Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
17 – 21 August 2026

Virtual Hearing

Name of Registrant:	**Johanne Louise Walker**
NMC PIN:	93C0319E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 7 June 1996
Relevant Location:	Hartlepool
Type of case:	Misconduct
Panel members:	George Duff (Chair, Lay member) Donna Green (Registrant member) Jane Malcolm (Lay member)
Legal Assessor:	Juliet Gibbon
Hearings Coordinator:	Jumu Ahmed
Nursing and Midwifery Council:	Represented by Alice Hands, Case Presenter
Miss Walker:	Not present and not represented
Facts proved:	Charges 1, 2
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Walker was not in attendance and that the Notice of Hearing letter had been sent to Miss Walker's registered email address by secure email on 16 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 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 Miss Walker's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Miss Walker

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

Ms Hands referred the panel to the email correspondence between Miss Walker and the NMC in June 2026 and Miss Walker's email dated 14 August 2026 which stated:

> *'Yes you have the correct details but I will not be attending* […]*'*

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

- No application for an adjournment has been made by Miss Walker;
- Miss Walker email in August 2026 indicates that she had received the Notice of Hearing;
- Miss Walker stated that she would not be attending her hearing and that she was content for the panel to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- One witness has attended today to give live evidence;
- Not proceeding may inconvenience the witness, their employer and, if they are involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2022;

- Further delay may have an adverse effect on the ability of the witness to accurately recall the events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Walker 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 has made no response to the allegations. 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 by the registrant and, of its own volition, the panel can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Walker'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 Miss Walker. The panel will draw no adverse inference from Miss Walker's absence in its findings of fact.

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

Ms Hands made an application for this case to be held partly in private on the basis that proper exploration of Miss Walker's case involved reference to [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

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

Having heard that there will be reference to Miss Walker's [PRIVATE], the panel determined to hold the hearing partly in private as and when such issues are raised.

Details of charge

That you, a registered nurse:

1. On 2 May 2022, moved Resident A along a corridor to their room using a sling and hoist, rather than a wheelchair.

2. Undertook the actions in Charge 1 because you "*weren't going to be spat at"*.

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

Background

A referral was made by HC-One (the employer) on 7 July 2022. The charges arose whilst Mrs Walker was employed as a registered nurse at Brierton Lodge Care Home ('the Care Home').

On 2 May 2022, Sarah Thorpe, a Nursing Assistant, and Lisa Mann, Care Assistant, observed Miss Walker transferring Resident A from the lounge to his bedroom on a hoist by herself. This was a failure to follow Resident A's care plan, breached his dignity and local policies. In the local interview notes, the witnesses reported that Miss Walker said she had moved the patient in a toileting sling so that she did not get 'bashed', 'hit' or 'spat on' by the resident. In the local investigation, Miss Walker acknowledged that what she had done was wrong.

HC-one undertook a local fact finding investigation, and a disciplinary hearing was held on 21 June 2022 and Miss Walker was dismissed on the same day.

Decision and reasons on application to admit 'Investigation Report' dated 6 June 2022 as hearsay evidence

Ms Hands made an application under Rule 31 to allow Tracey Normanton's (Ms Normanton) investigation report dated 6 June 2022 into evidence. The investigation report included Sarah Thorpe's (Ms Thorpe), a Nursing Assistant, interview minutes dated 23 May 2022 and 6 June 2022. The investigation report also included Lisa Mann's (Ms Mann), Care Assistant, investigation minutes dated 13 May 2022 and 6 June 2022. Neither Ms Thorpe or Ms Mann made NMC witness statements and were not being called to give oral evidence to the panel.

Ms Hands referred the panel to the cases of *Ogbonna v Nursing and Midwifery Council* [2010] EWHC 272 (Admin), *Karout v Nursing and Midwifery Council* [2019] EWHC 28, *Bonhoeffer v General Medical Council* [2011] EWHC 1585 (Admin), *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), and *Horncastle v United Kingdom* [2015] 60 E.H.R.R 31.

Ms Hands submitted that Ms Thorpe and Ms Mann were direct witnesses to charge 1 and provided their accounts of the incident. She said that Ms Normanton, the Deputy Manager of the Home, undertook the internal investigation including the interviews with Ms Thorpe and Ms Mann, and will be giving live evidence, and therefore it was not sole and decisive evidence. She submitted that the evidence was given at the time of the incidents and there was no suggestion that they had fabricated their evidence.

Ms Hands submitted that Miss Walker had received the investigation report and did not challenge it or object to it, that she had chosen not to participate in the hearing and had therefore waived her right to challenge the evidence.

Ms Hands therefore submitted that it would be fair to admit the investigation report dated 6 June 2022 into evidence as 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.

In reaching its decision, the panel considered all the evidence before it, submissions from Ms Hands and the legal advice. In particular, the panel had regard to the seven principles derived from *Thorneycroft*. These are:

- Whether the statement is the sole and decisive evidence in support of the charges;
- The nature and extent of the challenge to the contents of the statement;
- Whether there was any suggestion that the witness had reason to fabricate their allegation;
- The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;
- Whether there was a good reason for the non-attendance of the witnesses;
- Whether the regulator had taken reasonable steps to secure the witness' attendance;
- Whether the registrant did not have prior notice that the witness statements would be read.

