Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday 18 June 2026 – Wednesday 24 June 2026
Monday 24 August – Tuesday 25 August 2026

Virtual Hearing

Name of Registrant:	**Suzanne Tuffnell**
NMC PIN:	07G1261E
Part(s) of the register:	Registered Nurse – Children RNC – 21 September 2007
Relevant Location:	Stockton-on-Tees
Type of case:	Misconduct
Panel members:	Margaret Wolff (Chair, Lay member) Vanessa Bailey (Registrant member) Gary Trundell (Lay member)
Legal Assessor:	Natalie Byrne
Hearings Coordinator:	Fionnuala Contier-Lawrie
Nursing and Midwifery Council:	Represented by Alice Hands, Case Presenter
Mrs Tuffnell:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 4a, 4b, 4c, 5a, 5b, 5c, 6, 7a, 7b, 8, 9, 11, 12a, 12b, 13a, 13b, 14b, 14c, 15a, 15b, 16a, 16b, 16c
Facts not proved:	Charges 10, 14a
Fitness to practise:	Impaired
Sanction:	Strike-off

Interim order:	Suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Tuffnell was not in attendance and that the Notice of Hearing letter had been sent to Mrs Tuffnell's registered email address by secure email on 20 May 2026.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Tuffnell's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Tuffnell

The panel next considered whether it should proceed in the absence of Mrs Tuffnell. It had regard to Rule 21 and heard the submissions of Ms Hands who invited the panel to continue in the absence of Mrs Tuffnell. She submitted that Mrs Tuffnell had voluntarily absented herself.

Ms Hands referred the panel to an email from Mrs Tuffnell dated 16 March 2026, from Mrs Tuffnell which [PRIVATE] therefore would not be able to attend the hearing and that she is content for the hearing to proceed in her absence.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Tuffnell. In reaching this decision, the panel has considered the submissions of Ms Hands, the communication with Mrs Tuffnell's email and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Tuffnell;
- Mrs Tuffnell has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Witnesses are expecting to attend to give live evidence
- Not proceeding may inconvenience the witnesses, their employer(s)employers and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Tuffnell in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email

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

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

Details of charge

That you, a Registered Nurse:

1. On 16 August 2022 told Colleague A you were too busy to help her.

2. On 17 August 2022 criticised Colleague A for wearing black scrubs.

3. On an unknown date said to Colleague A '*I was your size before I lost 4 stone*' or words to that effect.

4. On an unknown date, told Colleague A to wear a Trust rainbow uniform scrub top:
   a) That was not hers;
   b) That was too small and did not fit properly;
   c) Which split down one side due to the fact it was too small.

5. On an unknown date said to Colleague A:

a. ‘*I’m surprised they’ve let you in the building*’ or words to that effect;
b. That you were ’shocked’ she had got the job or words to that effect;
c. That you ‘*would not have given her the job*’ or words to that effect.

6. On various occasions checked work carried out by Colleague A when there was no need for you to do so as it had already been signed off by others.

7. On an unknown date, in response to Colleague A’s questions about patient care, responded:
   a. ‘*None of your fucking business*’ or words to that effect;
   b. ‘*Just read the care notes*’ or words to that effect.

8. On an unknown date said to Colleague A that she was ‘*keen and a know it all and none of the staff liked*’ her, or words to that effect.

9. On an unknown date said to Colleague A in relation to her position within the work place, ‘*you’re at the bottom where you will always be*’ or words to that effect.

10. On an unknown date you failed to provide adequate supervision when assistance was sought by Colleague A.

11. In October 2022 you shouted at Colleague A.

12. On an unknown date in front of other staff members said to Colleague A:
    a. ‘*Are you listening to me? I’m not going to tell you again*’ or words to that effect;
    b. ‘*Actually, move round here so I can tell you’re listening to me*’ or words to that effect.

13. On an unknown date when taking a patient for a walk with Colleague A:

a. Grabbed her hood and aggressively pulled it down over her face;
b. Said to her ‘Do your hood up if you’re that fucking cold’ or words to that effect.

14. In relation to Colleague A’s non-epileptic [PRIVATE]:
    a. Failed to support her.
    b. Told staff not to leave her on her own.
    c. Pressured her to tell colleagues about her condition.

15. Your conduct at charges 1-14 harassed Colleague A, in that your conduct:
    a. Was unwanted
    b. Had the purpose or effect of creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague A.

16. On various unknown dates:
    a. Left the unit unattended for extended periods of time;
    b. Failed to tell staff where you were;
    c. Were not contactable by staff.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Hands under Rule 31 to admit into evidence the signed interview minutes that were undertaken by Butterwick Hospice Care during an internal grievance investigation and in response to further allegations made regarding the professional conduct and behaviour of Mrs Tuffnell which led to a disciplinary investigation.

Additionally, Ms Hands submitted that this was an application for the admission of documents from the local grievance and disciplinary investigations.

Ms Hands referred to a number of relevant cases, of which the panel will have regard to when considering whether it is fair to admit this hearsay evidence, including *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)* and *Bonhoeffer v GMC [2011] EWHC 1585 (Admin).*

Ms Hands submitted that Mrs Tuffnell received the NMC's documents on 6 November 2024 and also received the NMC's bundle in advance of the hearing which included the interview minutes. Ms Hands submitted that Mrs Tuffnell did not object to their inclusion or apply for redactions and therefore, had plenty of notice of the evidence the NMC would rely upon in support of the charges and has not objected to it.

Ms Hands submitted that Mrs Tuffnell has consented to the hearing proceeding in her absence; therefore, she could not have tested the evidence even if the witnesses had attended. Mrs Tuffnell was advised that she could request a postponement of the hearing in order to attend, but did not do so.

Ms Hands told the panel that the interview minutes are signed by the individual witnesses and they have confirmed the accuracy and truth of the contents. Ms Hands told the panel that 11 witnesses were interviewed during a period of approximately two-months (March to May 2023). The accounts given were contemporaneous, at a time when the allegations were fresh in the memories of those who made them.

Ms Hands submitted that the majority of the witnesses have provided consistent accounts of Mrs Tuffnell's professional conduct and behaviour. There is no evidence to suggest that the witnesses had reasons to fabricate their allegations.

Ms Hands told the panel that it will hear oral evidence from colleague A on each of the allegations, therefore, the interview minutes are not the sole or decisive evidence. Oral

evidence will also be given by Clare Scott who undertook the interviews with the witnesses and exhibited the documents. Ms Hands told the panel that the interviews were part of fair and rigorous investigation processes and Mrs Tuffnell had the opportunity to respond to the allegations on two occasions.

