Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 2 February 2026 – Wednesday, 11 February 2026
Friday, 27 February 2026

Virtual Hearing

Name of Registrant:	Louise Haigh-Walsworth
NMC PIN:	09E0249E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (November 2009)
Relevant Location:	East Riding of Yorkshire
Type of case:	Misconduct
Panel members:	Rachel Carter (Chair, Registrant member) Rashmika Shah (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Gillian Hawken Andrew Reid (27 February 2026)
Hearings Coordinator:	Eidvile Banionyte Ifeoma Okere (27 February 2026)
Nursing and Midwifery Council:	Represented by Leesha Whawell, Case Presenter
Miss Haigh-Walsworth:	Present and represented by Chuba Nwokedi, instructed by the Royal College of Nursing (RCN)
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e, 2, 3 and 4
Facts not proved:	None
Fitness to practise:	Stage not reached

Sanction:	Stage not reached
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

1) On an unknown date in the nurse's office, demonstrated intimidating and/or bullying and/or harassing behaviour towards colleagues in that you:

    a) Spoke about members of staff in a derogatory manner.
    b) Pointed to Colleague A and called her a "*spy"* or words to that effect. ,

2) On an unknown date, demonstrated intimidating and/or bullying behaviour towards an unknown colleague in that you called them "cabbage" when referring to their intelligence.

3) On an unknown date, demonstrated discriminatory and/or bullying behaviour towards an unknown colleague in that you said they were "*too fat to run to the alarm bells*" or words to that effect.

4) On dates unknown, demonstrated bullying and/or intimidating and/or aggressive behaviour in that you:

    a) Sought to undermine the authenticity of colleagues' sickness absences in the presence of other members of staff.
    b) Called colleagues "*idiots"* or words to that effect.
    c) Said you disliked Colleague B and/or "*intended to get rid of him*", or words to that effect.
    d) Told Colleague C "*You are a waste of time"* or words to that effect.
    e) Told Colleague C she was "*a fucking liar"* and/or that she "*needs to watch her mouth"*, or words to that effect.
    f) Shouted at Colleague D for not completing care plans.
    g) Shouted at Colleague A in the corridor.

5) On dates unknown, demonstrated discriminatory behaviour in that:

    a) On hearing Colleague G and Colleague H communicating in Czech, threatened them with supervision and/or disciplinary action.
    b) You stated only *"Blacks"* worked night shifts.
    c) You referred to black colleagues as having "*blackatude."*
    d) You referred to colleagues of Indian heritage as "*rag heads."*
    e) When referring to colleagues of different nationalities and cultures, used the term "*truffle shuffle*."
    f) You referred to colleagues of ethnic minorities as "*baboons*" and/or other types of monkey.
    g) You referred to colleagues of different ethnicities as "*stinky*", or words to that effect.
    h) You said to Colleague B "*you live in England so I would hope you have a better understanding of the English language"* or words to that effect.

6) Your conduct at some or all of Charge 5 was racist in nature.

7) On 29 July 2021 demonstrated discriminatory behaviour towards Colleague H in that when she asked you to repeat something you said *"I don't have time to repeat. You are in [the] UK, do you know that you are in the UK", "England, this is England, and in this country, we speak English*" or words to that effect.

8) On one or more occasion between August 2022 and October 2022, demonstrated discriminatory behaviour towards colleagues of Filipino heritage in that you said they should not be working as nurses and/or carers due to their ethnicity.

9) Your conduct at charge 8 was racist in nature.

10) In or around July 2022, you failed to report a safeguarding incident regarding Resident A and Resident B in a timely manner or at all.

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

Preliminary matters regarding disclosure

At the outset of the hearing, Ms Whawell, on behalf of the Nursing and Midwifery Council (NMC), addressed the panel in relation to the disclosure request, made by the Royal College of Nursing (RCN) to the NMC, on 23 January 2026. She explained that this request was in relation to a copy of the incident report/Datix, with reference to the safeguarding issue involving Residents A and B, as well as the safeguarding policy that was in place at the time.

Ms Whawell advised that this request was forwarded to those that may be of assistance on 26 January 2026, at which point the NMC was told that files from 2022 would have been archived. This was then escalated to the general manager on 28 January 2026 and as a result of which the NMC was informed that the archives are in Inverness and that a copy is being sought now. Ms Whawell informed the panel that the person who the NMC have been liaising with is now out of office until 9 February 2026.

Regarding the incident reports, Ms Whawell submitted that Witness 2 in her witness statement said that that there was no safeguarding report in relation to the first safeguarding incident and that there were some progress notes in the patient's notes. In relation to the second incident, Witness 2 said that she had completed an incident report and exhibited this. Ms Whawell submitted that this exhibit is not before the panel, but it was sent to you and your representative.

Mr Nwokedi, on your behalf, confirmed that this disclosure request was made by the RCN to the NMC and explained that he was happy to proceed with the case until those documents become available if they do.

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

The panel decided to proceed whilst awaiting the update regarding the disclosure.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Whawell, on behalf of the NMC, to amend the charges. She submitted that there is no opposition to the amendments by you or Mr Nwokedi.

Ms Whawell submitted that the amended charges narrow the number of charges and concentrate matters that are evidence by way of the live witnesses that the NMC intends to call. She submitted that the proposed amended charges are a better reflection of the evidence in this case.

Ms Whawell explained that the old Charge 4f has now become 1d, 4g has become 1e, 5f has become 1a, Charge 7 has become 1c, Charge 8 has become 1b and Charge 10 has become Charge 4. She further submitted that in relation to the two motivation charges, the racial motivation is encapsulated in Charge 2, and the bullying in Charge 3.

Ms Whawell submitted that you had prior notice of the proposed amendments. She submitted that there is no unfairness in the charges being amended generally or at this stage.

Mr Nwokedi confirmed that this application was not opposed by you.

