this faster and been able to communicate this better and more effectively. I failed in my leadership to provide my team with the knowledge on how to react to the changing needs of the ward, I have not given them a voice. My communication was ineffective, and I failed to provide the safe environment to allow my team to express their concerns and escalate. For the team there was potential for them to feel stressed and over worked, leading to them to being unhappy in their work. For the patient this could mean lack of timely intervention.

Charge 3.1B, 4a, c and d

Escalating changes and maintaining dignity of patients is a fundamental part of the nurses role, the facts having found that I have failed at this in relation to charge 3.1b, 4a 4c and 4d is devastating however as previously stated accept the findings of the panel. On reflection my role was to support junior colleagues in the care they gave, educating, guiding and encouraging, I should have been a role model. I am finding it hard to put into coherent words as to how I feel about this fact findings, the only word that is swimming around in my head is devastation, I have numerous years of experience and am aware of the potential impact of not having passed urine, not having an appropriate blood levels. I should have acted differently. I can see that as stated above the excessive hours have had a direct influence on how I have responded to changes, with excessive tiredness leading to ineffective communication and reactions.

Charges 6a

My role as a ward manager as previously stated was to guide, support the team, also to ensure that the ward was a safe environment, a safe environment includes the team feeling they are able to talk freely without fear or concern. I know it was not my intention, I know I didn't set out to make anyone feel that way. But I did, I accept I did, that's how the individual felt. On reflection I can see how my actions were seen as controlling and intimidating, my honest intention was to be supportive. Having had time out, time to reflect and focus I know how I behaved was inappropriate, my lack of self-awareness and being able to see how I have impact people and in particular colleague C is unfair and I apologise whole heartedly for this. With reflection and less fatigue, I think the root of the problem is communication and tiredness, this is not an excuse, more trying to work out how I have been this person. I didn't not share enough with the team, if I had been more

open in communication with them, would I have been more approachable. I know I am not very good at hiding what I am thinking, my face often telling a story. I have worked on that but if you don't know me is this a hurdle. As a leader I should have been the swan, the voice of reason.'

You further demonstrated insight into how as a ward manager your role was to support junior staff and create a safe working environment and you did not do that.

'My role as a ward manager as previously stated was to guide, support the team, also to ensure that the ward was a safe environment, a safe environment includes the team feeling they are able to talk freely without fear or concern.

Having had time out, time to reflect and focus I know how I behaved was inappropriate, my lack of self-awareness and being able to see how I have impact people and in particular colleague C is unfair and I apologise whole heartedly for this.'

As a result, the panel were of the view that you had remediated the concerns raised and had developed insight in regards to charges 1, 2a, 6a)ii), and 6a)iii).

In regards to charges 3.1b, 4a, 4c and 4d, the panel considered that you had developing insight into your clinical failings and understood that your actions were wrong, and negatively impacted patient safety and your colleagues. However, the panel considered that you have not provided sufficient evidence to demonstrate that you understand fully what should have happened in those clinical scenarios.

The panel acknowledged that you had been working in a non-clinical setting and it has been six years since the charges found proved arose. The panel further noted your managers testimonial, in which they state that there is *'No evidence of any concerns in how she treats colleagues'* and that you are *'a good communicator and a very pleasant colleague to work with'.*

The panel were of the view that further efforts could and should have been taken by you to address the clinical concerns and it did not have before it any evidence of training, that was relevant to and directly addressed those patient scenarios nor did the panel have any detailed reflection on the potential clinical risk of your failings in these scenarios. Therefore, there was still a lack of sufficiently developed insight in regards to the concerns raised in charges 3.1b, 4a, 4c and 4d.

The panel was of the view that in regards to risk of repetition, it was highly unlikely that you would repeat matters of the kind found proved in charges 1, 2a, 6a)ii) and 6a)iii). However, the panel were not satisfied that the clinical concerns regarding your basic nursing practice arising in charges 3.1b, 4a, 4c and 4d were highly unlikely to be repeated by you. The panel noted your lack of insight into the need for remediation (such as evidence of retraining and reflection upon the clinical risks identified in these charges), therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because the public would be concerned if a nurse who had multiple breaches of the fundamental tenets of the code and had not sufficiently demonstrated insight and remediation into clinical failings after six years, was allowed to practice unrestricted. The panel also determine that members of the public would be hesitant, or even reluctant, to engage with members of the profession if they knew that there was a risk of them not receiving proper safe and adequate care when needed and in their most vulnerable state.

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 also finds your fitness to practise impaired on the grounds of public interest.

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

Interim order

Following the finding of impairment, and that this hearing was about to go part heard. Ms Mukhia invited the panel to make an interim conditions of practise order for 12 months to cover the

period until the hearing resumed, and to reflect the panels finding on impairment on both public protection and public interest grounds.

You told the panel you were neutral on the application for an interim conditions of practice order. You told the panel you have been practicing in the same role for 6 years and there has been no issues but understood why an interim order would be needed at this stage.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order would be appropriate at this stage, following their finding on impairment and the lack of remediation in regards to the clinical concerns.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be in line with the panel's findings of the further remediation required and current impairment on public protection and public interest grounds. This will be for a period of 12 months to cover the period until the hearing is concluded.

> 'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.
>
> 1. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from either:
>   - your line manager.
>   - mentor or supervisor
>
> 2. You must limit your nursing practice to one substantive employer (not agency or bank).

3. You must ensure that you are supervised by a registered nurse that is deemed suitably qualified by your employer any time you are in a clinical role, delivering patient care.

4. You will send your case officer evidence that you have successfully completed any training courses relevant to your clinical failings as identified by the panel, and any reflections on the clinical risks that were associated with your failings, 7 days to the resuming hearing.