Ms Hands submitted that as Mrs Tuffnell will not give oral evidence, her accounts during the interviews are important to understanding her response to the allegations and account of her relationship with colleague A. Senior and junior members of staff who worked on the ward were also interviewed, on some occasions, more than once.

Ms Hands told the panel that the NMC contacted Jen Plews and Alison ‘Shelley’ Eeles on two occasions to ask if they would give oral evidence. Both individuals confirmed that for personal reasons, they did not want to do so. Ms Hands submitted that the NMC made and exhausted all reasonable efforts to get these witnesses to attend to give oral evidence. The NMC also asked Julie Evans if she would attend to give oral evidence.

Ms Hands submitted that the grievance outcome letter dated 14 April 2023 is relevant to the narrative background and the author of the letter will give oral evidence, which will allow the panel the opportunity to ask her questions.

Ms Hands submitted that the disciplinary outcome letter dated 25 May 2023 is relevant as the panel does not have sight of the minutes of the disciplinary meeting held with the Registrant on 24 May 2023.

Ms Hands submitted that the summary of Mrs Tuffnell’s response to the allegations during that meeting, therefore, provides a narrative background. In both investigations, Mrs Tuffnell had the opportunity to respond to the allegations and was on notice that findings relevant to her practice would be made.

Ms Hands submitted that in all the circumstances of the case, it is fair to admit the interview minutes and grievance and disciplinary outcome letters into evidence and that it will be for the panel to decide on the weight that it attaches to the 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 submissions by Ms Hands and the case of *Thorneycroft v NMC* in reaching its decision.

The panel considered that it would be premature for it to make a final decision on whether to admit the documents at this stage. The panel decided it wanted to hear from Ms Scott and Colleague A before making its decision on whether the hearsay evidence is relevant.

The panel considered that not all the statements attached to Ms Scott's witness statement speak to the charges and determined that CS9, CS10, CS15 and CS20 do not reach the threshold of relevance for it to be appropriate to admit them as hearsay.

The panel also considered whether all reasonable efforts had been made to contact those people whose statements are in the hearsay evidence being asked to be admitted.

The panel therefore requested more information on what efforts the NMC had made to contact potential witnesses. It noted that at least one is a registrant and would have a duty of cooperation, whereas others who declined who may not have any obligation to the NMC, whether they are still minded to speak to their statement.

The panel also requested a signed copy of the disciplinary meeting minutes.

Subsequent to hearing the oral evidence of Colleague A and Clare Scott, the panel considered this matter further. In response to the panel's request for more information on the contact made with potential witnesses by the NMC, Ms Hands told the panel that there does not appear to have been any further contact made by the NMC with those witnesses.

Ms Hands also provided the panel with a signed copy of the disciplinary meeting minutes, as requested. Ms Hands submitted that although Mrs Tuffnell is not present and therefore is not aware of this new signed document, however she had agreed to the hearing proceeding in her absence and clearly knew that the panel would be considering the documents from the internal investigation and did not object or challenge that.

With regard to relevance, Ms Hands submitted that this document touches on some of the charges and in Mrs Tuffnell's absence, they may also be important to the panel for understanding her response to some of those allegations and when considering the consistency of the accounts she has given.

Ms Hands also submitted that the document is not sole or decisive evidence for any of the charges, there is no evidence to suggest that the evidence has been fabricated and therefore, the evidence would be fair to both parties for the document to be admitted into evidence.

In light of signed document and having heard from both witnesses the panel decided that with the exception of the documents already stated above, the panel accepted the rest into evidence as hearsay.

The panel considered that Mrs Tuffnell had signed the document herself and knew that these documents were included in the internal investigation which would be put before the panel and that she did not object to these being provided.

The panel also considered that Mrs Tuffnell had chosen voluntarily to absent herself from these proceedings and would not be in a position to cross-examine this witness in any

case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence, the hearsay evidence but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

Mrs Tuffnell has been a registered nurse since 2007 and had been employed at Butterwick Hospice Care for 11 years in a nursing role. Colleague A joined Butterwick Hospice Care in August 2022 and held the role of healthcare assistant until she resigned on 30 April 2023.

During Colleague A's employment, she raised concerns about Mrs Tuffnell's bullying and harassing conduct and behaviour towards her. Colleague A alleged that this behaviour started almost immediately upon her employment at the unit and continued throughout her employment.

Colleague A sought to resolve the matter via an informal grievance to her employer in December 2022. This was followed by a formal grievance in February 2023. An investigation took place into the allegations, which involved interviewing other members of staff, Colleague A and Mrs Tuffnell.

Following this grievance, other staff members began to raise similar concerns about Mrs Tuffnell's bullying and harassing behaviour towards them or their colleagues. Concerns were also raised about Mrs Tuffnell taking long and frequent periods of absence from the ward without telling staff where she was going and that she was uncontactable during these

periods of time. This led to a disciplinary investigation, during which members of staff were interviewed and a hearing took place.

On 4 July 2024, the NMC received an employment referral from Butterwick Hospice Care with concerns regarding Mrs Tuffnell. An investigation by the NMC followed and regulatory concerns were identified as bullying, intimidating and harassing behaviour towards colleagues and failures in safe patient care, in that Mrs Tuffnell regularly left the unit unattended for periods of time, leaving staff unable to contact her in relation to patient care needs.

Decision and reasons on facts

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

The panel has drawn no adverse inference from the non-attendance of Mrs Tuffnell.

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

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

- Witness 1: Colleague A, Health Care Assistant at Butterwick Hospice (“the Hospice”)
- Witness 2: Clare Scott, People Director at Butterwick Hospice (“the Hospice”)

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

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

Charge 1)

That you, a Registered Nurse:

On 16 August 2022 told Colleague A you were too busy to help her.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A and Colleague A's grievance letter dated 17 February 2023.

Colleague A wrote the following in her grievance letter:

> *'Started my first day 16/08/22 to a frosty reception…….She said she was to* [SIC] *busy for me and said Chris would have to look after me'*

The panel also heard in Colleague A's oral evidence that Mrs Tuffnell was not welcoming, made some unsupportive remarks and on her first day, her induction pack was not available for her and that another colleague was told to show her around.