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

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

Details of charge (as amended)

That you, a registered nurse:

1. Between May 2019 and January 2023, whilst employed as a deputy manager of a care home, demonstrated inappropriate and/or abusive behaviour toward colleagues in that you:

    a. Referred to colleagues as "baboons" in reference to their ethnicity.
    b. Commented that colleagues with Filipino heritage should not be in the industry, or words to that effect.
    c. Said to Colleague H: *"You are in the UK, do you know you are in the UK…in this country we speak English?"* or words to that effect.
    d. Shouted at Colleague D in the presence of others.
    e. On or around 12 October 2022, shouted at Colleague I in the presence of others.

2. Demonstrated conduct at charge 1(a) and/or 1(b) and/or 1(c) motivated by your hostility or discriminatory attitude towards people of a different race including colour, nationality, ethnic or national origin.

3. Demonstrated conduct at charge 1(d) and/or 1(e) which amounted to bullying in that it was unwanted behaviour that was offensive, intimidating, malicious or insulting.

4. In or around July 2022, failed to report a safeguarding incident involving two residents in a timely manner or at all.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Whawell under Rule 31 to allow hearsay evidence contained within the local investigation report and interviews and separately, the NMC witness statement and Witness 6's exhibit into evidence.

Firstly, regarding exhibit HR2 (the HR surgery documentation), Ms Whawell submitted that these are notes of conversations held with various staff members at the Home during what is termed an "HR surgery". NMC Witness 1, described what an HR surgery is in his statement and noted that these are infrequent exercises which give an opportunity to discuss matters and they are held when it comes to light that there are difficulties with any particular team or where there is evidence of dissatisfaction among the workforce. Ms Whawell submitted that this particular HR surgery took place between 15 and 16 of November 2022.

With regards to the interview notes with the staff members, the NMC seeks to rely upon the evidence of staff who are not NMC witnesses attending this hearing. Ms Whawell explained that these interviews, conducted by Witness 1, are exhibited at HR7, HR8, HR9, HR12, HR13, HR14 and HR15.

Ms Whawell submitted that these interview notes go to the general background in this case and give context to the concerns which are in the charges. She submitted that they

also support specific allegations that are within the charges that relate to your behaviour, such as shouting and using racially motivated comments, and the NMC says that they provide possible corroboration of the charges.

Ms Whawell then addressed the panel regarding the second part of the hearsay application, Witness 6's statement and related exhibits. Ms Whawell explained that Witness 6 had passed away last year and therefore could not be called. She submitted that Witness 6's evidence goes to the background of the case, she has experience of you and specifically her evidence supports the other live evidence that the panel will hear about you swearing and shouting.

Ms Whawell submitted that the NMC are applying for all local statements to be before the panel, some of which are supportive, and some of which are not.

Ms Whawell submitted that all of this evidence is relevant as context and background. She submitted that as the issues in this case relate to your alleged behaviour towards staff at the Home, and that at the heart of those matters is an understanding of how the Home operated. Ms Whawell submitted that none of the evidence within HR2 or the other local interviews are sole and decisive. She submitted that the contents of these interviews can be challenged by the several live witnesses attending. With regards to fabrication, Ms Whawell submitted that there is no suggestion that the witnesses had reasons to fabricate their evidence. Regarding whether there is good reason for the non-attendance of witnesses and whether the NMC has taken reasonable steps to secure their attendance, Ms Whawell submitted that it is going to be a matter for the panel.

Ms Whawell invited the panel to allow all this evidence as it is relevant and fair and it ought to be admitted.

Mr Nwokedi, on your behalf, submitted that this evidence, if allowed in, would create substantial prejudice without permitting you to test the evidence. He submitted that the key prejudice is that the panel may be influenced by repeated, untested accusations of racism

and discrimination that go far beyond what could properly be proved by live evidence and witness statements.

Mr Nwokedi submitted that the NMC cannot fairly run a case on the specific incidents in the charges whilst simultaneously inviting the panel to consider a broader, untested picture of pervasive racism drawn from other alleged slurs. He submitted that the NMC does not seek findings on these alleged slurs, and the makers of said statements are not called, and in any case, the accounts in those statements are vague and incapable of being properly tested. He submitted that admitting this hearsay application would be unfair in principle.

Mr Nwokedi submitted that the live witnesses attending this hearing will provide sufficient information on the background and context.

Mr Nwokedi submitted that this is a classic situation where hearsay may operate as a "*cumulative character assassination*".

Mr Nwokedi submitted where reliability is weak and prejudice is high; the proper course of action is to refuse the admission of evidence. He submitted that the panel can fairly determine this case without this hearsay evidence.

With regards to Witness 6's witness statement and exhibit, Mr Nwokedi submitted that whilst her non-attendance is understandable, it does not automatically render her statement admissible or determinative. He submitted that her evidence does not provide concrete first-hand examples with regards to the allegations that have been put forward by the NMC, there are no concrete first-hand examples of racist conduct, or discriminatory language. Mr Nwokedi submitted that the panel has available to it a number of live witnesses who can give direct evidence about the matters actually alleged.

In answering the panel's question, Ms Whawell explained to the panel what steps have been taken to secure the attendance of the witnesses referred to in this application.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor also referred the panel to *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), and *Mansaray v NMC [2023]* EWHC 730 (Admin) which outline principles for the panel to consider when determining whether it is fair to admit hearsay evidence.

The panel gave this application serious consideration. The panel considered this application in two parts.

The panel first considered the application regarding Witness 6's witness statement and the exhibit. It determined that Witness 6's evidence is relevant to the charges as it gives context about what your behaviour was at certain points surrounding the allegations. The panel also determined that this evidence is not sole or decisive as it speaks about the general background and there is other material from live witnesses to support what is being outlined in this statement. The panel determined that the allegations to which this evidence relates to are the less serious ones in this case and that it is clearly not possible for Witness 6's to attend. The panel further noted that you challenged the contents of this statement and that there is suggestion that it is not truthful. The panel determined that on balance, it was fair and relevant to allow this hearsay into evidence but it would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

With regards to the other hearsay evidence, the panel determined that this evidence was not sole and decisive. It noted that there was a significant challenge from you with regards to this evidence and the exhibits. The panel also noted that it would be unable to question the witnesses in order to try and understand the context and the relevance of their evidence. The panel was of the view that it would be unfair to allow this evidence in without you having the opportunity to challenge it.

