Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 7 July – Tuesday, 15 July 2025
Thursday, 13 November – Friday, 14 November 2025
Monday, 29 December 2025
Monday, 23 February – Thursday, 26 February 2026

Virtual Hearing

Name of Registrant:	**Tom Bell**
NMC PIN:	21H0055W
Part(s) of the register:	Registered Nurse, Sub Part 1 RNA, Adult Nurse (17 December 2021)
Relevant Location:	Monmouthshire County
Type of case:	Misconduct
Panel members:	Jimmy Carr (Chair, Lay member) Vivienne Stimpson (Registrant member) Chanelle Gibson-McGowan (Lay member)
Legal Assessor:	Graeme Henderson (7 – 15 July 2025, and 23 - 26 February 2026) Michael Bell (13 – 14 November 2025, and 29 December 2025)
Hearings Coordinator:	Clara Federizo (7 – 15 July 2025, and 13 – 14 November 2025) Amira Ahmed (29 December 2025) Nicola Nicolaou (23 – 26 February 2026)
Nursing and Midwifery Council:	Represented by Dominic Bardill, Case Presenter (7 – 15 July 2025) Giedrius Kabasinskas (23 – 26 February 2026)
Mr Bell:	Not present and unrepresented
Facts proved:	1(i), 1(v), 1(vi), 1(vii), 3(i), 3(ii), 3(iii), 3(iv), 6a, 6b, and 7(i)
Facts not proved:	1(ii), 1(iii), 1(iv), 1(viii) 1(ix), 1(x), 1(xi), 1(xii), 1(xiii) 2, 3(v), 3(vi), 4(i), 4(ii), 4(iii), 5, 6c, and 7(ii)

Fitness to practise:	Impaired (but not in relation to Charges 6b and 7 (i)
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 Mr Bell was not in attendance and that the Notice of Hearing letter had been sent to Mr Bell's registered email address by secure email on 4 June 2025.

Mr Bardill, 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 detailed information about the allegation, including the time and dates of the hearing. It also outlined Mr Bell's rights to attend, to be represented, and to call evidence, as well as the panel's power to proceed in his absence.

The panel noted that the Notice initially contained details of a physical hearing venue, which was subsequently changed to a virtual hearing. The panel considered the NMC's telephone call note dated 7 July 2025, which records that Mr Bell was informed the hearing would instead take place virtually via Microsoft Teams. The panel further noted that Mr Bell confirmed he did not wish to attend the hearing, and that he had also been advised he could still choose to attend at any point during the proceedings should he change his mind.

In light of all the information before it, the panel was satisfied that Mr Bell had been properly 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 Mr Bell

The panel next considered whether it should proceed in the absence of Mr Bell. It had regard to Rule 21 and heard the submissions of Mr Bardill who invited the panel to continue in the absence of Mr Bell.

Mr Bardill referred the panel to the documentation setting out the chronology of contact between the NMC and Mr Bell. He submitted that there had been consistent efforts to engage Mr Bell and that there had been partial engagement from Mr Bell himself. In particular, he highlighted the telephone note dated 7 July 2025, in which Mr Bell more recently confirmed that he did not wish to attend the hearing.

Mr Bardill submitted that Mr Bell had voluntarily absented himself. He noted that throughout prior communications regarding these proceedings, Mr Bell had never indicated an intention to attend. Furthermore, during the most recent telephone conversation with the NMC, Mr Bell did not request an adjournment or suggest that he wished to attend at a later date. Accordingly, Mr Bardill submitted that there was no realistic prospect that adjourning the hearing would secure Mr Bell's attendance in the future. He also emphasised the public interest in the expeditious disposal of the case.

The panel accepted the advice of the legal assessor.

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

The panel has decided to proceed in the absence of Mr Bell. In reaching this decision, the panel has considered the submissions of Mr Bardill, the NMC's communications with Mr Bell, and the advice of the legal assessor. It has had regard to the factors set out in the decision of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Bell;
- Mr Bell is aware of the hearing taking place and confirmed he does not wish to attend;

- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Seven witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2023;
- 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 Mr Bell in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his 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 Mr Bell's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Bell.

The panel will draw no adverse inference from Mr Bell's absence in its findings of fact.

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

At the outset of the hearing, Mr Bardill made a request that this case be held partially in private on the basis that proper exploration of Mr Bell's case involves some

reference to Mr Bell's health and personal circumstances, which are directly linked to the allegations. 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(2) requires allegations involving health to be heard in private, and Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in connection with Mr Bell's health or personal circumstances, as and when such matters are raised, in order to protect his privacy in these proceedings.

Decision and reasons on application to admit hearsay evidence from Colleague D

The panel heard an application made by Mr Bardill under Rule 31 to allow the written statement and supporting exhibits of Colleague D into evidence. Colleague D was not present at this hearing. Despite the NMC's efforts to secure her attendance, Colleague D was unable to attend the hearing due to [PRIVATE].

[PRIVATE].

Mr Bardill further explained that Colleague D had initially indicated her willingness to give evidence despite [PRIVATE]. [PRIVATE]. The NMC offered various reasonable adjustments, such as giving evidence with cameras off, scheduled breaks and support from a witness liaison officer, but even with these, Colleague D remained feeling unable to attend.

Mr Bardill submitted that Colleague D's evidence is highly relevant. In the preparation of this hearing, the NMC had indicated to Mr Bell in the Case Management Form (CMF), dated 24 January 2025, that it was the NMC's intention for Colleague D to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Colleague D, Mr Bell made the decision not to

attend this hearing. On this basis Mr Bardill advanced the argument that there was no lack of fairness to Mr Bell in allowing Colleague D's written statement and exhibits into evidence. In these circumstances, Mr Bardill submitted that Mr Bell's position would not be materially different from the situation had Colleague D attended this hearing, because Mr Bell would not have questioned Colleague D in any event.

Mr Bardill also emphasised that this is not an attempt to introduce surprise or late evidence. Colleague D's statement and supporting documents have been part of the case for some time. He submitted that the panel could admit her evidence as hearsay, recognising it has not been tested under cross-examination, and attach appropriate weight accordingly.

Finally, Mr Bardill submitted that the balance of fairness supports admitting the evidence. He submitted there is a strong public interest in proceeding with the case and ensuring the allegations against Mr Bell are properly considered. He therefore invited the panel to admit Colleague D's evidence as hearsay.

The panel accepted the advice of the legal assessor who referred the panel to rule 31 of the rules which states

> *'31. (1) Upon receiving the advice of the legal assessor, and subject only to the*
> *requirements of relevance and fairness, a Practice Committee considering an allegation may admit oral, documentary or other evidence, whether or not such evidence would be admissible in civil proceedings (in the appropriate Court in that part of the United Kingdom in which the hearing takes place'*

It considered the application to admit Colleague D's evidence as hearsay in light of the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin). In particular it had regard to the following factors set out in that case:

> *'(i) whether the statements were the sole or decisive evidence in support of the charges;*
> *(ii) the nature and extent of the challenge to the contents of the statements;*

(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;
(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;
(v) whether there was a good reason for the non-attendance of the witnesses;
(vi) whether the Respondent had taken reasonable steps to secure their attendance; and
(vii) the fact that the Appellant did not have prior notice that the witness statements were to be read.'

The panel considered that Colleague D's evidence was directly relevant to the allegations, particularly the charges which allege bullying and threatening behaviour by Mr Bell, as well as incidents linked to potential risk of harm to residents. The issue that the panel had to decide was whether it was fair to admit the statement as evidence.

The panel recognised that the NMC had taken reasonable steps in terms of factor (vi) to secure Colleague D's attendance and that Colleague D had a good reason for non-attendance due to [PRIVATE]. It also considered that there was no reason for Colleague D to fabricate the allegations but there was a considerable passage of time between the alleged incidents and the date of the hearing.

The panel already determined that Mr Bell had elected not to attend this hearing, and he had prior notice as he was provided Colleague D's evidence before the hearing. He had informed the NMC that he disputed all allegations on the basis that they had been fabricated. The NMC had not provided any proper notice that it would be applying for this evidence to be admitted as hearsay. It noted that he had been contacted by telephone and the telephone entry log recorded that a message lacking any detail had been left that a hearsay application would be made.

However, the panel determined that it would not be fair to admit Colleague D's evidence as hearsay. The panel acknowledged that Mr Bell strictly denied the allegations.

The panel determined that some of the most serious charges, namely Charges 4 and 5, relied solely or decisively on Colleague D's evidence. It noted that the allegations involved potential risk of harm to vulnerable residents, but there was no supporting documentation such as patient records, accident forms or statements from other staff to corroborate Colleague D's account. The panel could not properly assess whether escalation procedures were properly followed, without having Colleague D available to answer questions.