The panel bore in mind that Rule 31 provides that evidence may be admissible provided it is both relevant and fair to do so. In considering relevance, the panel considered that the interview minutes notes and investigation/hearing notes for both Ms Thorpe and Ms Mann,

as applied for, directly relate to the charges. The panel was therefore satisfied that the evidence is relevant.

In considering fairness, the panel considered each of the *Thorneycroft* principles above in turn.

The panel considered that the evidence of Ms Thorpe and Ms Mann contained in the investigation report is not the sole and decisive evidence in support of the charges. The panel considered that the charges are also otherwise supported by the evidence from Ms Normanton and the investigation report will be exhibited as part of her evidence. The panel bore in mind that Ms Normanton is scheduled to attend and give live evidence to this hearing, and her evidence can be challenged by the panel. The panel noted that Miss Walker had made admissions to charge 1 during her interviews with Ms Normanton as part of the local investigation.

The panel noted that Miss Walker has been provided with the investigation report and witness statements and has not challenged the contents of it at any time. Furthermore, Miss Walker had not attended her hearing and therefore had waived her right to cross examine Ms Normanton on the content of the investigation report.

The panel next considered whether there is any suggestion that either Ms Thorpe or Ms Mann had reason to fabricate their evidence. There was no evidence before the panel to suggest that either witness had any reason to fabricate their evidence given during the local investigation.

The panel considered that the charges are serious, and that an adverse finding would have a significant impact on Miss Walker's nursing career. However, the panel noted that any inconsistencies or challenges to the hearsay evidence could be explored by the panel in Miss Walker's absence.

The panel noted that the NMC had not provided any reason as to why Ms Thorpe or Ms Mann had not provided NMC witness statements or been called to give evidence. Consequently, it was unable to ascertain whether there is a good reason for their non-attendance. The panel further considered that there is no information before it as to the extent of the NMC's efforts to secure them as witnesses.

Further, the panel had not been informed whether Miss Walker had prior knowledge of the hearsay application but she was aware of the content of the investigation report.

The panel was satisfied that the hearing notes and interview minutes contained in the investigation report were made close to the date of the alleged incident as the interviews took place in May and June 2022.

Bearing all the above in mind, the panel considered that admitting the hearsay evidence contained in the investigation report would not prejudice the fairness of this hearing. The panel determined that the weight it would attribute to the hearsay evidence will be determined in its decision-making on facts.

The panel therefore accepted Ms Hands' hearsay application, and decided to admit the investigation report dated 6 June 2022 into evidence.

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 Miss Walker.

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 witness called on behalf of the NMC:

- Tracy Normanton (now Walker): Deputy Home Manager at the Care Home.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1

1. On 2 May 2022, moved Resident A along a corridor to their room using a sling and hoist, rather than a wheelchair.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and live evidence of Ms Normanton.

The panel had regard to Ms Normanton's investigation report dated 6 June 2022, which stated:

> '*4 – interviews and Witness Statements*
> *Interview/Statement 1 – Lisa Mann Care Assistant/ 13/05/2022*

- *Lisa stated that she witnessed Johanne Walker using the hoist in the lounge by herself from the corridor*
- *Lisa stated that she ran up the corridor to the lounge to assist.*
- *Lisa stated she offered help and pulled a wheelchair open to lower Resident A.*
- *Lisa stated that Johanne Walker said "I am not using that"*
- *Lisa stated that Johanne pushed Resident A to his bedroom in the hoist.*

  […]
- *Lisa stated that Resident A was in a toileting sling*

Second Interview with Lisa Mann – 06/06/2022

- *Lisa stated that she saw JW hoisting Resident A alone in the lounge from the corridor*
- […]
- *Lisa stated she ran to help*
- […]
- *Lisa stated JW did not use the wheelchair and pushed the hoist towards the door with Resident A in it*
- […]
- *Lisa stated she knew it was wrong but did not say anything as JW is in a higher position*
- *Lisa stated JW took Resident A to his room*
- *Lisa stated she did not assist in putting the sling on'*

'*Interview/Statement 1 – Sarah Thorpe Nursing Assistant23/05/2022*

- *Sarah stated that* […] *she heard shouting.*
- *Sarah walked to the lounge where the shouting was coming from and witnessed Johanne Walker pushing the hoist with Resident A in it out of the lounge*
- […]
- *Sarah state that she said to Johanne "you are not pushing him in that are you?"*

- *Sarah stated that Johanne replied "I am making a clinical judgement, I am not getting hit or spat at by him"*
- *Sarah stated that Johanne pushed the hoist with Resident A in it to his bedroom* […]