In these circumstances, the panel came to the view that it would be unfair to accept into evidence the interview notes and various exhibits, specifically HR7, HR8, HR9, HR12, HR13, HR14 and HR15, relating to local interviews with seven former colleagues who were not appearing to give evidence at this hearing. The panel requested that the NMC redact the witness and exhibit bundles accordingly.

Background

The charges arose whilst you were employed by [PRIVATE] as a Deputy Manager of [PRIVATE] (the Home). You commenced your employment at the Home in 2016 and held the Deputy Manager role from 1 May 2019 to 5 January 2023.

The Home is a care home with 103 beds and provides nursing and residential care for residents of varying ages, with and without dementia. The Home employed staff from different ethnicities.

The crux of these concerns is in relation to your behaviour towards colleagues and subordinates (Charges 1-3). Charge 4 concerns your alleged failure regarding a safeguarding issue that was reported to you.

You were suspended on 21 November 2022, pending an internal investigation, however, on 5 January 2023 you resigned from your role. As such, [PRIVATE] concluded that, as a result of your resignation, its investigation was unable to continue. You were referred to the NMC following this.

Direction for disclosure

Following the disclosure matters raised on day one of the hearing, the panel requested an update on the outstanding disclosure of the safeguarding policy at the Home.

Ms Whawell confirmed that there was no update and that the NMC were still awaiting a response.

The panel directed the NMC to obtain this document by Monday, 9 February 2026.

Application to adjourn

At the conclusion of the NMC case, Mr Nwokedi made an application to adjourn for the weekend, till Monday, 9 February 2026, for your evidence. He submitted that your evidence would take longer than half-a-day and that it would be unfair to keep you under affirmation over the weekend.

Ms Whawell objected to this application. She submitted that no unfairness would be caused to you by proceeding today and that there is limited time left in the hearing and that completing the facts stage in time is important to all parties to the hearing.

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

The panel determined to adjourn until Monday morning. It determined that this was a proportionate stance because it was awaiting disclosure of the safeguarding policy, following its direction. Furthermore, the panel was of the view that being under affirmation over the weekend risked unfairness to you, particularly noting that you might need to speak to and instruct Mr Nwokedi if the safeguarding policy was disclosed.

Decision and reasons on facts

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

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

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

- Witness 2: Unit Manager on the Memory Lane Unit at the Home, at the time of the allegations.
- Colleague I: Head of Activities at the Home, at the time of the allegations.
- Witness 4: Carer at the Home, at the time of the allegations.
- Colleague H: Care Assistant at the Home, at the time of the allegations.
- Witness 1: Regional Support Manager at [PRIVATE], at the time of the allegations.

The panel also heard evidence from you under affirmation.

Further direction regarding disclosure

At the conclusion of your case, on day six of the hearing, and before the legal advice, Ms Whawell enquired with the panel whether the NMC should continue to make enquiries

about the safeguarding policy or whether the panel would be releasing it from this direction.

Mr Nwokedi made no observations regarding this.

The panel decided to release the NMC from its earlier direction.

Whilst the panel is under a duty to make enquires and it would have been assisted by the safeguarding policy, in the interests of all parties, it was fair to proceed without it. It noted that it had the evidence of Witness 1, who addressed the safeguarding policy issue and it would not be proportionate to halt the proceedings.

During the course of its deliberations, the [PRIVATE] Safeguarding Adults Policy, which had previously been requested by the panel, was obtained by the NMC. The parties agreed that the policy should be made available to the panel together with short written submissions from each of them. The panel received and had careful regard to the policy and the written submissions.

Ms Whawell submitted that the policy was issued on 12 May 2022 and was therefore in place at the time of the incident in Charge 4.

Ms Whawell submitted that the policy confirms that safeguarding adults includes "*protecting their [adult's] rights to live in safety, free from abuse and neglect*" and "*people and organisations working together to prevent risk of abuse or neglect and to stop them from happening*" (page 4).

Ms Whawell submitted that abuse in its various forms is outlined in the policy, including sexual abuse (page 6). Although there was no real dispute between the parties that the incident amounted to a safeguarding concern, she submitted that the section confirms that sexual abuse includes inappropriate looking or touching and/or sexual acts to which the adult has not consented. She submitted that this accurately reflected the situation of a resident without capacity exposing her breasts to another resident.

Under the heading “Responding to allegations of abuse” (page 9), paragraph 1 states:

> “*If a member of staff has suspicion or evidence of abuse it is a requirement that they pass their concerns to the General Manager or to the senior person on duty immediately. If the person to whom it is reported does not take immediate action, the member of staff must contact the Regional Director or Managing/Divisional Director or any member of the support services*.”

Ms Whawell submitted that the evidence before the panel was that the General Manager was not present at the Home and that you were informed, although you say you were off duty.

Ms Whawell further referred to paragraph 3 of the same section, which states:

> *“The person to whom the abuse has been reported has a duty to follow this policy and that of the local authority Safeguarding or Adult Support and Protection team. This means they must report all allegations of abuse or potential abuse to their local team and record this on the Barchester clinical governance system.”*

Ms Whawell submitted that the abuse was reported to you and that, whether or not you were off duty, it was your responsibility under the policy, as the most senior person to whom the incident was reported, to report the matter to the local safeguarding team and record it on the Barchester clinical governance system. She submitted that the policy supported Witness 1’s evidence that, in the circumstances of this case, you were responsible for reporting the safeguarding incident.

Mr Nwokedi referred the panel to page 9 of the policy under the heading “Responding to allegations of abuse”, which states:

> *“If a member of staff has suspicion or evidence of abuse it is a requirement that they pass their concerns to the General Manager or to the senior person on duty immediately. If the person to whom it is reported does not take immediate action,*

the member of staff must contact the Regional Director or Managing/Divisional Director or any member of the support services."