The panel deemed that Colleague A's statement in her grievance letter was written shortly after the event in question. The panel found the account of Colleague A to be credible and that her oral evidence was consistent with the details outlined in the grievance letter.

The panel determined that it was more likely than not that Mrs Tuffnell said these things to Colleague A and that on the balance of probabilities, it found this charge proved.

Charge 2)

On 17 August 2022 criticised Colleague A for wearing black scrubs.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Colleague A's grievance letter, dated 17 February 2023, Colleague A's NMC witness statement and the internal witness statement of Sam Benton (Ms Benton), dated 23 March 2023.

The panel noted that Colleague A stated in her grievance letter:

"Second day I was told my black scrubs were not suitable as it was a childrens [SIC] *unit and we needed to look happy"*

"This became an issue going on about my black scrub top. So I ordered my own scrub tops as none fit me."

Colleague A stated in her NMC witness statement:

"When I started, I didn't receive my uniform immediately and I was wearing my own black scrubs in the interim as there were no spare tops that fit me. Suzanne said, "They're absolutely not going to work for me…this is a children's ward!". I was really embarrassed and went home that evening and purchased new colourful scrubs on Amazon at my own expense."

The panel also heard in Colleague A's oral evidence that she had ordered herself a number of different scrubs in the interim of waiting for her uniform to arrive and that Mrs Tuffnell also allegedly had an issue with the replacement scrubs Colleague A had ordered.

Ms Benton, a colleague of Colleague A and Mrs Tuffnell stated in the internal grievance meeting on 23 March 2023, that Colleague A had sourced her own black scrubs and that Mrs Tuffnell did not like this as the colour was not appropriate and as a result, Colleague A felt body shamed.

Ms Benton also stated:

> *'ST can be sharp-doesn't think before she speaks'*

The panel deemed Colleague A to be very clear and consistent throughout her documentary evidence and during her oral evidence. The panel considered that there was nothing which contradicts what Colleague A has told it and that although the panel acknowledges it has not had the opportunity to hear from Ms Benton in person, her statement in the grievance interview corroborates the accounts of Colleague A.

The panel concluded that Colleague A's account was plausible, consistent and that it had no reason to disbelieve her evidence.

The panel therefore found this charge proved.

Charge 3)

> On an unknown date said to Colleague A '*I was your size before I lost 4 stone*' or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Colleague A's grievance letter dated 17 February 2023, the internal witness statement of Ms Benton, dated 23 March 2023, the investigation interview questions of Alison (Shelley) Eeles (Ms Eeles), dated 25 April 2023, Clare Scott's (Ms Scott) NMC witness statement and the investigation interview of Jen Plews (Ms Plews), dated 12 May 2023.

The panel considered the statement of Colleague A in her internal grievance letter which states:

> *"She said infront of Lee and Sam Benton ive* [SIC] *been thinking I was your size before I lost 4 stone and tops fit me so just one on today"*

The panel also heard from Colleague A in her oral evidence that Mrs Tuffnell had referenced her weight several times.

Ms Plews states in the internal grievance investigation:

> *'ST said whilst looking at me 'You don't eat anyway'*
>
> *'ST comes to me and tells me she has an eating disorder'*
>
> *'ST behaviours, comments to me would cause me to relapse'*
>
> *'ST is a bully, she even started on Shelley about her weight and [PRIVATE]'*

Ms Benton stated in her internal grievance interview when asked whether there were comments made to staff [PRIVATE]:

> *'Yes – AE about her weight. JP weight and not eating.'*

In Ms Eeles' investigation interview she states:

'When St is on shift she causes a bad atmosphere, [PRIVATE]'

The panel considered that all of the accounts provided are consistent throughout and point to Mrs Tuffnell having made comments about weight to several of her colleagues, as well as Colleague A.

The panel found that it is more likely than not that Mrs Tuffnell made the comment as written in the charge, or words to that effect.

The panel therefore found this fact proved.

Charge 4a, b and c)

On an unknown date, told Colleague A to wear a Trust rainbow uniform scrub top:

a) That was not hers;
b) That was too small and did not fit properly;
c) Which split down one side due to the fact it was too small.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Colleague A's grievance letter, dated 17 February 2023, Colleague A's NMC witness statement and the internal witness statement of Ms Benton, dated 23 March 2023.

The panel noted that in Colleague A's NMC witness statement she states:

'When I started, I didn't receive my uniform immediately and I was wearing my

own black scrubs in the interim as there were no spare tops that fit me……. Before they could arrive, Suzanne relentlessly harassed me about wearing black scrubs, but it was a nonissue. She threw a rainbow top at me and said, "Look, just wear this!". She forced me to wear a top that didn't fit me and I had to walk around wearing it when it had split up the sides. I felt so humiliated.'

Colleague A told the panel in her oral evidence that Mrs Tuffnell had made her wear scrub top that was not hers and did not fit.

Ms Benton stated in her internal grievance interview that she had witnessed this interaction and that Mrs Tuffnell made Colleague A get changed and that the scrubs did not fit her.

During oral evidence, Colleague A described the incident clearly and was able to indicate to the panel exactly where the split in the scrubs was. Colleague A described in her oral evidence how this was done infront of other colleagues and that she felt mortified and humiliated by Mrs Tuffnell.

Ms Benton stated in her internal grievance interview:

'I don't like body shaming – it is disgusting. If I was asked to wear something that doesn't fit on my first day I wouldn't come back.'

On considering the contemporaneous evidence and oral evidence of Colleague A, the panel found that she was clear, credible and consistent throughout and that her accounts were corroborated by the evidence of Ms Benton.

The panel therefore found this charge proved in its entirety.

Charge 5a, b and c)

On an unknown date said to Colleague A:

a. '*I'm surprised they've let you in the building*' or words to that effect;
b. That you were 'shocked' she had got the job or words to that effect;
c. That you '*would not have given her the job*' or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Colleague A's grievance letter and Colleague A's NMC witness statement.

Colleague A stated in her NMC witness statement in reference to Mrs Tuffnell:

> *'One time, she implied (incorrectly) that I didn't have the correct experience or qualifications. She asked how I got the job and remarked, "I'm surprised they've let you in the building.'*

Colleague A stated in her grievance letter:

> *'The first weekend I worked with her we were bathing a child and she hadn't had any conversations about my history about my life/work experiences, and saif she was shocked that I had gotten the job'*

The panel heard the oral evidence of Colleague A who described in detail the context behind the conversation and describes how they were bathing a child in a wash cot when Mrs Tuffnell made the comments regarding Colleague A's ability to do the job and her qualifications.