Second interview with Sarah Thorpe – 06/06/2022

- *Sarah stated she went upstairs for a signature and heard Resident A shouting from the lounge*
- *Sarah stated that she saw JW pushing the hoist out of the lounge with Resident A in it*
- *Sarah stated that she said you are not pushing him along in that are you*
- *Sarah stated that JW replied I am, and something along the lines I am making a clinical judgement*
- *Sarah stated JW pushed him to his room in the hoist and put him on his bed*
- *Sarah stated LM was walking along with a wheelchair*
- *Sarah stated she went back upstairs later and JW stated I am sure you would have done that* […]
- *Sarah stated she cannot remember if Resident A was shouting.'*

The panel also had regard to the 'interview / statement 3 with Johanne Walker RGN/ 24/05/2022':

- *Johanne stated that Resident A was in the tv lounge, And she put a sling on him on her own as he needed to go to his bedroom*
- *Johanne stated that Lisa brought a wheelchair and that she put Resident A in the wheelchair.*
- *Johanne stated that Resident A was pushing himself out of his chair so* [s]*he hoisted him back up*
- *Johanne stated she pushed the hoist with Resident A in it to his bedroom.*
- *Johanne stated the wheelchair did not have a lapstrap and she could not do a best interest decision to fasten a lapstrap.*

- *Johanne stated that she would not do this normally, but believes it was the safest option.*
- *Johanne stated she considered leaving Resident A in the lounge but thought his bed was the safest option*
- *Johanne stated she chose the safest option and would do this again*

Second interview with Johanne Walker – 26th May 2022

- *JW stated she put the sling on on her own whilst waiting for the next person*
- [J]*W stated she did not hoist him up she waited for the second person and Resident A was co-operative*
- *JW stated she can't remember who the second person was but thinks it was Lisa*
- *JW stated Resident A had to go to his room to be checked and that he gave verbal consent*
- *JW stated she tried to put him in a wheelchair but he was hyperextending and she felt he was not safe*
- *JW stated in hindsight she could have put him in a wheelchair but felt he would put himself on the floor so she did not try it*
- *JW stated did hoist him from lounge to bedroom as felt safest option but knows against moving and handling*
- *JW stated she would have used a wheelchair with another resident.'*

The panel had regard to Ms Normanton's summary in the investigation report, which stated:

'[…] *I have reviewed Resident A's safer peoples handling plan with states Resident A transfers by hoist with a toileting sling and two staff into a wheelchair. The plan also states that Resident A can become aggressive and that he requires reassurance and a calm approach.'*

The panel noted from Ms Normanton's witness statement:

‘4. On 3 May 2022, it was reported that Johanne had incorrectly moved and transferred one of our residents.

5. It was reported that Johanne had refused to put the resident into a wheelchair to move him to his room, but instead had single-handedly put him into a toileting sling and hoisted him then moved him up the corridor in the hoist.

6. The resident was vulnerable as he was immobile. For any movements, he needed to be transferred in a hoist with 2 members of staff, for example from a chair to his wheelchair, or bed to wheelchair and vice versa. He also had dementia and could become aggressive if he didn’t understand what was being asked.

[…]

9. The procedure for putting a resident into a sling and hosting them is that there must always be 2 members of staff and you hoist to the lowest place you can, so no one swings in the air. You then place them straight into a wheelchair, bed, chair, or next available option. You must also ensure you are using the correct sling.

[…]

15. When I interviewed Johanne, she admitted what she had done straight away, but also said she would do it again […]’

The panel was of the view that Ms Normanton’s evidence was consistent throughout her documentary evidence and her live evidence. The panel took into account Ms Thorpe’s and Ms Mann’s evidence, albeit it was hearsay, and the panel noted that the evidence was taken close to the date of the incident.

The panel took into account that Miss Walker made admissions in the local interviews and disciplinary hearing to moving Resident A along the corridor to his room using a sling and hoist, rather than a wheelchair, and acknowledged that this was wrong.

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

Charge 2

2. Undertook the actions in Charge 1 because you "*weren't going to be spat at"*.

This charge is found proved.

In reaching this decision, the panel took into account the documentary and live evidence of Ms Normanton. It also had regard to the investigation report dated 6 June 2022.

The panel had regard to Ms Normanton's investigation report dated 6 June 2022, which stated:

> '*4 – interviews and Witness Statements*
> *Interview/Statement 1 – Lisa Mann Care Assistant/ 13/05/2022*
>
> […]

- *Lisa stated that another staff member questioned why Johanne was pushing the hoist and that Johanne replied that she was "doing it, as I am not getting hit off him again"*

Second Interview with Lisa Mann – 06/06/2022

- *Lisa stated that she saw JW hoisting Resident A alone in the lounge from the corridor*
- […]

- *Lisa stated that she got a wheelchair and JW said I am not using that, I am not getting bashed, or words to that effect*
- […]
- *Lisa stated ST* [Sarah Thorpe] *questioned what JW was doing and JW had replied I am not getting bashed*
- […]
- *Lisa stated JW took Resident A to his room*
- […]*'*