Mr Nwokedi submitted that your case has always been, and continues to be, that you were not on duty at the time of the incident. He submitted that responsibility would have been with the General Manager, Colleague F, who had started working in that role at that time. He submitted that you maintain that you would not have been on shift the next day and that another member of management would have received the paperwork.

Mr Nwokedi also referred to a paragraph towards the bottom of page 9 of the policy which states:

"All allegations of abuse will be reported immediately to the local authority Safeguarding/Adult Support and Protection team and to the relevant regulatory body."

Mr Nwokedi submitted that, as management may not be present at weekends or in the evenings, it would be the expectation of the most senior nurse on shift to make the referral.

Mr Nwokedi further referred to Section C (page 12), which contains a supplementary flow chart. The first box in Appendix 1 states:

"Witnessed abuse/allegation/suspicion of abuse - Immediate referral to appropriate safeguarding authority and record on Barchester clinical governance system. Advice will determine next step. If police intend to undertake inquiry no internal investigation will commence until instructed. Maintain the person's safety and confidentiality, preserve integrity of forensic evidence."

Mr Nwokedi submitted that this highlights the need for an immediate referral to be made by those present and that, in this case, that would have been the nurse on duty, Colleague K.

Mr Nwokedi submitted that you maintain that you did not fail to report a safeguarding incident in a timely manner.

The panel made the following findings in relation to the charges:

Panel decision and reasons on facts

The panel considered the witness and documentary evidence provided by both the NMC and you. Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor who referred to relevant case law including the following: *Byrne v GMC [2021]* EWHC 2237 (Admin); *Hindle v NMC [2025]* EWHC 373 (Admin); *Lambert-Simpson v HCPC [2023]* EWHC 481 (Admin); *H v Isle of Wight Council [2001]* 2 WLUK 691; and *Majrowski v Guy's and St Thomas' NHS Trust [2006]* UKHL 34. The panel also had careful regard to the NMC's guidance documents called Evidence (DMA-6), Particular features of misconduct charging (PRE-2e) and Misconduct (FTP-2a).

At the outset of its deliberations and being fully aware that the burden of proof in this case remains on the NMC throughout, the panel was of the view that it would be helpful at the beginning of its findings to consider the possibility of witness collusion. It was mindful of Mr Nwokedi's submission that there was "*at least some collusion, some conversations between the nurses"*.

The panel noted that there was evidence of active and ongoing discussions about the events that led to the charges in this case between some of the witnesses. Witness 2, for example, who was the Unit Manager at the time, would have heard information from the nursing staff, carers and other colleagues about you. She, however, had a balanced view, she explained to the panel that she had initially got on well with you, said that you were a good and caring nurse before becoming a deputy manager. Colleague I also stated that she had a good working relationship with you prior to Colleague F joining.

Other witnesses in this case also gave fair and balanced views about you. The panel determined that there was a sense of balance in the evidence that witnesses gave, the accounts were different, in that they related to their own personal experiences rather than being an amalgamation of the experiences of others and hearsay. Some focused more on experience of racism from you and others on your bullying. The panel also determined that the accounts witnesses gave were very individual and had there been any collusion, those accounts would have been much more similar. The panel noted that when challenged during the hearing, witnesses gave clarity and remained consistent in their accounts. The panel was satisfied that there was no ulterior motive other than genuine concerns about staff and residents.

Taking all of the above into account, the panel did not accept that there has been any collusion between witnesses.

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

Charge 1a

> "That you, a registered nurse, between May 2019 and January 2023, whilst employed as a deputy manager of a care home, demonstrated inappropriate and/or abusive behaviour toward colleagues in that you:
>
> a) Referred to colleagues as "baboons" in reference to their ethnicity."

This charge is found proved.

In reaching this decision, the panel took into account Colleague I's and your evidence.

Colleague I was clear in her written evidence that when on the minibus, going to or from Morrisons, you made a statement referring to colleagues as "*baboons*":

'The Home employed staff from all ethnicities and at the time, there was quite a lot of dark skinned staff. In the minibus, Ms Haigh-Walsworth would refer to these staff members as "baboons".'

Colleague I, in her oral evidence stated that you made the comment "*not just in the mini-bus, also in [your] office".* She told the panel that she was shocked and challenged you, saying "*you cannot say that"*, Colleague I stated that you said "*I can, they are"*.

When considering the oral evidence of Colleague I, the panel determined that she was a convincing and credible witness, who came with very strong principles about resident care, linked to what she was saying and this underpinned and gave context to the authenticity of her evidence. The panel was of the view that Colleague I was very clear about what had happened, and that she gave a cogent account. In her re-examination, she confirmed that she thought that "*baboons*" referred to black carers, because the majority of the carers at the time were of black ethnicity and that you used to refer to them as being "*lazy*" in the same conversation. Colleague I thought that this was a very unusual phrase, which she had not heard before in a racial context, and hence she "*remembered the phrase baboons specifically"*.

In your written evidence, in response to this allegation, you explained:

'We did not have a conversation about ethnicities of staff, and I would not randomly discuss that or use those words.'

In your oral evidence, you denied this allegation.

Against this background, the panel considered it was likely that you did make the comment. The panel was of the view that Colleague I was a credible witness who had a detailed and specific recollection of the events and your comments.

The panel preferred the evidence of Colleague I and therefore found it more likely than not that you referred to colleagues as "*baboons*" in reference to their ethnicity.

The panel next considered the stem of Charge 1 and was in no doubt that these comments demonstrated inappropriate and abusive behaviour towards colleagues. It determined that it was dehumanising and offensive to use an animal term to refer to human beings.

The panel therefore found this charge proved on the balance of probabilities.

Charge 1b

> "That you, a registered nurse, between May 2019 and January 2023, whilst employed as a deputy manager of a care home, demonstrated inappropriate and/or abusive behaviour toward colleagues in that you:
>
> b) Commented that colleagues with Filipino heritage should not be in the industry, or words to that effect."

This charge is found proved.