The panel noted that whilst there was no independent witness to this incident, there was supporting evidence and the panel found that Colleague A's evidence was consistent, detailed and credible and as such, fits with the overall context of the relationship between Colleague A and Mrs Tuffnell.

The panel also noted that Mrs Tuffnell has not specifically denied saying these words, or words to that effect.

The panel also noted that importance of the charge stating ‘’words to that effect’’ and that the evidence to support this charge spoke to the substance of this and therefore on the balance of probabilities, it found this charge proved in its entirety.

Charge 6)

> On various occasions checked work carried out by Colleague A when there was no need for you to do so as it had already been signed off by others.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A and Colleague A’s grievance letter.

Colleague A stated in her grievance letter:

> *‘When ever* [SIC] *I worked with Jack he always seemed happy with me able to answer my questions, support and teach. Sue would say she wanted to double check everything even if he had signed me off.’*

In Colleague A’s oral evidence, she told the panel that Mrs Tuffnell would often ask her to do things again as she did not see her do them and that other colleagues had told Colleague A that Mrs Tuffnell did not do this with them.

Whilst the panel noted that there was no reference to this by Colleague A in her NMC witness statement, the panel determined that it was similar to conduct proved elsewhere.

The panel found that Colleague A was consistent throughout her evidence and therefore found this charge proved.

Charge 7a and b)

On an unknown date, in response to Colleague A's questions about patient care, responded:

a. '*None of your fucking business*' or words to that effect;
b. '*Just read the care notes*' or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Colleague A's NMC witness statement and Colleague A's grievance letter.

Colleague A stated in her NMC witness statement:

'When I had genuine questions about patient care, she would shut me down and say that it was "none of your fucking business" or "just read the care notes!….'

Colleague A also stated in her grievance letter:

'Several times when I have had a genuine question regarding a childcare/ learning I get a short none of your business answer without establishing any learning at all'

Colleague A told the panel during her oral evidence that there were issues with the care notes that she had identified and gave several examples of times where she was concerned about this, namely an incident where she was concerned about a child's temperature and asked Mrs Tuffnell twice about it as she had identified errors in the care notes.

Colleague A told the panel in oral evidence that Mrs Tuffnell had told her to *"Just read the fucking care plan".*

The panel considered that Colleague A gave a high level of detail in her oral evidence about the incidents and as to why Colleague A was so concerned about being told to just read the care notes, partly because she wanted to learn more and also that she was finding errors in the care notes.

The panel also considered the propensity of the way in which Mrs Tuffnell spoke to Colleague A and deemed Colleague A to be reliable and consistent with her accounts on the use of language from Mrs Tuffnell to her.

The panel therefore found that on the balance of probabilities, Mrs Tuffnell did say words to this effect and found this charge proved in its entirety.

Charge 8)

> On an unknown date said to Colleague A that she was '*keen and a know it all and none of the staff liked*' her, or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Ms Scott's oral evidence and Colleague A's grievance letter.

Colleague A stated in her grievance letter:

> *'At my month review she did it whilst I was checking the grab bag and asked me what I wanted from my career……..She said I had definitely made improvements I had*

settled in, because at first I was keen and a know it all and none of the staff liked me at all. I was completely gutted…'

In Colleague A's oral evidence she told the panel in detail about the incident and the discussion regarding her career progression and her education and skills. Colleague A explained to the panel in detail the effect it had on her and how she was emotional about it even though she did not believe that she was that unpopular.

Ms Scott told the panel in her oral evidence that she was aware of this conversation and that the language used was inappropriate.

The panel considered that Colleague A's account of the incident in her grievance letter was contemporaneous and she was consistent and clear with the details of this in her oral evidence and that it was clear she remembers the details of the conversation and the impact it had on her.

The panel also considered that Ms Scott's evidence corroborated Colleague A's account.

The panel therefore found that on the balance of probabilities, this fact is found proved.

Charge 9)

On an unknown date said to Colleague A in relation to her position within the work place, '*you're at the bottom where you will always be*' or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Colleague A's NMC witness statement and Colleague A's grievance letter.

Colleague A stated in her NMC witness statement:

> *'It felt like she took enjoyment in embarrassing me. There was an occasion where I agreed to watch a colleague's patient whilst they were away and joked, "Does that make me the area manager?". Suzanne said, "No you're at the bottom where you will always be." It didn't feel like banter, it felt pointed.'*

In her grievance letter, Colleague A states:

> *'[…] we were having lunch and someone got up from the table and asked me to keep an eye on their patient, and I joked and said oh I'm now the area manager of the butterwick… and she said no your [SIC] at the bottom where you will always be and I remember Jen looked at me just horrified'*

The panel heard in Colleague A's oral evidence that in relation to this incident, Colleague A was only making a joke which then turned into a nasty comment from Mrs Tuffnell, which another staff member was witness to.

The panel considered that Colleague A's accounts of this incident were consistent and detailed throughout her statements and oral evidence and on the balance of probabilities, found that it was more likely than not that Mrs Tuffnell did say words to that effect.

The panel found this charge proved.

Charge 10)

> On an unknown date you failed to provide adequate supervision when assistance was sought by Colleague A.

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence before it.

The panel first considered that the NMC had not provided any formal documentation on how supervision should be delivered and therefore did not have a clear benchmark of what should have been delivered in practice.

The panel considered that Colleague A stated in her grievance letter:

> *'When ever* [SIC] *I worked with Jack he always seemed happy with me able to answer my questions, support and teach. Sue would say she wanted to double check everything even if he had signed me off.'*

The panel considered that what is stated by Colleague A in her grievance is that Mrs Tuffnell did supervise her, albeit without Colleague A asking and when it had already been signed off by other colleagues. The panel considered that this charge relates specifically to when assistance was sought by Colleague A and that the evidence before it, did not refer to this.

The panel considered that it was unclear as to whether or not the alleged lack of supervision related to patient care, practice or development.

The panel also considered that the specificity of the charge stating "on an unknown date'', suggests a particular incident. However, when Colleague A was questioned in her oral evidence, the panel did not hear a specific example of when assistance was sought by her.

The panel found that there was insufficient evidence to support this charge and the NMC had not discharged its evidential burden.

The panel found this charge not proved.

Charge 11)

In October 2022 you shouted at Colleague A.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Colleague A's grievance letter and Ms Plews' grievance interview.