'*Interview/Statement 1 – Sarah Thorpe Nursing Assistant 23/05/2022*

- *Sarah stated that* […] *she heard shouting.*
- *Sarah walked to the lounge where the shouting was coming from and witnessed Johanne Walker pushing the hoist with Resident A in it out of the lounge*
- […]
- *Sarah state that she said to Johanne "you are not pushing him in that are you?"*
- *Sarah stated that Johanne replied "I am making a clinical judgement, I am not getting hit or spat at by him"*
- *Sarah stated that Johanne pushed the hoist with Resident A in it to his bedroom.*
- *Sarah stated that she returned to* […] *later and Johanne stated to her "I know I am not meant to do that but I am not getting hit or spat at by him. I am sure you would have done it"*
- […]

The panel noted Ms Normanton's witness statement:

'17. I believe what happened was prior to Johanne moving the resident, Johanne had given him medication, which he spat at her, and for this reason she took him out of the lounge to his bedroom. It came across as if she did this as sort of a punishment, as he had spat at her.

18. However, if the resident was being aggressive, then Johanne shouldn't have tried to move him and should have gone back later when he was calm or she should have asked the care assistants to help her.'

The panel noted there was no documentary evidence before it to support Ms Normanton's view that Miss Walker's actions had been done to punish Resident A for spitting a tablet at her.

In her oral evidence, Ms Normanton explained that Miss Walker had mentioned spitting in her interviews with her, but Ms Normanton could give no reason for why that was not recorded in the interview notes. She also said that Miss Walker had talked about spitting when Ms Normanton met with her to tell her she was being suspended. Ms Normanton went onto say that it was paracetamol that Resident A had spat out. However, there was no available record of that meeting.

The panel noted Ms Thorpe's first interview, on 25 May 2022, in which she stated that Miss Walker said that she had hoisted Resident A because she did not want to get spat at on two occasions, one as she was moving Resident A and then after the incident. However, in her second interview, she did not refer to Miss Walker saying this. In Ms Mann's interview, the panel noted that she said Miss Walker used the words 'hit' and 'bashed' during the incident itself.

The panel, however, also noted, the Colleague Meeting Minutes of Miss Walker's disciplinary interview with Carole Thomson on 21 June 2022. In that meeting it was put to Miss Walker that another member of staff had heard her say "I'm not doing it as I don't want to get spat at again". She had responded *"Again, I can't remember if I said that or not but if that's what the other staff have said happened. I do understand what I did was one hundred percent wrong".*

The panel did not have any other contemporaneous evidence to support this charge. The panel also noted that Miss Walker did not provide any consistent explanation as to why she had hoisted Resident A to his room rather than using a wheelchair.

The panel heard from Ms Normanton's live evidence that Resident A was vulnerable, he had dementia, was largely immobile and needed the assistance of two people for transfers. He would regularly spit, nip, scratch and hit members of staff when he was anxious or unsure. The panel heard from Ms Normanton that the resident had spat out his medication at Miss Walker before the incident occurred. When asked how to deal with this behaviour she stated that it was best to 'stand to one side and leave the resident until he calmed down or ask another member of staff to help'. The panel found Ms Normanton's evidence credible.

Therefore, the panel was satisfied that Miss Walker moved Resident A along a corridor to his room using a sling and hoist, rather than a wheelchair because she did not want Resident A to spit at her or, in the terms of the perhaps clumsily written charge, because she "weren't going to be spat at".

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

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Walker'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, Miss Walker's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Hands told the panel that it was clear from Ms Normanton's evidence that Resident A should have been left in his chair and that Miss Walker should have revisited him when he was in a better mood and with another staff member to support her in moving the resident to his room. Ms Hands submitted that Resident A was particularly vulnerable as he was diagnosed with dementia and was easily confused and immobile, and that this was reflected in his care plan. She told the panel that Ms Normanton, during her evidence, identified a number of risks arising from Miss Walker's actions:

- that the hoist could have tipped over whilst Miss Walker was pushing it down the corridor, as Resident A would have been swinging and unstable, which could have had fatal consequences;
- that the manoeuvre could have caused Resident A extra distress, in addition to compromising his dignity; and
- that it is difficult to push a hoist like this for any distance, such that anything could have happened.

Ms Hands submitted that Miss Walker was up to date with relevant training, including on safer people handling, transporting residents safely, and wheelchair clamp use. She therefore submitted that Miss Walker was aware of the risks, and of how she could and should have provided safe care to Resident A in these circumstances.

Ms Hands told the panel that the NMC Code sets out the values and behaviours expected of all registered professionals, that it represents the fundamental tenets of the profession and the core principles that underpin safe, effective and compassionate care. She submitted that the following parts of the Code are relevant to this case:

- treat people with kindness, respect and compassion;
- work with colleagues to preserve the safety of those receiving care;
- take measures to reduce, as far as possible, the likelihood of mistakes, near misses, harm, and the effect of harm if it takes place;
- treat people in a way that does not take advantage of their vulnerability, or cause them upset or distress; and
- identify priorities and manage time, staff and resources effectively, dealing with risk so that the quality of care delivered is maintained and improved, putting the needs of those receiving care first.