In reaching this decision, the panel took into account Colleague I's and your evidence.

Colleague I stated the below in her written evidence:

> *'Additionally when [Colleague S] was the Home's manager, the Home employed a lot of carers with Filipino heritage. Ms Haigh-Walsworth would say because of their ethnicity they should not be in the industry. For context, I know that [Colleague S] had property in the UK and that she would rent them out to staff members from the Home. I believe once they had secured a job at the Home,*

[Colleague S] would supply accommodation and would receive an incentive from them.'

'I believe Ms Haigh-Walsworth would make this comment because of this arrangement. I said to Ms Haigh-Walsworth when she would make these comments that she cannot make those comments because it was rude. Ms Haigh-Walsworth would respond with "well it's true".'

In her oral evidence, Colleague I explained that she was "*shocked that someone would come out with that"*. She also explained that other times you would use this phrase around the office and that this was "*just the way [you] spoke"* and that you were "*not hiding anything"*.

You denied this allegation in your oral evidence.

As per the Charge 1a, the panel preferred the evidence of Colleague I. The panel was of the view that Colleague I was a credible witness who had a detailed and specific recollection of the events and your comments.

The panel preferred the evidence of Colleague I and therefore found it more likely than not that you commented that colleagues with Filipino heritage should not be in the industry, or words to that effect.

The panel next considered the stem of Charge 1 and was in no doubt that these comments demonstrated inappropriate and abusive behaviour towards colleagues. It was racist in that it was a slur and criticism of a group of people of a certain ethnicity and inherently inappropriate and abusive towards that cohort of people.

The panel therefore found this charge proved on the balance of probabilities.

Charge 1c

> "That you, a registered nurse, between May 2019 and January 2023, whilst employed as a deputy manager of a care home, demonstrated inappropriate and/or abusive behaviour toward colleagues in that you:
>
> c) Said to Colleague H: *"You are in the UK, do you know you are in the UK…in this country we speak English?"* or words to that effect."

This charge is found proved.

In reaching this decision, the panel took into account Colleague H's and your evidence.

Colleague H, in her written evidence, stated that:

> *'It was very difficult for me report anything to Miss Haigh-Walsworth because she speaks very quickly and when I asked her to repeat what she said (as I did not understand her), Miss Haigh-Walsworth used to say: "I don't have time to repeat", "You are in UK, do you know that you are in UK? "England, this is England, and in this country, we speak English". This happened on 29 July 2021.'*
>
> *'This made me want to die. I left the room and I cried like a baby, as I felt so stupid. This caused me a lot of stress, as I need to work, and needed to report myself (in my role as Care Assistant) to Miss Haigh-Walsworth as Deputy Manager. It was a painful experience and I started to go to the psychologist as I was angry and always cried when I used think about the incident.'*

In her oral evidence, Colleague H explained that she avoided speaking to you in person and to avoid any tension, she stated:

> "*You are on top of me and you need to respect me and to speak to me properly. If you are not polite, I prefer to be far away from that person"*

Colleague H also said, for the same reason, that she chose to correspond with you over emails and text messages. She explained that only recently has she been able to talk about this incident without crying.

The panel found that Colleague H was very open and clear in her evidence, the emotion was visible and the impact of this comment on her was significant. She gave a vivid account of the context in which the incident arose and stated that she wished that she could have stopped you to put you in your place but that she did not have the vocabulary to do this. The panel determined that her oral evidence supported what she had written in her statement and found her to be fair, clear and honest.

The panel further noted, while you stated that you did not say this comment as alleged, or remember the interaction with Colleague H, you spoke about your frustrations towards colleagues, including Colleague H, putting stickers on other peoples' forms, or not coming in for swabbing. You stated, "*if there was any interaction, it would have been around that, not the English language"*. You stated that you were under a lot of work pressure at the time, particularly given the Covid-19 pandemic context and the need to completed these tests correctly.

The panel preferred the clear evidence of Colleague H and found that it is more likely than not that you said these words as per the charge.

The panel next considered the stem of Charge 1 and was in no doubt that this comment demonstrated inappropriate and abusive behaviour towards Colleague H. It was racist in nature as it served to demean someone whose first language was not English.

The panel therefore found this charge proved on the balance of probabilities.

Charge 1d

> "That you, a registered nurse, between May 2019 and January 2023, whilst employed as a deputy manager of a care home, demonstrated inappropriate and/or abusive behaviour toward colleagues in that you:
>
> d) Shouted at Colleague D in the presence of others."

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's and your evidence.

In her written evidence, Witness 2 stated:

> '*Here, I went into work on my day off (on a date which I cannot recall), and Miss Haigh-Walsworth took me from the room which I was in, and brought me into the office at the Home. I do not know why Miss Haigh-Walsworth did this.*
>
> *Colleague K, Miss Haigh-Walworth [sic], [Colleague L] and [Colleague D] were in the office. There was absolutely no reason for [Colleague K], [Colleague L] and I to be present during this discussion, which was purely to humiliate and intimidate [Colleague D].*
>
> *…*
>
> *[Colleague D] had not written many care plans. Miss Haigh-Walsworth shouted in front of all those in the office, which there was no need for, questioning why*

[Colleague D] had not managed to complete the care plans, and that the care plans needed to be completed within seven days of admission…'

'[Colleague D] and I spoke about the incident afterwards, and I reassured them. [Colleague D] cried after the incident, which was awful.'

Witness 2's oral evidence was consistent with this. She explained that she felt embarrassed for Colleague D and she wished she could have done more to help her. She confirmed that Colleague D cried after this incident.

In your written evidence you stated:

'I deny Charge 1 c) as alleged in the witness statement of [Witness 2] paragraph 79. It was part of my role and responsibility to address when care plans had not been completed but this would always have been done in a constructive manner. Colleague D is [Colleague D] but no comments were obtained from [Colleague D].'

In your oral evidence you explained that you did not shout and that this was a meeting and that is why it was not just Colleague D, but others present as well.