Balancing all these factors against the principles established in the case of *Thorneycroft*, the panel concluded that while Colleague D's evidence was relevant, admitting it as hearsay would cause significant unfairness to Mr Bell as the evidence was sole or decisive in relation to the most serious charges, that could potentially lead to findings of misconduct and a serious sanction. Without the ability to cross-examine Colleague D, the panel could not test the reliability and weight of her evidence, which would undermine the fairness of the proceedings.

Accordingly, the panel determined not to admit Colleague D's evidence to ensure that the hearing remained fair to Mr Bell, particularly given the seriousness of some allegations and the potential consequences for his registration.

In these circumstances, the panel refused the application.

Decision and reasons to amend the charge

The panel heard advice from the legal assessor that there may be an issue of undercharging in relation to Charge 1. He advised that as currently drafted, the charge alleges that Mr Bell, in his managerial role, displayed aggressive and intimidating behaviour towards other staff members that he was in charge of. However, he advised that this could be interpreted merely as Mr Bell being difficult to work with, which may not in itself meet the threshold of misconduct, especially if it is simply a matter of poor leadership or rudeness. He referred to the case of *Idu v East Suffolk & North Essex Foundation Trust* [2019] EWCA Civ 1649. Evidence that a registrant had *'become unmanageable'* might be regarded as an employment issue need not necessarily result in a finding of misconduct.

The legal assessor highlighted that the evidence emerging from the papers as well as the hearing suggested Mr Bell's behaviour went beyond simply being difficult to work with. He outlined first, that Mr Bell may have contravened rules in front of others, and second, that such behaviour could have involved disregarding the safety of residents e.g. by interrupting staff handovers, which are important for safe care.

Therefore, to better capture this, the legal assessor proposed an amendment to the stem of Charge 1, adding wording to the stem of Charge 1 to reflect on these further regulatory concerns. He also suggested the panel would wish to correct typographical errors. The legal assessor emphasised that these were only suggestions, and it would ultimately be for the panel to decide whether to amend the charges. He also reminded the panel that if the panel make a decision to amend, Mr Bell must be informed.

Mr Bardill submitted that it would be proper and appropriate for the panel to consider amending the charge to reflect this more serious nature. There was no objection to such amendments, and he agreed that it would ultimately be a matter for the panel to decide.

The panel was informed that the proposed amendments were emailed to Mr Bell for his comment, but no reply was received.

Charge 1

1. Between 1 June 2023 and 8 August 2023, on one of more of the following occasions displayed aggressive and or intimidating behaviour at Foxhunters Care Home ("the Home"), **and/or contravened the rules of the Home and/or disregarded the health, safety and well-being of the residents of the Home,** namely:

i. ~~Was~~ **Were** vaping when Colleague C tried to complete a handover with you.
[…]

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules. It also had regard to the case of *PSA v NMC and Jozi* [2015] EWHC 764 (Admin). It noted that it was required to play a proactive role and in particular exercise its power to amend in the event that it considered there was undercharging.

The panel recognised that the current wording of Charge 1 focused too narrowly on allegations of Mr Bell's intimidating and aggressive behaviour towards colleagues, without adequately addressing the impact of his conduct on contravening his employer's rules on the health, safety and wellbeing of patients and residents.

The panel accepted that the stem of Charge 1 needed to be expanded to include reference to the risk posed to the health, safety and wellbeing of patients and residents. The panel was satisfied that this better reflected the witness evidence heard so far during the proceedings.

In considering fairness, the panel acknowledged it was late in the process to amend the charge, and that Mr Bell, who was absent and not represented, should have prior notice to respond. However, the panel determined that its overriding responsibility is to protect the public. It considered that failing to amend the charge could constrain later stages of the hearing because the original wording did not capture the full gravity of Mr Bell's conduct and its potential to risk patient safety and wellbeing.

While the panel recognised this amendment might make the charge more serious, it concluded that such an amendment, as applied for, was in the interest of justice and necessary to reflect the evidence heard, protect residents and uphold public confidence in the profession. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and to better reflect the evidence before the panel. Although this amendment was made to reflect on the evidence, the panel had to decide at a later stage whether it accepted any of this evidence.

Details of charge (as amended)

That you, a registered nurse:

1. Between 1 June 2023 and 8 August 2023, on one or more of the following occasions displayed aggressive and/or intimidating behaviour at Foxhunters Care Home ("the Home"), and/or contravened the rules of the Home and/or disregarded the health, safety and well-being of the residents of the Home, namely:

    i. Were vaping when Colleague C tried to complete a handover with you.
    ii. Vaped in the presence of colleagues D and E during a handover.
    iii. Walked out of handovers in an aggressive manner.
    iv. Raised your voice/argued with someone on the phone.
    v. When Colleague D was handing over to you spoke to others present but did not speak to Colleague D.
    vi. When Colleague D communicated information to you during handover looked at your phone and or watch.
    vii. When carrying out handovers with Colleague D, did not engage with Colleague D.
    viii. Sat at the back of the room and looked out the window during handover with Colleague D.
    ix. Said "sorry", or words to effect, in a derogatory tone to Colleague D.
    x. During a handover with Colleague E, did not listen to Colleague E as they were providing information.
    xi. Threw the handover paperwork onto a table.
    xii. Threatened not to come in for shift.
    xiii. Slouched in a chair and stared at Colleague E during handover.

2. On an unknown date, at the Home, kicked a chair across the room.

3. On an unknown date, following Resident A's fall:

i. Lifted Resident A up using an inappropriate manual handling technique, namely hooking your arms under Resident A's arms.
ii. Did not use a hoist.
iii. Did not make any clinical observations of Resident A before lifting up Resident A.
iv. Did not complete any physical observations such as taking their blood pressure and pulse, after Resident A was off the floor.
v. Did not record/document the fall.
vi. Did not record/document any observations in Resident A's care plan

4. On 3 April 2023 after a resident suffered an unwitnessed fall during the night:

i. Did not record/document the incident.
ii. Did not call the out of hours doctor.
iii. Did not document that the resident's hair had been cut back and a dressing put in place.

5. On 13 May 2023 after a resident suffered an unwitnessed fall overnight, did not escalate the incident.

6. On one or more of the following occasions, without authorisation, left the Home, whilst on shift;

a. 16 June 2023
b. 17 June 2023
c. 25 June 2023.

7. On or around 10 June 2023 displayed intimidating behaviour towards Colleague F:

i. Sent to Colleague F, one or more Facebook Messenger messages as set out in Schedule A.

ii. Said to colleagues' words to the effect that Colleague F was starting rumours and telling lies.

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

Schedule A

Facebook Messenger messages

1. So It's you that's started all this rumour over a week ago what are you getting out of this honesty
2. By the way I'm reporting you too
3. Talking about my private life in work
4. Not on
5. You openly spreading rumours in a work place not professional at all
6. Yeah I did call you vunt (sic) from the comfort of my own home not in the work place
7. And no I didn't even had Person A to tell everyone, bet thing you can do is message [Person B] (Colleague and apologise for spreading all this and put it right.
8. Yea okay, your just causing shit because you got nothing better to do
9. Yes you have you been spreading lies about me in my work place
10. Grow up will you
11. Your a pathetic person mind I got to be fair to you causing shit because your life is that boring, I'm telling you now I will be reporting you and continue to do so because you don't' do your job do you let's be honest
12. A fucking lot let me tell you
13. Causing all this shit in a work place is sackable just to let you know

14. I've been told by Litrally eveyome (sic) you been saying it about me the last week or so
15. Why start saying it about me?
16. Is it because your jelous (sic)
17. Because of your dad pathetic life
18. Put this right [Colleague F] it's all bullshit and you know it
19. Because of your pathetic life it was meant to say

This hearing was adjourned on 15 July 2025 and resumed on 13 November 2025.

Decision and reasons on service of Notice of Hearing and proceeding in absence

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

The panel acknowledged that a Notice of Hearing letter had been sent to Mr Bell's registered email address by secure email on 1 October 2025 for the resuming dates. The panel was satisfied that Mr Bell had been served with the Notice in accordance with the requirements of Rules 11 and 34 and this provided with information about the dates of the resuming in camera in November 2025, as well as the future resuming dates in January 2026.

The panel next decided to proceed in the absence of Mr Bell. It recognised that the attendance of parties was not required on 13 and 14 November 2025 as the panel was to reconvene privately in camera to deliberate on facts. It also noted that in any event, Mr Bell had previously confirmed he does not wish to attend the hearing and there is a strong public interest in the expeditious disposal of the case.

The panel will draw no adverse inference from Mr Bell's absence in its findings of fact.