Ms Hands submitted that, in this regard, it is relevant that Miss Walker was the lead nurse on shift on 2 May 2022, and that Ms Mann, during an internal interview, said: *"I didn't dare say anything, as she is higher."* She submitted that this suggests a hierarchy fostered by Miss Walker on the ward, which had the potential to put patient safety at risk.

Furthermore, Ms Hands submitted that other staff were available to help Miss Walker move Resident A, but that she did not seek the support. She therefore submitted that Miss Walker's conduct in relation to Resident A, and her reasons for acting as she did, amount to a breach of the NMC Code.

Ms Hands invited the panel to take into account two contextual factors when deciding whether the facts found proved amounted to serious misconduct: staff shortages and Miss Walker’s [PRIVATE].

In relation to staff shortages, Ms Hands submitted that, during the disciplinary meetings on 17 and 21 June, Miss Walker referred to staff shortages on the day of the incident which was the first time she had raised this issue. However, Ms Normanton, in her oral evidence, said that she was not aware of any staff shortages that day. She referred the panel to the evidence of Ms Mann and Ms Thorpe, who stated that that they were ready, willing and able to assist Miss Walker in moving Resident A safely, had she allowed them to do so.

[PRIVATE].

In any event, Ms Hands submitted that this cannot justify her actions and nor does it absolve her of her responsibilities under the Code.

Ms Hands, therefore, invited the panel to find that Miss Walker's conduct amounted to serious and 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Hands submitted that limbs a, b and c of the Grant test have been met, in that Miss Walker's conduct has in the past put Resident A at unwarranted risk of harm, has in the past brought the nursing profession into disrepute and has breached the fundamental tenets of the nursing profession. She submitted that Resident A was vulnerable, both physically and mentally. He had a care plan for mobilisation, which Miss Walker herself had prepared and was therefore aware of, and which should have been followed. Ms

Hands submitted that there would be a future risk of harm to patients or residents if these concerns were not addressed and were to be repeated.

Ms Hands further submitted that Ms Walker's conduct demonstrated a deep-seated attitudinal issue. She said that the NMC's guidance states that deep-seated attitudinal issues are resistant to change, and that they pose risks to the safety and wellbeing of people receiving care, to public confidence in the profession, and to professional standards generally. She submitted that, although this was a single incident, the guidance makes clear that behaviour contrary to the values in the Code may reflect more than a single lapse in judgement. She further submitted that Miss Walker was challenged on her method of moving Resident A by Ms Thorpe but she had proceeded regardless, and did not seek advice or guidance from another registered nurse on duty.

Regarding Miss Walker's insight and any steps she has taken to remediate the concerns, Ms Hands submitted that she has not engaged with the fitness to practise process, and has provided no reflection or insight to the NMC. Therefore, she said that the panel will need to consider the internal investigation and disciplinary interview notes.

Ms Hands said that it could be argued that, during the disciplinary interviews, Miss Walker took some accountability for the way she moved Resident A. However, the NMC invites the panel to find that she demonstrated only limited accountability, insight and remorse — for example, she provided multiple, differing explanations across the four internal interviews as to her reasons for moving Resident A in this way.

Ms Hands submitted that Miss Walker is therefore likely to be liable in the future to act in a way that puts a patient or patients at unwarranted risk of harm, to bring the profession into disrepute, and/or to breach one or more of the fundamental tenets of the profession. For these reasons, she submitted that the combination of a deep-seated attitudinal issue and a lack of insight and accountability presents a serious future risk to the health, safety and wellbeing of the public.

In addition, Ms Hands submitted that, in the absence of any evidence of insight, training or supervision undertaken by Miss Walker, the conduct could not be easily remediable.

Ms Hands said that, during Miss Walker's local investigation interview on 26 May, she accepted that, in hindsight, she could have used a wheelchair. She said that, in a situation where Resident A was hyperextending and there was no lap strap available, she would not have been able to ensure his safety. However, Ms Normanton's evidence was that these explanations were not reasonable: a lap strap was irrelevant, as no one with dementia should be moved in a wheelchair using one, since the risk of strangulation from a resident not understanding what was happening was too high. Ms Hands said that, during Miss Walker's disciplinary interviews, she did accept that what she did was wrong, and said that she would not do it again.

Ms Hands submitted that Miss Walker has not engaged with the NMC investigation or this hearing and therefore the panel has no evidence before it to be assured that Miss Walker has insight into, or has reflected on, the incident, or that she has taken any action to strengthen her practice or undertaken any relevant training. Ms Hands submitted that Miss Walker has told the NMC on several occasions that she has left nursing with no intention of returning, which makes it less likely that the concerns have been remedied.

As to whether it is highly unlikely that the conduct will be repeated, Ms Hands submitted that, given the complete lack of insight and engagement from Miss Walker, there is currently no prospect of remediation, particularly given her stated intention not to return to practice. The panel cannot therefore be assured that the concerns have been fully addressed, or that repetition of the conduct is highly unlikely. She therefore invited the panel to make a finding of impairment to protect public safety, and/or to uphold proper professional standards and conduct, and/or to maintain public confidence in the profession.