The panel accepted the evidence of Witness 2. It determined that Witness 2 was very clear in her evidence, had a good and consistent recollection of the events, which included the emotional reaction of Colleague D after the event. The panel was mindful of your evidence in which you described yourself on a number of occasions as being "*direct*". On the balance of probabilities, the panel found that you did shout at Colleague D in the presence of others.

The panel next considered the stem of Charge 1 and was in no doubt that this comment demonstrated inappropriate and abusive behaviour towards Colleague D. The panel was of the view that as a deputy manager, you had a right and duty to question Colleague D

about the care plans but shouting at a junior colleague was wholly inappropriate and abusive.

The panel therefore found this charge proved on the balance of probabilities.

Charge 1e

> "That you, a registered nurse, between May 2019 and January 2023, whilst employed as a deputy manager of a care home, demonstrated inappropriate and/or abusive behaviour toward colleagues in that you:
>
> e) On or around 12 October 2022, shouted at Colleague I in the presence of others."

This charge is found proved.

In reaching this decision, the panel took into account Colleague I's and your evidence.

In her written statement, Colleague I explained:

> *'Ms Haigh-Walsworth spoke to me in a horrible, condescending manner. Ms Haigh-Walsworth shouted at me with a nasty attitude in front of other staff. The door was open and residents were sitting in the foyer at the Home, and I am sure that residents could hear. I told Miss Haigh-Walsworth to not talk to me in this manner. Miss Haigh-Walsworth continued to do so, and she wound me up. [Colleague F] was not in the Home at the time because he was away on holiday. This was around 12:30pm and I cannot recall the exact date of this incident but I believe this occurred on 12 October 2022.'*

In her oral evidence, Colleague I accepted that this was a heated conversation, she accepted that her behaviour was inappropriate because she was upset for the residents. Colleague I also said that "*it started off in a tone, then got progressively louder, then became like a screaming match I suppose"*. Colleague I stated that the door to the office was open; the clinical nurse was there; and residents and their families were outside the door. Colleague I stated that "*everyone could hear this*" and that you "*wanted to be heard"*. Colleague I also stated that you wanted to tell her off in front of people.

You denied this charge in your written evidence. You explained:

> *'[Colleague I] was the head of activities and would arrange excursions for residents. On 12 October 2022 I had raised with [Colleague I] an issue about the activities, that some residents were being taken out more than others and it wasn't fair that the same residents would be taken out every time when it was important that all residents get an opportunity to go out into the community. We had noticed the regular residents who went out were those who walked and were easier to take out. I had a chat with [Colleague I] about this, and she later came back into office angry and shouting.*
>
> *She was shouting and swearing and said she was sick of being picked on and that she had got permission from [Colleague F]. I remember that this was odd because he had been on holiday at the time. We told her she didn't need to be rude and swear and to stop shouting.'*

You maintained your denial in your oral evidence. You accepted that it was "*a direct conversation, a frank, open conversation".* You maintained that it was a normal conversation until Colleague I said that Colleague F was of the view that the same people could go. You said that that was when Colleague I started "*screaming, shouting, leaning over the desk"*. You said that you were not shouting but described yourself as "*loud and direct"*.

The panel found Colleague I to be open, consistent and credible.

The panel considered the context and background of this event. It accepted that the exchange was heated and that, as Colleague I stated, she had been "*wound up*" by you, and it is more likely than not that both of you were shouting. Colleague I also stated that she felt like you talked to her like a child, she felt intimidated, embarrassed and demoralised.

The panel next considered the stem of Charge 1 and was in no doubt that shouting at Colleague I in the presence of others demonstrated inappropriate and abusive behaviour. The panel concluded that you were a senior nurse in a management role and therefore this was inappropriate and abusive in that you should not have shouted in a professional meeting even if the other party was doing so.

The panel therefore found this charge proved on the balance of probabilities.

Charge 2

> "Demonstrated conduct at charge 1(a) and/or 1(b) and/or 1(c) motivated by your hostility or discriminatory attitude towards people of a different race including colour, nationality, ethnic or national origin."

This charge is found proved.

In reaching this decision, the panel considered the language used by you, as found proved, the context of the situation and your personal motivation in coming to the decision as to whether or not racial motivation was established.

With regards to Charge 1a, the panel determined that this comment related to race. It determined that your use of term "*baboon*" was motivated by your hostility and discriminatory attitude towards people of black ethnicity.

With regards to Charge 1b, the panel determined that the words used demonstrated your negative, hostile and discriminatory view towards a racial group, specifically colleagues of Filipino heritage.

Finally, with regards to Charge 1c, the panel determined that your comment was motivated by your hostility and discriminatory attitude towards colleagues whose first language is not English. The panel concluded that you displayed hostile and discriminatory view towards colleagues of different nationality.

In your oral evidence, you stated that *"I am not racist either at work or in my personal life."* However the panel found that this is not demonstrated in the facts found proved in Charges 1a, 1b and 1c. The panel also found the evidence of Colleague H and Colleague I consistently supported this conclusion.

The panel therefore found this charge proved in its entirety.

Charge 3

> "Demonstrated conduct at charge 1(d) and/or 1(e) which amounted to bullying in that it was unwanted behaviour that was offensive, intimidating, malicious or insulting."

This charge is found proved.

In reaching this decision, the panel considered your behaviour, as found proved, and the context of the situation.

The panel determined that as a deputy manager, you were in a position of authority and power. It also determined that shouting at your staff and reducing them to tears amounted to bullying and that such behaviour was unwanted, offensive, intimidating and insulting.

With regards to malicious behaviour, the panel determined that shouting at Colleague D in front of the residents and other colleagues was malicious as a Senior manager, you could and should have spoken to her at a different time and in a different environment that would have not caused as much distress to Colleague D. The panel also determined that shouting at Colleague D in front of other colleagues, one being more junior, and inviting them to attend a meeting of a disciplinary nature just for them to observe was in the panel's view, malicious behaviour.

The panel therefore found this charge proved in its entirety.