Background

The charges arose while Mr Bell was employed as a registered nurse at Foxhunters Care Community ('the Home'). The Home is a 70-bedded nursing and residential care community. The residents at the Home have various residential and nursing needs, including dementia. The NMC received several referrals in July 2023 regarding concerns in relation to Mr Bell's practice and conduct.

On 12 July 2023, Mr Bell initially self-referred following disciplinary proceedings, and further referrals were made by Colleague A, the Home Director, and by Monmouthshire County Council's Adult Safeguarding Manager. These referrals led to an NMC investigation into a series of incidents that occurred during June 2023.

The NMC investigation identified a number of regulatory concerns relating to incidents that took place at the Home in June 2023, while Mr Bell was working as the sole night nurse. The allegations include intimidating and aggressive behaviour towards colleagues, inappropriate handling following a resident fall, failure to respond appropriately in emergency situations, and leaving the home short-staffed.

The regulatory concerns are:

1. Intimidating and/or harassing behaviour, in that you:

    - displayed violent and aggressive conduct towards colleagues.
    - kicked a chair and table across the room.
    - harassed one or more colleague(s).
    - shouted and displayed aggressive/intimidating behaviour in the presence of colleagues and patients.

2. Failure to take appropriate action after a resident fall, in that you:

    - did not undertake appropriate observations.
    - did not use appropriate manual handling techniques.

3. Failure to address emergency situations appropriately.

4. Leaving the Home unattended/short staffed on one or more occasions.

Mr Bell denied most allegations, acknowledging only that he had left the building during the night of 15 – 16 June. He stated he believed he had otherwise acted professionally and disputed concerns about his manual handling. He later informed the NMC that he no longer intended to practise as a nurse, [PRIVATE], and would not engage further with the investigation.

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 Mr Bardill on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mr Bell.

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

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

- Colleague A: Home Director at the Home at the time of the alleged incidents
- Colleague B: Care assistant at the Home at the time of the alleged incidents
- Colleague C: Staff Nurse at the Home at the time of the alleged incidents

- Colleague E: Staff Nurse at the Home at the time of the alleged incidents
- Colleague F: Care assistant at the Home at the time of the alleged incidents
- Colleague G: Staff Nurse at the Home at the time of the alleged incidents
- Colleague H: Managing Director for Wenvoe Care Home Ltd (a sister company for Dormy Care Communities).

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.

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

Charge 1(i)

1. *"Between 1 June 2023 and 8 August 2023, on one or more of the following occasions displayed aggressive and/or intimidating behaviour at Foxhunters Care Home ("the Home"), and/or contravened the rules of the Home and/or disregarded the health, safety and well-being of the residents of the Home, namely:*

    i. *Were vaping when Colleague C tried to complete a handover with you."*

This charge is found proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague C and Colleague E.

In her statement, Colleague C described:

> *'*[…] *in around June 2023, I went to give handover to Tom and he was vaping and on his phone. Smoking and vaping are both not allowed in Foxhunters. I think we had a bit of a disagreement about this and I said that I would not be handing over to him while he was vaping and on his phone and he was not listening to me. Registered nurse* [Colleague E] *then took over the handover.'*

The panel accepted the evidence of Colleague C. It further noted that during oral evidence it was stated that the vaping occurred in proximity to a resident who was using an oxygen mask.

The panel also took account of supporting evidence from Colleague E, who described a further occasion when Mr Bell was seen vaping at work. She stated that this was against policy and that Mr Bell would have known this:

> *"There was another occasion, I cannot remember the date, but Tom came into the Deri Nursing Hub, pulled out his vape and started vaping. This was against policy, which Tom would have been made aware of. When you started at Foxhunters, you would be expected to log on and read all of the policies and procedures and vaping was explicitly mentioned in the 'Smoking at Work Policy WPM07' at 5.1…as not being allowed in the buildings."*

The panel next reviewed the Home's 'Smoking at Work' policy. Although it noted that the document before it had been last reviewed in November 2023, there is also an indication of a *'next planned review in 12 months'* and the panel thus concluded that this policy was reviewed yearly. The panel was satisfied that this policy was in force during the relevant period and that this applied to vaping and electronic cigarettes. The policy expressly prohibited:

‘4.1 Any and all of the workplace of Foxhunters is smoke-free. This includes any company vehicles. Smoking is not permitted unless in a designated area.

[…]

4.4 This policy applies equally to the use of electronic cigarettes and due to potential health and safety implications, employees are not permitted to charge electronic cigarettes at work or in vehicles.’

The panel acknowledged evidence that Mr Bell had experienced difficulties accessing certain e-learning materials during his induction. It noted that his induction consisted of two weeks with the deputy manager and one week with a trainer. On 20 November 2023 Mr Bell signed a document that affirmed he received the learning to complete for his induction, but on 2 December 2023, he emailed that he did not have access.

However, the panel concluded that Mr Bell’s technical issues did not negate his responsibility. The panel accepted that hard copies of policies were available within the Home and that prohibitions on smoking and vaping in care environments are widely known. In addition, the panel noted oral evidence that, when challenged by Colleague C, Mr Bell’s response was *“Oh, you caught me”,* which more likely than not indicated that Mr Bell knew his actions were not permitted.

The panel was satisfied that Colleague C’s account was supported by the notes of her investigation interview with Colleague A on 21 July 2023. Colleague C’s response to the question *‘Have you witnessed TB displaying any aggressive, threatening or intimidating behaviour towards others and if so when was this?’* was:

‘During handover one time he was vaping, I told him to stop and he said “aw you have caught me”. I felt intimidated and uncomfortable in the way that TB was looking at me I can’t explain the feeling (just like oh my god).’

The panel did not find that this incident demonstrated aggressive or intimidating behaviour. However, it concluded that, on the balance of probabilities, Mr Bell's actions amounted to a contravention of the rules of the Home as he more likely than not knew that he was not permitted to vape at the time. Further, the panel determined that vaping also constituted a disregard for the residents' health and safety, particularly given the proximity of medical oxygen equipment at the time.

Accordingly, the panel finds Charge 1(i) proved.

Charge 1(ii)

1. *"Between 1 June 2023 and 8 August 2023, on one or more of the following occasions displayed aggressive and/or intimidating behaviour at Foxhunters Care Home ("the Home"), and/or contravened the rules of the Home and/or disregarded the health, safety and well-being of the residents of the Home, namely:*

    ii. *Vaped in the presence of Colleagues D and E during a handover."*

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague E and the Notes of investigation interview with Colleague C on 21 July 2023.

The panel considered the witness statement of Colleague E, in which she referred to another occasion on which she observed Mr Bell vaping. However, she stated that she *'cannot remember the date'* of this incident. As a result, the panel could not be satisfied that this incident occurred within the specific timeframe set out in the charge.

The panel further noted that the witness statement of Colleague D had been excluded following a hearsay application and therefore could not be relied upon. The

panel had no evidence available before it to establish that vaping took place during a handover in the presence of Colleague D and/or Colleague E within the relevant period.

While the panel accepted that, had the incident been proven to have occurred during that timeframe, it would likely have amounted to a breach of the Home's smoking policy and could have posed potential health and safety risks, the evidential gap and uncertainty regarding the dates and context meant that the NMC had not discharged the burden of proof for this charge.

Accordingly, the panel finds Charge 1(ii) not proved.

Charge 1(iii)

1. *"Between 1 June 2023 and 8 August 2023, on one or more of the following occasions displayed aggressive and/or intimidating behaviour at Foxhunters Care Home ("the Home"), and/or contravened the rules of the Home and/or disregarded the health, safety and well-being of the residents of the Home, namely:*

    iii. *Walked out of handovers in an aggressive manner."*

This charge is found NOT proved.

The panel reviewed all the documentary evidence before it, including the internal investigation materials and the oral and written witness evidence. The panel noted that although there was some general reference to examples of aggressive behaviour, including reports of items being slammed on a desk, there was no evidence identifying any specific occasion on which Mr Bell walked out of a handover, nor any evidence describing such conduct being done in an aggressive manner. The panel concluded that there was no admissible evidence before it to support the allegation.

In the absence of any documentary or oral evidence demonstrating that Mr Bell walked out of a handover, and that he did so in an aggressive manner, the panel determined that the NMC had not discharged the burden of proof for this charge.

Accordingly, the panel finds Charge 1(iii) not proved.

Charge 1(iv)

1. *"Between 1 June 2023 and 8 August 2023, on one or more of the following occasions displayed aggressive and/or intimidating behaviour at Foxhunters Care Home ("the Home"), and/or contravened the rules of the Home and/or disregarded the health, safety and well-being of the residents of the Home, namely:*

    iv. *Raised your voice/argued with someone on the phone."*

This charge is found NOT proved.