Colleague A describes an incident which took place in October in her grievance letter:

> *'The first time BW came in October she said that the O2 hadn't been prescribed… I said its better to let nurse take charge. Sue shouted at me to get the care plan checked…'*

In Colleague A's oral evidence she described this incident in detail relating to the oxygen and when asked by Ms Hands if she was shouted at by Mrs Tuffnell, she said *"yes infront of patients and colleagues".*

Ms Plews references an incident whereby she had witnessed Mrs Tuffnell raising her voice and that it was a heated incident between her and Colleague A.

The panel considered that Colleague A had remained consistent throughout her accounts and was able to give an extremely detailed account of the incident in her oral evidence.

The panel considered Ms Plews' evidence which points to another incident whereby Mrs Tuffnell has raised her voice and considered that this may be indicative of the way in which she would speak to Colleague A on occasions.

The panel found that it was more likely than not that this had taken place and found this charge proved.

Charge 12a and b)

On an unknown date in front of other staff members said to Colleague A:

a. '*Are you listening to me? I'm not going to tell you again*' or words to that effect;

b. '*Actually, move round here so I can tell you're listening to me*' or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Colleague A's grievance letter, Colleague A's NMC witness statement and Julie Evans' (Ms Evans) grievance interview. Colleague A stated in her NMC witness statement:

> '*There was an incident where I was caring for providing personal care to a patient and Suzanne shouted at me, "Are you listening to me? I'm not going to tell you again!" I asked her not to speak to me like that and told her that I was capable of looking after the patient whilst listening to her. I was so upset by how she had spoken to me in front of others. I left and said that I would not put up with it.'*

Colleague A stated in her grievance letter:

> *'A child in his chair grabbed my hand and I said morning to him. There was a lot of staff in the room. I was stood next to his chair as there were no seats. She said "are you paying attention" I said yes, other people were still actually talking. What was worse was there were 2 new members of staff that I hadn't even been introduced to yet. The child continued grabbing me so I held his hand. She said are you actually listening I want you to pay attention a mistake has been made now pay attention I don't want anyone teaching this medication bodd [SIC] at all (I don't do meds) I said*

I am listening. She said actually move round here so I can tell your [SIC] listening to me.'

Colleague A explained this incident to the panel in her oral evidence and said that she was 'in floods of tears' as a result.

Ms Evans explains in her grievance interview that she had witnessed this incident and states:

'There was a drug error a day before – ST discovered this. She said to Colleague A come over and listen. There was a patient there and Colleague A was talking to him. ST told Colleague A to listen.'

The panel considered that Colleague A was compelling in her oral evidence and her account remained consistent with those in her contemporaneous statements.

The panel also considered that Ms Evans' account of the incident was corroboration for Colleague A's evidence and it had no reason to believe these events were fabricated.

The panel found this charge proved in its entirety.

Charge 13a and b)

On an unknown date when taking a patient for a walk with Colleague A:

a. Grabbed her hood and aggressively pulled it down over her face;
b. Said to her 'Do your hood up if you're that fucking cold' or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Colleague A's grievance letter and Colleague A's NMC witness statement.

Colleague A states in her NMC witness statement:

> *'On another occasion, we were taking a patient for a walk and I advised that we should wrap them up to keep them warm. Out of nowhere, Suzanne grabbed my hood and aggressively pulled it down over my face and said, "Do your hood up if you're that fucking cold!". I was shocked and embarrassed because others had seen it happen.'*

In Colleague A's oral evidence, she described this incident in detail, including the date, the weather that day and that the staff taking the children out were all wrapped up. During her oral evidence, Colleague A told the panel that Mrs Tuffnell pulled the hood down, the back of her jacket came up and that she nearly went back inside but that the children wouldn't have their walk if she did that, so she stayed.

The panel considered Colleague A's evidence to be very detailed and found her to be a credible witness. The panel found that Colleague A was able to give considerable detail around the incident throughout her statements and her oral evidence and how it had impacted her.

The panel therefore found this charge proved in its entirety.

Charge 14a)

In relation to Colleague A's [PRIVATE]

a. Failed to support her.

This charge is found NOT proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A and Colleague A's NMC witness statement.

Colleague A references her [PRIVATE] in her NMC witness statement:

'[PRIVATE].'

Colleague A describes how she felt unsupported by Mrs Tuffnell [PRIVATE]

The panel considered that the word 'failure' in the charge, implies that there was a duty to do more. However, the NMC did not establish what should have been done in addition. The panel noted that it was the perception of Colleague A that she felt unsupported. However, given the information before the panel, it is not clear what support should have been given and the NMC have not identified what support would have been appropriate. [PRIVATE]

The panel found that there was insufficient evidence to support this charge and found this charge not proved.

Charge 14b and c)

In relation to Colleague A's [PRIVATE]

b. Told staff not to leave her on her own.
c. Pressured her to tell colleagues about [PRIVATE]

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the oral evidence of Colleague A, Colleague A's NMC witness statement and Mrs Tuffnell's response bundle.

Colleague A references these incidents in her NMC witness statement:

"[PRIVATE]"

During Colleague A's oral evidence, in response to panel questions, she said that not being left alone went on for about two weeks and happened when both Jack and Mrs Tuffnell were the nurses on duty. Colleague A told the panel that in the meeting which resulted in her having to tell her colleagues about [PRIVATE] the meeting was between her, Mrs Tuffnell and Ms Evans. Colleague A told the panel that she was pressured by Mrs Tuffnell and Julie Evans to tell her colleagues.

Mrs Tuffnell stated in her registrant response bundle to the NMC:

"This HCA then disclosed to me that [PRIVATE], so I told her we need a risk assessment. This was to ensure her safety as well as the safety of the children and the team. The result of the risk assessment was that this HCA could not be left alone at any time, this was difficult operationally as we were short staffed. From this point the HCA misconstrued my actions which gave rise to the accusation of bullying"

The panel considered the evidence of both Colleague A and Mrs Tuffnell in relation to these incidents and determined that it preferred Colleague A's evidence as it found her to be a credible witness who was consistent with her evidence throughout.

The panel found this charge proved.

Charge 15a and b)

Your conduct at charges 1-14 harassed Colleague A, in that your conduct:

a. Was unwanted
b. Had the purpose or effect of creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague A.

This charge is found proved in respect of Charges 2-9 and 11-13.

In reaching this decision, the panel took into account all of the evidence before it.

The panel referred to the NMC guidance FTP-2a on bullying and harassment when making its decision.