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*, *Nandi v*

General Medical Council [2004] EWHC 2317 (Admin), Mallon v General Medical Council [2007] ScotCS CSIH 17, *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin), *R (on the application of Remedy UK Ltd) v The General Medical Council* [2010] EWHC 1245 (Admin)*, General Medical Council v Meadow* [2007] QB 462 (Admin) and *CHRE v NMC and Grant.*

Decision and reasons 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.'*

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

The panel was of the view that Miss Walker's actions did fall significantly short of the standards expected of a registered nurse and amounted to breaches of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> *2.6 recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***8 Work co-operatively***

To achieve this, you must:

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

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

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

20.5 treat people in a way that does not take advantage of their vulnerability or 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 Miss Walker actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

The panel noted that Miss Walker was one of the registered nurses on duty and a senior member of staff. On the day in question, Miss Walker had members of staff available who offered to help her move Resident A, but she refused their offers of help. The panel noted that Miss Walker had drawn up Resident A's care plan in which it says that the resident "can become verbally and physically aggressive. Resident A needs reassurance and talked to in a calm manner." She would have been aware that Resident A could regularly spit, nip, scratch and hit members of staff when he was anxious or unsure and knew what the correct approach was. The panel was of the view that Miss Walker's actions in moving the resident on her own in a toileting sling to avoid being spat at had the potential to cause Resident A harm as well as infringing his dignity.

[PRIVATE].

The panel found that Miss Walker's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Walker'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. 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.

The panel considered the factors set out in the cases of *Grant* [2011] EWHC 927 (Admin) and *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin).

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 concluded that limbs a), b) and c) of Dame Janet Smith's test in *Grant* are all engaged in this case, both in the past and the future.

The panel decided that Miss Walker's misconduct is liable to put patients at unwarranted risk of harm, and that the public interest required a finding of current impairment. Moving a vulnerable resident along the corridor to their room using a toileting sling and hoist rather than a wheelchair in order to avoid being spat at had put a vulnerable resident at unwarranted risk of harm, breaches the fundamental tenets of the profession and brings the profession into disrepute.

In coming to its conclusion that Miss Walker's fitness to practise is currently impaired, the panel considered the questions posed in the case of *Cohen* namely:

1) Whether the conduct is easily remediable
2) Whether it has been remedied (or evidence to that effect)
3) Whether that conduct is highly unlikely to be repeated

In assessing these questions, the panel noted that Miss Walker had chosen not to engage with the NMC or this hearing as a whole. She has not provided the panel with an explanation as to why she had decided to move a vulnerable resident along the corridor to their room using a sling and hoist rather than a wheelchair. The panel considered that the conduct could potentially be remedied through training, in particular on handling feedback and learning from ones actions, and supervision, subject to insight and a willingness to strengthen practice.

However, Miss Walker has not provided the panel with any evidence of further relevant training or steps she had undertaken to address the concerns. Furthermore, Miss Walker has not provided the panel with any evidence of insight, remorse or reflection. On the contrary, the panel noted that during her first local fact finding interview, she had stated that she would do it again and had said to Ms Thorpe that if Ms Thorpe was in the same position, that she would act in a similar matter. Furthermore, the panel noted that Resident A was a resident with known challenging behaviours due to his dementia, and therefore was of the view that the circumstances were not unique. Since being dismissed from the Home, Miss Walker has indicated that she has not worked in a nursing role since 2022

and does not want to practise as a registered nurse in the future. The panel therefore concluded that Miss Walker had not remediated her misconduct.

The panel considered the likelihood of repetition.

The panel had already concluded that there is limited evidence of insight, that there is no evidence of remorse, reflection and strengthening of practice. Furthermore, the panel determined that the behaviours exhibited by Resident A were recorded in his care plan and the circumstances would not have been unique.

The panel determined that although this was a single and isolated incident, and therefore would not usually be considered a deep seated attitudinal concern. However, the panel was concerned about the very limited insight and remorse that Miss Walker had shown during the local disciplinary process and the lack of engagement with the NMC proceedings. The panel was of the view that, although Miss Walker had admitted to charge 1 and did not dispute charge 2, she also changed her recollection of events at each stage of the local investigation and disciplinary process. Further, she does not appear to be remorseful or want to take steps to address the concern with either training, reflection or supervision and has failed to provide any additional information to explain her actions. On the contrary, she initially said that she would do it again. The panel concluded that Miss Walker's lack of acknowledgment and recognition of the potential impact of her actions taken together with her lack of insight and engagement suggests that there may be attitudinal concerns.

In the circumstances, the panel could not be satisfied that it is highly unlikely that Miss Walker's conduct would be repeated in the future.

The panel also determined that the nature of misconduct, if repeated, would place patients at risk of harm. The panel therefore decided that a finding of current impairment is necessary on the grounds of public protection.

The panel also decided that a finding of current impairment was required for public interest reasons.