In reaching this decision, the panel reviewed the documentary evidence, internal investigation interview notes and witness evidence, particularly that of Colleague B, who referred to occasions when Mr Bell appeared to be arguing on the phone and to one incident where Colleague B was concerned about Mr Bell's behaviour in *"kicking a chair"* and *"storming out of the room"* following a telephone conversation.

In his witness statement, Colleague B described:

> *'As above, personal mobile phones should not be used while working on the units within Foxhunters. Tom would often be on his phone while doing a medication round. Tom would always have his earphones in and was often on his phone arguing or on FaceTime. I* [sic] *Tom was on FaceTime as I would see this on his phone screen and hear him talking to people. I believe he was mainly talking to Person A. This concerned me because if Tom was not giving his full attention to the medications he was administering, he could have made a medication error and potentially given a resident an overdose'*

However, the panel noted that Colleague B's evidence was inconsistent. In his interview he described Mr Bell as *'arguing with someone on the phone',* but in his oral evidence to the panel he stated that Mr Bell had not been shouting and was instead *"talking loudly".*

The panel further noted that Colleague B was unable to recall the specific dates on which the incidents occurred. Accordingly, the panel could not be satisfied, on the balance of probabilities, that the incidents he described took place within the timeframe identified in the charge. The panel considered whether any other witness evidence or investigation material linked an incident of Mr Bell raising his voice or arguing on the phone to the relevant period between 1 June 2023 to 8 August 2023, but it found no additional reliable or time-specific evidence in support of this charge.

In the absence of clear, consistent and dated evidence demonstrating that Mr Bell raised his voice or argued on the phone during the specified period, the panel concluded that the NMC had not discharged the burden of proof in respect of this charge.

Accordingly, the panel finds Charge 1(iv) not proved.

Charges 1(v), 1(vi) and 1(vii)

1. *"Between 1 June 2023 and 8 August 2023, on one or more of the following occasions displayed aggressive and/or intimidating behaviour at Foxhunters Care Home ("the Home"), and/or contravened the rules of the Home and/or disregarded the health, safety and well-being of the residents of the Home, namely:*

    v. *When Colleague D was handing over to you spoke to others present but did not speak to Colleague D.*
    vi. *When Colleague D communicated information to you during handover looked at your phone and or watch.*

vii. *When carrying out handovers with Colleague D, did not engage with Colleague D."*

These charges are found proved.

In reaching this decision, the panel took into account the oral and written evidence of Colleague C and Colleague E, together with interview notes from the internal investigation and relevant policy documentation.

The panel had regard to the witness statement of Colleague E, who described an occasion during handover when Mr Bell did not engage with the nurse giving clinical information (Colleague D):

> *'I also witnessed Tom on his phone during a handover and he did not engage with the nurse who was giving the handover to him. The nurse who handed over to him was* [Colleague D], *Nurse and whenever she stopped talking, Tom would look up at her until she started talking again and he then went back to his phone.* [Colleague C], *Nurse also witnessed this.'*

The panel also considered the evidence of Colleague C, who stated that Mr Bell frequently used his phone during handovers:

> *'Tom was spending a lot of time on his phone. During handovers Tom would often have his phone on the table. He would periodically pick up his phone, text, and then put it back down again. Tom only answered a phone call once during a handover* […]*'*
>
> *'*[…] *in around June 2023, I went to give handover to Tom and he was vaping and on his phone.'*

The panel accepted the consistent witness evidence that Mr Bell, during handovers, was repeatedly on his phone or looking at his phone instead of engaging. The panel noted that Colleague E's evidence was corroborated by other witnesses, including Colleague C, whose statement confirmed similar patterns of disengagement and lack

of cooperation during handovers. The panel therefore considered that this demonstrated a pattern of dismissive/disengaged behaviour, which it was more likely than not was also displayed towards Colleague D.

The panel further took account of oral evidence given by Colleague E, who told the panel that Mr Bell's behaviour during handover made the process uncomfortable and intimidating. She stated that Mr Bell would *"slouch in the chair and stare at* [her]*"* and that *"body language during the interaction came across as aggressive to* [her]*".* She told the panel that when Colleague D paused speaking Mr Bell would briefly look up, but when she resumed, he would return to his phone. She said she reported this behaviour to management at the time. The panel noted that Colleague E confirmed in oral evidence that this intimidating behaviour occurred specifically within the handover context.

The panel also took account of Colleague E's oral evidence that Colleague D appeared intimidated and anxious when handing over to Mr Bell. She stated that "[Colleague D] *was afraid of him she would shake and stutter, he wasn't listening and she was a nervous wreck"*. The panel considered that this supported the overarching allegation that Mr Bell's conduct was intimidating and undermined the professional environment in which handovers were conducted.

Having considered the evidence cumulatively, the panel was satisfied, on the balance of probabilities, that it was more likely than not that Mr Bell spoke to others but did not speak to Colleague D during handover, he looked at his phone and/or watch whilst Colleague D was communicating information, and he failed to engage with Colleague D during handover.

The panel further noted that handover is a critical process within the Home, directly linked to the health, safety and wellbeing of residents, and governed by workplace expectations of attentiveness and participation. It determined that by failing to engage with Colleague D, speaking to others during handover, and diverting his attention to his phone or watch, the panel considered that Mr Bell risked missing essential clinical information, thereby disregarding the standards and safeguards inherent to the handover process.

Accordingly, the panel finds Charges 1(v), 1(vi) and 1(vii) proved.

Charges 1(viii) and 1(ix)

1. *"Between 1 June 2023 and 8 August 2023, on one or more of the following occasions displayed aggressive and/or intimidating behaviour at Foxhunters Care Home ("the Home"), and/or contravened the rules of the Home and/or disregarded the health, safety and well-being of the residents of the Home, namely:*

   viii. *Sat at the back of the room and looked out the window during handover with Colleague D.*
   ix. *Said "sorry", or words to effect, in a derogatory tone to Colleague D."*

These charges are found NOT proved.

In reaching this decision, the panel reviewed all of the documentary evidence before it, including the internal investigation materials and the oral and written witness evidence. The panel noted that there was no evidence in the bundle or in oral testimony to support the allegation beyond hearsay attributed to Colleague D. As the panel had determined that it could not rely on untested hearsay evidence from Colleague D, and there was no other documentary or oral evidence to establish the allegation, the panel concluded that the NMC had not discharged its burden of proof for these charges.

Accordingly, the panel finds Charges 1(viii) and 1(ix) not proved.

Charge 1(x)

1. *"Between 1 June 2023 and 8 August 2023, on one or more of the following occasions displayed aggressive and/or intimidating behaviour at Foxhunters Care Home ("the Home"), and/or contravened the rules*

of the Home and/or disregarded the health, safety and well-being of the residents of the Home, namely:

x. During a handover with Colleague E, did not listen to Colleague E as they were providing information."

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Colleague E. In her witness statement, she stated:

'I had previously reported Tom to [Colleague A] *for his unprofessionalism in a handover. During the handover Tom did not listen to me as I was providing him with the information. He threw the handover paperwork down onto the table and threatened not to come in that night. I finished the handover and immediately reported it. By the time Tom came in for the next night shift, he acted differently towards me. It was very awkward and he would just slouch in the chair and stare at me as I gave the handover. His body language during the interaction came across as aggressive towards me.'*

The panel was satisfied that the evidence above was credible and consistent. However, the panel noted that there was no credible evidence before it that the behaviour exhibited by Mr Bell was within the timescale of the stem of the charge. Therefore, the panel found that the NMC had not discharged its burden of proof and found charge 1(x) not proved.

Charges 1(xi), 1(xii) and 1(xiii)

1. "Between 1 June 2023 and 8 August 2023, on one or more of the following occasions displayed aggressive and/or intimidating behaviour at Foxhunters Care Home ("the Home"), and/or contravened the rules of the Home and/or disregarded the health, safety and well-being of the residents of the Home, namely:

xi. Threw the handover paperwork onto a table.

xii. Threatened not to come in for shift.

xiii. Slouched in a chair and stared at Colleague E during handover."

These charges are found NOT proved.

In reaching this decision, the panel took into account the oral and written evidence of Colleague E.

Although there was evidence that such behaviour had occurred, the panel noted that Colleague E was unable to recall specific dates, and that the allegation could not be reliably placed within the period covered by the charge, namely between 1 June 2023 to 8 August 2023. In these circumstances, the panel concluded that the NMC had not established, on the balance of probabilities, that the incident occurred within the relevant timeframe.