The panel found that the conduct in charges 2-9 and 11-13 was unwanted and had the purpose or effect of creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague A.

Charges 2-6

Colleague A describes a number of incidents and how they made her feel, in her grievance letter:

> *'...I was completely humiliated. The first weekend I worked with her we were bathing a child and she hadn't had any conversations about my history about my life/work experiences, and saif she was shocked that I had gotten the job having not worked in a care home for 2 years she would never have allowed it, yet I had other of my colleagues had been the cleaner with no care experience'*

Colleague A states in her grievance interview:

> *'Ever since I started— I have not had a nice experience. [PRIVATE] LH and SH ensured me that I wasstarting whereas ST didn't know I was starting. Black scrubs was one of the rst issues- it has been relentless. Her attitude she was unwelcoming and is deliberately embarrassing and intimidating me in front of everyone. She has humiliated me.'*

Charge 7

Colleague A states in her NMC witness statement:

> *'During my time at the Hospice, Suzanne would humiliate, undermine and bully me in front of others. There were too many incidents and comments to recall. She was sarcastic and snappy, and she was very critical of everything I did. No one else had an issue with my work, I felt like she was setting me up for failure. When I had genuine questions about patient care, she would shut me down and say that it was "none of your fucking business" or "just read the care notes!". It was as if she thought that I was beneath her.'*

Charge 8

Colleague A states in her grievance letter:

> *'…at first I was keen and a know it all and none of the staff liked me at all. I was completely gutted, I found it so hard to continue that day I felt like I'd been getting on great with everyone except her for weeks and then she said they didn't like me. I felt really isolated.'*

Charge 9

Colleague A states in her NMC witness statement:

> *'It felt like she took enjoyment in embarrassing me. There was an occasion where I agreed to watch a colleague's patient whilst they were away and joked, "Does that make me the area manager?". Suzanne said, "No you're at the bottom where you will always be." It didn't feel like banter, it felt pointed.'*

Colleague A also states in her grievance interview:

'ST putting me down as always'

Charge 11

Colleague A describes an incident which took place in her grievance letter:

'The first time BW came in October she said that the O2 hadn't been prescribed…I said its better to let nurse take charge. Sue shouted at me to get the care plan checked...'

Charge 12

Colleague A stated in her grievance interview:

'she is a bully. I was ready to go home. Everyone was there. Everyone asked how I was I stayed out of her way and started crying'

Charge 13

The panel considered the evidence from this charge for which it found It proved and noted that this incident included more than just verbal attacks but also unwanted and physical contact.

The panel also considered Mrs Tuffnell's registrant response whereby she states:

'[…] was shocked, upset and in total disbelief that my actions had been interpreted as bullying by my colleagues. I am also ashamed that I have been perceived as a bully. I am assertive, as patient safety is my priority but on reflection, I can understand how my management style could be misinterpreted. On reflection I can understand that my colleagues had no other option but to report my behaviour as it was not

acceptable, and no one should have to put up with that at work even though it was not intentional, that is how it was perceived and that was my fault."

In Ms Scott's oral evidence, when asked if Mrs Tuffnell was a bully she stated *"Yes".*

The panel considered all of the evidence it had before it and noted that there is evidence of comments and accounts from a number of health care assistants who gave evidence during the internal inquiry who have described Mrs Tuffnell as a bully.

In considering the evidence given from reliable sources, the panel considered that there was nothing from them to undermine their accounts. The panel found that the evidence paints a picture of how Mrs Tuffnell's communication and unwanted conduct with Colleague A had created an inappropriately hostile and intimidating environment and therefore found this charge proved in relation to charges 2-9 and 11-13.

Charge 16a, b and c)

On various unknown dates:

a. Left the unit unattended for extended periods of time;
b. Failed to tell staff where you were;
c. Were not contactable by staff.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the registrant response bundle of Mrs Tuffnell, the grievance interview of Ms Plews, Ms Eeles and Ms Benton.

Ms Plews states in her grievance interview in response to the question of whether she had witnessed Mrs Tuffnell leaving the unit when she is the only nurse on duty for long periods of time, to which she responds:

'Oh gosh yes'

Ms Eeles states in her grievance interview that Mrs Tuffnell leaves the unit for a period of 10-30 minutes usually and does not inform staff if she leaves.

Ms Benton states in her grievance interview that Mrs Tuffnell never informs staff when she leaves the unit, she does not know where she is going and sometimes she can be ages.

The panel also considered Mrs Tuffnell's response to these claims in her registrant response bundle whereby she states:

> '*Management were aware of this but as they only had two nurses employed with no clinical lead, if I was to take time off then the unit would have closed impacting on the children and families. In hindsight I should have taken time off and this incident would probably never have happened, I would have had time to de stress and sort things out which would have led to a better relationship with colleagues.'*
>
> *'I always let a member of staff know where I was. I was happy with delegating care to the HCA's as they are trained on a par with nurses, and I felt that they were competent to take over the care of the children in my absence. When the Clinical Lead was in post I was not required to do this anymore.'*

The panel considered all the evidence as stated above and found that the evidence to show that Mrs Tuffnell did leave the unit without informing anyone, for a lengthy period of time and were uncontactable, outweighed the evidence of Mrs Tuffnell.

The panel found that there was compelling evidence of concern from a number of people stating that Mrs Tuffnell would often leave without informing anyone and was often uncontactable and therefore found this charge proved.

The hearing was adjourned until 24 August 2026.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Tuffnell was not in attendance and that the Notice of Hearing letter had been sent to Mrs Tuffnell's registered email address by secure email on 2 July 2026.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the time, dates and that the resuming hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Tuffnell's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Tuffnell

The panel next considered whether it should proceed in the absence of Mrs Tuffnell. It had regard to Rule 21 and heard the submissions of Ms Hands who invited the panel to continue in the absence of Mrs Tuffnell. She submitted that Mrs Tuffnell had voluntarily absented herself.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Tuffnell. In reaching this decision, the panel has considered the submissions of Ms Hands and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Tuffnell;
- The NMC have not received any correspondence from Mrs Tuffnell since March 2026
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Tuffnell in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. The panel noted that Mrs Tuffnell was content for the hearing to proceed in her absence on the original hearing date 18 June 2026. Furthermore, the limited disadvantage is the consequence of Mrs Tuffnell's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Application for continued anonymisation of Colleague A

Ms Hands made an application to the panel on behalf of the NMC, for the continued use of the cypher ''Colleague A'' for the complainant, in order to protect her anonymity.