5. You must keep a reflective practice profile. The profile will:
   • Detail examples of cases where you undertake or assist with clinical care relevant to the previous clinical failings.
   • Set out the nature of the care given.
   • Be signed by a manager or supervisor each time.
   • Contain feedback from manager or supervisor on how you gave the care.

   You must send your case officer a copy of the profile 7 days to the resuming hearing.

6. You must keep us informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

7. You must keep us informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

8. 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.

9. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of up to 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Dunn informed the panel that the NMC revised its proposal and submits that a conditions of practice order for 3 years with a review is more appropriate in light of the panel's findings.

Ms Dunn submitted the following aggravating features:

- Conduct which put people receiving care at risk of harm.
- Limited insight shown in relation to charges 3.1b, 4a, 4c and 4d.
- A pattern of misconduct over a period of time

Ms Dunn further submitted the following mitigating features:

- Early admission of the facts in charge 1 and 6a)iii)
- An apology to Colleague C as set out within your previous reflective account
- Some evidence that you have worked safely and professionally in a similar role since the events causing concerns.

The panel also bore in mind your submissions.

You submitted to the panel that the person you were in 2018-19 when the concerns first arose, was not the same person sitting before it today. You submitted that the events that occurred are etched on your mind forever, and you left that role burnt out both physically and emotionally, and take full responsibility for your actions.

You submitted that you have been on the register for 27 years, accumulating a wealth of experience while also learning every day. You further submitted that you have learnt from the experiences you have had and taken time to reflect. You submitted that since you left the role as a ward manager you have worked for another company where you use your nursing and education knowledge to undertake healthcare assessments. You told the panel that you have to work independently, remotely, and use a very different skill set, which you have excelled at and have an exemplary record.

You submitted that you understood how not providing any training certificates and reflection around the impairment could be viewed as being disinterested or a lack of insight, especially

given the length of time this process has taken. However, you submitted that this was not the case, and it is more to do with you being overwhelmed and focusing on different areas instead.

You submitted to the panel there has been difficulty with your interim conditions of practice order, particularly around the condition of supervision. You submitted that your company cannot provide 100% supervision when you are working as your manager is also not a health care professional. You suggested to the panel that you could provide a named nursing colleague that is on the register who could undertake some sort of documented clinical supervision or reflection with you, which you already do as you are always discussing cases and best outcomes for the individuals with your fellow nursing colleagues. You further submitted that you had several colleagues that would be willing to do this.

You submitted that you have 15 working years left of your career, and you are hopeful that you will be able to remain on the register, proving that you are worthy of the trust placed on those on the register.

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

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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 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 that put patients at a risk of harm
- Lack of retraining in relevant clinical areas
- Failure to work collaboratively with colleagues

The panel also took into account the following mitigating features:

- Early admission of the facts in charge 1 and 6a)iii)
- Apology to Colleague C
- Evidence that you have worked safely and effectively without further incident, (albeit in a very different nursing role), in particular this has evidenced good insight into consciously working the appropriate amount of hours
- Inexperience in your first management role at the relevant time
- Developing insight into clinical failings and good insight into your failure to work collaboratively (albeit untested as not presently in a management role)

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

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your practise would not protect the public. The panel also determined 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 your registration would be appropriate. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*

- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel had regard to the fact that these incidents happened a long time ago and that, other than these incidents, you have had an unblemished career of 27 years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

The panel determined that it would be possible to formulate relevant, proportionate, workable and measurable conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that given you have been working for some time with further insight which it recognises is developing sufficiently, to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case. The panel was also of the view that the impairment in this case was not wholly incompatible with remaining on the register.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse. Furthermore, the panel considered that a conditions of practice order would be sufficient to protect the public.

The panel determined that the following conditions are appropriate and proportionate in this case:

‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must ensure that you are indirectly supervised by a line manager any time you are working. Your supervision must consist of:
    a) Documented monthly one to ones, directly reflecting your adherence to the conditions of practice order

2. You will send your case officer evidence of any relevant courses undertaken or relevant training successfully completed in the following areas:
    a) Management of urinary retention
    b) Management of low haemoglobin
    c) Nursing leadership

3. You must provide testimonial evidence from:
    a) Your line manager or a registered healthcare professional attesting to how you have demonstrated leadership in your nursing role. For example, buddy/mentorship of a junior colleague within the team
    b) Testimonial evidence from another registered nurse whom you work with attesting to your clinical knowledge and appropriate decision making in regards to service users.

4. You must keep a reflective practice profile detailing reflections on when you have demonstrated nursing leadership within your role. For example, buddying or mentoring a junior colleague in the team

    You must send your case officer a copy of the profile 7 days before your next review.

5. You must keep us informed about anywhere you are working by:

a) Telling your case officer within seven days of accepting or leaving any employment.
b) Giving your case officer your employer's contact details.

6. You must keep us informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

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

8. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for up to 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future reviewing panel would be assisted by:

- Up to date testimonials from your line manager
- Testimonials from registered nursing colleague(s), related to clinical knowledge and appropriateness of decision making
- Evidence of retraining in relevant clinical areas
- Testimonial evidence from a line manager and/or nursing colleague(s), evidencing when you have demonstrated nursing leadership in your role
- A reflection from you regarding how you demonstrated nursing leadership in your role.
- Your continued engagement with the process

This will be confirmed to you in writing.

Interim order

As the conditions of practice 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 your own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Dunn. She submitted that the panel should impose an interim suspension order for a period of 18 months to cover any potential period of appeal.

The panel also took into account your submissions to which you had no objections to the interim order.

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

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months due to cover any potential period of appeal.

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

That concludes this determination.