The panel accepted that the incidents may have occurred, however, there was no reliable evidence that it took place within the charged date range. The panel noted that the relevant evidence indicated that the 'slouching' behaviour during Colleague E's handover may have occurred in March, which fell outside the period specified in the charge. The panel therefore determined that the NMC had not discharged the burden of proof and found Charges 1(xi), 1(xii) and 1(xiii) not proved.

Charge 2

2. "On an unknown date, at the Home, kicked a chair across the room."

This charge is found NOT proved.

In reaching this decision, the panel took into account the written and oral evidence of Colleague B, including his investigatory interview dated 5 July 2023 and his later NMC witness statement dated November 2023.

In both documents, Colleague B stated that Mr Bell had been arguing on the telephone, hung up, and then *'kicked a chair across the room'* causing a table to fall over before leaving the lounge. The panel noted that these two statements were broadly consistent with each other and were made relatively close in time to the alleged incident.

However, the panel also considered Colleague B's oral evidence at the hearing, which provided a more detailed account of the circumstances and the physical environment. In his live evidence, Colleague B described the chair as a fabric, substantial and fairly heavy chair, and his description suggested that Mr Bell had moved or shifted the chair rather than forcefully kicking it across the room. The panel considered this to be materially different from the wording of the charge, which alleged a chair being kicked *'across the room'* implying significant force and the movement of a light object over a distance.

The panel further noted that there was no corroborative evidence from any other witnesses, despite another nurse and a resident reportedly being present at the time. The panel also considered the passage of time between the incident and the hearing. The panel concluded that the oral evidence, which suggested a less dramatic and less forceful action, did not support the allegation.

In light of these inconsistencies, and given that the sole available evidence from Colleague B did not establish that Mr Bell kicked a chair across the room as alleged, the panel concluded that the NMC had not discharged the burden of proof for this charge.

Accordingly, the panel found Charge 2 not proved.

Charges 3(i), 3(ii), 3(iii) and 3(iv)

3. "On an unknown date, following Resident A's fall:

i. Lifted Resident A up using an inappropriate manual handling technique, namely hooking your arms under Resident A's arms.

ii. *Did not use a hoist.*

iii. *Did not make any clinical observations of Resident A before lifting up Resident A.*

iv. *Did not complete any physical observations such as taking their blood pressure and pulse, after Resident A was off the floor."*

These charges are found proved.

In reaching this decision, the panel had regard to the oral and written evidence from Colleague B. It noted that Resident A had fallen and was on the floor, and that Mr Bell lifted her up by hooking his arms under her arms and moving her onto the bed. The panel accepted Colleague B's evidence that Resident A could not normally get herself up from the floor and would have required assistance and equipment. In his evidence, he stated:

> *'When Tom arrived to assist, he was on the phone arguing with Person A, another care assistant, who he had formed a relationship with. Personal phones should not be used whilst on the unit. Tom did not seem in a good mood and was stomping around and was very blunt in his speech. Tom hooked his arms under Resident A's and picked her up and put her on the bed.'*

In oral evidence, Colleague B said:

> *"From what I can remember, he sort of like knelt down a little bit, poked his arms under her armpits and just pulled her up from the floor."*

The panel also considered the Home's Falls Management Policy and Procedure, specifically section 5.7 which stated:

> *'5.7 Falls and the Ambulance Service*
> *Foxhunters does not operate a 'No lift policy'. However, there is no expectation that staff will ever physically lift the Ladies and Gentlemen and Moving and Handling equipment will always be used to safely assist the*

Ladies and Gentlemen. Risk assessments will be undertaken for all manual handling and incidents of falls. Where the Ladies and Gentlemen is injured or medically unwell, the emergency services will be contacted. If the Ladies and Gentlemen has fallen, has capacity and is not injured but cannot get up, Foxhunters will identify mechanisms to safely assist the Ladies and Gentlemen from the floor.'

The panel also took into account Mr Bell's interview notes of investigatory meeting on 6 July 2023, in which he denied lifting Resident A in the manner suggested and said that he would never use that technique, but stated that he *'used her weight'* to rock her forward rather than a recognised manual-handling method:

'Me and [Colleague B] *picked her up off the floor but I didn't use poor techniques. I used her weight, stood behind and got her to rock back and fore then stood her up. Just as I was taught in manual handling.'*

The panel heard in evidence that Mr Bell had an All Wales Passport (a manual handling training certificate) which assures competence in manual handling in care settings. The panel noted that Mr Bell had not been offered manual handling training during his employment

Colleague H who at the time provided support to the Home as a registered nurse reviewing documentation, was also formally a manual handling trainer. In her witness statement she stated:

'If the resident is in a chair it is possible to get the resident from a sitting to standing position by rocking them back and forth like that (this a manual handling technique), but I would not consider it possible to use that technique to get someone from sitting on the floor to standing by doing that.'

The panel considered that Mr Bell accepted, when interviewed, that he should not use a manual handling technique by hooking his arms under Resident A's arms. However, Mr Bell denied using that technique. The panel preferred the evidence of Colleague B who consistently stated, during the local investigation, in his witness

statement, and live evidence that this was a technique that Mr Bell used. The panel considered that the method used was inappropriate in the circumstances and therefore found charge 3(i) proved.

In relation to charge 3(ii), the panel considered Colleague B's account that a hoist should have been used and that none was. This was consistent with Mr Bell's own admissions at his interview, where he accepted that a hoist was not used and that Resident A was instead manually assisted from the floor. The panel therefore determined that this charge was found proved.

In relation to charge 3(iii), the panel considered that the relevant policy required a clinical assessment following a fall before attempting to move a resident, in order to identify potential injuries. It had regard to Colleague B's evidence that Mr Bell did not carry out such an assessment and instead lifted Resident A shortly after ending a telephone call. There was no evidence of any observations or assessment undertaken prior to lifting. The panel considered that the absence of an initial risk assessment made the technique used inappropriate and therefore found this charge proved.

In relation to charge 3(iv), the panel accepted the evidence that no post-fall clinical observations, such as blood pressure or pulse, were carried out after Resident A was moved to the bed. The panel considered that Colleague B's account on this point was consistent across his statement, investigatory interview and oral evidence, and that Mr Bell did not suggest that any observations were performed afterwards. On this basis, the panel determined that, on the balance of probabilities, it was more likely than not that Mr Bell did not complete any physical observations such as taking their blood pressure and pulse, after Resident A was off the floor.

Charges 3(v) and 3(vi)

3. "On an unknown date, following Resident A's fall:

v. Did not record/document the fall.

vi. Did not record/document any observations in Resident A's care plan"

This charge is found NOT proved.

When considering the charges concerning failure to record or document the fall and any observations in Resident A's care plan, the panel considered that the NMC had not provided the patient records, accident forms, care plan or any contemporaneous documentation for Resident A. The panel noted that such records would normally be expected where a finding of non-documentation was sought.

The panel determined that while Colleague B had referred to an apparent absence of documentation, he also stated in oral evidence that he could not recall fully and thought he might have documented the matter. The panel considered that he could only speak to what he personally observed and might not have seen documentation completed later.

The panel took the view that it would be inappropriate to make a finding based solely on an assumption or on the limited comments of one witness, particularly where Colleague B himself indicated uncertainty and there was no independent evidence to confirm the absence of recording. The panel therefore determined that it could not safely conclude that paperwork had not been completed.

In the absence of primary records and with no corroborative evidence, the panel concluded that the NMC had not discharged the burden of proof.

Accordingly, the panel finds Charges 3(v) and 3(vi) not proved.

Charges 4(i), 4(ii) and 4(iii)

4. "On 3 April 2023 after a resident suffered an unwitnessed fall during the night:

i. Did not record/document the incident.

ii. *Did not call the out of hours doctor.*
iii. *Did not document that the resident's hair had been cut back and a dressing put in place."*

These charges are found NOT proved.

In reaching its decision, the panel took into account all the documentary and witness evidence before it.

The panel noted that the only reference to the events of 3 April 2023 were from the evidence of Colleague D. The panel had already concluded that Colleague D's account amounted to hearsay and was not supported by any contemporaneous records, documentary material or corroborative witness evidence. The panel also confirmed that, once it determined that Colleague D's hearsay evidence could not be relied upon, it could not use any of the exhibits or connected material attached to that statement as proof of the matters alleged.

The panel further noted that the NMC had not produced any primary documentation relating to the incident in question, such as care records, accident forms or notes evidencing whether contact had been made with the out of hours doctor, or whether treatment and dressing of the wound had been recorded.

In reviewing the investigation interview notes, the panel also noted that no questions about the incident were put to Mr Bell, and there was therefore no direct or contemporaneous account to support the allegation.

In the absence of any evidence before it relating to the incident of 3 April 2023, the panel concluded that the NMC had not discharged the burden of proof.

Accordingly, the panel finds Charges 4(i), 4(ii) and 4(iii) not proved.