Ms Hands referred the panel to a number of relevant cases.

Ms Hands submitted that as the witness does now not fall within a category of anonymisation as set out by the NMC, it is for the panel to exercise its discretion to grant legal anonymity.

Ms Hands submitted that the panel should consider whether it is strictly necessary in the interest of justice to derogate from principles of open justice, in applying a cypher to the name of the complainant, who was also a witness in the case. Ms Hands submitted that it is strictly necessary and that an order which would withhold the witnesses name from the panel's determination, which would become a public document, would be proportionate in protecting her privacy.

Ms Hands submitted that the information included in the determination includes references to Colleague A's [PRIVATE] bullying and harassment towards Colleague A and Colleague A's personal [PRIVATE] circumstances.

Ms Hands also submitted that up to this point Colleague A has provided evidence on the basis that she would remain anonymous and therefore there is a reasonable expectation that she would remain as such.

Decision and reasons on anonymisation

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

The panel were reminded that there is a presumption of open justice in these proceedings.

The panel noted that this application was borne out of a change in NMC policy, regarding the anonymisation of witnesses post 13 April 2026. However, there is currently no written guidance from the NMC on this point.

The panel therefore, carefully considered the case of *PMC v A Local Health Board* [2025] EWHC 1126 and noted that a withholding order was granted in those proceedings based on a witness satisfying the following criteria;

- Extreme vulnerability
- Severity of the case as a whole
- Serious infringement on private life

The panel considered that in Colleague A's evidence, she disclosed personal and painful matters, including her experience of bullying and harassment in the workplace and her distress of having to disclose an aspect of her [PRIVATE] to colleagues. The panel also noted that whilst giving evidence, Colleague A disclosed information about [PRIVATE].

The panel was also mindful of the fact that Colleague A had been assured throughout these proceedings that she would be anonymised, and that when she gave evidence she was referred to as Colleague A. The panel considered the effect that this might have had on her willingness to be open, or even engage with these proceedings, should she have been told she would not be anonymised to begin with.

The panel determined that Colleague A satisfied all three criteria in the case referred to above. The panel also considered that publishing her name after she had been assured by the NMC that this would not happen, could have an adverse effect on confidence in the regulator.

The panel noted that the NMC's application was not for a reporting restriction, but for Colleague A's continued use of her cypher. The panel was of the view that there was sufficient information within the determination for the public to identify why regulatory steps had been taken against Mrs Tuffnell and that there was no overriding public interest which should compel the identification of Colleague A. The panel concluded therefore, that it was interests of justice to retain Colleague A's anonymity to protect her interests.

The panel's recommendation to the NMC is that Colleague A retain her cypher and retain her anonymity in these proceedings.

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 Mrs Tuffnell's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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, Mrs Tuffnell's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Ms Hands 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 Hands identified the specific, relevant standards where in her submission, Mrs Tuffnell's actions amounted to misconduct. Ms Hands submitted that the following parts of the Code had been breached and amounted to misconduct:

8 Work co-operatively
To achieve this, you must:
8.2 maintain effective communication with colleagues
8.7 be supportive of colleagues who are encountering [PRIVATE] or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues
To achieve this, you must:
9.1 provide honest, accurate and constructive feedback to colleagues
9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

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

To achieve this, you must:
11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

Ms Hands referred the panel to the relevant areas in the evidence which demonstrated the misconduct and submitted that there is cogent evidence upon which the panel can find that Mrs Tuffnell's conduct amounted to serious professional misconduct.

Submissions on impairment

Ms Hands 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Hands invited the panel to find that the first three limbs of Grant were engaged, that is:

- She has in the past acted and is liable in the future to act so as to put patient or patients at unwarranted risk of harm.
- She has in the past bought and is liable in the future to bring the nursing

profession into disrepute.

- and has in the past committed a breach of one of the fundamental tenants of the profession and or is liable to do so in future

Ms Hands referred the panel to the case of Cohen and the General Medical Council.

Ms Hands submitted that in relation to public safety, the panel should take into account that there was repeated bullying and harassment of Colleague A, over a period of six months and that this created an environment in which junior colleagues felt unable to challenge or question Mrs Tuffnell's decisions.

Ms Hands submitted that Mrs Tuffnell leaving the ward without a qualified nurse and without leaving a means of contacting her, places patients at risk of harm as they might not get the care and treatment they need in a timely way.

Ms Hands referred the panel to Mrs Tuffnell's documentary evidence and submitted that the evidence before the panel points to denial and a lack of accountability from Mrs Tuffnell. Ms Hands referred the panel to her failure to correct her behaviours or conduct when warned and a lack of accountability for her actions, which Ms Hands submitted, increases the likelihood of this behaviour being repeated. Additionally, Ms Hands submitted that there has been limited insight shown by Mrs Tuffnell on how to act differently in future.

Ms Hands submitted that the NMC invites the panel to find that Mrs Tuffnell's conduct does demonstrate a deep-seated attitudinal issue, which refers to an ingrained mindset or belief system that is contrary to the values and behaviours that underpin the NMC code.

Ms Hands submitted that across the evidence before the panel, Mrs Tufnell has demonstrated very limited insight into the impact of her conduct on her colleagues and potential impact on patients.

Ms Hands also submitted that Mrs Tuffnell has not practised as a nurse in a similar field, which means that there is no evidence of current safe clinical practice.

Ms Hands submitted that the panel could therefore be satisfied in this case that Mrs Tuffnell is impaired on all three grounds of public safety, public confidence and professional standards.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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 Mrs Tuffnell's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Tuffnell's 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

The panel recognised that 1.1 was a section relating specifically to patients. However, treating people with kindness and compassion are values that the panel would expect of all nurses, especially in a senior leadership role, as Mrs Tuffnell was.

> **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
8.4 work with colleagues to evaluate the quality of your work and that of the team
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk
8.7 be supportive of colleagues who are encountering [PRIVATE] or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:
9.1 provide honest, accurate and constructive feedback to colleagues
9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance
9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times
9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.5 treat people in a way that does not……cause them upset or distress
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that in relation to the charges found proved 1-9, 11-3 and 15, as these charges related to bullying and harassing behaviour, these amounted to misconduct.