Charge 4

> "In or around July 2022, failed to report a safeguarding incident involving two residents in a timely manner or at all."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's, Witness 1's, Witness 2's and your evidence.

In her written evidence, when describing a safeguarding incident, Witness 4 explained:

> '*I reported the above to [Colleague L] immediately. [Colleague L] stated that I did not have to report this incident to Miss Haigh-Walsworth, which I found strange. [Colleague L] had stated that the incident did not need to be reported, but the residents needed to instead be observed as the incident had not occurred before and the incident could have been Resident A's mistake. A few minutes later,*

[Colleague L] then stated that I needed to report the safeguarding incident. I am unaware of why [Colleague L] changed her position.

[Colleague L] called Miss Haigh-Walsworth on her personal mobile, which was on speaker phone whilst [Colleague K], [Colleague L] and Miss Haigh-Walsworth were present. This could have been around 18:20. I reported everything in front of [Colleague K], [Colleague L] and Miss Haigh-Walsworth. Miss Haigh-Walsworth merely stated that [Colleague K] had to write the incident down in the progress notes within the care plan and inform the familied of Resident A and Resident B. I asked if I should write the incident in Resident A and Resident B's progress notes, to which Miss Haigh-Walsworth informed me that this was not my job. As noted below, safeguarding concerns should be reported immediately after a report is made.'

In her oral and written evidence, together with her local statement, Witness 4 stated that Colleague L called you on her phone and she put it on speaker phone. She described how you were informed of what had happened and what had been done. You told Colleague K to write down the incident in the progress notes and to inform the family. Witness 4 stated that when she was next on duty, she spoke with the General Manager, Colleague F, and asked him what had happened with the first incident. She stated that he did not know about the first incident.

"There was no safeguarding alert completed following this incident, but an incident form was completed.

Witness 4 had repeatedly informed me of the above incident around three or four times, and drafted a statement (requested by Colleague F). You and Colleague L firmly denied that the above safeguarding incident occurred and that no phone call had been received by Witness 4/ Colleague K regarding this matter. Colleague L and you both stated that Witness 4 was a 'fucking liar' and that she needs to 'watch her mouth'."

Witness 2 also stated in her oral evidence that when the second safeguarding incident came to light it became apparent that a previous safeguarding report had not been done.

In his written evidence, Witness 1 stated:

> *'The above incident was escalated to Miss Haigh-Walsworth the same day the incident occurred in July 2022 (the exact date I cannot recall) by [Colleague K] Nurse, [Witness 4] carer and [Colleague L] team leader, in order for them to report the incident to safeguarding. This occurred on loudspeaker and the staff referred to above were privy to the discussion. Miss Haigh-Walsworth was on loudspeaker, whom I believe had advised to keep the residents separate and to monitor.*
>
> *The statement regarding this incident did not clearly identify what occurred next. However, I understand that the matter was handed to the Safeguarding team by [Witness 2] on a date unknown to me and it was found that there was no evidence that the incident was notified to the Safeguarding team or the CQC.'*

He furthermore added:

> *'I consider that the safeguarding matters were likely substantiated and there was no evidence of safeguarding referrals being made. I reviewed our clinical governance as part of the local investigation and ascertained there was no record of a safeguarding incident being raised and uploaded onto our system. It is my expectation that even if an allegation is not substantiated or if the Home is unable to put measures to ensure that vulnerable people are protected, it should be raised to the relevant people in order to illustrate what has been done and it is their decision whether measures are enough. The process of raising a safeguarding to the local safeguarding team did not take place, and inherently, the safeguarding incident repeated itself.'*

In his oral evidence, Witness 1 explained that he considered this incident to be a matter of safeguarding and ultimately, this would have been the responsibility of the general manager to raise, or if the manager is away, it is on the deputy manager to raise. Witness 1 was very clear in relation to the responsibilities in this incident and stated that it would have been you as the deputy general manager or the general manager that would be responsible. He further stated that you, as the most senior nurse that had been told about the incident, would have been responsible for the writing up. He went on to say that when you had returned to duty you should have sent a safeguarding notification and also should have referred the incident to the Care Quality Commission (CQC).

In your written evidence, you denied this charge:

> *'There is no interview with [Colleague K] who was the nurse on shift. I recall a telephone conversation whilst driving home from work. Whilst I cannot remember the full details of the call, for a safeguarding incident I would have advised documentation to be completed as necessary which would have included completing an incident form, SOVA, NOK, and progress notes etc, as required.*
>
> *At [PRIVATE] they still used paper and any nurse on shift could do the incident form and safeguarding. The nurses had a faxable copy of safeguarding paperwork that they could complete if necessary and if they believed there was a safeguarding concern they could complete the form and fax it off. At [PRIVATE] the managers did not do all of the safeguarding.'*

In your oral evidence you explained that when you received the call from Colleague L, the line was "*poor*", this was contradictory to your written evidence which did not mention a poor line. You also said that you could not recall the details of the conversation. You explained that you "*could have followed this up."* You also said that you did not recall this incident being reported. You also stated that this would have been Colleague K's duty to report the safeguarding incident, that he had worked at home many times and that he would know how to do it.

The panel noted that there was no evidence before it to suggest that you had asked Colleague K to report the safeguarding incident.

The panel also noted that there is no evidence that the safeguarding report was done.

The panel had regard to the safeguarding policy. The panel was satisfied that the policy makes it clear that it is the manager, the deputy manager or the most senior person notified who is responsible where a member of staff has a suspicion or evidence of abuse, and that allegations must be reported immediately.

The panel was satisfied that you were notified. The panel determined that you had responsibility. The panel found that you maintained that responsibility and did not discharge it or properly pass it on.

The panel found that even if you considered that another nurse was the senior person on duty, you did not actually tell him what to do in relation to a safeguarding referral. Instead, you directed that the matter be recorded in the progress notes and that the families be informed.

The panel found your evidence on this issue to be inconsistent and contradictory. It noted that at different stages you suggested that the telephone call did not occur as described, that there was no mention of safeguarding concerns, that responsibility lay with another member of staff, and that the line was poor and you could not hear clearly.