Charge 5

5. *"On 13 May 2023 after a resident suffered an unwitnessed fall overnight, did not escalate the incident."*

This charge is found NOT proved.

In reaching its decision, the panel considered the evidence available before it in relation to the alleged unwitnessed fall on 13 May 2023. The panel noted that there was no independent or corroborative evidence before it which substantiated the allegation that Mr Bell failed to escalate the incident. The panel noted that there are no contemporaneous records or interview material produced by the NMC to support the charge, and there was no witness evidence confirming what actions were/were not taken following the fall.

The panel reminded itself that the burden of proof rests with the NMC. In the absence of any reliable documentary or witness evidence capable of establishing that the incident was not escalated, the panel concluded that the NMC had not discharged its burden of proof for this charge.

Accordingly, the panel finds Charge 5 not proved.

Charges 6a, 6b, and 6c

6. *"On one or more of the following occasions, without authorisation, left the Home, whilst on shift;*

    a. *16 June 2023*
    b. *17 June 2023*
    c. *25 June 2023."*

These charges are found proved (in relation to charges 6a and 6b only)

In reaching its decision, the panel took into account the oral and written evidence of Colleague B, Colleague C, Colleague F and Colleague H, as well as the hearing

minutes from disciplinary hearing on 20 July 2023, together with Mr Bell's interview notes.

The panel noted that the wording of the charge was framed on a "one or more occasions" basis, and therefore, if the allegation was proved in relation to any one of the listed dates, the charge as a whole would be capable of being found proved.

The panel first considered the events of 16 June 2023. It placed weight on the notes taken from Mr Bell's interview on 19 June 2023, in which he accepted that he had left the Home during his shift on that date following personal difficulties. In that account, he acknowledged informing colleagues that he was leaving briefly but nevertheless departed the premises while responsible for residents. The panel considered this to be an admission that he had left the Home without proper authorisation. The panel considered this to be reliable and contemporaneous evidence and, on the balance of probabilities, was satisfied that Mr Bell left the Home whilst on duty on 16 June 2023 without authorisation.

The panel next considered the allegation relating to 17 June 2023. The panel noted reference in the investigative interview material to Mr Bell having left the Home to go to McDonald's during a night shift around this period. Mr Bell's response when challenged was:

> *'I literally went across the road, there was nothing in the fridge. No one told me any different.* [Person C] *didn't tell me any different, no one did.'*

Although there was limited direct witness evidence, the panel considered that Mr Bell's admissions recorded in the minutes from the disciplinary hearing on 20 July 2023 above provided credible evidence that a further incident of leaving the Home without authorisation had occurred on or around this date.

The panel also considered the evidence relating to 25 June 2023, including the statement of Colleague F and Colleague C, which described an incident in which Mr Bell left the Home during a night shift for a period of approximately 20–25 minutes, after asking a colleague to cover for him. The panel considered the evidence of

Colleague F and also the Investigation Meeting notes dated 19 June 2023 which directly references the location within the Home, and the staff present as witnesses as identical to the circumstances contained within the statement and exhibit of Colleague F. The Investigation Meeting notes are dated six days prior to the date charged at 6c. The panel also noted that Colleague F was the only member of staff who witnessed the events in question. The evidence suggests the date articulated in Colleague F's evidence is incorrect and the facts attributed to that date are identical to the incident dated 16 June 2023. The panel concluded that it is unlikely that two separate incidents occurred on two separate dates, with the identical set of circumstances. The panel therefore found Charge 6c not proved.

Notwithstanding the above, having reviewed the evidence cumulatively and bearing in mind that Charge 6 was framed on an alternative basis, the panel was satisfied that it was more likely than not that Mr Bell left the Home without authorisation on at least one of the occasions particularised.

Accordingly, the panel finds Charges 6a, and 6b proved, but did not find Charge 6c proved.

Charge 7(i)

> *7. "On or around 10 June 2023 displayed intimidating behaviour towards Colleague F:*
>
> *i. Sent to Colleague F, one or more Facebook Messenger messages as set out in Schedule A."*

This charge is found proved.

In reaching this decision, the panel had regard to the oral and written evidence of Colleague F and the collated Facebook Messenger messages with Mr Bell.

The panel was satisfied that there was clear evidence that Mr Bell sent Facebook Messenger messages to Colleague F on or around 10 June 2023. The panel had

regard to Colleague F's witness statement and had sight of screenshots of the Facebook messages between Colleague F and Mr Bell, which was contemporaneous evidence and consistent with her description of the incident and the argument that had taken place. The panel considered the content and tone of the messages to be intimidating.

The panel determined that, on the balance of probabilities, it was more likely than not that, on or around 10 June 2023, Mr Bell displayed intimidating behaviour towards Colleague F in sending her Facebook Messenger messages as set out in Schedule A.

Accordingly, the panel finds Charge 7(i) proved.

Charge 7(ii)

> 7. *"On or around 10 June 2023 displayed intimidating behaviour towards Colleague F:*
>
> ii. *Said to colleagues' words to the effect that Colleague F was starting rumours and telling lies."*

This charge is found NOT proved.

The panel was not satisfied that there was sufficient evidence to support this charge. The panel noted that while the messages sent to Colleague F referred to rumours and lies, this material related to messages sent directly to Colleague F and did not demonstrate that Mr Bell had actually made such comments about her to other colleagues, as alleged.

The panel carefully reviewed the witness statements and internal investigation records but found no direct evidence from any other colleague confirming that Mr Bell had made such remarks to them. The limited material from which this allegation arises was indirect and hearsay in nature. Thus, the panel concluded that it was

insufficient to satisfy the burden of proof. The NMC had not provided sufficient evidence to establish the charge.

Accordingly, the panel finds Charge 7(ii) not proved.

The hearing resumed on 23 February 2026.

Decision and reasons on service of Notice of Hearing and proceeding in absence

The panel was aware that Mr Bell was not in attendance at this hearing and that the Notice of Hearing letter had been sent to Mr Bell's registered email address by secure email on 15 January 2026.

Mr Kabasinskas, on behalf of the 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). He invited the panel to proceed in Mr Bell's absence. Mr Kabasinskas submitted that there has been no communication from Mr Bell in relation to this resuming hearing.

The panel accepted the advice of the legal assessor.

The panel was satisfied that Mr Bell had been served with the Notice in accordance with the requirements of Rules 11 and 34 and this provided information about the resuming dates in February 2026.

The panel next decided to proceed in the absence of Mr Bell. The panel noted that there has been no engagement by Mr Bell throughout the course of these proceedings, and concluded that he had voluntarily absented himself from these proceedings. It further considered that there is no evidence before it to suggest that an adjournment would secure the attendance of Mr Bell. Further, the panel considered that there is a strong public interest in the expeditious disposal of the case.

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 Mr Bell's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has recently, redefined fitness to practise as a registrant's ability to practise safely and effectively without restriction. (Reference: DMA–1 updated 28 January 2026).

The panel, in reaching its decision, recognised its statutory duty to protect the public and maintain public confidence, and declare and maintain standards 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 had to determine whether the facts found proved amounted to misconduct. Secondly, only if the facts found proved amounted to misconduct, the panel had to decide whether, in all the circumstances, Mr Bell's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel noted that whilst there is no statutory definition of misconduct it should have regard to the definition supplied by the late Lord Clyde in the Privy Council case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

Mr Kabasinskas identified the specific, relevant standards where Mr Bell's actions amounted to misconduct. He submitted that Mr Bell's actions fell far below the standards expected of a registered nurse and amounted to misconduct.

Submissions on impairment

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

Mr Kabasinskas submitted that Mr Bell's actions had the potential to cause harm to residents and colleagues as a result of his incorrect moving and handling technique, leaving the Home unattended during a shift, and intimidating behaviour. Mr Kabasinskas submitted that Mr Bell's actions have breached fundamental tenets of the nursing profession and brought the profession into disrepute.

Mr Kabasinskas submitted that there is no evidence before the panel of any remorse, insight, or strengthened practice by Mr Bell. He submitted that Mr Bell has not engaged with the NMC in relation to the investigation. Mr Kabasinskas submitted that the concerns in this case have not been addressed, and therefore there remains a risk of repetition and consequent risk of harm to the public. Mr Kabasinskas invited the panel to make a finding of current impairment on the ground of public protection.