In relation to Charge 14, the panel acknowledges that it was unfortunate that Colleague A was pressured into telling colleagues about her condition and that staff were told not to leave her on her own. The panel understands that this may have been distressing for Colleague A. However, it noted that there were other senior colleagues at that meeting and that Mrs Tuffnell had not been aware that Colleague A [PRIVATE] and that she had a legitimate concern about safety. On that basis, while the panel accepted it was handled badly, it found that this does not reach the threshold of serious professional conduct.
In relation to Charge 16, the panel noted that on multiple occasions, Mrs Tuffnell left unqualified staff on duty which left the clinical area at risk. The panel acknowledged that the hospice should have ensured adequate staffing levels to allow for reasonable staff breaks, but this did not excuse Mrs Tuffnell's actions in repeatedly leaving the unit without telling colleagues that she was doing so and without leaving any means of contacting her in an emergency. Ultimately Mrs Tuffnell had a responsibility to ensure staff were supported and patient safety was maintained at all times. The panel found Mrs Tuffnell's actions were serious and likely to be considered deplorable by fellow practitioners.

The panel found that Mrs Tuffnell's actions 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, Mrs Tuffnell's 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:28/01/2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

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

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

d) *……'*

The panel was satisfied that limbs a, b and c of the *Grant* test were engaged.

The panel found that patients were put at risk and could have been caused physical and emotional harm as a result of Mrs Tuffnell's misconduct. The panel considered that in Mrs Tuffnell leaving the unit unattended for long periods of time without informing anyone, was putting patients at a real risk of harm. The panel considered that the vulnerable children receiving care from Mrs Tuffnell could have been caused distress by being witness to Mrs Tuffnell shouting and swearing at colleagues. The panel also considered that Mrs Tuffnell had created an environment where the concerns of staff relating to patients were dismissed, again causing potential harm to patients. The panel determined that Mrs Tuffnell's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mrs Tuffnell has taken steps to strengthen her practice. The panel considered that it had no evidence before it to show that Mrs Tuffnell has fully reflected on the impact of her conduct and that there is no evidence that she has remediated in any meaningful way. The panel considered the online training courses which were carried out by Mrs Tuffnell. However, it had no evidence before it to show that Mrs Tuffnell had put this into practice in a nursing capacity.

The panel considered that Mrs Tuffnell has shown a continuing misunderstanding that her conduct was unacceptable, in her reflection claiming that colleagues had misinterpreted her actions. It found little evidence of any meaningful remorse. The panel noted that Mrs Tuffnell was warned about her behaviour, both during the internal grievance procedure and investigation, but her bullying behaviour continued. The panel considered that this suggests a deep-seated attitudinal issue and therefore there was a real risk of repetition.

The panel therefore determined that a finding of impairment is necessary on the grounds of public protection as Mrs Tuffnell's misconduct was found to have put patients at a risk of harm and that there was a real risk of repetition due to the deep-seated attitudinal concerns suggested.
The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is also required because public confidence in the profession would be undermined if a finding of impairment were not made in this case. It considered that an informed member of the public would be concerned to learn of the events that took place on the unit and the risk that Mrs Tuffnell's actions posed to staff well-being and the safety of vulnerable children.

Therefore, the panel also found Mrs Tuffnell's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had 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 Hands outlined the aggravating and mitigating factors in this case.

Ms Hands referred the panel to the NMC guidance: Available sanction order (Reference: SAN-3) and went through each sanction in turn.

Ms Hands submitted that for the reasons outlined by the panel, Mrs Tuffnell's conduct does raise fundamental questions about her professionals and that public confidence in the profession could not be maintained by the imposition of any sanction other than removal from the register.

Ms Hands submitted that a sanction which protects the public from these concerns demonstrates the unacceptability of such conduct and would maintain public confidence in the profession in this case.

Ms Hands submitted that there is no amount of insight or reflection in this case which could keep people receiving care and members of the public safe, maintain public confidence in the profession and uphold professional standards.

Ms Hands submitted that there is no realistic prospect that Mrs Tuffnell will be able to demonstrate insight and strengthen practise should the panel impose a period of suspension and therefore, given all the circumstances, the panel is invited to impose a striking off order as a practical and appropriate sanction.

Decision and reasons on sanction

Having found Mrs Tuffnell's 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:

- Her conduct put vulnerable children at risk of harm
- She has shown little insight or remediation
- A pattern of misconduct over a period of time, continuing despite being brought to her attention twice
- She was a senior, experienced nurse with leadership responsibilities

The panel also took into account the mitigating features:

- Evidence of attendance at a relevant training course on bullying and harassment in the work place
- Four positive testimonials expressing appreciation of her work
- The panel noted Mrs Tuffnell's account that she had a stressful period at work, that she had been dealing with [PRIVATE] and had suffered a recent bereavement. The panel decided to apply limited weight to this as there was an absence of corroborating material or supporting evidence.

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 Mrs Tuffnell's 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 Mrs Tuffnell's 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 to place a conditions of practice on Mrs Tuffnell's registration. In considering whether conditions of practice are appropriate, the panel had

regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). Having found that the concerns relating to Mrs Tuffnell's practice were attitudinal, the fact she has indicated she is not currently working and does not intend to return to nursing and lack of engagement, the panel determined that a conditions of practice order would not be appropriate in the circumstances. The panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*

- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

Whilst the panel acknowledged that the risks identified could be managed by Mrs Tuffnell being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved. Given Mrs Tuffnell's lack of engagement, limited evidence of insight or remorse and absence of any recent training and development, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely. The panel also noted that Mrs Tuffnell has indicated that she does not intend to return to nursing practice.

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

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). [set out panels reasons] Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'*.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*

- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel found that the charges found proved raise serious concerns about Mrs Tuffnell's professionalism and that due to a lack of insight and remorse, there is a high risk of repetition.

The panel found that public confidence in the profession would be undermined, should she remain on the register, due to the nature of the conduct relating to creating an unsafe environment for patients.

The panel considered that Mrs Tuffnell had shown no meaningful insight or remediation and that the concerns were deep seated attitudinal.

The panel also considered that there was no realistic prospect that after suspension, Mrs Tuffnell's practice would improve, as she has also indicated she is not currently practising and does not intend to return to do so.

Mrs Tuffnell's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mrs Tuffnell's actions were serious and to allow her to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Tuffnell's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

Interim order

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

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

Submissions on interim order

The panel took account of the submissions made by Ms Hands. She submitted that a suspension order of 18 months is the appropriate order to protect the public during the appeal period of 28 days.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the

facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.

This will be confirmed to Mrs Tuffnell in writing.