In contrast, the panel found that the NMC witnesses were consistent in their written and oral evidence. The panel also had regard to the documentary evidence. The panel therefore preferred the written and oral evidence of the witnesses together with the documentary material.

The panel determined that managers retain overall responsibility and that, having been notified of the safeguarding concern, you should have ensured that a safeguarding referral was made and followed up.

Accordingly, the panel found that it is more likely than not that you failed to report the safeguarding incident in a timely manner or at all.

Interim order

As the hearing has concluded at the facts stage and all charges have been found proved, the panel considered whether it should proceed to consider an interim order pending the next stages of the fitness to practise process.

The panel determined that it was appropriate to consider whether an interim order is required in the specific circumstances of this case, pending the determination of misconduct, impairment and, if necessary, sanction.

The panel may only make an interim order if it is satisfied that it is necessary for the protection of members of the public, is otherwise in the public interest, or is in your own interests.

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

Representations on interim order

Ms Whawell, on behalf of the NMC, made an application for an interim order pursuant to Article 31 of the Nursing and Midwifery Order 2001.

Ms Whawell reminded the panel that the power to impose an interim order arises where a case is part heard following findings of fact. She referred the panel to the NMC guidance on interim orders and submitted that the test is whether an order is necessary for:

- the protection of members of the public;
- otherwise in the public interest; or
- in your own interest.

Ms Whawell submitted that only one ground needs to be satisfied.

Ms Whawell submitted that there is a direct link between the concerns found proved and your practice, as the matters arose in your role as Deputy Manager of the care home.

In relation to risk of harm, Ms Whawell submitted that emotional harm had been caused to colleagues and that there was potential harm arising from safeguarding failures.

In relation to risk of repetition, Ms Whawell submitted that there is currently a lack of insight, as reflected in the panel's findings, and that there is therefore a high risk of repetition.

Ms Whawell acknowledged that you have no previous fitness to practise history and that you have practised without restriction. However, she submitted that public confidence would be seriously damaged if you were permitted to practise unrestricted whilst the case remains part heard.

Ms Whawell submitted that no workable conditions could be formulated and invited the panel to impose an interim suspension order for 18 months, having regard to current listing timescales.

Mr Nwokedi opposed the application. He submitted that the panel must ask itself whether it is necessary to restrict your practice today. Mr Nwokedi emphasised that there has been no finding of current impairment and that the panel has not yet dealt with misconduct or impairment.

Mr Nwokedi submitted that there is no present immediate risk and no material suggesting immediate danger to the public. He highlighted that there has been no patient harm and no findings of dishonesty.

Mr Nwokedi submitted that the incidents occurred between 2019 and 2022 and that you have continued to practise without restriction since that time. He submitted that there has been no repetition, no new complaints and no escalation. Mr Nwokedi stated that the absence of repetition is powerful evidence against the necessity of an interim order.

In the alternative, Mr Nwokedi submitted that if the panel was minded to impose an interim order, conditions could be formulated, including restrictions on managerial or supervisory roles, supervision in the workplace and safeguarding training.

Decision and reasons on interim order

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

The panel was mindful of its findings of fact. In particular, it had found proved that:

- you used racially discriminatory language;
- your conduct was motivated by hostility and discriminatory attitudes towards colleagues of particular ethnic backgrounds;
- you displayed bullying and intimidating behaviour towards colleagues;
- you failed to appropriately address a serious safeguarding concern.

The panel considered that these findings provide sufficient evidence of serious concern in relation to your professional conduct.

The panel next considered whether an interim order is necessary for the protection of members of the public.

The panel confirmed that patients, visitors and colleagues are all members of the public.

The panel noted that there is a risk of harm to patients because of the safeguarding issues. It further considered that there was also a risk to colleagues and potentially patients because of your bullying and discriminatory behaviour.

The panel expressed concern that the racially motivated behaviour was extremely concerning. It considered that the concerns around racism and bullying were demonstrative deep seated attitudes, and therefore, very difficult to remediate.

The panel also considered the safeguarding concerns and noted your continued denial.

The panel acknowledged that you have worked without restriction since 2022 and that there has been no reported repetition. It also acknowledged that there had been no interim order previously imposed. However, the panel considered that just because there had not been any report of repetition does not mean there will not be repetition. It considered that the findings indicate deep seated attitudinal issues which remain very present.

The panel determined that if there were repetition there would be a high risk of serious harm to colleagues and patients.

The panel therefore determined that the ground of protection of members of the public is met.

The panel then considered whether an interim order is necessary otherwise in the public interest.

The panel considered its findings, including that you used the term "*baboon*" motivated by hostility and discriminatory attitudes towards people of Black ethnicity, that you displayed negative and hostile discriminatory views towards colleagues of Filipino heritage, and that you displayed hostile and discriminatory views towards colleagues of different nationality.

The panel determined that due to the nature of the case and the seriousness of the matters found proved, public confidence in the profession and the NMC as a regulatory would be seriously damaged if no interim order were imposed at this time.

The panel therefore determined that the public interest ground is also met.

The panel considered whether conditions of practice would be sufficient.

The panel acknowledged that safeguarding issues might be addressed through training or supervision. However, it considered that the discriminatory and bullying behaviour reflects deep seated attitudinal issues and that interim conditions of practice would not be sufficient to protect the public.

The panel did consider whether supervision would sufficiently address the risks in this case, particularly in circumstances where you had already shown hostility towards colleagues of different ethnic backgrounds. The panel concluded that it would not.

The panel was unable to formulate workable conditions that would adequately address the risk arising from the attitudinal concerns.

The panel was therefore driven to the conclusion that an interim suspension order is necessary.

The panel considered proportionality and determined that the risk to members of the public outweighs your interest in practising unrestricted at this stage.

The panel considered the appropriate duration of the interim order. It noted that there are delays in listing substantive hearings and that the matter may not be concluded until the end of the year or later.

The panel determined that an interim suspension order for a period of 18 months is appropriate in light of current timescales.