Mr Kabasinskas submitted that the misconduct in this case raises fundamental questions about Mr Bell's ability to uphold the standards and values set out in the Code. He submitted that a finding of current impairment is otherwise in the public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments including *Roylance* and *Grant.*

Decision and reasons on misconduct

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

The panel was of the view that Mr Bell's actions did fall short of the standards expected of a registered nurse, and that Mr Bell'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*
> ***1.2** make sure you deliver the fundamentals of care effectively*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> ***2.1** work in partnership with people to make sure you deliver care effectively*
> ***2.6** recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***6 Always practise in line with the best available evidence***
> *To achieve this, you must:*
> ***6.2** maintain the knowledge and skills you need for safe and effective practice*
>
> ***8 Work cooperatively***
> *To achieve this, you must:*
> ***8.1** respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> ***8.2** maintain effective communication with colleagues*
> ***8.5** work with colleagues to preserve the safety of those receiving care*
>
> ***10 Keep clear and accurate records relevant to your practice***

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
***10.1** complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
***13.4** take account of your own personal safety as well as the safety of people in your care*
***13.5** complete the necessary training before carrying out a new role*

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel had to be satisfied, in accordance with *Roylance* that in each case there had been a significant departure/ falling short from the standards expected of a registered nurse.

The panel considered each charge in turn.

Regarding Charge 1(i), the panel concluded at the facts stage that Mr Bell's actions were not intimidating, but were in breach of the Home's policy. The panel determined that Mr Bell's actions of vaping against the Home's policy had the potential to cause harm to vulnerable residents, particularly as he vaped at the nurses hub near a resident down the corridor who was wearing an oxygen mask. Further, the panel considered that Mr Bell would have been aware of the Home's policy from his induction when he was first employed. Mr Bell had a duty as a registered nurse, and in his position of authority as the nurse in charge, to ensure the safety and wellbeing of staff and residents in the Home and to set standards for other employees. The

panel considered that Mr Bell's actions fell far short of the standards expected of a registered nurse and amounted to misconduct.

Regarding Charges 1(v), 1(vi), and 1(vii), the panel considered that Mr Bell's behaviour was intimidating. The panel accepted evidence that Mr Bell was not engaged during handover as he was looking at his phone. Further, the panel heard in evidence that Mr Bell's behaviour made colleagues feel uncomfortable. The panel considered that Mr Bell's intimidating behaviour, and lack of engagement during handover, posed an unacceptable risk to patient care and had the potential to impact the safety and wellbeing of the residents at the Home. The panel noted, however, that were was no evidence before it of any direct impact on patient care.

The panel heard evidence that the Home could have up to 70 residents and that Mr Bell frequently worked night shifts at the Home, and was familiar with the residents. Despite this, the presentation of residents could change daily and so Mr Bell's engagement in every handover would have been crucial. The purpose of handover was for the staff of the outgoing shift to convey information, regarding the ongoing care of the residents, to the staff of the incoming shift. This was primarily done through the oral handover, although some information was contained in the written handover document. It was essential that the conveyor of the information was not distracted nor were the recipients. In any event Mr Bell appeared not to be paying attention. The oral handover was an opportunity for the incoming shift to ask questions and raise issues arising out of the information it received. By not engaging, Mr Bell would not be in a position to raise any issue arising from the oral handover.

The panel was of the view that Mr Bell, as the nurse in charge, to be disengaged during handover and was creating a distraction to others was so serious a departure from the standards expected or a registered nurse that it amounts to misconduct.

Regarding Charges 3(i), 3(ii), 3(iii), and 3(iv), the panel concluded that Mr Bell's incorrect manual handling techniques were against the Home's manual handling policy. The policy was in place to ensure safe and effective nursing practice, and to prevent any risk of harm to residents through the use of improper moving and handling techniques.

The panel accepted evidence that Mr Bell was distracted and was talking on the phone when he arrived to find the resident on the floor. His immediate reaction was to pick the resident up using an unauthorised method. The panel determined that Mr Bell had a duty as the nurse in charge to ensure that the resident was assessed for any signs of injury prior to that resident being moved. He ought to have carried out or delegated proper observations.

The panel concluded that there was a risk of harm to the resident due to Mr Bell's failure to see that observations were conducted both before and after the lift. There was clear evidence that he was not fully focused on the task at hand, did not conduct an initial assessment to check for signs of injury, did not follow the Home's manual handling policy when assisting the resident from the floor, and did not conduct any physical observations following the fall. The panel was of the view that this departure from standards was so serious as to amount to misconduct.

Regarding Charge 6a, and 6b, the panel considered that Mr Bell would have known the Home's protocol regarding a nurse in charge leaving the Home whilst on shift. The panel noted that as the nurse in charge, and the only nurse on shift on 16 June 2023, Mr Bell was responsible for ensuring that the Home was not left unattended. He would be well aware that this would be a requirement of the Home's registration and that this requirement was designed to protect the wellbeing of residents.

The evidence was that Mr Bell left the Home for approximately 20 minutes on 16 June 2023 due to what he claimed were personal reasons. The panel considered that Mr Bell was putting his own personal agenda above the needs of the residents at the Home. He would have been well aware that he should have summoned the assistance of another registered nurse before leaving. Although he spoke to junior colleagues, he did not follow the Home policy to ensure that a nurse provided cover in his absence. By leaving without any nursing cover being in place he placed residents at risk, should an incident requiring clinical management occur whilst he was absent. The panel therefore considered that Mr Bell's actions at Charge 6a were sufficiently serious as to amount to misconduct.

The panel was mindful that the event set out in Charge 6b occurred the day after the events in Charge 6a. However, the panel noted that there was another nurse working at the Home on 17 June 2023 at the relevant time. The panel took into account the disciplinary hearing notes dated 20 July 2023 in which Mr Bell stated:

> *'Everyone goes over to McDonalds.* [Colleague A] *sends staff to McDonalds all the time. Nurses and carers go there all the time. There's McDonalds wrappers everywhere.'*

The panel accepted evidence to the effect that members of staff frequently left the premises to attend a branch of McDonalds which was across the road from the Home. The panel accepted the evidence of Colleague H who stated that visits to McDonalds were different for the day shift as there was more than one nurse. It was noted during investigations by the Home that Mr Bell texted that nurse and asked her if she wanted anything from McDonalds.

The panel considered that there was a material difference between Charge 6a and Charge 6b as there was another registered nurse present while Mr Bell was absent in respect of this latter charge. The panel was of the view that while Mr Bell should not have left his shift on 17 June 2023, the presence of another nurse mitigated any risk to residents whilst Mr Bell was absent. The panel therefore considered that Mr Bell's actions at Charge 6b, while inappropriate, was not sufficiently serious as to amount to misconduct.

Regarding Charge 7(i), the panel considered that Mr Bell was in a position of authority as a senior member of staff, and his language towards Colleague F was inappropriate and unprofessional. The panel noted from the evidence of Colleague F that this conversation occurred whilst Mr Bell was at work, and lasted for approximately two minutes. However, there was no further evidence in the form of rosters etc. that the panel could rely on and it was not clear if Mr Bell was on a work break at the material time or else on duty.

The panel recognised that Mr Bell was a senior colleague of Person A. The panel heard evidence that Mr Bell, Colleague F, and Person A also knew each other

outside of the workplace and that Person A and Colleague F were friends. Mr Bell was in a personal relationship with Person A. The panel considered carefully Mr Bell's conduct in relation to this charge, the context, and the apparent conflict that had arisen as a result of allegations made between the parties that were of a personal and sensitive nature.

The panel was of the view that Mr Bell, in continuing the conversation when it became heated showed a lack of judgement, arising from frustration due to apparent rumours being spread about him in the Home that he alleged came from Colleague F. Colleague F stated in oral evidence that she had shared information of a personal nature to Person A. In the Facebook messages, Colleague F stated *'they aren't lies facts'*. The panel noted that the apparent rumours were of a highly personal and sensitive nature. This was a short, two-way, private conversation in which there was a falling out.

The panel considered the NMC guidance on *'Misconduct'* (Reference: FTP–2a Last Updated: 06/05/2025), particularly the section entitled *'Bullying'*. The panel considered that whilst Mr Bell's language was inappropriate, and intimidating, it did not constitute bullying. The panel concluded that there was no evidence before it that there was a course of conduct, or a single issue of such seriousness that it amounted to bullying, but rather, a conversation between two people, however unfortunate, on a sensitive personal issue. The panel therefore considered that Mr Bell's behaviour was not sufficiently serious as to amount to misconduct.

The panel found that Mr Bell's actions in respect of the charges found proved (with the exception of Charge 6b and 7(i) did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

In this regard the panel considered the test approved by Mrs Justice Cox in the case of *Grant* in paragraph 76:

"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 first began considering whether limb (a) of the Grant test was engaged. For this limb to be engaged the panel did not require to find that there was actual harm. It had to be satisfied that Mr Bell's misconduct placed the residents at unwarranted risk of harm.