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

The panel determined that a finding of impairment on public interest grounds is required because of the nature of the matters found proved. The public would be concerned to learn that a registered nurse who had acted in this way and not taken steps to strengthen her practice did not lead to a finding that their fitness to practise was currently impaired.

The panel concluded that public confidence in the profession, and in the NMC as its regulator, would be undermined if a finding of impairment were not made in this case. The panel decided that all three relevant limbs of Dame Janet Smith's test required a finding of current impairment in the public interest – an unwarranted risk of harm to Resident A, the reputation of the profession and Miss Walker's breach of fundamental tenets of the profession.

Having regard to the above, the panel was satisfied that Miss Walker's fitness to practise is currently impaired.

Sanction

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

In the Notice of Hearing, dated 16 July 2026, the NMC had advised Miss Walker that it would seek the imposition of a striking-off order if it found Miss Walker's fitness to practise currently impaired.

Ms Hands submitted that the aggravating factors include:

1. Ms Walker's conduct put a vulnerable resident at risk of harm and failed to uphold his dignity or show him respect in the way she cared for him.
2. Ms Walker appears to have been unable to place the resident's safety above her own frustration at, or reaction to, his having spat at her.
3. Ms Walker was a senior registered nurse on duty during the shift in question and should therefore have been leading by example, both in the care she provided to residents and in her work with colleagues.
4. Ms Walker demonstrated a complete lack of reflection, insight and engagement during the NMC investigation and hearing process, such that she has not shown that she has strengthened her clinical practice and/or remediated her misconduct.

In relation to mitigating circumstances, Ms Hands said that Miss Walker had not provided any mitigation. [PRIVATE]. However Ms Hands submitted that the panel should attach little weight to this evidence as Miss Walker had not provided a cogent explanation for why she treated Resident A as she did, rather than acting in accordance with his care plan and the Home's policies.

In relation to the type of order the panel should impose, Ms Hands submitted that no further action and a caution order would not be appropriate nor proportionate due to the seriousness of the charges found proved.

In relation to a conditions of practice order, Ms Hands submitted that Miss Walker had not provided evidence of remorse, or a willingness to take steps to address the concerns through training, reflection or supervision. On the contrary, she initially said that she would act in the same way again. Furthermore, because of the panel's findings that Miss Walker may have attitudinal issues, she submitted that, it is unlikely that workable conditions could be formulated to address adequately the public protection and public interest concerns arising from the potential attitudinal issues.

Miss Hands further submitted that given that Miss Walker has repeatedly stated to the NMC that she does not currently, and does not intend in future to, practise as a registered nurse, it would not be possible to formulate conditions capable of being monitored and assessed, nor is there any evidence that she would engage with conditions in order to demonstrate strengthened practice. Therefore, a conditions of practice order would not be appropriate.

Regarding a suspension order, Ms Hands submitted that the panel has no evidence before it that provides any assurance that Miss Walker could realistically return to unrestricted practice in the future.

Ms Hands said that, as the panel found limited evidence of insight and no evidence of remorse, reflection or strengthened practice, and that Miss Walker has not taken steps to remediate her misconduct nor has the intention to practise as a registered nurse, on a practical level a suspension order would likely leave Miss Walker in a cycle of reviews in which she would be unable to demonstrate remediation because she is not practising.

Ms Hands submitted that the charges found proved sit at the more serious end of the spectrum and therefore calls into question Miss Walker's suitability to continue practising.

She said that Miss Walker's actions put a vulnerable resident at unnecessary risk of harm, violated his dignity and caused him distress. Ms Hands submitted that Miss Walker had failed to manage Resident A's behaviour in accordance with his care plan, which she had created, and breached the Home's local policies.

In these circumstances, Ms Hands submitted that the charges found proved are so serious that public confidence in the profession could not be maintained if Miss Walker was able to continue practising without any period of removal from practice. She submitted that it is not possible to say with confidence either that Miss Walker could be fit to practise in future, or that a period out of practice would be sufficient to allow her to strengthen her practice through reflection and the development of professional skills and insight. Ms Hands further submitted that Miss Walker has indicated that she will not return to practice. Therefore, a suspension order would not be a suitable sanction in this case.

Ms Hands, therefore, submitted that the only appropriate and proportionate order would be a striking-off order. She submitted the charges found proved do raise fundamental questions about Miss Walker's professionalism. As a result of Miss Walker's conduct, public confidence in the nursing profession could not be maintained if she was not removed from the register. She further submitted that Miss Walker has not engaged, has not provided evidence of remorse, insight, reflection nor a willingness to engage with the NMC process. Therefore, there is not a realistic prospect that, following a period of suspension, she would have gained insight and taken steps to remediate the concerns.

Decision and reasons on sanction

Having found Miss Walker'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:

- Lack of compliance with training and policies which led to a breach of dignity and risk of harm
- Miss Walker's inability to control her emotions towards Resident A
- Lack of insight, reflection, and remorse
- Clear evidence (via her own care plan documentation) that she understood the resident's needs and the resident's behaviour
- Help was offered by both Ms Thorpe and Ms Mann and she refused their help
- Very limited engagement with the fitness to practise process

The panel determined that there were no significant mitigating circumstances. [PRIVATE].