The panel found that whilst there is no evidence before it that the residents were caused harm, they were put at risk of harm as a result of Mr Bell's misconduct. The panel considered that Resident A was put at risk of harm as a result of Mr Bell's inappropriate moving and handling technique and failure to require documentation. Mr Bell's action of leaving the Home unattended when he was the sole nurse on duty on 16 June 2023 had the potential to put residents and staff at risk of harm if anything were to occur whilst he was absent. Further, Mr Bell's action of not engaging with the handover had the potential to put residents at unwarranted risk of harm as crucial information may have been missed by him or the other recipients of the information. The panel considered that Mr Bell's misconduct had breached fundamental tenets of the nursing profession in that he knowingly disregarded the

rules designed for the safety of the residents and therefore brought its reputation into disrepute.

The panel was satisfied that limbs (a) – (c) of *Grant* were engaged with regard to the past.

In considering whether limbs (a) – (c) of *Grant* were engaged with regard to the future the panel began by considering insight. The panel considered that Mr Bell has not provided any material demonstrating an understanding of how his actions put residents and staff at an unwarranted risk of harm, nor has he produced material demonstrating an understanding of why what he did was wrong and how this impacted negatively on the reputation of the nursing profession.

The panel considered the factors set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) in determining whether or not Mr Bell has taken steps to strengthen his practice. The panel considered that the misconduct in this case is capable of remediation, however it considered that there was no evidence before it of any remorse, insight, or steps taken by Mr Bell to strengthen his practice. The panel has not had sight of any training certificates or reflective pieces by Mr Bell addressing his misconduct. The panel considered that as Mr Bell has not engaged with the NMC in relation to these proceedings, nor has he addressed the misconduct identified, it cannot be satisfied that the risk of repetition, and subsequent risk of harm, is unlikely.

The panel determined that limbs (a) to (c) of Grant were engaged with regard to the future. Accordingly, panel therefore decided that a finding of impairment was necessary on the grounds of public protection.

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

The panel considered that a member of the public would be concerned to learn that a registered nurse who had disregarded the health, safety, and wellbeing of fellow colleagues and residents was permitted to work without sufficient regulatory action being taken. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also found Mr Bell's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Bell's fitness to practise is currently impaired as it was of the view that Mr Bell is unable to practise safely and effectively without restriction.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. This guidance has been the subject of significant recent revision.

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Kabasinskas began by making reference to the SG and addressed the panel on what the NMC considered to be aggravating and mitigating features. He then addressed the panel by discussing which sanctions were available in ascending order.

Mr Kabasinskas submitted that taking no action or imposing a caution order would not be appropriate given the seriousness of the misconduct.

Regarding a conditions of practice order, Mr Kabasinskas submitted that some of the misconduct in this case was identified as being attitudinal in nature, and that Mr Bell has not demonstrated a willingness to respond positively to retraining. Mr Kabasinskas submitted that there are no proportionate, workable, or measurable conditions that can be formulated to manage the risk identified in this case.

Regarding a suspension order, Mr Kabasinskas submitted that Mr Bell's misconduct raises fundamental questions about his professionalism, and that removal from the register is necessary to protect the public and engage the public interest. Mr Kabasinskas submitted that as Mr Bell has not engaged with the NMC regarding these proceedings, and had previously stated to the NMC that he does not intend to return to nursing practice, a suspension order would not be appropriate in this case.

Mr Kabasinskas submitted that a striking off order was the only appropriate and proportionate sanction to protect the public, maintain public confidence in the nursing profession, and engage the public interest, in light of the attitudinal concerns identified and Mr Bell's lack of insight and strengthened practice.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having heard the submissions on behalf of the NMC the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the SG and considered following to be aggravating features:

- conduct which deliberately or recklessly put vulnerable people receiving care at risk of suffering harm
- vulnerability of the residents in Mr Bell's care (frailty, residents on end-of-life care, and residents prone to falls)
- absence of insight or reflection
- failure to attend hearings, or to engage in the Fitness to Practise (FtP) process, without providing evidence of a good reason
- failure to work collaboratively with colleagues by disengaging during handover and not following the correct manual handling procedure

The panel also took into account the following mitigating features:

- personal mitigation – Mr Bell was under a period of stress at the time of the incidents

The panel first considered whether to take no action but concluded that this would not be appropriate in view of the seriousness of the case and the public protection issues raised. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Bell's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Bell's misconduct was not at the lower end of the spectrum.

The panel also took into account the fact that the SG indicates that a caution order would be appropriate if any of the following bullet points were engaged:

- significant evidence of re-training and reflection
- significant insight which makes repetition highly unlikely

- a sanction is necessary to uphold professional standards and public confidence in the profession, but the professional is able to practise safely and a more restrictive sanction would be disproportionate

The panel had already determined that Mr Bell has not engaged and had neither produced evidence of retraining or insight nor had he produced any evidence of reflection. As such there was no assurance that Mr Bell would be able to practise safely in the future.

The panel decided that it would be neither proportionate nor in the public interest to impose a caution order taking into account the public protection concerns it identified.

The panel next considered whether placing conditions of practice on Mr Bell's registration would be a sufficient and appropriate response. The panel was of the view that there are no practical or workable conditions that could be formulated to manage the risk, protect the public, or engage the public interest, given the nature of the charges in this case. The panel noted that Mr Bell has not engaged with the NMC in relation to these proceedings and has not provided any evidence of a willingness to respond positively to retraining. In any event the charges, that resulted in a finding of misconduct did involve clinical errors that required retraining. Furthermore, the panel concluded that the placing of conditions on Mr Bell's registration would not adequately address the seriousness and attitudinal concerns of Mr Bell's misconduct and would not protect the public or engage the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The latest edition of the SG states that in considering a suspension order the panel should take into account a number of key factors the most relevant of which were:

- *is it realistic that the professional could return to unrestricted practice in the future, even if it is not appropriate for them to do so now?*

- *What would the registrant need to do in order to be fit to practise in the future? Is it realistic that they will be able to do this?*

The panel took into account that Mr Bell has not engaged with the NMC in relation to these proceedings, and therefore it could not be satisfied that it was realistic for it to make a finding that he could return to unrestricted practise in the future. In the absence of any input by Mr Bell the panel was unable to make any assessment of what he would '*need to do in order to be fit to return to practise in the future'.*

The panel also noted the SG states that the sanction of suspension may be appropriate when:

> *'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.'*

The panel concluded that Mr Bell had not engaged in the proceedings, nor had he shown any insight. The panel noted an email sent by Mr Bell to his NMC Case Officer dated 20 May 2025 in response to an invitation to a case conference which stated:

> *'No I'm sound cheers mate there isn't any eveidence* [sic] *supporting what I'm being accused of and I've asked them to take me off the register about a year ago I'm not interested cheers mate'*

In this case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction bearing in mind the public interest and public protection concerns raised.

Finally, in considering a striking-off order, the panel had particular regard to SAN-3 '*Deciding between suspension and strike off*' in the recently revised SG and, in particular, the last two bullet points :

- *'Consider the professional's insight and attitude to addressing the concerns, and whether it is realistically possible that these will change positively during the suspension period. If it is unlikely the professional will try to address the concerns, there may not be appropriate for them to be suspended in the hopes that they will eventually return to practice.*
- *Professionals are under an obligation to cooperate with their regulator. Where professionals have failed to engage with the fitness to practise process, it won't usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight.'*

The panel also had careful regard to that part of the SG relating to striking off orders and noted that it had to consider the following:

- *'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 as Mr Bell has not engaged with the NMC regarding these proceedings, it could not say, with confidence, that there was a purpose to be served by imposing a suspension order with review. There was an absence of any communication demonstrating insight and reflection. As such the panel had no information upon which it could devise recommendations that might assist a future reviewing panel.

Although Mr Bell's misconduct could not readily be categorised on the NMC list of '*Highest risk cases'* as set out in the SG and that the panel, in its determination on impairment, had concluded that the misconduct was remediable, the panel was

particularly mindful that the SG states that '*where professionals have failed to engage with the fitness to practise process, it won't usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight.'*

The panel was of the view that since he has failed to engage with the fitness to practise process, it would be inappropriate to allow Mr Bell to remain on the NMC Register as it had no material to suggest he would be capable of safe practise in the future. Any order, other than a striking off, 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 Mr Bell's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themself, the panel concluded that nothing short of this sanction would be sufficient in this case in light of the public protection and public interest issues raised.

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 Mr Bell's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Kabasinskas. He submitted that an interim suspension order was the only appropriate and proportionate order to protect the public and engage the public interest. Mr Kabasinskas invited the panel to impose an interim suspension order for a period of 18 months to allow time for any possible appeal.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

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

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

This will be confirmed to Mr Bell in writing.

That concludes this determination.