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

The panel 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 Miss Walker'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 Miss Walker'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 order on Miss Walker'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).

The panel considered the concerns could be remediable if Miss Walker had shown insight and willingness to undertake the steps needed to strengthen her practice.

However, the panel was of the view that a conditions of practice order would not be workable as Miss Walker is not currently practising as a registered nurse and has been out of practice for approximately four years. She would therefore have to undertake a return to practice course before she could practise as a registered nurse in the future. In addition, conditions require insight and a willingness to engage, neither of which are present in Miss Walker's case.

Therefore, and having regard to the nature and seriousness of Miss Walker's misconduct, the panel determined that a conditions of practice order would not be appropriate in these 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 Miss Walker 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. The panel noted that Miss Walker has not practised as a registered nurse for a period of four years and has failed to engage with the NMC's investigation. Given Miss Walker's lack of engagement, insight and remorse, together with no evidence of training and development, or interest in undertaking training or 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

was of the view that a suspension order would serve no practical purpose in these circumstances. Miss Walker has indicated on a number of occasions that she does not intend to return to nursing practice. A suspension order provides a period of time in which a registrant can address concerns and demonstrate fitness to return; here there is no evidence of willingness to use that time constructively. The panel was of the view that it is not realistic, on the evidence before it, that Miss Walker would be able to return to unrestricted practice in the future.

Key questions applied:

1. Can the risk to the public only be managed by temporary removal from the register?
2. Would suspension be sufficient to protect the public, public confidence in the profession, and professional standards?
3. Is it realistic that the registrant could return to unrestricted practice in future, even if not appropriate now?
4. What would the registrant need to do to become fit to practise again — and is it realistic they would do it?

The panel's answer to (3) and (4) was no: absent engagement, insight, reflection, and remorse, there is no realistic pathway back to safe, unrestricted practice, and no indication Miss Walker intends to take that pathway. It noted that Miss Walker retains her registration and could, in principle, use it in the future if she chose to engage, but there is nothing before the panel which suggests that she will.

The panel considered that the underlying impairment, while very serious, is not of a kind fundamentally incompatible with continued registration. The concerns are, in principle, remediable but that the remediation depends on insight, reflection, and a willingness to engage, none of which Miss Walker has shown.

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

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 considered that there are fundamental questions about Miss Walker's professionalism, given there are multiple breaches of the NMC Code. However, as set out above, the concerns are in principle remediable. But, that remediation depends on insight, reflection, and a willingness to engage, none of which Miss Walker has shown.

There is no realistic prospect that Miss Walker would use a period of suspension to develop insight or strengthen her practice given she has not shown any insight, remorse, or remediation to date, has left the profession and has not engaged with the fitness to practise process. In these circumstances, public confidence in the profession would be undermined were Miss Walker be allowed to stay on the register.

The striking-off order guidance goes on to give examples of cases most likely to lead to a strike-off. These include deliberately putting people receiving care at serious risk of harm and failing to engage with the fitness to practise process. The panel considered that Miss Walker's case falls into both of these categories because she intentionally put a very vulnerable patient at serious risk of harm and she has not only not fully engaged with the

fitness to practise process but has failed to show insight, remorse, reflection or any willingness to remediate.

Miss Walker's misconduct was a significant departure from the standards expected of a registered nurse, and is fundamentally incompatible with her remaining on the register due to her failure to adequately engage and lack of commitment to strengthen her practice. The panel was of the view that the findings in this particular case demonstrate that Miss Walker'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.

The panel considers that other sanctions may have been proportionate had Miss Walker shown that she wanted to return to practice and demonstrated insight into her misconduct. Miss Walker has not engaged, nor shown any insight or remorse about her misconduct, and has indicated that she does not wish to strengthen or return to nursing practice. The panel therefore decided that the only proportionate sanction is a striking-off order.

The panel considered that a striking-off order would provide effective public protection. Further, having regard to the effect of Miss Walker'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 sanction 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.

This will be confirmed to Miss Walker in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Walker'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 an interim suspension order is necessary and proportionate in order to protect the public and maintain the public interest over any appeal period. She submitted that this order should be imposed for a period of 18 months so as to allow sufficient time for any appeal to take place.

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 having decided that there was a risk to the public arising from Miss Walker's practice which required her to be struck off the register it was self-evident that an interim order suspending her from practice was required. The panel also considered that an interim suspension order was required in order to maintain the reputation of the profession, and the NMC as its regulator because of the nature of the misconduct found proved.

This order will cease either in 28 days if there is no appeal or at the conclusion of the appeal if one is lodged. As an appeal may take up to 18 months to come to a conclusion,

the panel decided on an interim order for that period. This length of order is not prejudicial to Miss Walker because this interim order will cease to take effect if an appeal concludes earlier than 18 months from now.

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

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

That concludes this determination.